Medicare B CONNECTION
medicare.fcso.com
FIRST COAST SERVICE OPTIONS, INC.
A Newsletter for MAC Jurisdiction N Providers
September 2015

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# Influenza vaccine payment allowances update for 2015-2016 season

### Provider types affected

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

### Provider action needed

Change request (CR) 9299 informs MACs about the payment allowances for seasonal influenza virus vaccines. These payment allowances are updated on an annual basis effective August 1st of each year. Make sure that your billing staffs are aware that the payment allowances are being updated.

The pending payment allowances will be updated in the influenza vaccine pricing Web page. Providers may visit the webpage at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html* for the updated prices.

### Background

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

The Medicare Part B payment allowances for the following *Current Procedural Terminology* (*CPT*®) or Healthcare Common Procedure Coding System (HCPCS) codes below apply for the effective dates of August 1, 2015-July 31, 2016:

- *90655* Payment allowance is pending
- *90656* Payment allowance is pending
- *90657* Payment allowance is pending
- *90661* Payment allowance is pending
- *90685* Payment allowance is pending
- *90686* Payment allowance is pending

See **INFLUENZA**, Page 11

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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.

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

# About the 'Medicare B Connection'

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

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

## Who receives the *Connection*

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

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

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

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

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

## Publication format

The *Connection* is arranged into distinct sections.

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

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

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

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

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

# Medicare Part B advance beneficiary notices

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

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

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

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

## Patient liability notice

The Centers for Medicare & Medicaid Services' (CMS) has developed the Advance Beneficiary Notice of Noncoverage (ABN) (Form CMS-R-131), formerly the "Advance Beneficiary Notice." Section 50 of the *Medicare Claims Processing Manual* provides instructions regarding the notice that these providers issue to beneficiaries in advance of initiating, reducing, or terminating what they believe to be noncovered items or services. The ABN must meet all of the standards found in Chapter 30. Beginning March 1, 2009, the ABN-G and ABN-L was no longer valid; and notifiers must use the revised Advance Beneficiary Notice of Noncoverage (CMS-R-131). Section 50 of the *Medicare Claims Processing Manual* is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c30.pdf#page=44*.

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

## ABN modifiers

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

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

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

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

# GA modifier and appeals

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

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

Nonassigned claims containing the modifier GA in which the patient has been found liable must have the patient's written consent for an appeal. Refer to the applicable contact section located at the end of this publication for the address in which to send written appeals requests.

Consolidated Billing

# 2016 annual update of HCPCS codes for skilled nursing facility consolidated billing update

## Provider types affected

This *MLN Matters*® article is intended for physicians, other providers, and suppliers submitting claims to Medicare administrative contractors (MACs), including home health & hospice (HH&H) MACs and durable medical equipment (DME) MACs, for services provided to Medicare beneficiaries who are in a Part A covered skilled nursing facility (SNF) stay.

## Provider action needed

### Stop – impact to you

If you provide services to Medicare beneficiaries in a Part A covered SNF stay, information in change request (CR) 9340 could impact your payments.

### Caution – what you need to know

CR 9340 provides the 2016 annual update of Healthcare Common Procedure Coding System (HCPCS) codes for SNF consolidated billing (SNF CB) and explains how the updates affect edits in Medicare claim processing systems. By the first week in December 2015, the new code files for Part B processing, and the new Excel and PDF files for Part A processing will be available at *http://www.cms.gov/SNFConsolidatedBilling*; and become effective on January 1, 2016.

### Go – what you need to do

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

## Background

The common working file (CWF) currently has edits in place for claims received for beneficiaries in a Part A covered SNF stay as well as for beneficiaries in a non-covered stay. These edits allow only those services that are excluded from consolidated billing to be separately paid.

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

## Additional information

The official instruction, CR 9340, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3349CP.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: January 4, 2016

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# Skilled nursing facility consolidated billing and erythropoietin (EPO, Epoetin Alfa)

***Note**: This article was revised September 11, 2015, to reflect the updated regulation reference in the first paragraph of the "Background" section of the article and to update several Web addresses. All other information remains the same. This information was previously published in the 3rd Quarter 2005 Medicare B Update! Pages 41-42.*

## Provider types affected

Skilled nursing facilities (SNF), physicians, suppliers, and providers.

## Provider action needed

This special edition article describes SNF consolidated billing (CB) as it applies to erythropoietin (EPO, epoetin alfa) and related services.

## Background

The original Balanced Budget Act of 1997 list of exclusions from the PPS and consolidated billing for SNF Part A residents specified the services described in Section 1861(s)(2)(O) of the Social Security Act — the Part B erythropoietin (EPO) benefit. This benefit covers EPO and items related to its administration for those dialysis patients who can self-administer the drug, subject to methods and standards established by the Secretary for its safe and effective use (see 42 CFR 494.80(a)(2) and (a)(4), 494.90(a)(4), and 494.100). (See *MLN Matters*® article *SE0431* for an overview of SNF CB and a list of "excluded services.")

Regulations at 42 CFR 414.335 describe payment for EPO and require that EPO be furnished by either a Medicare approved end-stage renal disease (ESRD) facility or a supplier of home dialysis equipment and supplies. The amount that Medicare pays is established by law. Thus, the law and implementing regulations permit a SNF to unbundle the cost of the Epogen® drug when it is furnished by an ESRD facility or an outside supplier, which can then bill for it under Part B.

An SNF that elects to furnish EPO to its Part A resident itself cannot be separately reimbursed over and above the Part A SNF PPS per diem payment amount for the Epogen® drug. As explained above, the exclusion of EPO from CB and the SNF PPS applies only to those services that meet the requirements for coverage under the separate Part B EPO benefit, i.e., those services that are furnished and billed by an approved ESRD facility or an outside dialysis supplier.

By contrast, if the SNF itself elects to furnish EPO services (including furnishing the Epogen® drug) to a resident during a covered Part A stay (either directly with its own resources, or under an "arrangement" with an outside supplier in which the SNF itself does the billing), the services are no longer considered Part B EPO services, but rather, become Part A SNF services. Accordingly, they would no longer qualify for the exclusion of Part B EPO services from CB, and would instead be bundled into the PPS per diem payment that the SNF receives for its Part A services.

**Note**: EPO (Epoetin (Alfa, trade name Epogen®)/ DPA (Darbepoetin Alfa, trade name Aranesp®) are not separately billable when provided as treatment for any other illness or condition. In this case, the SNF is responsible for reimbursing the supplier. The SNF should include the charges on the Part A bill filed for that beneficiary.

## Additional information

*MLN Matters*® SE0431, containing the list of services excluded from SNF CB, can be found at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0431.pdf*.

The *Medicare Renal Dialysis Facility Manual*, Chapter II, Coverage of Services can be found at *http://www.cms.gov/manuals/downloads/pub_29.zip*.

Also, you can find the *Medicare Benefit Policy Manual* Chapter 11 regarding billing and payment details for EPO and DPA at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c11.pdf*.

The CMS consolidated billing can be found at *https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html*.

It includes the following relevant information:

- General SNF consolidated billing information;
- HCPCS codes that can be separately paid by the Medicare carrier (i.e., services not included in consolidated billing);
- Therapy codes that must be consolidated in a non-covered stay; and
- All code lists that are subject to quarterly and annual updates and should be reviewed periodically for the latest revisions.

Lastly, the CMS skilled nursing facility prospective payment system (SNF PPS) can be found at *http://www.cms.gov/SNFPPS/05_ConsolidatedBilling.asp*.

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Implementation Date: N/A

Drugs & Biologicals

# 2016 annual clotting factor furnishing fee update

## Provider types affected

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

## Provider action needed

### Stop – impact to you

The Centers for Medicare & Medicaid Services (CMS) includes the clotting factor furnishing fee in the published national payment limits for clotting factor billing codes. For 2016, the clotting factor furnishing fee is $0.202 per unit.

### Caution – what you need to know

Change request (CR) 9295 announces the update to the clotting factor furnishing fee for 2016. A furnishing fee for items associated with clotting factor is required by Section 1842(o)(5)(C) of the Social Security Act, as added by Section 303(e)(1) of the Medicare Modernization Act.

### Go – what you need to do

Make sure that your billing staffs are aware of this update to the annual clotting factor furnishing fee for 2016.

## Background

CMS includes the clotting factor furnishing fee in the published national payment limits for clotting factor billing codes. When the national payment limit for a clotting factor is not included on the average sales price (ASP) Medicare Part B drug pricing file or the not otherwise classified (NOC) pricing file, the MACs must make payment for the clotting factor as well as make payment for the furnishing fee.

Effective for dates of service from January 1, 2016, through December 31, 2016, the clotting factor furnishing fee of $0.202 per unit is included in the published payment limit for clotting factors and shall be added to the payment for a clotting factor when no payment limit for the clotting factor is published either on the ASP or NOC drug pricing files.

## Additional information

The official instruction, CR 9295, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3340CP.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 #: R3340CP
Implementation Date: January 4, 2016



### Never miss an appeals deadline again

When it comes to submitting a claims appeal request, *timing is everything*. Don't worry – you won't need a desk calendar to count the days to your submission deadline. Try our "time limit" calculators on our Appeals of claim decisions page. Each calculator will *automatically calculate* when you must submit your request based upon the date of either the initial claim determination or the preceding appeal level.

Durable Medical Equipment

# Updated 'NCD Manual' for speech generating device

## Provider types affected

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

## Provider action needed

Change request (CR) 9281 updates the *Medicare National Coverage Determinations Manual* to add a revised scope of benefit national coverage determination (NCD) for speech generating devices (SGDs) covered under the Medicare benefit category for durable medical equipment (DME). Please make sure that your billing staff are aware of these changes.

