Medicare B CONNECTION

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FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction N Providers

October 2015

In this issue

2016 amounts in controversy required to sustain appeal rights for an ALJ hearing or federal district court review

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.

Section 1869(b)(1)(E) of the Social Security Act (the Act), as amended by Section 940 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), requires an annual reevaluation of the dollar amount in controversy required for an administrative law judge (ALJ) hearing or federal district court review.

The amount that must remain in controversy for ALJ hearing requests filed on or before December 31, 2015, is $150. This amount will remain at $150 for ALJ hearing requests filed on or after January 1, 2016.

The amount that must remain in controversy for review in

federal district court requested on or before December 31, 2015, is $1,460. This amount will increase to $1,500 for appeals to federal district court filed on or after January 1, 2016.

Click *here* for more information regarding when to file an appeal.

Contents

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.

Quarterly update to the correct coding initiative edits

Provider types affected

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

Provider action needed

Change request (CR) 9326 informs MACs about the release of the latest package of correct coding initiative (CCI) edits, version 22.0, which will be effective January 1, 2016. Make sure that your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment in Part B claims. The coding policies developed are based on coding conventions defined in the American Medical Association's *Current Procedural Terminology* manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practice, and review of current coding practice.

The latest package of CCI edits, version 22.0, effective January 1, 2016, will be available via the CMS data center (CDC). A test file will be available on or about November 2, 2015, and a final file will be available on or about November 17, 2015.

Version 22.0 will include all previous versions and updates from January 1, 1996, to the present. In the past, CCI was organized in two tables: column 1/column 2 correct coding edits and mutually exclusive code (MEC) edits. In order to simplify the use of NCCI edit files (two tables), on April 1, 2012, CMS consolidated these two edit files into the column one/column two correct coding edit file. Separate consolidations have occurred for the two-practitioner NCCI edit files and the two NCCI edit files used for OCE. It will only be necessary to search the column one/column two correct coding edit file for active or previously deleted edits. CMS no longer publishes a mutually exclusive edit file on its website for either practitioner or outpatient hospital services, since all active and deleted edits will appear in the single column one/column two correct coding edit file on each website. The edits previously contained in the mutually exclusive edit file are NOT being deleted but are being moved to the column one/column two correct coding edit file. Refer to the CMS NCCI Web page for additional information at *http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html*.

Additional information

The official instruction, CR 9326, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3353CP.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: MM9326
Related Change Request (CR) #: CR 9326
Related CR Release Date: September 18, 2015
Effective Date: January 1, 2016
Related CR Transmittal #: R3353CP
Implementation Date: January 4, 2016

Claim processing MSP policy and procedures regarding ongoing responsibility for medicals

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8984, through which the Centers for Medicare & Medicaid Services (CMS) outlines its Medicare claim processing requirements specific to ongoing responsibility for medicals (ORM) for liability insurance (including self-insurance), no-fault insurance, and workers' compensation in Medicare secondary payer (MSP) situations.

Liability insurance (including self-insurance), no-fault insurance, and workers' compensation laws or plans are required to report settlements, judgments, awards, or other payments to CMS, including ORM. The purpose of CR 8984 is to educate and instruct sure that your billing staffs are aware of these changes.

Note: MSP claims impacted by employer Group Health Plan coverage will be not affected by this change.

Background

Pursuant to Section 1862(b)(8) of the Social Security Act, "applicable plans" (liability insurance (including self-insurance), no-fault insurance, and workers' compensation laws or plans) are required to report settlements, judgments, awards or other payments involving individuals who are or were Medicare beneficiaries to CMS. The applicable plan is the "responsible reporting entity" (RRE) for this process. The required reporting includes instances where the RRE has ORM associated with specified medical conditions. This information is collected to determine primary claims payment responsibility. Examples of ORM include, but are not limited to, a no-fault insurer agreeing to pay medical bills submitted to it until the policy in question is exhausted or a workers' compensation plan being required under a particular state law to pay associated medical costs until there is a formal decision on a pending workers' compensation claim.

The RRE may assume responsibility for ORM for one or more alleged injuries/illnesses without assuming ORM for all alleged injuries/illnesses in an individual's liability insurance (including self-insurance), no-fault insurance, or workers' compensation claim. For example, if an individual is alleging both a broken leg and a back injury, the RRE might assume responsibility for the broken leg but continue to dispute the alleged back injury.

When ORM ends (for example, a policy limit is reached or a settlement occurs which terminates the RRE responsibility to pay on an ongoing basis), the RRE reports an ORM termination date, and this information is uploaded to Medicare's common working file (CWF) by the Benefit Coordination & Recovery Center (BCRC).

Note: An ORM report is not a guarantee that medicals will be paid indefinitely or through a particular date.

Pursuant to Section 1862(b)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1395y(b)(2)(A)(ii)), Medicare is precluded from making payment where payment "has been made, or can reasonably be expected to be made…" under liability insurance (including self-insurance), no-fault insurance, or a workers' compensation law or plan, hereafter, referred to as non-group health plan (NGHP). Where ORM has been reported, the primary plan has assumed responsibility to pay, on an ongoing basis, for certain medical care related to the NGHP claim. Consequently, Medicare is not permitted to make payment for such associated claims absent documentation that the ORM has terminated or is otherwise exhausted.

CR 8984 includes modifications to Medicare systems to automate the fact that ORM responsibility is assumed, exists, or did exist for a particular period of time. All MACs shall reference the modified CWF MSPD screen to determine if ORM exists in association with MSPD (No-Fault – 14), E (Workers Compensation -15), and L (Liability - 47) records for the date(s) of service at issue. When claims are processed, Medicare will compare the diagnosis code(s) on the claim with the diagnosis code(s) associated with the ORM record. All MACs shall deny claims where the ORM indicator is present for the period covered by the claim and the diagnosis code(s) match(es) (or match(ed)) within the family of diagnosis codes). As stated, documentation from the RRE that the ORM terminated or is otherwise exhausted may require that the previously denied claim be reprocessed. (Any claim will also process for a potential Workers' Compensation Medicare Set-Aside (WCMSA) denial where there is no denial based upon the ORM indicator.)

As stated above, MACs shall deny payment for claim lines with open ORM for the date of service for the associated diagnosis code(s) or family of diagnosis codes. The prompt payment rules do not override this requirement; therefore, a conditional payment cannot be made to providers when ORM exists for the item or service in question. However, as stated, the reported ORM is not a guarantee that medicals will be paid indefinitely or through a particular date. Consequently, if a claim is denied on the basis of ORM and the MAC receives information that the policy limit has been appropriately exhausted -- even though the claim in question is for services prior to the ORM termination date -- the claim may be paid if it is otherwise covered and reimbursable. This type of situation could occur where there has been a delay in billing to the RRE or where part of a group of claims submitted to the RRE was sufficient to exhaust the policy.

When Medicare denies claims due to the ORM indicator, the remittance advice for the denied claim will reflect one of the following claims adjustment reason codes (CARC) and remittance advice remarks codes (RARC):

See **MSP**, next page

MSP

From previous page

- **CARC 19** – "This is a work-related injury/illness and thus the liability of the Workers' Compensation Carrier." Also, RARC N728 – "A workers' compensation insurer has reported having ongoing responsibility for medical services (ORM) for this diagnosis"—will appear. (Note: To be used with Group Code PR.)
- **CARC 20** – "This injury/illness is covered by the liability carrier." Also, RARC N725 – "A liability insurer has reported having ongoing responsibility for medical services (ORM) for this diagnosis" —will appear. (Note: To be used with Group Code PR.)
- **CARC 21** – "This injury/illness is the liability of the no-fault carrier." Also, RARC N727 – "A no-fault insurer has reported having ongoing responsibility for medical services (ORM) for this diagnosis" —will appear. (**Note**: To be used with group code PR.)

However, Medicare payment will be made for services if the following codes and conditions are met (assumption: primary payer did not pay for an acceptable reason; for example, benefits appropriately exhausted, or benefits no longer covered due to state imposed limits, etc.):

- Any of the following CARCs are found on the ORM claim: 26, 27, 31, 32, 35, 49, 50, 51, 53, 55, 56, 60, 96, 119, 149, 166, 167, 170, 184, 200, 201, 204, 242, 256, B1 (if a Medicare covered visit), B14; and
- The service is covered and otherwise reimbursable by Medicare.

Additional information

Important: Providers, physicians, and other suppliers should know that CMS is implementing use of the ORM indicator on a gradual basis, beginning in January 2016. Appeal rights apply to all claims denied due to ORM as part of MSP claim processing.

The official instruction, CR 8984, was issued to your MAC regarding this change via two transmittals. The first transmittal is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R114MSP.pdf* and the second transmittal is at

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3358CP.pdf.