## Background

Key information in the revised NCD in Chapter 1 of the *NCD Manual* is as follows:

SGDs are considered to fall within the DME benefit category established by Section 1861(n) of the Social Security Act. They are covered for patients who suffer from severe speech impairment and have a medical condition that warrants the use of a device based on the following definitions.

SGDs are defined as DME that provide an individual who has severe speech impairment with the ability to meet his or her functional, speaking needs. SGDs are devices or software that generate speech and are used solely by the individual who has severe speech impairment. The speech is generated using one of the following methods:

- Digitized audible/verbal speech output, using prerecorded messages;
- Synthesized audible/verbal speech output which requires message formulation by spelling and device access by physical contact with the device-direct selection techniques;
- Synthesized audible/verbal speech output which permits multiple methods of message formulation and multiple methods of device access; or
- Software that allows a computer or other electronic device to generate audible/verbal speech.

Other covered features of the device include the capability to generate email, text, or phone messages to allow the patient to "speak" or communicate remotely, as well as the capability to download updates to the covered features of the device from the manufacturer or supplier of the device.

If an SGD is limited to use by a patient with a severe speech impairment and is primarily used for the purpose of generating speech, it is not necessary for the device to be dedicated only to audible/verbal speech output to be considered DME. Computers and tablets are generally not considered DME because they are useful in the absence of an illness or injury.

### Nationally non-covered indications

Internet or phone services or any modification to a patient's home to allow use of the SGD are not covered by Medicare because such services or modifications could be used for non-medical equipment such as standard phones or personal computers. In addition, specific features of an SGD that are not used by the individual who has a severe speech impairment to meet his or her functional speaking needs are not covered. This would include any computing hardware or software not necessary to allow for generation of speech, email, text or phone messages, such as hardware or software used to create documents and spreadsheets or play games or music, and any other function a computer can perform that is not directly related to meeting the functional speaking communication needs of the patient, including video communications or conferencing. These features of a speech generating device do not fall within the scope of Section 1861(n) of the Social Security Act and the cost of these features are the responsibility of the beneficiary. Suppliers of SGDs are encouraged to furnish the beneficiary with a voluntary advance beneficiary notice (ABN) which informs that these features are not covered by Medicare and the beneficiary is liable for the expense of these features.

### Other

MACs acting within their respective jurisdictions have discretion to cover or not cover speech generating devices based on their individual reasonable and necessary determinations.

## Additional information

The official instruction, CR 9281, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R184NCD.pdf*. The revised portion of the *NCD Manual* is part of CR 9281.

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: MM9281
Related Change Request (CR) #: CR 9281
Related CR Release Date: August 21, 2015
Effective Date: July 29, 2015
Related CR Transmittal #: R184NCD
Implementation Date: September 21, 2015

Laboratory/Pathology

# NCD for screening for colorectal cancer using Cologuard™

## Provider types affected

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

## Provider action needed

### Stop – impact to you

This article is based on change request (CR) 9115 which announces effective October 9, 2014, the Centers for Medicare & Medicaid Services (CMS) has determined that the evidence is sufficient to cover Cologuard™ – a multitarget stool DNA test – as a colorectal cancer screening test for asymptomatic, average risk beneficiaries, aged 50 to 85 years.

### Caution – what you need to know

CR 9115 instructs the MACs that effective for claims with dates of service on or after October 9, 2014, Medicare will recognize new Healthcare Common Procedure Coding System (HCPCS) code G0464, (Colorectal cancer screening; stool-based DNA and fecal occult hemoglobin (for example, KRAS, NDRG4 and BMP3)) as a covered service. Only laboratories authorized by the manufacturer to perform the Cologuard™ test may bill for this service.

### Go – what you need to do

Make sure that your billing staff are aware of these changes.

## Background

The Social Security Act (the Act) (Sections 1861(s)(2)(R) and 1861(pp) - see *http://www.ssa.gov/OP_Home/ssact/title18/1861.htm*) and regulations at 42 CFR 410.37 (see *http://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol2/pdf/CFR-2011-title42-vol2-sec410-37.pdf*) authorize coverage for screening colorectal cancer (CRC) tests under Medicare Part B. The statute and regulations authorize the Secretary to add other tests and procedures (and modifications to such tests and procedures for colorectal cancer screening) as the Secretary determines appropriate in consultation with appropriate experts and organizations.

As part of the CMS – Food and Drug Administration (FDA) Parallel Review Pilot Program, CMS finalized a NCD for screening for CRC using Cologuard™ – a multitarget stool DNA test. After considering public comments and consulting with appropriate organizations, effective October 9, 2014, CMS has determined that the evidence is sufficient to cover Cologuard™ – a multitarget stool DNA test – as a colorectal cancer screening test for asymptomatic, average risk beneficiaries, who are ages 50 to 85 years.

Effective for claims with dates of service on or after October 9, 2014, MACs will recognize the new HCPCS code G0464 as a covered service. Be aware that claims for HCPCS code G0464 must also include ICD-9 diagnosis codes V76.41 and V76.51. Once ICD-10 is implemented, the claim must reflect ICD-10 diagnosis codes Z12.12 and Z12.11.

MACs will only pay for HCPCS code G0464 when it is submitted on types of bill (TOB) 13x hospital outpatient departments), 14x (hospital non-patient laboratories), or 85x (critical access hospitals. Payments will be made on TOB 13x and 14x based on the clinical laboratory fee schedule (CLFS). Payment for TOB 85x will be based on reasonable cost.

**Note**: HCPCS code G0464 is in the January 1, 2015 CLFS and integrated outpatient code editor (IOCE) updates with an effective date of October 9, 2014. Therefore, MACs shall apply contractor pricing to claims containing HCPCS G0464 with dates of service October 9, 2014, through December 31, 2014.

You can refer to the revised Pub. 100-03, *Medicare NCD Manual*, Chapter 1, Section 210.3, Colorectal Cancer Screening Tests, for coverage policy. For claim processing instructions, refer to revised Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 18, Section 60, Colorectal Cancer Screening. Both of these revised manuals are included as attachments to CR 9115.

Effective for dates of service on or after October 9, 2014, Medicare Part B will cover the CologuardTM test once every three years for Medicare beneficiaries that meet all of the following criteria:

- Age 50 to 85 years;
- Asymptomatic (no signs or symptoms of colorectal disease including but not limited to lower gastrointestinal pain, blood in stool, positive guaiac fecal occult blood test or fecal immunochemical test); and
- At average risk of developing colorectal cancer (no personal history of adenomatous polyps, colorectal cancer, or inflammatory bowel disease, including Crohn's Disease and ulcerative colitis; no family history of colorectal cancers or adenomatous polyps, familial adenomatous polyposis, or hereditary nonpolyposis colorectal cancer).

There is no coinsurance or deductible for tests paid under the CLFS. Therefore, there is no coinsurance or deductible for HCPCS code G0464.

Medicare will pay for this service for eligible beneficiaries only once every three years. Next eligible dates will be displayed on all common working file (CWF) provider query screens. Subsequent claim lines for HCPCS code G0464 received in the same three-year period will be denied using the following:

- **Claim adjustment reason code (CARC) 119** – "Benefit maximum for this time period has been reached;"
- **Remittance advice remarks code (RARC) N386**

See **CANCER**, next page

# CANCER

From previous page

– "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, if a claim is received with a GZ modifier indicating no signed Advance Beneficiary Notice (ABN) is on file.

To be eligible for this service, beneficiaries must be aged 50-85 or the claim line item will be denied with the following messages:

- **CARC 6** – "The procedure/revenue code is inconsistent with the patient's age. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
- **RARC N129** – "Not eligible due to the patient's age."
- **Group code CO** assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

Failure to include the required ICD-9 or ICD-10 codes on the claim line will result in denial of the claim line with the following messages:

- **CARC 167** – "This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
- **RARC N386** – "This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *www.cms.gov/mcd/search.asp* on the CMS website. If you do not have web access, you may contact the contractor to request a copy of the NCD."
- **Group code CO** assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

Claim line items submitted on TOBs other than 13x, 14x, or 85x will be denied with the following messages:

- **CARC 170** – "Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
- **RARC N95** – "This provider type/provider specialty may not bill this service."
- **Group code CO** assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

All other indications for colorectal cancer screening not otherwise specified in the Act and regulations, or otherwise specified in Section 210.3 of the *NCD Manual*, remain nationally non-covered.

## Additional information

The official instruction, CR 9115, was issued to your MAC regarding this change via two transmittals. The first updates the *Medicare National Coverage Determinations Manual* and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R183NCD.pdf*. The second transmittal updates the *Medicare Claims Processing Manual* and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3319CP.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: MM9115
Related Change Request (CR) #: CR 9115
Related CR Release Date: August 6, 2015
Effective Date: October 9, 2014
Related CR Transmittal #: R183NCD and R3319CP
Implementation Date: September 8, 2015, for non-shared MAC edits; January 4, 2016, for shared systems changes



## Take action to combat the flu

Now is the perfect time for providers to vaccinate Medicare beneficiaries, as it can take two weeks after vaccination to develop antibodies that protect against seasonal influenza. As a health care provider, you play an important role in setting an example by getting yourself vaccinated and recommending and promoting influenza vaccination.

## Preventive Services

# INFLUENZA

From front page

- *90687* Payment allowance is pending
- *90688* Payment allowance is pending
- Q2035 Payment allowance is pending
- Q2036 Payment allowance is pending
- Q2037 Payment allowance is pending
- Q2038 Payment allowance is pending

Payment for the following *CPT*®/HCPCS codes may be made if your MAC determines their use is reasonable and necessary for the beneficiary, for the effective dates of August 1, 2015-July 31, 2016:

- *90630* Payment allowance is pending
- *90654* Payment allowance is pending
- *90662* Payment allowance is pending
- *90672* Payment allowance is pending
- *90673* Payment allowance is pending

Payment allowances will be published in the Centers for Medicare & Medicaid Services (CMS) influenza vaccine pricing Web page at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html*.

**HCPCS Q2039 flu vaccine adult** - not otherwise classified payment allowance is to be determined by your MAC with effective dates of August 1, 2015-July 31, 2016.

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

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

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

Annual Part B deductible and coinsurance amounts do not apply. All physicians, non-physician practitioners, and

suppliers who administer the influenza virus vaccination and the pneumococcal vaccination must take assignment on the claim for the vaccine.

**Note**: MACs will not search their files either to retract payment for claims already paid or to retroactively pay claims prior to the implementation date of CR 9299. However, they will adjust claims that you bring to their attention.

## Additional information

The official instruction, CR 9299, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3341CP.pdf*. The revised portion of the *NCD Manual* is part of CR 9281.

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: MM9299
Related Change Request (CR) #: CR 9299
Related CR Release Date: August 28, 2015
Effective Date: August 1, 2015
Related CR Transmittal #: R3341CP
Implementation Date: No later than November 24, 2015

# Claims submission alternatives for providers who have difficulties submitting ICD-10 claims

## Provider types affected

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

## Provider action needed

This *MLN Matters*® special edition article offers physicians, providers, and suppliers information that will assist them in avoiding claims processing disruptions after implementation of International Classification of Diseases, Tenth Edition (ICD-10) on October 1, 2015. It provides information for providers who have difficulties submitting ICD-10 claims due to being unable to complete necessary systems changes or having issues with billing software, vendor(s), or clearinghouse(s).


## Background

For FROM dates of service (on professional and supplier claims) or dates of DISCHARGE/THROUGH dates (on institutional claims) on or after October 1, 2015, entities covered under the Health Insurance Portability and Accountability Act (HIPAA) **are required to use ICD-10 code sets** adopted under HIPAA.

## ICD-10 claim submission alternatives

If you have difficulties submitting ICD-10 claims due to being unable to complete the necessary systems changes or having issues with your billing software, vendor(s), or clearinghouse(s), the following claims submission alternatives are available:

- Free billing software;
- Provider internet portals;
- Direct data entry (DDE); and
- Paper claims.

Each claims submission alternative is discussed in more detail below.

**Please note that these claims submission alternatives REQUIRE THE USE OF ICD-10 code sets for FROM dates of service (on professional and supplier claims) or dates of DISCHARGE/THROUGH dates (on institutional claims) on or after October 1, 2015.**

### Free billing software

**Providers who submit claims to MACs**

You may download the free billing software that the Centers for Medicare & Medicaid Services (CMS) A/B MACs offer on their web pages. The software has been updated to support ICD-10 codes and requires either a network service vendor (NSV) or dial-up or both to transmit claims. The software download is free, but there may be fees associated with submitting claims through an NSV or dial-up. The MAC Web pages also provide information about NSVs.

This billing software only works for submitting fee-for-service (FFS) claims to Medicare. It is intended to provide submitters with an ICD-10 compliant claims submission format; it does not provide coding assistance.

Information about the free billing software is available on each of the CMS contractor websites. Please refer to the document that provides Web page access to all contractors titled *Contractors' ICD-10 claim submission alternatives Web pages*.

**Please note that submitting electronic claims to Medicare using the free billing software does not change the requirement for ICD-10 compliant claims to be submitted for FROM dates of service (on professional claims) or dates of DISCHARGE/THROUGH dates (on institutional claims) on or after October 1, 2015. Any claims containing ICD-9 codes for FROM dates of service (on professional claims) or dates of DISCHARGE/THROUGH dates (on institutional claims) on or after October 1, 2015, will be rejected by Medicare.**

**Providers who submit claims to DME MACs**

DME suppliers may download the free billing software that CMS offers via the *Common Electronic Data Interchange (CEDI)* website. The software has been updated to support ICD-10 codes and requires NSV connectivity to transmit Medicare DME claims to CEDI. The software download is free, but there may be fees associated with submitting claims through an NSV. The list of approved NSVs and an NSV frequently asked questions document is available at *http://www.ngscedi.com/nsv*. You must also have a CEDI trading partner/submitter ID to use the free billing software to submit claims to CEDI.

- If you currently do not have a CEDI trading partner ID (begins with A08, B08, C08, or D08) to submit claims

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# ALTERNATIVES

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directly to CEDI (for example, you submit claims through a clearinghouse or billing service), you will need to complete the necessary CEDI enrollment forms to obtain a CEDI trading partner ID.

- If you currently have a CEDI trading partner ID, you will use that to submit claims with the free billing software.

You can find CEDI enrollment forms at *http://www.ngscedi.com/forms/formsindex.htm*. You should submit the forms to CEDI as soon as possible, but no later than September 15, 2015, to allow CEDI time to process your request and for any testing you might want to do prior to the October 1, 2015, ICD-10 implementation. You will also need to allow for any additional time to sign up and establish connectivity to CEDI through the NSV that you choose.

This billing software only works for submitting FFS claims to Medicare. It is intended to provide submitters with an ICD-10 compliant claims submission format; it does not provide coding assistance.

Information about the free billing software is available on each of the CMS contractor websites. Please refer to the document that provides Web page access to all contractors titled *Contractors' ICD-10 claim submission alternatives Web pages*.

**Please note that submitting electronic claims to Medicare using the free billing software does not change the requirement for ICD-10 compliant claims to be submitted for FROM dates of service on or after October 1, 2015. Any claims containing ICD-9 codes for FROM dates of service on or after October 1, 2015, will be rejected by Medicare.**

### Provider Internet portal

In some cases, you may be able to use your MAC's provider internet portal to submit ICD-10 compliant professional claims. All MACs offer the portals, and a subset of these MAC portals offer claims submission. Provider portal Internet claim submission is not available for institutional or supplier claims.

Information about registering for access to provider internet portals is available on each of the CMS contractor websites. Please refer to the document that provides Web page access to all contractors titled *Contractors' ICD-10 claim submission alternatives Web pages*.

**Please note that claims submitted via our provider portal must contain ICD-10 codes for FROM dates of service on or after October 1, 2015. Those submitted containing ICD-9 codes for FROM dates of service on or after October 1, 2015, will be rejected through normal claim editing processes. ICD-9 codes will still be accepted for FROM dates prior to October 1, 2015.**

### DDE

Providers that bill institutional claims are also permitted to submit claims electronically via DDE screens. DDE requires a connectivity service provided by an external company to establish the connection.

Information about registering to submit claims via DDE and lists of DDE service vendors is available on each of the CMS contractor websites. Please refer to the document that provides Web page access to all Contractors titled *Contractors' ICD-10 claim submission alternatives Web pages*.

**Please note that claims submitted via DDE must contain ICD-10 codes for dates of DISCHARGE/THROUGH dates on or after October 1, 2015. Those submitted containing ICD-9 codes for dates of DISCHARGE/THROUGH dates on or after October 1, 2015, will be returned to provider (RTP).**

### Paper claims

In limited situations, you may submit paper claims with ICD-10 codes to Medicare. To find more information on when you may submit paper claims, visit *http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/ASCAWaiver.html*. Please note that to submit paper claims, you must meet the requirements to qualify for a waiver of the Administrative Simplification Compliance Act (ASCA) provisions.

Information about submitting paper claims and ordering claim forms is available on each of the CMS contractor websites. Please refer to the document that provides web page access to all contractors titled *Contractors' ICD-10 claim submission alternatives Web pages*.

#### Waivers subject to MAC evaluation

Providers must apply for and **meet all** of the following requirements to qualify for a waiver of the ASCA provisions:

- Your software vendor is not ICD-10 ready, and it will cause a financial hardship for you to switch to another vendor; **or**
- Your software is not ICD-10 ready, and it will cause a financial hardship for you to switch to new software; **and**
- Your MAC's provider Internet portal does not support electronic claims submissions; **and**
- It would cause financial hardship for you to procure the services of a billing agent/clearinghouse.

It is the provider's responsibility to submit all of the following documentation to the MAC to establish the validity of a waiver request:

- A letter from the vendor stating that their software is not ICD-10 compliant; **or**
- Attestation from the provider stating that your software is not ready for ICD-10; **and**
- Attestation of provider financial hardship; **and**
- Acknowledgement that paper claims must be submitted in a machine scannable format.

If the MAC determines that the waiver request meets the criteria described above and proper documentation has been provided, the MAC will grant the waiver request.

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## ALTERNATIVES

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**Corrective action plan (CAP)**

A provider who qualifies for a waiver to submit paper claims will be placed on a CAP not to exceed 120 days and must submit a CAP detailing the steps, with associated timelines, being taken to become ICD-10 compliant.

**Please note that submitting paper claims to Medicare, even if approved for an ASCA waiver, does not change the requirement for ICD-10 compliant claims to be submitted for FROM dates of service (on professional and supplier claims) or dates of DISCHARGE/THROUGH dates (on institutional claims) on or after October 1, 2015. Any paper claims containing ICD-9 codes for FROM dates of service (on professional and supplier claims) or dates of DISCHARGE/THROUGH dates (on institutional claims) on or after October 1, 2015, will be returned as unprocessable by Medicare.**

### Information and resources

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

- General ICD-10-CM/PCS information: *http://www.cms.gov/Medicare/Coding/ICD10/index.html*;
- ICD-10 fee-for-service provider resources including claim processing and billing, coding, unspecified ICD-10-CM codes, home health provider information, NCDs and LCDs, testing and results, features and benefits, and calls and background: *https://www.cms.gov/Medicare/Coding/ICD10/Medicare-Fee-for-Service-Provider-Resources.html*;
- General equivalence mappings: *http://www.cms.gov/Medicare/Coding/ICD10/2015-ICD-10-CM-and-GEMs.html*; and
- ICD-10 national coverage determinations: *http://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html*.