You may find further information about the mandatory reporting required by liability insurance (including self-insurance), no-fault insurance, and workers' compensation laws or plans by going to *http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Non-Group-Health-Plans/Overview.html*.

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: MM8984
Related Change Request (CR) #: CR 8984
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Related CR Transmittal #: R114MSP and R3358CP
Implementation Date: October 5, 2015

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Correct your claims on the 'SPOT'

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

Save time – correct your claims online!

Revised paper claim form CMS-1500 (version 02/12)

All paper claims are required to be submitted using the new CMS-1500 (02/12) form.

The National Uniform Claim Committee (NUCC) recently revised the CMS-1500 claim form to align the paper claim form with changes in the 5010 837P and accommodate ICD-10 reporting needs. On June 10, 2013, the White House Office of Management and Budget (OMB) approved the revised paper claim form, CMS-1500 (version 02/12). The Centers for Medicare & Medicaid Services (CMS) adopted form CMS-1500 (02/12), which replaced the older CMS-1500 claim form (08/05), effective with claims received on and after April 1, 2014.

- Medicare began accepting claims on the revised form, (02/12), on January 6, 2014;
- As of April 1, 2014, Medicare **only accepts** paper claims on the **revised CMS-1500 claim form, (02/12)**; and
- **As of April 1, 2014, Medicare no longer accepts claims on the old claim form CMS-1500 (08/05)**

The grace period for providers and suppliers to transition to the new form expired on April 1, 2014.

When completing the claim form, ensure to use all **capital typeface**.

The revised form has a number of changes. The two most prevalent changes are new indicators to differentiate between ICD-9 and ICD-10 codes and new qualifiers to identify the role of the provider entered in item 17.

- The NUCC created a presentation that reviews the changes in detail. *Click here* to view the NUCC presentation on the CMS-1500 (02/12) paper claim form.

Item 17 qualifiers

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

- **DN** – referring provider
- **DK** – ordering provider
- **DQ** – supervising provider

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

- **Note**: Claims submitted with a national provider identifier (NPI) and without one of the qualifiers notated above or an invalid qualifier will be **returned as an unprocessable claim (RUC)**.

Item 21 and 24E diagnosis changes

The revised form uses letters, instead of numbers, as diagnosis code pointers, and expands the number of possible diagnosis codes on a claim to 12.

Item 21

- For version 02/12, it may be appropriate to report either ICD-9-CM or ICD-10-CM codes depending upon the dates of service (i.e., according to the effective dates of the given code set), up to 12 diagnosis codes.
  - Enter up to 12 diagnosis codes. **Note**: this information appears opposite lines with letters A-L. Relate lines A- L to lines of service in 24E by the letter of the line. Use the highest level of specificity.
    - Do not provide narrative description in this field.
    - Do not insert a period in the ICD-9-CM or ICD-10-CM code.
  - The "ICD Indicator" identifies the ICD code set being reported. Enter the applicable ICD indicator as a single digit between the vertical, dotted lines.
  - **Indicator code set**
    - 9 – ICD-9-CM diagnosis
    - 0 – ICD-10-CM diagnosis

Reminder: Regardless of the paper claim form version in effect, providers **cannot submit ICD-10** codes for claims with dates of service **prior to October 1, 2015**.

Item 24E

- For version 02/12, the reference will be a letter from A-L.
- When completing the claim form, ensure to use all **capital typeface**. This is especially important when indicating letter "I" and "L".

Additional changes

The following additional changes are also included in the revised form:

Item 8

- Form version 02/12: Leave blank.

Item 9b

- Form version 02/12: Leave blank.

Item 11b

- Form version 02/12: Enter employer's name, if applicable. If there is a change in the insured's insurance status, e.g., retired, enter either a 6-digit (MM | DD | YY) or 8-digit (MM | DD | CCYY) retirement date preceded by the word, "RETIRED." Provide this information to the right of the vertical dotted line.

Item 14

- Form version 02/12: Although this version of the form includes space for a qualifier, Medicare does not use this information; **do not enter a qualifier in item 14**.

ASCA reminder

Only providers that meet the Administrative Simplification Compliance Act (ASCA) exception requirements are permitted to submit their claims to Medicare on paper, which must be submitted on a valid CMS-1500 claim form. Those providers meeting these exceptions are permitted to submit their claims to Medicare on paper.

More information about ASCA exceptions can be found in Chapter 24 of the *Medicare Claims Processing Manual*.

Source: CMS Internet-only manual (IOM) *Pub. 100-04 Medicare Claims Processing Manual, Chapter 24, Section 20.4*; *Chapter 26*; *Change request (CR) 8509*; *NUCC website*

Ambulatory Surgical Center

October 2015 update of the ASC payment system

Provider types affected

This *MLN Matters*® article is intended for providers submitting claims to Medicare administrative contractors (MACs) paid under the ambulatory surgical center (ASC) payment system for services provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 9310 describes changes to billing instructions for various payment policies implemented in the October 2015 ASC payment system update and includes updates to the Healthcare Common Procedure Coding System (HCPCS) used in the ASC payment system. Make sure that your billing staffs are aware of these updates.

Background

Key changes to be implemented in the October 2015 ASC payment system update are as follows:

New separately payable procedure code

Effective October 1, 2015, a new HCPCS code C9743 has been created. The short descriptor is: Bulking/spacer material impl (**Note**: The short descriptor field is limited to 28-characters, including spaces. This short descriptor is exactly 28 characters.)

The long descriptor is: Injection/implantation of bulking or spacer material (any type) with or without image guidance (not to be used if a more specific code applies). This code is being assigned the ASC payment indicator (ASC PI) of "G2" (Non office-based surgical procedure added in 2008 or later; payment based on OPPS relative payment weight).

Revised coding guidance for intraocular or periocular injections of combinations of anti-inflammatory drugs and antibiotics

Intraocular or periocular injections of combinations of anti-inflammatory drugs and antibiotics are being used with increased frequency in ocular surgery (primarily cataract surgery). One example of combined or compounded drugs includes triamcinolone and moxifloxacin with or without vancomycin. Such combinations may be administered as separate injections or as a single combined injection. Because such injections may obviate the need for post-operative anti-inflammatory and antibiotic eye drops, some have referred to cataract surgery with such injections as "dropless cataract surgery."

As stated in Chapter VIII, Section D, Item 20 of the 2015 *NCCI Policy Manual*, injection of a drug during a cataract extraction procedure or other ophthalmic procedure is not separately reportable. (The *NCCI Policy Manual* is available in the *Downloads* section at *https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html*.) Specifically, no separate procedure code may be reported for any type of injection during surgery or in the perioperative period. Injections are a part of the ocular surgery and are included as a part of the ocular surgery and the HCPCS code used to report the surgical procedure.

According to *Chapter 17*, Section 90.2, of the *Medicare Claims Processing Manual*, the compounded drug combinations described above and similar drug combinations should be reported with HCPCS code Q9977 (Compounded drug, not otherwise classified), and are packaged as surgical supplies in both the hospital outpatient department (HOPD) and the ASC. Although these drugs are a covered part of the ocular surgery, no separate payment will be made. In addition, these drugs and drug combinations may not be reported with HCPCS code C9399.

According to *Chapter 30*, Section 40.3.6 of the *Medicare Claims Processing Manual*, physicians or facilities should not give advance beneficiary notices (ABNs) to beneficiaries for either these drugs or for injection of these drugs because they are fully covered by Medicare. Physicians or facilities are not permitted to charge the patient an extra amount (beyond the standard copayment for the surgical procedure) for these injections or the drugs used in these injections because they are a covered part of the surgical procedure. Also, physicians or facilities cannot circumvent packaged payment in the HOPD or ASC for these drugs by instructing beneficiaries to purchase and bring these drugs to the facility for administration.

Drugs, biologicals, and radiopharmaceuticals

- **Drugs and biologicals with payments based on average sales price (ASP), effective October 1, 2015**
  - For 2015, payment for nonpass-through drugs, biologicals and therapeutic radiopharmaceuticals is made at a single rate of ASP + 6 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological, or therapeutic radiopharmaceutical. In 2015, a single payment of ASP + 6 percent for pass-through drugs, biologicals, and radiopharmaceuticals is made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items. Payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. Updated payment rates effective October 1, 2015, are available in the October 2015 ASC Addendum BB at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html*.
- **Drugs and biologicals based on ASP methodology with restated payment rates**

See **ASC**, next page

ASC

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

- **Drugs and biologicals with outpatient prospective payment system (OPPS) pass-through status, effective October 1, 2015**
  - For October 2015, two new HCPCS codes have been created and are shown in Table 1 below for reporting drugs and biologicals in the ASC setting with OPPS pass-through status, where there have not previously been specific codes available.