### Additional information

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

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Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A



# Healthcare provider taxonomy code set update

### Provider types affected

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

### What you need to know

Change request (CR) 9260 instructs MACs to obtain the most recent healthcare provider taxonomy code (HPTC) set and to update their internal HPTC tables and/or reference files.

### Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that covered entities use the standards adopted under this law for electronically transmitting certain health care transactions, including health care claims. The standards include implementation guides, which dictate when and how data must be sent, including specifying the code sets which must be used. The institutional and professional claim electronic standard implementation guides (X12 837-I and 837-P) each require use of valid codes contained in the HPTC set when there is a need to report provider type or physician, practitioner, or supplier specialty for a claim.

The National Uniform Claim Committee (NUCC) maintains the HPTC set for standardized classification of health care providers, and updates it twice a year with changes effective April 1 and October 1. These changes include the addition of a new code and addition of definitions to existing codes.

You should note that:

1. Valid HPTCs are those that the NUCC has approved for current use;
2. Terminated codes are not approved for use after a specific date;
3. Newly approved codes are not approved for use prior to the effective date of the code set update in which each new code first appears; and
4. Specialty and/or provider type codes issued by any entity other than the NUCC are not valid.

CR 9260 implements the NUCC HPTC code set that is effective on October 1, 2015, and instructs MACs to obtain the most recent HPTC set and use it to update their internal HPTC tables and/or reference files. The HPTC set is available from the Washington Publishing Company (WPC) at *http://www.wpc-edi.com/codes*.

When reviewing the Health Care Provider Taxonomy code

See **HPTC**, next page

# Claim status category and claim status codes update

## Provider types affected

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

## What you need to know

Change request (CR) 9276 informs MACs about the changes to the claim status category and claim status codes.

## Background

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

The National Code Maintenance Committee meets at the beginning of each ASC X12 trimester meeting (January/February, June, and September/October) and makes decisions about additions, modifications, and retirement of existing codes. The codes sets are available at *http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-category-codes/* and *http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-codes/*. The Committee has decided to allow the industry six months for implementation of newly added or changed codes.

All code changes approved during the September/October 2015 committee meeting will be posted on those sites on or about November 1, 2015. MACs must complete entry of all applicable code text changes, add new codes, and terminate use of deactivated codes by the implementation date of CR 9276.

These code changes are to be used in editing of all ASC X12 276 transactions processed on or after the date of implementation and to be reflected in the ASC X12 277 transactions issued on and after the date of implementation of CR 9276.

## Additional information

The official instruction, CR 9276, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3344CP.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: MM9276
Related Change Request (CR) #: CR 9276
Related CR Release Date: August 28, 2015
Effective Date: January 1, 2016
Related CR Transmittal #: R3344CP
Implementation Date: January 4, 2016



# HPTC

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set online, you can identify revisions made since the last release by the color code:

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

## Additional information

The official instruction, CR issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3336CP.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: MM9260
Related CR Release Date: August 21, 2015
Related Transmittal #: R3336CP
Change Request (CR) #: 9260
Effective Date: October 1, 2015
Implementation Date: January 4, 2016 - Contractors with the capability to do so shall implement this CR effective October 1, 2015

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

## Provider types affected

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

## What you need to know

Change request (CR) 9270 instructs MACs to update systems based on the CORE 360 uniform use of claim adjustment reason code (CARC) and remittance advice remark code (RARC) rule publication. These system updates are based on the CORE code combination list to be published on or about October 1, 2015.

## Background

The Department of Health and Human Services (HHS) adopted the Phase III Council for Affordable Quality Healthcare (CAQH) committee on operating rules for information exchange (CORE) electronic funds transfer (EFT) and electronic remittance advice (ERA) operating rule set, required by January 1, 2014, by the Affordable Care Act.

CR 9270 deals with the regular update in CAQH CORE defined code combinations per operating rule 360 - uniform use of claim adjustment reason codes and remittance advice remark codes (835) rule.

CAQH CORE will publish the next version of the code combination list on or about October 1, 2015. This update is based on July 1, 2015, CARC and RARC updates as posted at the Washington Publishing Company (WPC) website. (Visit *http://www.wpc-edi.com/reference* for CARC and RARC updates and *http://www.caqh.org/CORECodeCombinations.php* for CAQH CORE defined code combination updates.)

## Additional information

The official instruction, CR 9270, issued to your MAC


regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3335CP.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: MM9270
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Related CR Release Date: August 21, 2015
Effective Date: January 1, 2016
Related CR Transmittal #: R3335CP
Implementation Date: January 4, 2016

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# Increasing tax withholding to 100 percent for the Internal Revenue Service Federal Payment Levy Program

## Provider types affected

This *MLN Matters*® article is intended for physicians, providers, and suppliers who submit claims to Medicare administrative contractors (MACs) and who may owe back taxes to the Internal Revenue Service (IRS).

## What you need to know

Change request (CR) 9154 instructs the Healthcare Integrated General Ledger Accounting System (HIGLAS) system maintainer to make necessary programming changes to increase the tax withhold percentage from 30 percent to 100 percent. If you owe back taxes to the IRS and those taxes are eligible to be withheld from payments due you from Medicare, the withhold rate will increase from the current 30 percent to 100 percent on October 16, 2015.

## Background

In July 2000, the IRS, in conjunction with the Department of the Treasury, started the Federal Payment Levy Program (FPLP) which is authorized by Internal Revenue Code Section 6331 (h) (see *http://www.gpo.gov/fdsys/pkg/USCODE-2011-title26/pdf/USCODE-2011-title26-subtitleF-chap64-subchapD-partIIsec6331.pdf*), as prescribed by the Taxpayer Relief Act of 1997 Section 1024 (see *http://www.gpo.gov/fdsys/pkg/PLAW-105publ34/html/PLAW-105publ34.htm*).

Through the FPLP, authority is provided to the Centers for Medicare & Medicaid Services (CMS) to collect overdue taxes through a levy on certain federal payments. This includes federal payments made to providers, contractors and vendors doing business with the government.

Consistent with this authority, CMS introduced CR 6125 in October of 2008, which reduced federal payments subjected to the levy by the required 15 percent, or the exact amount of the tax owed if it is less than 15 percent of the payment. You can review the *MLN Matters*® article MM6125, corresponding to CR 6125, at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm6125.pdf*.

In December 2014, the Internal Revenue Code Section 6331(h) was amended by the Tax Increase Prevention Act of 2014 Section 209(a) (see *http://www.gpo.gov/fdsys/pkg/BILLS- 113hr5771enr/html/BILLS-113hr5771enr.htm*), which mandated an increase to the tax levy to 30 percent. In order to do this, CMS introduced CR 9154. You can review the *MLN Matters*® article MM9154 corresponding to CR 9154, at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9154.pdf*.

In April 2015, the Internal Revenue Code Section 6331(h) was amended by the Medicare Access and CHIP Reauthorization Act of 2015, Section 413(a), which increases the tax levy withholding to 100 percent.

## Additional information

The official instruction, CR 9285, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1536OTN.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-LearningNetworkMLN/MLNMattersArticles/index.html* under - How Does It Work.

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Change Request (CR) #: CR 9285
Implementation Date: October 16, 2015
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# CMS conducts final successful Medicare FFS ICD-10 end-to-end testing week in July

From July 20 through 24, 2015, Medicare Fee-For-Service (FFS) health care providers, clearinghouses, and billing agencies participated in a third successful ICD-10 end-to-end testing week with all Medicare Administrative Contractors (MACs) and the durable medical equipment (DME) MAC common electronic data interchange (CEDI) contractor. CMS was able to accommodate most volunteers, representing a broad cross-section of provider, claim, and submitter types.

This final end-to-end testing week demonstrated that CMS systems are ready to accept and process ICD-10 claims. Approximately 1,200 providers and billing companies participated, and testers submitted over 29,000 test claims. View the *results*.

Overall, participants in the July end-to-end testing week were able to successfully submit ICD-10 test claims and have them processed through Medicare billing systems. The acceptance rate for July was similar to the rates in *January* and *April*, but with an increase in the number of testers and test claims submitted. Most of the claim rejections that occurred were due to errors unrelated to ICD-9 or ICD-10.

Through its robust system release testing, CMS has ensured that the Medicare FFS claims processing systems changes for ICD-10 implementation have been thoroughly tested and validated. CMS also has conducted an unprecedented additional level of testing to help providers prepare for ICD-10. This was the final end-to-end testing week, but providers are encouraged to participate in *acknowledgement testing*, which can be completed at any time prior to the implementation date.

### Be Prepared

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


CMS has created a number of ICD-10 tools and resources for providers. One tool is the "*Road to 10*," aimed specifically at smaller physician practices with primers for clinical documentation, clinical scenarios, and other specialty-specific resources to help with implementation.

For more information, visit the *Medicare FFS Provider Resources* Web page.

## 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.

# Opting out of Medicare and/or electing to order and refer services

***Note**: This article was revised September 14, 2015, to eliminate references to a two-year opt-out period for residents. The references to the two-year opt-out period for other providers was removed in a prior revision. All other information is unchanged. This information was previously published in the January 2015 Medicare B Connection, Pages 42-44.*

## Provider types affected

This *MLN Matters*® special edition is intended for physicians and non-physician practitioners who opt out of Medicare and/or elect to order and refer services to Medicare beneficiaries and who would otherwise submit claims to Medicare contractors (carriers and Medicare administrative contractors (A/B MACs) for services to Medicare beneficiaries.

## What you need to know

This *MLN Matters*® special edition article informs physicians and non-physician practitioners who wish to opt-out of Medicare of the need to provide certain information in a written affidavit to their Medicare contractor (Medicare carrier or MAC). Make sure that your billing staffs are aware of this information.

## Background

Physicians and practitioners who do not wish to enroll in the Medicare program may "opt-out" of Medicare. This means that neither the physician, nor the beneficiary submits the bill to Medicare for services rendered. Instead, the beneficiary pays the physician out-of-pocket and neither party is reimbursed by Medicare. A private contract is signed between the physician and the beneficiary that states, that neither one can receive payment from Medicare for the services that were performed. The physician or practitioner must submit an affidavit to Medicare expressing his/her decision to opt-out of the program. The following shows physicians and other practitioners who are permitted by statute to opt-out of the Medicare program:

- Physicians who are:
  - Doctors of medicine or osteopathy;
  - Doctors of dental surgery or dental medicine;
  - Doctors of podiatry; or
  - Doctors of optometry; and
  - Who are legally authorized to practice dentistry, podiatry, optometry, medicine, or surgery by the State in which such function or action is performed.
- Practitioners who are:
  - Physician assistants;
  - Nurse practitioners;
  - Clinical nurse specialists;
  - Certified registered nurse anesthetists;
  - Certified nurse midwives;
  - Clinical psychologists;
  - Clinical social workers; or
  - Registered dietitians or nutrition professionals; and
  - Legally authorized to practice by the state and otherwise meet Medicare requirements.

### Filing an affidavit to opt-out

Physicians and non-physician practitioners who want to opt-out must file a written affidavit with Medicare in which they agree to opt-out of Medicare and to meet certain other criteria.

- In general, the law requires that during the opt out period, physicians and non-physician practitioners who have filed affidavits opting out of Medicare must sign private contracts with all Medicare beneficiaries to whom they furnish services that would otherwise be covered by Medicare, except those who are in need of emergency or urgently needed care.
- They cannot sign such contracts with beneficiaries in need of emergency or urgent care services.
- Moreover, physicians and non-physician practitioners who opt-out cannot choose to opt-out of Medicare for some Medicare beneficiaries but not others; or for some services and not others.

- The Centers for Medicare & Medicaid Services (CMS) does not have a standard affidavit form, however, many MACs have a form available on their website. To locate your MAC's website, refer to *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/contact_list.pdf*.

  Otherwise, those physicians and practitioners who wish to opt-out must provide the information mentioned in writing to the MAC within their service jurisdiction. Currently there is not an option to submit an opt-out affidavit online.
  - The affidavit must be in writing and signed by the physician/non-physician practitioner.
  - It must include various statements to which the physician/non-physician practitioner must agree; for example, the physician/non-physician practitioner must agree not to submit claims to Medicare for any services furnished during the opt-out period, except for emergency or urgent care services furnished to beneficiaries with whom the physician/non-physician practitioner has not previously entered into a private contract.
  - It must identify the physician/non-physician practitioner sufficiently so that the Medicare contractor can ensure that no payment is made to

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the physician/non-physician practitioner during the opt-out period.

- It must be filed with all Medicare contractors who have jurisdiction over the claims the physician/non-physician practitioner would have otherwise filed with Medicare and must be filed no later than 10 days after entering into the first private contract to which the affidavit applies.

The following specific information must be included in the affidavit:

- The physician/non-physician practitioner's legal name;
- Medicare specialty;
- Taxpayer identification number (TIN) (Social security number (SSN)) (required if a national payer identifier (NPI) has not been assigned);
- Address (If the address in the affidavit is a P.O. Box, the Medicare contractor may request a different address);
- Telephone number;
- Medicare billing ID/provider transaction number (PTAN) (if the provider was previously enrolled and one had been assigned); and
- NPI (only if one has been assigned).

Physicians/non-physician practitioners who have never enrolled in Medicare are not required to enroll in Medicare before they can opt-out of Medicare.

A nonparticipating physician or practitioner may opt-out of Medicare at any time and the effective date of the affidavit record must comply with the following:

- The opt-out period begins the date the affidavit is signed, provided the affidavit is filed within 10 days after he or she signs his or her first private contract with a Medicare beneficiary.
  - Physicians or practitioners that opt out in multiple contractor jurisdictions are required to file a separate affidavit with each contractor. If the physician or practitioner does not timely file all required affidavits, the opt-out period begins when the last such affidavit is filed. Any private contract entered into before the last required affidavit is filed becomes effective upon the filing of the last required affidavit. The furnishing of any items or services to a Medicare beneficiary under such contract before the last required affidavit is filed is subject to standard Medicare rules.

If the physician or non-physician practitioner had been enrolled in Medicare and had signed a Part B participation agreement and is now opting out, the participation agreement terminates at the same time the enrollment terminates. If an enrolled physician/non-physician practitioner is opting out, the existing enrollment record will be automatically end dated. The effective date of the opt-out affidavit shall comply with the following:

- A participating physician may properly opt-out of Medicare at the beginning of any calendar quarter, provided that the affidavit is submitted to the participating physician's Medicare contractor at least 30 days before the beginning of the selected calendar quarter.
- A private contract entered into before the beginning of the selected calendar quarter becomes effective at the beginning of the selected calendar quarter and the furnishing of any items or services to a Medicare beneficiary under such contract before the beginning of the selected calendar quarter is subject to standard Medicare rules.

### Opt-out providers who may order and certify items and services

There are differences between providers who are permitted to opt-out and providers who opt-out and elect to order and certify items and services. The following physicians and non-physician practitioners are permitted to order and certify:

Physicians (doctor of medicine or osteopathy, doctor of dental medicine, doctor of dental surgery, doctor of podiatric medicine, doctor of optometry, optometrists) may only order and certify DMEPOS products/services and laboratory and X-ray services payable under Medicare Part B);

- Physician assistants;
- Clinical nurse specialists;
- Nurse practitioners;
- Clinical psychologists;
- Interns, residents, and fellows;
- Certified nurse midwives; and
- Clinical social workers.

CMS emphasizes that generally Medicare will only reimburse for specific items or services when those items or services are ordered or certified by providers or suppliers authorized by Medicare statute and regulation to do so. The denial will be based on the fact that neither statute nor regulation allows coverage of certain services when ordered or certified by the identified supplier or provider specialty.

CMS would like to highlight the following limitations:

- Chiropractors are not eligible to order supplies or services for Medicare beneficiaries. All services ordered by a chiropractor will be denied.
- Home health agency (HHA) services may only be ordered or certified by a doctor of medicine (M.D.), doctor of osteopathy (D.O.), or doctor of podiatric medicine (DPM). Claims for HHA services ordered by any other practitioner specialty will be denied.
- Optometrists may only order and certify DMEPOS products/services, and laboratory and X-ray services payable under Medicare Part B.
- Residents who have provisional licenses from the

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state and are permitted to enroll in Medicare are also eligible to opt-out of Medicare. However, the opted out resident may only furnish under private contracts the types of services that he or she is specifically authorized to furnish under State law at the direction of his or her teaching institution. Although the opt-out option is available, CMS encourages licensed residents to enroll via the CMS-855O since their employment arrangement could change.

If an opt-out provider elects to order and certify services, Medicare contractors must develop for the following information through an additional information request:

- An NPI (if one is not contained on the affidavit voluntarily);
- Confirmation if an Office of Inspector General (OIG) exclusion exists (if not contained on the affidavit);
- Date of birth; and
- Social security number (if not contained on the affidavit).

If the above information is not obtained, the opt-out provider will not be able to order and certify services. If the opt-out provider refuses to report the information listed immediately above, then the opt-out provider cannot order and certify, but the failure to report this additional information does not affect the provider's right to opt out of Medicare.

The Medicare contractor must ask the opt-out physician or non-physician practitioner if he or she has been excluded by the OIG and may specifically ask for a copy of the private contract he or she uses in order to ascertain whether he or she has been excluded from the Medicare program.

### Additional information

You may want to review *MLN Matters*® article MM8100, titled *Effect of Beneficiary Agreements Not to Use Medicare Coverage and When Payment May be Made to a Beneficiary for Service of an Opt-Out Physician/Practitioner*, which is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm8100.pdf*.

The official Medicare requirements for opting out are in the Chapter 15, Section 40, of the *Medicare Benefit Policy Manual* and is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf*.

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

*MLN Matters*® Number: SE1311 *Revised*
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A



## Processing Issues

# Delay in implementing single-chamber and dual-chamber cardiac pacemakers

### Issue

On August 13, 2013, the Centers for Medicare & Medicaid Services (CMS) issued a final decision memorandum regarding coverage of implanted permanent cardiac pacemakers, single chamber or dual chamber, and determined they are reasonable and necessary for the treatment of non-reversible symptomatic bradycardia due to sinus node dysfunction and second and/or third degree atrioventricular block.

### Resolution

On February 20, 2015, CMS released change request (CR) 9078, transmittals *179* and *3204*, implementing national coverage determination (NCD) 20.8.3 July 6, 2015, for claims with dates of service on and after August 13, 2013, for those beneficiaries who meet specific coverage criteria.

### Status/date resolved

**Open:**
There is a temporary delay in implementing NCD 20.8.3 meaning that all editing and decisions on coverage relative to CR 9078 will be made at the local Medicare administrative contractor (MAC) level until further CMS notice. CMS will advise of the new implementation date in the near future.