Table 1: Drugs and biologicals with OPPS pass-through status, effective October 1, 2015

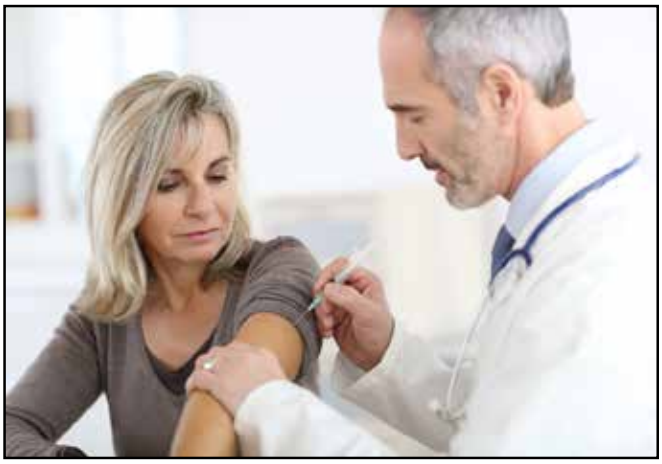
HCPCS code	Short descriptor	Long descriptor	ASC PI
C9456	Inj, isavuconazonium sulfate	Injection, isavuconazonium sulfate, 1 mg	K2
C9457	Lumason contrast agent	Injection, sulfur hexafluoride lipid microsphere, per ml	K2

- **New HCPCS codes and dosage descriptors for certain drugs, biologicals, and biosimilar biological products**
  - Effective October 1, 2015, one new HCPCS code has been created for reporting drugs and biologicals in the ASC setting, where there have not previously been specific codes available. This new code is listed in Table 2.

Table 2: New HCPCS codes and dosage descriptors for certain drugs, biologicals, and biosimilar biological products, effective October 1, 2015

HCPCS code	Short descriptor	Long descriptor	ASC PI
Q9979	Injection, alemtuzumab	Injection, alemtuzumab, 1 mg	K2

- **Revised payment indicators and effective dates for HCPCS codes 90620, 90621, and Q5101**
  - Effective January 23, 2015, the payment indicators for HCPCS codes 90620 (Menb pr w/omv vaccine im) will change from ASC PI=Y5 (Non-surgical procedure/item not valid for Medicare purposes because of coverage, regulation and/or statute; no payment made) to ASC PI=K2 (Drugs and biologicals paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate).



  - Effective October 29, 2014, the payment indicator for HCPCS code 90621 (Menb rlp vaccine im) will change from ASC PI=Y5 (Non-surgical procedure/item not valid for Medicare purposes because of coverage, regulation and/or statute; no payment made.) to ASC PI=K2 (Drugs and biologicals paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate).
  - Effective September 3, 2015, the payment indicator for HCPCS code Q5101 (Injection, filgrastim (G-CSF), biosimilar, 1 microgram) will change from ASC PI Y5 (non-surgical procedure/item not valid for Medicare purposes because of coverage, regulation and/or statute; no payment made.) to ASC PI=K2 (Drugs and biologicals paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate). Suppliers who think they may have received an incorrect payment impacted by this change may request their MAC to adjust previously processed claims. These codes are listed in Table 3, along with the effective date for the revised payment indicator.

Table 3: Drug and biological with revised payment indicator and effective date

HCPCS code	Short descriptor	Long descriptor	ASC PI	Eff date
90620	Menb rp w/omv vaccine im	*Meningococcal recombinant protein and outer membrane vesicle vaccine, serogroup B, 2 dose schedule, for intramuscular use*	K2	2/1/15

See **ASC**, next page

ASC

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HCPCS code	Short descriptor	Long descriptor	ASC PI	Eff date
90621	Menb rlp vaccine im	*Meningococcal recombinant lipoprotein vaccine, serogroup B, 3 dose schedule, for intramuscular use*	K2	2/1/15
Q5101	Inj filgrastim g-csf biosim	Injection, Filgrastim (G-CSF), Biosimilar, 1 microgram	K2	09/03/15

Coverage determinations

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

Additional information

The official instruction, CR 9310, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3361CP.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: MM9310
Related Change Request (CR) #: CR 9310
Related CR Release Date: September 25, 2015
Effective Date: October 1, 2015
Related CR Transmittal #: R3361CP
Implementation Date: October 5, 2015

Drugs and Biologicals

January 2016 quarterly ASP drug pricing files and revisions to prior files

Provider types affected

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

Provider action needed

Medicare will use the January 2016 quarterly average sales price (ASP) Medicare Part B drug pricing files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after January 1, 2016, with dates of services from January 1, 2016, through March 31, 2016.

Change request (CR) 9351, from which this article is taken, instructs MACs to implement the January 2016 ASP Medicare Part B drug pricing file for Medicare Part B drugs, and if they are released by the Centers for Medicare & Medicaid Services (CMS), to also implement the revised October 2015, July 2015, and April 2015, and January 2015 files. Make sure your billing personnel are aware of these changes.

Background

The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply MACs with the ASP and not otherwise classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the outpatient prospective payment system (OPPS) are incorporated into the *Medicare Claims Processing Manual*, Chapter 4, Section 50, outpatient code editor (OCE).

The following table shows how the files will be applied.

Files	Effective for dates of service
January 2016 ASP and ASP NOC	January 1 through March 31, 2016
October 2015 ASP and ASP NOC	October 1 through December 31, 2015
July 2015 ASP and ASP NOC	July 1 through September 30, 2015
April 2015 ASP and ASP NOC	April 1 through June 30, 2015

See **DRUG**, next page

HPSA

2016 annual update for the HPSA bonus payments

Provider types affected

This *MLN Matters*® article is intended for physicians submitting claims to Medicare administrative contractors (MACs) for services provided in health professional shortage areas (HPSAs) to Medicare beneficiaries.

Provider action needed

Change request (CR) 9342 alerts you that the annual HPSA bonus payment file for 2016 will be made available by the Centers for Medicare & Medicaid Services (CMS) to your MAC and will be used for HPSA bonus payments on applicable claims with dates of service on or after January 1, 2016, through December 31, 2016.

You should review physician bonuses Web page at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HPSAPSAPhysicianBonuses* each year to determine whether you need to add modifier AQ to your claim in order to receive the bonus payment, or to see if the ZIP code in which you rendered services will automatically receive the HPSA bonus payment. Make sure that your billing staffs are aware of these changes.

Background

Section 413(b) of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 mandated an annual update to the automated HPSA bonus payment file. CMS automated HPSA ZIP code file shall be populated using the latest designations as close as possible to November 1 of each year.

The HPSA ZIP code file shall be made available to contractors in early December of each year. MACs will implement the HPSA ZIP code file and for claims with dates of service January 1 to December 31 of the following year, shall make automatic HPSA bonus payments to physicians providing eligible services in a ZIP code contained on the file.

Additional information

The official instruction, CR 9342 issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3370CP.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: MM9342
Related Change Request (CR) #: CR 9342
Related CR Release Date: October 9, 2015
Effective Date: January 1, 2016
Related CR Transmittal #: R3370CP
Implementation Date: January 4, 2016

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

DRUG

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Files	Effective for dates of service
January 2015 ASP and ASP NOC	January 1 through March 31, 2015

Additional information

The official instruction, CR 9351, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3354CP.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: MM9351
Related Change Request (CR) #: CR 9351
Related CR Release Date: September 18, 2015
Effective Date: January 1, 2016
Related CR Transmittal #: R3354CP
Implementation Date: January 4, 2016

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Laboratory/Pathology

January 2016 changes to the laboratory national coverage determination edit software

Provider types affected

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

Provider action needed

Change request (CR) 9352 informs MACs about the changes that will be included in the January 2016 quarterly release of the edit module for clinical diagnostic laboratory services. Make sure that your billing staffs are aware of these changes.

Background

The national coverage determinations (NCDs) for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee and the final rule was published November 23, 2001. Nationally uniform software was developed and incorporated in Medicare's claims processing systems so that laboratory claims subject to one of the 23 NCDs were processed uniformly throughout the nation effective April 1, 2003.

CR 9352 communicates requirements to Medicare's shared system maintainers (SSMs) and MACs notifying them of changes to the laboratory edit module to update it for changes in laboratory NCD code lists for January 2016. Changes are being made to the NCD code lists as follows:

- Add ICD-10-CM codes N131 and N132 to the list of ICD-10-CM codes that are covered by Medicare for the urine culture, bacterial (190.12) NCD.
- Add ICD-10-CM code I481 to the list of ICD-10-CM codes that are covered by Medicare for the partial thromboplastin time (PTT) (190.16) NCD.
- Add ICD-10-CM code S069X0A to the list of ICD-10-CM codes that are covered by Medicare for the prothrombin time (PT) (190.17) NCD.
- Add ICD-10- ICD-10-CM code I481 to the list of ICD-10-CM codes that are covered by Medicare for the thyroid testing (190.22) NCD.