### Provider action

**None:**
CMS will advise of the new implementation date in the near future.

### Current processing issues

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

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."**

**Sign up for *eNews* by clicking *here*.**

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

New LCD

# Controlled substance monitoring and drugs of abuse testing – new Part A/B LCD

### LCD ID number: L36393 (Florida/Puerto Rico/ U.S. Virgin Islands)

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

In February 2014, the LCD titled "drugs of abuse testing" was published for a 45-day comment period. This was a national consensus draft that was based on data analysis and claims review, which identified an over-utilization and a high risk for improper claim payment of HCPCS codes G0431 (drug screen, qualitative; multiple drug classes by high complexity test method [e.g., immunoassay, enzyme assay], per patient encounter) and G0434 (drug screen, other than chromatographic; any number of drug classes, by clinical laboratory improvement amendment [CLIA] waived test or moderate complexity test, per patient encounter). Post payment review further supported provider misuse. Based on comments received following the 45-day comment period, it was decided this LCD would not be finalized and a new national consensus draft would be adopted during the October 2014 LCD cycle. This LCD has now been finalized with all the applicable 2015 HCPCS changes, and it also has revised the related coding articles to address the proper billing of the current HCPCS codes.

This new LCD has been developed to outline indications and limitations of coverage and/or medical necessity, procedure and diagnosis codes, documentation guidelines, and utilization guidelines for controlled substance monitoring and drugs of abuse testing.

### Effective date

This new LCD is effective for services rendered **on or after October 11, 2015**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

## Retired LCDs

# Microvolt t-wave alternans – retired Part B LCD

**LCD ID number: L29227 (Florida)**
**LCD ID number: L29365 (Puerto Rico/U.S. Virgin Islands)**

The Centers for Medicare & Medicaid Services (CMS) revised national coverage determination (NCD) 20.30 microvolt t-wave alternans (MTWA) diagnostic testing, removing the non-coverage of modified moving average (MMA) method of testing. Therefore, based on change request (CR) 9162 local coverage determination (LCD) microvolt t-wave alternans is being retired.

### Effective date

This LCD retirement is effective for claims processed **on or after September 11, 2015**, for services rendered **on or after January 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*.

# Multiple Part B local coverage determinations being retired

**LCD ID number: L29091, L29133, L29171, L29192, L29304 (Florida)**
**LCD ID number: L29106, L29151, L29322, L29347, L29406 (Puerto Rico/U.S. Virgin Islands)**

The following local coverage determinations (LCDs) are being retired based on national coverage determination (NCD) editing being implemented by the Centers for Medicare & Medicaid Services (CMS).

- Cardiac Output Monitoring by Thoracic Electrical Bioimpedance
- Diabetes Self-Management Training
- External Counterpulsation
- Hyperbaric Oxygen Therapy (HBO Therapy)
- Vagus Nerve Stimulation for Intractable Depression

### Effective date

This retirement of these LCDs is effective for services rendered **on or after October 1, 2015**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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


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## Revisions to LCDs

# Colorectal cancer screening – revision to the Part B LCD

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

The Centers for Medicare & Medicaid Services (CMS) determined evidence is sufficient to cover Cologuard™ a multitarget stool DNA test – as a colorectal cancer screening test for asymptomatic, average risk beneficiaries, aged 50 to 85 years. As a result, based on change request 9115, transmittal numbers 183 and 3319: National Coverage Determination (NCD) for Screening for Colorectal Cancer Using Cologuard™ A Multitarget Stool DNA Test, the "Indications and Limitations of Coverage and/or Medical Necessity" section of the local coverage determination (LCD) for colorectal cancer screening, was revised to add coverage criteria for screening for colorectal cancer using Cologuard™.

### Effective date

This LCD revision is effective for claims processed on or after **September 08, 2015**, for services rendered **on or after October 09, 2014**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

Coding guidelines for an LCD (when present) may be found by selecting "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*.

# G-CSF (Neupogen®, Granix™, Zarxio™) – revision to the Part B LCD

**LCD ID number: L29180 (Florida)**
**LCD ID number: L29431 (Puerto Rico/U.S. Virgin Islands)**

Based on the United States Food and Drug Administration's (FDA) approval of filgrastim-sndz (Zarxio), a biosimilar of filgrastim (Neupogen), the local coverage determination (LCD) for G-CSF (Neupogen®, Granix™) has been revised. The "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD has been updated to add the new FDA-approved biosimilar filgrastim-sndz (Zarxio) for the same indications as filgrastim (Neupogen). The "*CPT*®/HCPCS Codes" section was also revised to add HCPCS code Q5101 and descriptor.

In addition, the LCD was revised to add diagnosis codes V07.8 (Other specified prophylactic or treatment measure) and V66.2 (Convalescence following chemotherapy) to the "ICD-9 Codes that Support Medical Necessity" section of the LCD making the ICD-9-CM coding congruent with the text of the LCD.

The "Sources of Information and Basis for Decision" section of the LCD was updated to support the above revisions.

### Effective date

The LCD revision to add filgrastim-sndx (Zarxio) is effective for claims processed **on or after September 25, 2015**, for services rendered **on or after March 6, 2015**. The LCD revision to add diagnosis codes V07.8 and V66.2 is effective for claims processed **on or after September 25, 2015**. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

# Intravitreal bevacizumab (Avastin®) – revision to the LCD

**LCD ID number: L29959 (Florida)/L29961 (Puerto Rico/U.S. Virgin Islands)**

The local coverage determination (LCD) for intravitreal bevacizumab (Avastin®) has been revised based on change request (CR) 9167. New HCPCS code *Q9977* - compounded drug, unclassified has been added to the "*CPT*®/HCPCS Codes" section of this LCD.

### Effective date

This revision to this LCD is effective for services rendered **on or after July 1, 2015**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

# Noncovered Services – revision to the Part B LCD

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

The local coverage determination (LCD) for noncovered services was revised to remove several *CPT*® codes from noncoverage. *CPT*® code *76999* (ultrasound guided sclerotherapy) was removed from the "*CPT*®/HCPCS Codes - Unlisted Procedure Codes - Procedures" section of the LCD since this service (billed as *CPT*® codes *36470*/*36471* and *76942*) is addressed in another LCD (treatment of varicose veins of the lower extremity). In addition, the "*CPT*®/HCPCS Codes – Listed Procedure Codes - Procedures" section of the LCD was revised to remove *CPT*® codes *22856*, *22861*, and *22864* based on a reconsideration request. Removing a service from noncoverage should not be interpreted as a positive coverage statement and coverage by Medicare. Claims for such services, assuming all other requirements of the program are met, would always need to meet the medically reasonable and necessary threshold for coverage in a prepayment or post payment audit of the official medical record.

### Effective date

The LCD revision for *CPT*® code *76999* is effective for claims processed **on or after September 9, 2015**, for dates of service **on or after August 9, 2015**. The LCD revision for *CPT*® codes *22856*, *22861*, and *22864* is effective for services rendered **on or after September 9, 2015**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

## Additional information

# Implantable infusion pump for the treatment of chronic intractable pain – revision to the Part B "coding guidelines" attachment

**LCD ID number: L31254 (Florida, Puerto Rico/ U.S. Virgin Islands)**

Based on CR 9167 (Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes, the 'Coding Guidelines' attachment has been revised to include HCPCS code Q9977 (compounded drug, not otherwise classified). The effective date of this revision is based on the date of service.

### Effective date

This LCD revision is effective for services rendered **on or after July 1, 2015**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

# Noncovered services – revision to the Part A/B ICD-10-CM LCD 'Coding Guidelines' attachment

**LCD ID number: L33777 (Florida/Puerto Rico/ U.S. Virgin Islands)**

The local coverage determination (LCD) "Coding Guidelines" attachment for noncovered services was revised to remove *Current Procedural Terminology*® (*CPT*®) code *82438* based on national coverage determination (NCD 190.5) editing being implemented by the Centers for Medicare & Medicaid Services (CMS).

### Effective date

This revision to the LCD "Coding Guidelines" attachment is effective for services rendered **on or after October 1, 2015**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

# Self-administered drug (SAD) list – Part B: J3490/J3590/C9399

The Centers for Medicare & Medicaid Services (CMS) provides instructions to contractors regarding Medicare payment for drugs and biologicals incident to a physician's service. The instructions also provide contractors with a process for determining if an injectable drug is usually self-administered and therefore, not covered by Medicare. Guidelines for the evaluation of drugs for the list of excluded self-administered injectable drugs incident to a physician's service are in the *Medicare Benefit Policy Manual*, Pub. 100-02, Chapter 15, Section 50.2.

Effective for services rendered on or after September 28, 2015, the following drugs have been added to the MAC JN Part B self-administered drug (SAD) list.

- J3490/J3590/C9399 – Injection, Dulaglutide (Trulicity™)
- J3490/J3590/C9399 – Injection, Methotrexate Injection (Otrexup)
- J3490/J3590/C9399 – Injection, Peginterferon beta-1a (PLEGRIDY®)
- J3490/J3590/C9399 – Injection, Secukinumab (Cosentyx™)

Additionally, minor editorial changes were made to the SAD list.

The evaluation of drugs for addition to the SAD list is an ongoing process. Providers are responsible for monitoring the SAD list for the addition or deletion of drugs.

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

# Spinal cord stimulation for chronic pain – corrected revision effective date to the Part A/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. A correction was made to the effective date for the ICD-9 diagnosis codes 996.2, 996.63, and 996.75 that were previously added to support medical necessity for *CPT*® codes *63661-63664*, *63685*, and *63688* when the devices have complications and require removal, revision, or replacement.