These changes are effective for services furnished on or after January 1, 2016.

Additional information

The official instruction, CR 9352, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3366CP.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: MM9352
Related Change Request (CR) #: CR 9352
Related CR Release Date: October 2, 2015
Effective Date: January 1, 2016
Related CR Transmittal #: R3366CP
Implementation Date: January 4, 2016

Medicare Physician Fee Schedule Database

October update to the 2015 Medicare physician fee schedule database

***Note**: Change request 9266 instructs Medicare contractors to download and implement a new Medicare physician fee schedule database (MPFSDB).This article was revised September 30, 2015, to reflect the revised CR 9266 issued September 29. In the article, additional codes (G0105 and G0121) are added in the "What you need to know" section listing RVU changes. Also, a number of codes with a revised bilateral surgery indicator are listed in that same section. The CR release date, transmittal number, and the Web address for CR 9266 are also revised. This information was previously published in the August 2015 Medicare B Connection, Page 16.*

Provider types affected

This *MLN Matters*® article is intended for physicians, other providers, and suppliers who submit claims to Medicare administrative contractors (MACs) for services subject to the Medicare physician fee schedule database (MPFSDB) that are provided to Medicare beneficiaries.

What you need to know

Changes included in the October update to the 2015 MPFSDB are effective for dates of service on and after January 1 (unless otherwise stated). The key change is to the malpractice relative value units (RVU) of the following *CPT*®/HCPCS codes: *33471, 33606, 33611, 33619, 33676, 33677, 33692, 33737, 33755, 33762, 33764, 33768, 33770, 33771, 33775, 33776, 33777, 33778, 33779, 33780, 33781, 33783, 33786, 33803, 33813, 33822, 33840*, and *33851*; and the work RVUs for G0105 and G0121. The RVU changes for these codes are retroactive to January 1, 2015. In addition, effective January 1, 2015, codes *76641*, *76641*-TC, *76641*-26, *76642*, *76642*-TC, *76642-26*, *95866*, *95866*-TC, and *95866-26* have a revised bilateral surgery indicator = 3.

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

Background

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

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

Additional information

The official instruction, CR 9266, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3364CP.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-NetworkMLN/MLNMattersArticles/index.html under - How Does It Work.

MLN Matters® Number: MM9266 *Revised*
Change Request (CR) #: CR 9266
Related CR Release Date: September 29, 2015
Implementation Date: January 1, 2015
Related Transmittal #: R3364CP
Effective Date: October 5, 2015

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.

General Coverage

ICD-10 conversion and coding infrastructure revisions to NCDs – third maintenance update

Provider types affected

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

What you need to know

Change request (CR) 9252 is the third maintenance update of ICD-10 conversions/updates specific to national coverage determinations (NCDs). The majority of the NCDs included are a result of feedback received from previous ICD-10 NCD CRs. Specifically, they were contained in CR 7818, CR 8109, CR 8197, CR 8691, and CR 9087. Related *MLN Matters*® articles are *MM7818*, *MM8109*, *MM8197*, *MM8691*, and *MM9087*. Some are the result of revisions required to other NCD-related CRs released separately that included ICD-10 coding.

Edits to ICD-10 coding specific to NCDs will be included in subsequent, quarterly updates as needed. No policy-related changes are included with these updates. Any policy-related changes to NCDs continue to be implemented via the current, long-standing NCD process.

Background

CR 9252 creates and updates NCD editing, both hard-coded shared system edits as well as local MAC edits that contain ICD-10 diagnosis/procedure codes, plus all associated coding infrastructure such as HCPCS/*CPT*® codes, reason/remark codes, frequency edits, place of service (POS), type of bill (TOB), provider specialties, and so forth. The requirements described in CR 9252 reflect the operational changes that are necessary to implement the conversion of the Medicare local and shared system diagnosis and procedure codes specific to the 26 Medicare NCD spreadsheets, which are available at *https://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/CR9252.zip*.

NCD policies may contain specific covered, non-covered and/or discretionary diagnosis and procedure coding. These 26 spreadsheets are designated as such and are based on current NCD policies and their corresponding edits. You should be aware that nationally covered and non-covered diagnosis code lists are finite and cannot be revised without a subsequent CR. Discretionary code lists are to be regarded as CMS' compilation of discretionary codes based on current analysis/interpretation. MACs may or may not expand discretionary lists based on their individual local authority within their respective jurisdictions.

Some coding details are as follows:

1. Your MAC will use default Council for Affordable Quality Healthcare (CAQH) Committee on operating rules for information exchange (CORE) messages, where appropriate:
   - **Remittance advice remark code (RARC) N386** (This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered), along with
   - **Claim adjustment reason code (CARC) 50** (These are noncovered services because this is not deemed a "medical necessity" by the payer),
   - **CARC 96 (Non-covered charge(s).** At least one Remark Code must be provided [may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT]), and/or
   - **CARC 119** (Benefit maximum for this time period or occurrence has been reached).
2. When denying claims associated with the NCDs in the 26 spreadsheets, except where otherwise indicated, your MACs will use:
   - **Group code PR** (patient responsibility) assigning financial responsibility to the beneficiary (if a claim is received with occurrence code 32 (advance beneficiary notice), or with occurrence code 32 and a GA modifier (The provider or supplier has provided an advance beneficiary notice (ABN) to the patient), indicating a signed ABN is on file).
   - **Group code CO** (contractual obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier (The provider or supplier expects a medical necessity denial; however, did not provide an advance beneficiary notice (ABN) to the patient), indicating no signed ABN is on file)
   - For modifier GZ, your MAC will use CARC 50.

Additional information

The official instruction, CR 9252, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1537OTN.pdf*.

MLN Matters® Number: MM9252
Related Change Request (CR) #: CR 9252
Related CR Release Date: August 21, 2015
Effective Date: October 1, 2015
Implementation Date: January 4, 2016, Exceptions: FISS will implement the following NCDs: April 4, 2016: 260.1, 80.11, 270.6, 160.18, 110.10, 110.21, 250.5, 100.1, 160.24
Related CR Transmittal #: R1537OTN

Remittance advice remark and claims adjustment reason code and Medicare remit easy print and PC print update

Note: This article was revised October 13, 2015, to correct a code in the modified codes – RARC table. The code of N109 is now shown in that table, instead of the incorrect code of M109. All other information remains the same. This article was previously published in the August 2015 edition of *Medicare B Connection, Pages 19-20*.

Provider types affected

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

Provider action needed

Stop – Impact to You

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

Caution – what you need to know

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

Go – What you need to do

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

Background

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

The CARC and RARC changes that impact Medicare are usually requested by staff of the Centers for Medicare & Medicaid Services (CMS), in conjunction with a policy change. MACs are notified about these changes in the corresponding instructions from the specific

CMS component that implements the policy change, in addition to the regular code update notification. If a modification has been initiated by an entity other than CMS for a code currently used by Medicare, MACs must either use the modified code or another code if the modification makes the modified code inappropriate to explain the specific reason for adjustment. If any new or modified code has an effective date past the implementation date specified in CR 9278, MACs must implement on the effective date found at the WPC website.

The discrepancy between the dates may arise because the Washington Publishing Company (WPC) website gets updated only three times per year and may not match the CMS release schedule. CR 9278 lists only the changes that have been approved since the last code update by CR 9125, issued April 13, 2015, and does not provide a complete list of codes for these two code sets.