### Effective date

This LCD revision is effective for claims processed **on or after September 16, 2015**, for dates of service **on or after February 7, 2015**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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


### Learn the secrets to billing Medicare correctly

Who has the power to improve your billing accuracy and efficiency? You do – visit the *Tools to improve your billing* section where you'll discover the tools you need to learn how to consistently bill Medicare correctly – the first time. You'll find First Coast's most popular self-audit resources, including the E/M interactive worksheet, provider data summary (PDS) report, and the comparative billing report (CBR).

# Upcoming provider outreach and educational events

## Internet-based PECOS class

**When:** Thursday, October 8
**Time:** Time: 11:00 a.m.-12:30 p.m. **Type of event:** Face-to-Face

*http://medicare.fcso.com/Events/0293490.asp*

## Medicare Speaks 2015: Keeping you up-to-date and informed (St. Croix, U.S. Virgin Islands)

**When:** Tuesday-Wednesday, October 20-21
**Time:** 9:00 a.m.-1:00 p.m.

*http://medicare.fcso.com/Events/0302747.asp*

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

## Two easy ways to register

**Online** – Visit our provider training website at *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® Provider eNews for August 20, 2015

*MLN Connects® Provider eNews for August 20, 2015*
*View this edition as a PDF*

## In this edition:

### Countdown to ICD-10

- MLN Connects National Provider Call: Countdown to ICD-10 – Last Chance to Register
- Use of Unspecified Codes in ICD-10-CM
- List of Valid ICD-10-CM Codes
- ICD-10 Clinical Concepts Guides for Specialties

### MLN Connects® National Provider Calls and Events

- National Partnership to Improve Dementia Care and QAPI Call – Register Now
- Overview of the 2014 Annual Quality and Resource Use Reports Webcast – Register Now

### CMS Events

- Webinar for Comparative Billing Report on CT of the Abdomen and Pelvis for Referring Providers
- Hospital Quality Reporting Program Webinars: Impact of FY 2016 Payment Rule
- Hospital Quality Reporting Webinar Series: Early Management Bundle, Severe Sepsis/Septic Shock

### Claims, Pricers, and Codes

- Claims Hold for Diabetic Test Strips and Other Supply Items

### Announcements


- Additional Participants in Pilot Project to Improve Care and Reduce Costs for Medicare
- CMS Implements Changes in its Medical Review Education and Enforcement Strategies
- ESRD QIP PY 2016 Preview Period Extended
- Get Ready for DMEPOS Competitive Bidding

### Medicare Learning Network® Educational Products

- "National Site Visit Verification (NSV) Initiative" *MLN Matters®* Article – Released
- "Limiting the Scope of Review on Redeterminations and Reconsiderations of Certain Claims" MLN Matters Article – Released
- "PECOS Technical Assistance Contact Information" Fact Sheet – Revised

### *Medicare Learning Network®*

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

# MLN Connects® Provider eNews for August 27, 2015

*MLN Connects® Provider eNews for August 27, 2015*
*View this edition as a PDF*

### In this edition:

### Countdown to ICD-10

- Get ICD-10 Answers in One Place
- ICD-10 Resources
- Coding for ICD-10-CM: Continue to Report CPT/ HCPCS Modifiers for Laterality
- Claims that Span the ICD-10 Implementation Date
- ICD-10-CM POA Exempt Codes for FY 2016 Available
- MS-DRG Grouper and MCE Software Available
- Video Slideshow from June 18 MLN Connects ICD-10 Call Available

### MLN Connects® National Provider Calls and Events

- National Partnership to Improve Dementia Care and QAPI Call – Last Chance to Register
- Overview of the 2014 Annual Quality and Resource Use Reports Webcast – Register Now
- Medicare Quality Reporting Programs: 2017 Payment Adjustments Call – Registration Now Open
- New MLN Connects National Provider Call Audio Recordings and Transcripts

### Other CMS Events

- PQRS Webinars: Public Reporting of 2014 Measures

### Announcements

- Medicare ACOs Continue to Improve Quality of Care, Generate Shared Savings
- Registration Now Open for Round 1 2017 DMEPOS Competitive Bidding

### Medicare Learning Network® Educational Products

- "Medicare Enrollment for Physicians and Other Part B Suppliers" Fact Sheet – Revised
- New *Medicare Learning Network®* Educational Web Guides Fast Fact

# MLN Connects® Provider eNews for September 3, 2015

*MLN Connects® Provider eNews for September 3, 2015*
*View this edition as a PDF*

### In this edition:

### Countdown to ICD-10

- Access the ICD-10 Code Set
- List of Valid ICD-10-CM Codes
- "General Equivalence Mappings Frequently Asked Questions" Booklet – Revised
- "ICD-10-CM/PCS ICD-10-CM/PCS Myths and Facts" Fact Sheet – Revised
- "ICD-10-CM Classification Enhancements" Fact Sheet – Revised
- "ICD-10-CM/PCS The Next Generation of Coding" Fact Sheet – Revised
- Get Ready Now: Assess How ICD-10 Will Affect Your Practice
- Prepare for ICD-10 with MLN Connects Videos

### MLN Connects® National Provider Calls and Events

- Overview of the 2014 Annual Quality and Resource Use Reports Webcast – Register Now
- Hospital Inpatient and LTCH PPS FY 2016 Final Rule Call – Registration Now Open
- Medicare Quality Reporting Programs: 2017 Payment Adjustments Call – Register Now

### Announcements

- CMS to Extend Initiative to Improve Care for Nursing Facility Residents
- DMEPOS Competitive Bidding Program: Prepare for Round 1 2017
- New ST PEPPER Available
- EHR Incentive Programs: Determine Broadband Speed in Your Area

### Claims, Pricers, and Codes

- October 2015 Average Sales Price Files Now Available

### Medicare Learning Network® Educational Products

- "837P and Form CMS-1500" Web-Based Training Course – Revised

# MLN Connects® Provider eNews for September 10, 2015

*MLN Connects® Provider eNews for September 10, 2015*
*View this edition as a PDF*

**In this edition:**

## Countdown to ICD-10

- Updated Results for ICD-10 End-to-End Testing Week in July
- ICD-10 Coding and Clinical Documentation Resources
- New Webcasts Cover Dental, Lab, Pharmacy, and Radiology Services
- Audio Recording and Written Transcript from August 27 MLN Connects Call Available
- Finding ICD-10 Information Online Just Got Easier
- Revised ICD-10 Products Now Available in Hard Copy Format

## MLN Connects® National Provider Calls and Events

- Overview of the 2014 Annual Quality and Resource Use Reports Webcast – Last Chance to Register
- Hospital Inpatient and LTCH PPS FY 2016 Final Rule Call – Register Now
- Medicare Quality Reporting Programs: 2017 Payment Adjustments Call – Register Now
- Dialysis Facility Compare: Rollout of Five Star Rating Call – Registration Now Open
- 2014 Supplemental QRUR Physician Feedback Program Call – Registration Now Open

## Announcements

- HIV Screening for Older Adults and Others with Medicare
- 2014 Annual Quality and Resource Use Reports Available Soon
- CMS to Release CBR on Orthopedic Surgeons' Use of Modifiers 24 and 25 in September

## Claims, Pricers, and Codes

- Delay in Implementing Single Chamber and Dual Chamber Cardiac Pacemakers

## Medicare Learning Network® Educational Products

- "Skilled Nursing Facility (SNF) Consolidated Billing (CB)" Web-Based Training Course – Revised
- "HIPAA EDI Standards" Web-Based Training Course – Revised

# MLN Connects® Provider eNews for September 17, 2015

*MLN Connects® Provider eNews for September 17, 2015*
*View this edition as a PDF*

**In this edition:**

## Countdown to ICD-10

- Physician Orders for Lab, Radiology Services, and Other Services after ICD-10 Implementation
- Use of Unspecified Codes in ICD-10-CM
- Get ICD-10 Answers in One Place

## MLN Connects® National Provider Calls and Events

- Hospital Inpatient and LTCH PPS FY 2016 Final Rule Call – Last Chance to Register
- Medicare Quality Reporting Programs: 2017 Payment Adjustments Call – Last Chance to Register
- Dialysis Facility Compare: Rollout of Five Star Rating Call – Register Now
- 2014 Supplemental QRUR Physician Feedback Program Call – Register Now
- Improving Medicare Post-Acute Care Transformation Act – Registration Now Open

## Other CMS Events

- Physician Compare Public Reporting Information Sessions
- Medicare Learning Network Webinar: Medicare Basics for New Providers Part Three: Medicare Claim Review Programs, POE, and Protecting the Medicare Trust Fund

## Announcements

- Medicare-Covered Cardiovascular Disease Preventive Services
- Healthy Aging Month – Discuss Preventive Services with your Patients
- CMS Releases Plan to Address Health Equity in Medicare
- Early Flu Treatment Reduces Hospitalization Time, Disability Risk in Older People
- 2016 PQRS Payment Adjustment and Informal Review Process
- Million Hearts: Cardiovascular Disease Risk Reduction Model Application Deadline Extension

## Claims, Pricers, and Codes

- Delay in Implementing Single Chamber and Dual Chamber Cardiac Pacemakers

## Medicare Learning Network® Educational Products

- "Medicare-Required SNF PPS Assessments" Educational Tool – Released
- "Opting out of Medicare and/or Electing to Order and Certify Items and Services to Medicare Beneficiaries" *MLN Matters* article – Revised

## Preventive Resources

# 2015-2016 influenza resources for health care professionals

### Provider types affected

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

### What you need to know

- Keep this special edition *MLN Matters*® article and refer to it throughout the 2015 - 2016 flu season.
- Take advantage of each office visit as an opportunity to encourage your patients to protect themselves from the flu and serious complications by getting a flu shot.
- Continue to provide the flu shot as long as you have vaccine available, even after the new year.
- Remember to immunize yourself and your staff.