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

Changes in RARC list since CR 9125

New codes – RARC

Code	Modified narrative	Effective date
N753	Missing/Incomplete/Invalid attachment control number.	7/1/2015
N754	Missing/Incomplete/Invalid referring provider or other source qualifier on the 1500 claim form.	7/1/2015
N755	Missing/Incomplete/Invalid ICD Indicator on the 1500 Claim Form.	7/1/2015
N756	Missing/Incomplete/Invalid point of drop-off address,	7/1/2015
N757	Adjusted based on the federal indian fees schedule (MLR).	7/1/2015
N758	Adjusted based on the prior authorization decision.	7/1/2015
N759	Payment adjusted based on the National Electrical Manufacturers Association (NEMA) Standard XR-29-2013.	7/1/2015

Modified codes – RARC

Code	Modified narrative	Effective date
M47	Missing/Incomplete/Invalid payer claim control number. Other terms exist for this element including, but not limited to, internal control number (ICN), claim control number (CCN), document control number (DCN).	7/1/2015

See **REMITTANCE**, next page

REMITTANCE

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Code	Modified narrative	Effective date
MA74	Alert: This payment replaces an earlier payment for this claim that was either lost, damaged or returned.	7/1/2015
N432	Alert: Adjustment based on a recovery audit.	7/1/2015
N22	Alert: This procedure code was added/changed because it more accurately describes the services rendered.	7/1/2015
M39	Alert: The patient is not liable for payment of this service as the advance notice of non-coverage you provided the patient did not comply with program requirements.	7/1/2015
N109	Alert: This claim/service was chosen for complex review.	7/1/2015
M38	Alert: The patient is liable for the charges for this service as they were informed in writing before the service was furnished that we would not pay for it and the patient agreed to be responsible for the charges.	7/1/2015
N381	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.	7/1/2015
MA91	Alert: This determination is the result of the appeal you filed.	7/1/2015

Deactivated codes - RARC

Code	Current narrative	Effective date
N102	This claim has been denied without reviewing the medical/dental record because the requested records were not received or were not received timely.	07/01/2016

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

Changes in CARC list since CR 9125

New code – CARC

Code	Modified narrative	Effective date
270	Claim received by the medical plan, but benefits not available under this plan. Submit these services to the patient's dental plan for further consideration.	7/1/2015

Modified code – CARC

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

There have been no **deactivated** CARC codes since CR 9125.

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

Additional information

The official instruction, CR 9278, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3298CP.pdf*.

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

MLN Matters® Number: MM9278 *Revised*
Related Change Request (CR) #: CR 9278
Related CR Release Date: August 6, 2015
Effective Date: October 1, 2015
Related CR Transmittal #: R3298CP
Implementation Date: October 5, 2015

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

***Note**: This article was revised September 24, 2015 to change the link to the ordering referring report. That link was changed to https://data.cms.gov on the CMS website. For a complete list of any other changes to this article, please refer to the "Document history" section. All other information remains the same. This information was previously published in the May 2015 Medicare B Connection, Page 24.*

Provider types affected

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

Provider action needed

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

Background

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

Every provider or supplier that submits an enrollment application must furnish its NPI(s) in the applicable section(s) of the form CMS-855.

The Centers for Medicare & Medicaid Services (CMS) has implemented edits that verify that the NPI reported for physicians or non-physician practitioners in the attending or rendering physician fields on CAH method II claims for payment has a valid NPI and that the provider for that NPI is enrolled in Medicare in an approved status, otherwise the claim will be rejected.

If the physician or non-physician practitioner is not enrolled in Medicare, he/she will need to establish an enrollment record in the Provider Enrollment Chain and Ownership System (PECOS) with a valid NPI. He/she may submit their enrollment application electronically using the Internet-based Provider Enrollment, Chain, and Ownership System (PECOS) located at *https://pecos.cms.hhs.gov/pecos/login.do* or by completing the paper CMS-855I or CMS- 855O application, which is available at *http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-List.html*. Note that an application fee is not required as part of the physician's or non-physician practitioner's application submission.

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

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

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

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

Additional information

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

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

Document history

Date	Description
September 24, 2015	This article was revised to change the link to the ordering referring report. That link was changed to *https://data.cms.gov*.

See **CAH**, next page

Physician and non-physician practitioners' use of scribes

Physicians and non-physician practitioners (NPPs) may utilize the services of a scribe to assist with documentation during a clinical encounter, which may be in an office or facility setting, between the physician/NPP and the patient. A scribe can be an NPP, a nurse, clinical assistant, or other ancillary personnel allowed by the physician/NPP, to document his/her services in the patients' medical record.

A scribe's core responsibility is to capture an accurate and detailed description (handwritten, electronic, or otherwise) of the patient encounter in a timely manner. Scribes are clerical in nature and are not permitted to make independent decisions or translations while capturing or entering information into the health record beyond what is directed by the physician/NPP. Some practices utilize clinical staff to perform scribe functions, so it is important to clearly define and differentiate their clinical duties from their scribe duties. Even though it's acceptable for a physician/NPP to use a scribe, current Medicare documentation guidelines must be followed. The physician is ultimately accountable for the documentation and should sign and notate after the scribe's entry that the documentation accurately reflects the work done by the physician.

Documentation of scribed services should indicate who performed the service and who recorded the service. The scribe's note should include "written by [name and title of scribe], acting as scribe for Dr./NPP [name of physician/NPP]," and the date and time of entry into the medical record. The physician should legibly co-sign (either hard copy or electronic) and date the entry, indicating that the note accurately reflects work and decisions made and dictated by him/her.

Record entries made by a scribe should be made upon dictation by the physician and should document clearly the level of service provided at that encounter. This requirement is no different from any other encounter's documentation requirement. Medicare pays for medically necessary and reasonable services and expects the person receiving payment to be the one delivering the services and creating the record. The scribe should not act independently, and there is no payment for the services of the scribe.

Sources: *American Academy of Professional Coders – Use Scribes Appropriately*
American Health Information Management Association – Using Medical Scribes in a Physician Practice
American College of Emergency Physicians Scribe FAQ
The Joint Commission Scribe FAQ
Ensuring Proper Use of Electronic Health Record Features and Capabilities: A Decision Table

Widespread probe notification for myocardial perfusion imaging

Provider types affected

First Coast Service Options Inc. (First Coast) will conduct a widespread probe (WSP) in response to an aberrant billing pattern identified for *Current Procedural Terminology* (*CPT*®) code *78452* Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection.

First Coast will complete a WSP for dates of service February 1, 2015, to July 31, 2015, to validate documentation supports the medical necessity of myocardial perfusion studies as identified in the local coverage determination Cardiovascular Nuclear Imaging Studies (LCD 29093).

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MLN Matters® Number: SE1505 *Revised*
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Effective Date: N/A Related CR
Transmittal #: N/A
Implementation Date: N/A

Full implementation of edits on home health agency claims filed by ordering/referring providers

***Note**: This article was revised September 24, 2015, to change the link to the "Ordering Referring Report" under the "What you need to know" and "Questions and answers relating to the edits" sections. That link was changed to https://data.cms.gov on the Centers for Medicare & Medicaid Services website. For a complete list of any other changes to this article, please refer to the Document History Section. All other information remains the same. This article was previously published in the February 2014 Medicare B Connection, Pages 51-57.*

Provider types affected

This *MLN Matters*® special edition article is intended for:

- Physicians and non-physician practitioners (including interns, residents, fellows, and those who are employed by the Department of Veterans Affairs (DVA), the Department of Defense (DoD), or the Public Health Service (PHS)) who order or refer items or services for Medicare beneficiaries,
- Part B providers and suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) who submit claims to carriers, Part A/B Medicare administrative contractors (MACs), and DME MACs for items or services that they furnished as the result of an order or a referral, and
- Part A home health agency (HHA) services who submit claims to regional home health intermediaries (RHHIs), fiscal intermediaries (FIs, who still maintain an HHA workload), and Part A/B MACs.
- Optometrists may only order and refer DMEPOS products/services and laboratory and X-ray services payable under Medicare Part B.

Provider action needed

If you order or refer items or services for Medicare beneficiaries and you do not have a Medicare enrollment record, you need to submit an enrollment application to Medicare. You can do this using the Internet-based provider enrollment, chain, and ownership system (PECOS) or by completing the paper enrollment application (CMS-855O). Review the *Background* and *Additional information* sections and make sure that your billing staff is aware of these updates.

What providers need to know

Phase 1: **Informational messaging**: Began October 5, 2009, to alert the billing provider that the identification of the ordering/referring provider is missing, incomplete, or invalid, or that the ordering/referring provider is not eligible to order or refer. The informational message on an adjustment claim that did not pass the edits indicated the claim/service lacked information that was needed for adjudication.

Phase 2: Effective January 6, 2014, CMS will turn on the edits to deny Part B clinical laboratory and imaging, DME, and Part A HHA claims that fail the ordering/referring provider edits.

Claims submitted identifying an ordering/referring provider and the required matching NPI is missing will continue to be rejected.

Claims from billing providers and suppliers that are denied because they failed the ordering/referring edit will not expose a Medicare beneficiary to liability. Therefore, **an advance beneficiary notice is not appropriate in this situation**. This is consistent with the preamble to the final rule which implements the Affordable Care Act requirement that physicians and eligible professionals enroll in Medicare to order and certify certain Medicare covered items and services, including home health, DMEPOS, imaging and clinical laboratory.

Physicians and others who are eligible to order and refer items or services need to establish their Medicare enrollment record and must be of a specialty that is eligible to order and refer. Physicians and others who are eligible to order and refer items or services need to establish their Medicare enrollment record with a valid NPI and must be of a specialty that is eligible to order and refer. If the ordering/referring provider is listed on the claim, the edits will verify that the provider is enrolled in Medicare. The edits will compare the first four letters of the last name. **When submitting the CMS-1500 or the CMS-1450, please only include the first and last name as it appears on the ordering and referring file found on** *https://data.cms.gov***.** Middle names (initials) and suffixes (such as MD, RPNA etc.) should not be listed in the ordering/referring fields.

All enrollment applications, including those submitted over the Internet, require verification of the information reported. Sometimes, Medicare enrollment contractors may request additional information in order to process the enrollment application. Waiting too long to begin this process could mean that your enrollment application may not be processed prior to the implementation date of the ordering/referring Phase 2 provider edits.

Background

The Affordable Care Act, Section 6405, "Physicians Who Order Items or Services are required to be Medicare Enrolled Physicians or Eligible Professionals," requires physicians or other eligible professionals to be enrolled in the Medicare program to order or refer items or services for Medicare beneficiaries.

Some physicians or other eligible professionals do not and will not send claims to a Medicare contractor for the services they furnish and therefore may not be enrolled in the Medicare program. Also, effective January 1, 1992, a physician or supplier that bills Medicare for a service or item must show the name and unique identifier of the attending physician on the claim if that service or item was the result of an order or referral.

Effective May 23, 2008, the unique identifier was

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determined to be the NPI. The Centers for Medicare & Medicaid Services (CMS) has implemented edits on ordering and referring providers when they are required to be identified in Part B clinical laboratory and imaging, DME, and Part A HHA claims from Medicare providers or suppliers who furnished items or services as a result of orders or referrals.

Below are examples of some of these types of claims:

- Claims from clinical laboratories for ordered tests;
- Claims from imaging centers for ordered imaging procedures;
- Claims from suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) for ordered DMEPOS; and
- Claims from Part A home health agencies (HHA).

Only physicians and certain types of non-physician practitioners are eligible to order or refer items or services for Medicare beneficiaries. They are as follows:

- 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 refer 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 referred by providers or suppliers authorized by Medicare statute and regulation to do so. Claims that a billing provider or supplier submits in which the ordering/referring provider or supplier is not authorized by statute and regulation will be denied as a non-covered service. The denial will be based on the fact that neither statute nor regulation allows coverage of certain services when ordered or referred by the identified supplier or provider specialty.

CMS would like to highlight the following limitations:

- Chiropractors are not eligible to order or refer supplies or services for Medicare beneficiaries. All services ordered or referred by a chiropractor will be denied.
- Home health agency (HHA) services may only be ordered or referred 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 refer DMEPOS products/services, and laboratory and X-ray services payable under Medicare Part B.

Questions and answers relating to the edits

1. What are the ordering and referring edits?

The edits will determine if the ordering/referring provider (when required to be identified in Part B clinical laboratory and imaging, DME, and Part A HHA claims) (1) has a current Medicare enrollment record and contains a valid NPI (the name and NPI must match), and (2) is of a provider type that is eligible to order or refer for Medicare beneficiaries (see list above).

2. Why did Medicare implement these edits?

These edits help protect Medicare beneficiaries and the integrity of the Medicare program.

3. How and when will these edits be implemented?

These edits were implemented in two phases:

Phase 1 - Informational messaging: Began October 5, 2009, to alert the billing provider that the identification of the ordering/referring provider is missing, incomplete, or invalid, or that the ordering/referring provider is not eligible to order or refer. The informational message on an adjustment claim that did not pass the edits indicated the claim/service lacked information that was needed for adjudication. The informational messages used are identified below:

For Part B providers and suppliers who submit claims to carriers:

N264	Missing/incomplete/invalid ordering provider name
N265	Missing/incomplete/invalid ordering provider primary identifier

For adjusted claims, the claims adjustment reason code (CARC) code 16 (Claim/service lacks information which is needed for adjudication.) is used.

DME suppliers who submit claims to carriers (applicable to 5010 edits):

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N544 Alert: Although this was paid, you have billed with a referring/ordering provider that does not match our system record. Unless, corrected, this will not be paid in the future

For Part A HHA providers who order and refer, the claims system initially processed the claim and added the following remark message:

N272 Missing/incomplete/invalid other payer attending provider identifier

For adjusted claims the CARC code 16 and/or the RARC code N272 was used.

CMS has taken actions to reduce the number of informational messages. In December 2009, CMS added the NPIs to more than 200,000 PECOS enrollment records of physicians and non-physician practitioners who are eligible to order and refer but who had not updated their PECOS enrollment records with their NPIs. (NPIs were added only when the matching criteria verified the NPI.)

On January 28, 2010, CMS made available to the public, via the *Downloads* section of the "Ordering Referring Report" page on the Medicare provider/supplier enrollment website, a file containing the NPIs and the names of physicians and non-physician practitioners who have current enrollment records in PECOS and are of a type/specialty that is eligible to order and refer. The file, called the ordering referring report, lists, in alphabetical order based on last name, the NPI and the name (last name, first name) of the physician or non-physician practitioner.

To keep the available information up to date, CMS will replace the report twice a week. At any given time, only one report (the most current) will be available for downloading. To learn more about the report and to download it, go to *https://data.cms.gov*.

Phase 2: Effective January 6, 2014, CMS will turn on the Phase 2 edits. In Phase 2, if the ordering/referring provider does not pass the edits, the claim will be denied. This means that the billing provider will not be paid for the items or services that were furnished based on the order or referral.

Below are the denial edits for Part B providers and suppliers who submit claims to Part A/B MACs, including DME MACs:

254D or 001L	Referring/ordering provider not allowed to refer/order
255D or 002L	Referring/ordering provider mismatch

CARC code 16 or 183 and/or the RARC code N264, N574, N575 and MA13 shall be used for denied or adjusted claims.

Claims submitted identifying an ordering/referring provider and the required matching NPI is missing (edit 289D) will continue to be rejected. CARC code 16 and/or the RARC code N265, **N276 and MA13 shall be used for rejected claims due to the missing required matching NPI.**

Below are the denial edits for Part A HHA providers who submit claims:

Reason code	This reason code will assign when:
37236	▪ The statement "From" date on the claim is on or after the date the phase 2 edits are turned on ▪ The type of bill is '32' or '33' ▪ Covered charges or provider reimbursement is greater than zero but the attending physician NPI on the claim is not present in the eligible attending physician file from PECOS or the attending physician NPI on the claim is present in the eligible attending physician files from PECOS but the name does not match the NPI record in the eligible attending physician files from EPCOS or the specialty code is not a valid eligible code
37237	▪ The statement "From" date on the claim is on or after the date the phase 2 edits are turned on ▪ The type of bill is '32' or '33' ▪ The type of bill frequency code is '7' or 'F-P' ▪ Covered charges or provider reimbursement is greater than zero but the attending physician NPI on the claim is not present in the eligible attending physician file from PECOS or the attending physician NPI on the claims is present in the eligible attending physician files from PECOS but the name does not match the NPI record in the eligible attending physician files from PECOS or the specialty code is not a valid eligible code

Effect of edits on providers

I order and refer. How will I know if I need to take any sort of action with respect to these two edits?

In order for the claim from the billing provider (the provider who furnished the item or service) to be paid by Medicare for furnishing the item or service that you ordered or referred, **you, the ordering/referring provider, need to ensure that**:

a) You have a current Medicare enrollment record.

- If you are not sure you are enrolled in Medicare, you may:
  - i. Check the ordering referring report and if you are on that report, you have a current enrollment record in Medicare and it contains your NPI;
  - ii. Contact your designated Medicare enrollment contractor and ask if you have an enrollment

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record in Medicare and it contains the NPI; or

iii. Use Internet-based PECOS to look for your Medicare enrollment record (if no record is displayed, you do not have an enrollment record in Medicare).

iv. If you choose iii, please read the information on the Medicare provider/supplier enrollment Web page about Internet-based PECOS before you begin.

b) If you do not have an enrollment record in Medicare:

- You need to submit either an electronic application through the use of internet-based PECOS or a paper enrollment application to Medicare.

i. For paper applications - fill it out, sign and date it, and mail it, along with any required supporting paper documentation, to your designated Medicare enrollment contractor.

ii. For electronic applications – complete the online submittal process and either e-sign or mail a printed, signed, and dated certification statement and digitally submit any required supporting paper documentation to your designated Medicare enrollment contractor.

iii. In either case, the designated enrollment contractor cannot begin working on your application until it has received the signed and dated certification statement.

iv. If you will be using Internet-based PECOS, please visit the Medicare provider/supplier enrollment Web page to learn more about the web-based system before you attempt to use it. Go to *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html*, click on "Internet-based PECOS" on the left-hand side, and read the information that has been posted there. Download and read the documents in the *Downloads* section on that page that relate to physicians and non-physician practitioners. A link to Internet-based PECOS is included on that Web page.

v. If you order or refer items or services for Medicare beneficiaries and you do not have a Medicare enrollment record, you need to submit an enrollment application to Medicare. You can do this using Internet-based PECOS or by completing the paper enrollment application (CMS-855O). Enrollment applications are available via Internet-based PECOS or .pdf for downloading from the CMS forms page (*http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/index.html*).

c) You are an opt-out physician and would like to order and refer services. What should you do?