### Introduction

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

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

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

**Know what to do about the flu!**

### Payment rates for 2015-2016

Each year, CMS updates the Medicare Healthcare Common Procedure Coding System (HCPCS) and *Current Procedure Terminology* (*CPT*®) codes and payment rates for personal influenza (flu) and pneumococcal vaccines. Payment allowance limits for such vaccines are 95 percent of the average wholesale price (AWP), except where the vaccine is furnished in a hospital outpatient department, rural health clinic (RHC), or federally qualified health center (FQHC). In these cases, the payment for the vaccine is based on reasonable cost.

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

Effective for services provided on August 1, 2015, through those provided on July 31, 2016, the following Medicare Part B payment allowances for HCPCS and *CPT*® codes apply.

***CPT*® codes**

| *CPT*® code | Effective dates | Payment allowance |
|---|---|---|
| *90630* | 8/1/2015-7/31/2016 | $23.467 |
| *90654* | 8/1/2015-7/31/2016 | Pending |
| *90655* | 8/1/2015-7/31/2016 | Pending |
| *90656* | 8/1/2015-7/31/2016 | $13.880 |
| *90657* | 8/1/2015-7/31/2016 | $6.022 |
| *90661* | 8/1/2015-7/31/2016 | $22.288 |
| *90662* | 8/1/2015-7/31/2016 | $36.315 |
| *90672* | 8/1/2015-7/31/2016 | Pending |
| *90673* | 9/26/2015-7/31/2016 | $37.193 |
| *90685* | 8/1/2015-7/31/2016 | $24.596 |
| *90686* | 8/1/2015-7/31/2016 | $18.155 |
| *90687* | 8/1/2015-7/31/2016 | $9.134 |
| *90688* | 8/1/2015-7/31/2016 | $18.269 |

**HCPCS codes**

| HCPCS code | Effective dates | Payment allowance |
|---|---|---|
| Q2035 | 8/1/2015-7/31/2016 | $13.025 |
| Q2036 | 8/1/2015-7/31/2016 | Pending |
| Q2037 | 8/1/2015-7/31/2016 | $15.830 |
| Q2038 | 8/1/2015-7/31/2016 | $12.044 |
| Q2039 | 8/1/2015-7/31/2016 | **Flu vaccine adult** – Not otherwise classified: Payment allowance is to be determined by the local claims processing contractor. |

The above pricing, and any required updates, will be available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html*.

### Educational products for health care professionals

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

See **INFLUENZA**, next page

# INFLUENZA

From previous page

### 1. MLN Influenza Related Products for Health Care Professionals

- **Medicare Part B Immunization Billing chart**: *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/qr_immun_bill.pdf*
- **Preventive Services chart**: *http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/Downloads/MPS_QuickReferenceChart_1.pdf*
- **MLN Preventive Services Educational Products Web page**: *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/PreventiveServices.html*
- **Preventive Services Educational Products PDF**: *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/education_products_prevserv.pdf*

### 2. Other CMS resources

- **Immunizations Web page**: *http://www.cms.gov/Medicare/Prevention/Immunizations/index.html*
- **Prevention General Information**: *http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/index.html*
- **CMS Frequently Asked Questions**: *http://questions.cms.gov/faq.php*
- ***Medicare Benefit Policy Manual***: **Chapter 15, Section 50.4.4.2**: **Immunizations** *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf*
- ***Medicare Claims Processing Manual***: Chapter 18, Preventive and Screening Services *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf*

### 3. Other resources

The following non-CMS resources are just a few of the many available in you may find useful information and tools for the 2015–2016 flu season:

- **Advisory Committee on Immunization Practices** – *http://www.cdc.gov/vaccines/acip/index.html*
- Other sites with helpful information include:
  - **Centers for Disease Control and Prevention**: *http://www.cdc.gov/flu*;
  - **Flu.gov** - *http://www.flu.gov*;
  - **Food and Drug Administration**: *http://www.fda.gov*;
  - **Immunization Action Coalition**: *http://www.immunize.org*;
  - **Indian Health Services**: *http://www.ihs.gov*;
  - **National Alliance for Hispanic Health**: *http://www.hispanichealth.org*;
  - **National Foundation For Infectious Diseases**: *http://www.nfid.org/influenza*;
  - **National Library of Medicine and NIH Medline Plus**: *http://www.nlm.nih.gov/medlineplus/immunization.html*;
  - **National Network for Immunization Information**: *http:/www.immunizationinfo.org* ;
  - **National Vaccine Program**: *http://www.hhs.gov/nvpo*;
  - **Office of Disease Prevention and Health Promotion**: *http://healthfinder.gov/FindServices/Organizations/Organization/HR2013/office-of-disease-prevention-and-health-promotion-us-department-of-health-and-human-services*;
  - **Partnership for Prevention**: *http://www.prevent.org*; and
  - **World Health Organization**: *http://www.who.int/en*

## Beneficiary information

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

*MLN Matters*® Number: SE1523
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

# Phone numbers

### Customer service

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

### Education event registration hotline

904-791-8103 (NOT toll-free)

### Electronic data interchange (EDI)

888-670-0940

### Electronic funds transfers (EFT) (CMS-588)

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

### Fax number (for general inquiries)

904-361-0696

### Interactive voice response (IVR) system

877-847-4992

### Provider enrollment

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

### The SPOT help desk

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

# Addresses

### Claims

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

### Redeterminations

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

### Redetermination of overpayments

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

### Reconsiderations

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

### General inquiries

General inquiry request
P.O. Box 2360
Jacksonville, FL 32231-0018

Email**:** *FloridaB@fcso.com*
Online form: *http://medicare.fcso.com/Feedback/161670.asp*

### Provider enrollment

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

### Medical policy

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

### Medicare secondary payer

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

### Electronic data interchange (EDI)

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

### Overpayments

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

### Medicare Education and Outreach

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

### Fraud and abuse

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

### Freedom of Information Act requests

FOIA Florida
P.O. Box 45268
Jacksonville, FL 32232-5268

### Overnight mail and/or special courier service

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

# Websites

### Provider

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

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

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

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

### Beneficiaries

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

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877-660-1759 (speech and hearing impaired)

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904-791-8103 (NOT toll-free)

**Electronic data interchange (EDI)**
888-670-0940

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

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

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

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

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

# Addresses

**Claims**
Medicare Part B Claims
P.O. Box 45098
Jacksonville, FL 32232-5098

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

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

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

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

Email**:** *askFloridaB@fcso.com*
Online form: *http://medicare.fcso.com/Feedback/161670.asp*

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

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

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

**Electronic data interchange (EDI)**
Medicare EDI, 4C
P.O. Box 44071
Jacksonville, FL 32231-4071

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

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

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

**Freedom of Information Act requests**
FOIA USVI
P.O. Box 45073
Jacksonville, FL 32231-5073

**Special courier service**
First Coast Service Options Inc.
532 Riverside Avenue
Jacksonville, FL 32202-4914

# Websites

**Provider**
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*http://medicare.fcso.com*

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

Centers for Medicare & Medicaid Services

*http://www.cms.gov*

First Coast University

*http://www.fcsouniversity.com/*

**Beneficiaries**
Centers for Medicare & Medicaid Services

*http:// www.medicare.gov*

# Phone numbers

### Customer service

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

### Education event registration hotline

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

### Electronic data interchange (EDI)

888-875-9779

### Electronic funds transfers (EFT) (CMS-588)

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

### General inquiries

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

### Interactive voice response (IVR) system

877-847-4992

### Provider enrollment

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

### The SPOT help desk

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

# Addresses

### Claims

Medicare Part B Claims
P.O. Box 45036
Jacksonville, FL 32232-5036

### Redeterminations

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

### Redetermination of overpayments

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

### Reconsiderations

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

### General inquiries

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

Email**:** *askFloridaB@fcso.com*
Online form: *http://medicare.fcso.com/Feedback/161670.asp*

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

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

### Medicare secondary payer

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

### Electronic data interchange (EDI)

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

### Overpayments

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

### Medicare Education and Outreach

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

### Fraud and abuse

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

### Freedom of Information Act requests

FOIA Puerto Rico
P.O. Box 45092
Jacksonville, FL 32232-5092,

### Special courier service

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

# Websites

### Provider

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*http://www.cms.gov*

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

### Beneficiaries

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

# Order form for Medicare Part B materials

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

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

| Item | Acct Number | Cost per item | Quantity | Total cost |
|---|---|---|---|---|
| **Part B subscription** – The Medicare Part B jurisdiction N publications, in both Spanish and English, are available free of charge online at *http://medicare.fcso.com/Publications_B/index.asp* (English) or *http://medicareespanol.fcso.com/Publicaciones/* (Español). Nonprovider entities or providers who need additional copies may purchase an annual subscription. This subscription includes all issues published from October 2015 through September 2016. | 40300260 | $33 | | |
| **2015 fee schedule –** The Medicare Part B Physician and Nonphysician Practitioner Fee Schedules, effective for services rendered January 1 through December 31, 2015, are available free of charge online at *http://medicare.fcso.com/Data_files/* (English) or *http://medicareespanol.fcso.com/Fichero_de_datos/* (Español). Additional copies are available for purchase. The fee schedules contain payment rates for all localities. These items do not include the payment rates for injectable drugs, clinical lab services, mammography screening, or DMEPOS items.<br>**Note:** Requests for hard copy paper disclosures will be completed as soon as CMS provides the direction to do so. Revisions to fees may occur; these revisions will be published in future editions of the Medicare Part B publication. | 40300270 | $12 | | |
| Language preference: **English** [ ] **Español** [ ] | | | | |
| | | | | |
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