If you are a physician who has opted out of Medicare, you may order items or services for Medicare beneficiaries by submitting an opt-out affidavit to a Medicare contractor within your specific jurisdiction. Your opt-out information must be current (an affidavit must be completed every 2 years, and the NPI is required on the affidavit).

d) You are of a type/specialty that can order or refer items or services for Medicare beneficiaries.

When you enrolled in Medicare, you indicated your Medicare specialty. **Any** physician specialty (chiropractors are excluded) and **only** the non-physician practitioner specialties listed above in this article are eligible to order or refer in the Medicare program.

e) I bill Medicare for items and services that were ordered or referred. How can I be sure that my claims for these items and services will pass the ordering/referring provider edits?

- You need to ensure that the physicians and non-physician practitioners from whom you accept orders and referrals have current Medicare enrollment records and are of a type/specialty that is eligible to order or refer in the Medicare program. If you are not sure that the physician or non-physician practitioner who is ordering or referring items or services meets those criteria, it is recommended that you check the ordering referring report described earlier in this article.
- Ensure you are correctly spelling the ordering/referring provider's name.
- If you furnished items or services from an order or referral from someone on the ordering referring report, your claim should pass the ordering/referring provider edits.
- The ordering referring report will be replaced twice a week to ensure it is current. It is possible that you may receive an order or a referral from a physician or non-physician practitioner who is not listed in the ordering referring report but who may be listed on the next report.

f) Make sure your claims are properly completed.

- On paper claims (CMS-1500), in item 17, only include the first and last name as it appears on the ordering and referring file found on CMS.gov.
- On paper claims (CMS-1450), you would capture the attending physician's last name, first name and NPI on that form in the applicable sections. On the most recent form it would be fields in FL 76.
- On paper claims (CMS-1500 and CMS-1450), do not enter "nicknames", credentials (e.g., "Dr.", "MD", "RPNA", etc.) or middle names (initials) in the ordering/referring name field, as their use could cause the claim to fail the edits.
- Ensure that the name and the NPI you enter for the ordering/referring provider belong to a

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physician or non-physician practitioner and not to an organization, such as a group practice that employs the physician or non-physician practitioner who generated the order or referral.

- Make sure that the qualifier in the electronic claim (X12N 837P 4010A1) 2310A NM102 loop is a one (person). organizations (qualifier two) cannot order and refer.

If there are additional questions about the informational messages, billing providers should contact their local A/B MAC, or DME MAC.

Claims from billing providers and suppliers that are denied because they failed the ordering/referring edit shall not expose a Medicare beneficiary to liability. Therefore, **an advance beneficiary notice is not appropriate in this situation**. This is consistent with the preamble to the final rule which implements the Affordable Care Act requirement that physicians and eligible professionals enroll in Medicare to order and certify certain Medicare covered items and services including home health, DMEPOS, imaging and clinical laboratory.

g) What if my claim is denied inappropriately?
If your claim did not initially pass the ordering/referring provider edits, you may file an appeal through the standard claims appeals process or work through your A/B MAC or DME MAC.

h) How will the technical vs. professional components of imaging services be affected by the edits?
Consistent with the Affordable Care Act and 42 CFR 424.507, suppliers submitting claims for imaging services must identify the ordering or referring physician or practitioner. Imaging suppliers covered by this requirement include the following: IDTFs, mammography centers, portable X-ray facilities and radiation therapy centers. The rule applies to the technical component of imaging services, and the professional component will be excluded from the edits. However, if billing globally, both components will be impacted by the edits and the entire claim will deny if it doesn't meet the ordering and referring requirements. It is recommended that providers and suppliers bill the global claims separately to prevent a denial for the professional component.

i) Are the Phase 2 edits based on date of service or date of claim receipt?
The Phase 2 edits are effective for claims with dates of service on or after January 6, 2014.

j) A Medicare beneficiary was ordered a 13-month DME capped rental item. Medicare has paid claims for rental months one and two. The equipment is in the 3rd rental month at the time the Phase 2 denial edits are implemented. The provider who ordered the item has been deactivated. How will the remaining claims be handled?

Claims for capped rental items will continue to be paid for up to 13 months from the physician's date of deactivation to allow coverage for the duration of the capped rental period.

Additional guidance

1. **Terminology**: Part B claims use the term "ordering/referring provider" to denote the person who ordered, referred, or certified an item or service reported in that claim. The final rule uses technically correct terms:
   a. a provider "orders" non-physician items or services for the beneficiary, such as DMEPOS, clinical laboratory services, or imaging services and
   b. a provider "certifies" home health services to a beneficiary. The terms "ordered" "referred" and "certified" are often used interchangeably within the health care industry. Since it would be cumbersome to be technically correct, CMS will continue to use the term "ordered/referred" in materials directed to a broad provider audience.
2. **Orders or referrals by interns or residents**: The IFC mandated that all interns and residents who order and refer specify the name and NPI of a teaching physician (i.e., the name and NPI of the teaching physician would have been required on the claim for service(s)). The final rule states that state-licensed residents may enroll to order and/or refer and may be listed on claims. Claims for covered items and services from un-licensed interns and residents must still specify the name and NPI of the teaching physician. However, if states provide provisional licenses or otherwise permit residents to order and refer services, CMS will allow interns and residents to enroll to order and refer, consistent with state law.
3. **Orders or referrals by physicians and non-physician practitioners who are of a type/specialty that is eligible to order and refer who work for the Department of Veterans Affairs (DVA), the Public Health Service (PHS), or the Department of Defense (DoD)/Tricare**: These physicians and non-physician practitioners will need to enroll in Medicare in order to continue to order or refer items or services for Medicare beneficiaries. They may do so by filling out the paper CMS-855O or they may use Internet-based PECOS. They will not be submitting claims to Medicare for services they furnish to Medicare beneficiaries.
4. **Orders or referrals by dentists: Most dental services are not covered by Medicare**; therefore, most dentists do not enroll in Medicare. Dentists are a specialty that is eligible to order and refer items or services for Medicare beneficiaries (e.g., to send specimens to a laboratory for testing). To do so, they must be enrolled in Medicare. They may enroll by filling out the paper CMS-855O or they may use Internet-based PECOS. They will not be submitting claims to Medicare for services they furnish to Medicare beneficiaries.

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Additional information

For more information about the Medicare enrollment process, visit *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html* or contact the designated Medicare contractor for your state.

Medicare provider enrollment contact information for each state can be found at *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/Contact_list.pdf*.

The *Medicare Learning Network*® (MLN) fact sheet titled, "Medicare Enrollment Guidelines for Ordering/Referring Provider," is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_OrderReferProv_factSheet_ICN906223.pdf*.

Note: You must obtain a national provider identifier (NPI) prior to enrolling in Medicare. Your NPI is a required field on your enrollment application. Applying for the NPI is a separate process from Medicare enrollment. To obtain an NPI, you may apply online at *https://nppes.cms.hhs.gov/NPPES/Welcome.do*.

For more information about NPI enumeration, visit *http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/NationalProvIdentStand/index.html*.

Additional article updates

MLN Matters® article MM7097, "Eligible Physicians and Non-Physician Practitioners Who Need to Enroll in the Medicare Program for the Sole Purpose of Ordering and Referring Items and Services for Medicare Beneficiaries," is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7097.pdf*.

MLN Matters® article MM6417, "Expansion of the Current Scope of Editing for Ordering/Referring Providers for Claims Processed by Medicare Carriers and Part B Medicare Administrative Contractors (MACs)," is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6417.pdf*.

MLN Matters® article MM6421, "Expansion of the Current Scope of Editing for Ordering/Referring Providers for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers' Claims Processed by Durable Medical Equipment Medicare Administrative Contractors (DME MACs)," is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6421.pdf*;

MLN Matters® article MM6129, "New Requirement for Ordering/Referring Information on Ambulatory Surgical Center (ASC) Claims for Diagnostic Services," is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6129.pdf*.

MLN Matters® article MM6856, "Expansion of the Current Scope for Attending Physician Providers for free-standing and provider-based Home Health Agency (HHA) Claims processed by Medicare Regional Home Health Intermediaries (RHHIs)," is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6856.pdf*.

MLN Matters® article SE1311, "Opting out of Medicare and/or Electing to Order and Refer Services" is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1311.pdf* informs ordering and referring providers about the information they must provide in a written affidavit to their Medicare contractor when they opt-out of Medicare.

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

Important information for physicians and non-physician practitioners who opt out of Medicare and/or elect to order and certify services to Medicare beneficiaries is available in *MLN Matters*® article SE1311 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1311.pdf*.

Document history

Date	Description
9/24/15	This article was revised to change the link to the "Ordering Referring Report" page. That link was changed to *https://data.cms.gov* on the CMS website.
1/26/15	This article was revised to include a link to article SE1311, which includes important information for physicians and non-physician practitioners who opt out of Medicare and/or elect to order and certify services to Medicare beneficiaries.
4/19/13	This article was previously revised add references to the CMS-1450 form and to add question H. on page 9. Previously, it was revised on April 3, 2013, to advise providers to not include middle names and suffixes of ordering/referring providers on paper claims. Physicians and others who are eligible to order and refer items or services need to establish their Medicare enrollment record with a valid National Provider Identifier (NPI) and must be of a specialty that is eligible to order and refer. If the ordering/referring provider is listed on the claim, the edits will verify that the provider is enrolled in Medicare. The edits will compare the first four letters of the last name. When submitting the CMS-1500 or the CMS-1450, please only include the first and last name as it appears on the ordering and referring file found at *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/MedicareOrderingandReferring.html*.

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Provider enrollment requirements for writing prescriptions for Medicare Part D drugs

Note: This article was revised October 20, 2015, to communicate changes to and the delayed enforcement of the Part D prescriber enrollment requirement until June 1, 2016, and to provide clarifying information regarding the enrollment process. All other information remains the same. This article was previously published in the December 2014 Medicare B Connection, Pages 19-20.

Provider types affected

This *MLN Matters*® special edition is intended for physicians, dentists, and other eligible professionals who write prescriptions for Medicare beneficiaries for Medicare Part D drugs. The article is also directed to Medicare Part D plan sponsors.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) finalized CMS-4159-F, "Medicare Program; Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs" on May 23, 2014. CMS later published CMS-6107-IFC, "Medicare Program; Changes to the Requirements for Part D Prescribers," an interim final rule with comment ("IFC"), that made changes to the final rule (CMS-4159-F), on May 6, 2015.

Together, these rules require virtually all physicians and other eligible professionals, including dentists, who write prescriptions for Part D drugs to be enrolled in an approved status or to have a valid opt-out affidavit on file for their prescriptions to be coverable under Part D, except in very limited circumstances. To allow sufficient time for the prescribers to enroll in Medicare and the Part D sponsors and the pharmacy benefit managers (PBMs) to make the complex system enhancements needed to comply with the prescriber enrollment requirements, CMS announced a delay in enforcement of this rule until June 1, 2016.

Nevertheless, prescribers of Part D drugs should submit their Medicare enrollment applications or opt-out affidavits to their Part B Medicare administrative contractors (MACs) by January 1, 2016, or earlier, to ensure that MACs have sufficient time to process the applications and opt-out affidavits and avoid their patients' prescription drug claims from being denied by their Part D plans, beginning June 1, 2016 (Enrollment functions for physicians and other prescribers are handled by MACs).

The purpose of these rules is to ensure that Part D drugs are prescribed only by physicians and eligible professionals who are qualified to do so under state law and under the requirements of the Medicare program and who do not pose a risk to patient safety. By implementing these rules, CMS is improving the integrity of the Part D prescription drug program by using additional tools to reduce fraud, waste, and abuse in the Medicare program. Prescribers who are determined to have a pattern or practice of prescribing Part D drugs that are abusive and represents a threat to the health and safety of Medicare enrollees or fails to meet Medicare requirements will have their billing privileges revoked under 42 USC 424.535 (a) (14).

Background

If you write prescriptions for covered Part D drugs and you are not already enrolled in Medicare in an approved status or have a valid record of opting out, you should submit an enrollment application or an opt-out affidavit to your MAC by January 1, 2016, or earlier, so that the prescriptions you write for Part D beneficiaries are coverable on and after June 1, 2016.

To enroll in Medicare for the limited purpose of prescribing: You may submit your enrollment application electronically using the Internet-based Provider Enrollment, Chain, and Ownership System (PECOS) located at *https://www.cms.gov/medicare/provider-enrollment-andcertification/medicareprovidersupenroll/internetbasedpecos.html* or by completing the paper CMS-855O application, which is available at *https://www.cms.gov/Medicare/CMSForms/CMS-Forms/downloads/cms855o.pdf*, which must be submitted to the MAC that services your geographic area. Note that there is no application fee required for your application submission. For step-by-step instructions, refer to the PECOS how-to guide, available at *http://go.cms.gov/orderreferhowtoguide* or watch an instructional video at *http://go.cms.gov/videotutorial*.

The CMS-855O is a shorter, abbreviated form and takes

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MLN Matters® Number: SE1305 *Revised*
Related Change Request (CR) #: CR 6421, 6417, 6696, 6856
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: R642OTN, R643OTN, R328PI, and R781OTN
Implementation Date: N/A

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minimal time to complete. While the CMS-855O form states it is for physicians and non-physician practitioners who want to order and certify, it is also appropriate for use by prescribers, who want to enroll to also prescribe Part D drugs. (CMS is in the process of updating the CMS-855O form). If you do not see your specialty listed on the application, please select the *Undefined Physician/Non-Physician Type* option and identify your specialty in the space provided.

The average processing time for CMS-855O applications submitted online is 45 days versus paper submissions which is 60 days. However, your application could be processed sooner depending on the MAC's current workload.

To enroll to bill for services (and prescribe Part D drugs):

To enroll in Medicare to bill for your services, you may complete the CMS-855I application. The CMS-855R should also be completed if you wish to reassign your right to bill the Medicare program and receive Medicare payments for some or all of the services you render to Medicare beneficiaries. All actions can be completed via PECOS or the paper enrollment application.

For more information on enrolling in Medicare to bill for services refer to *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedEnroll_PECOS_PhysNonPhys_FactSheet_ICN903764.pdf.*

If you are a physician or non-physician practitioner who wants to opt-out of Medicare, you must submit an opt-out affidavit to the MAC that services your geographic area. Physicians and non-physician practitioners should be aware that if they choose to opt-out of Medicare, they are **not** permitted to participate in a Medicare Advantage Plan. In addition, once a physician or non-physician practitioner has opted out they are not permitted to terminate their opt-out affidavit early. Section 1802(b)(3)(B)(ii) of the Act establishes the term of the opt-out affidavit. The Act does not provide for early termination of the opt-out term.

Under CMS regulations, physicians and practitioners who have not previously submitted an opt-out affidavit under Section 1802(b)(3) of the Act, may choose to terminate their opt-out status within 90 days after the effective date of the opt-out affidavit, if the physician or practitioner satisfies the requirements of 42 CFR § 405.445(b). No other method of terminating opt-out status before the end of the two year opt-out term is available.

Prior to enactment of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), physician/practitioner opt-out affidavits were only effective for two years. As a result of changes made by MACRA, valid opt-out affidavits signed on or after June 16, 2015, will automatically renew every two years.

If physicians and practitioners that file affidavits effective on or after June 16, 2015, do not want their opt-out to

automatically renew at the end of a two year opt-out period, they may cancel the renewal by notifying all Medicare administrative contractors (MACs) with which they filed an affidavit in writing at least 30 days prior to the start of the next opt-out period. Valid opt-out affidavits signed before June 16, 2015, will expire two years after the effective date of the opt out. If physicians and practitioners that filed affidavits effective before June 16, 2015, want to extend their opt-out, they must submit a renewal affidavit within 30 days after the current opt-out period expires to all MACs with which they would have filed claims absent the opt-out.

For more information on the opt-out process, refer to *MLN Matters*® article SE1311, titled "Opting out of Medicare and/or Electing to Order and Certify Items and Services to Medicare Beneficiaries," which is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1311.pdf and https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2015-06-25-eNews.html*.

CMS would like to highlight the following limitations that apply to billing and non-billing providers:

- A resident is defined in 42 CFR § 413.75 as an intern, resident, or fellow who participates in an approved medical residency program, including programs in osteopathy, dentistry, and podiatry, as required in order to become certified by the appropriate specialty board. Interns, residents, and fellows may enroll in Medicare to prescribe if the state licenses them. Licensure can include a provisional license or similarly- regulated credential. Un-licensed interns, residents, and fellows must specify the teaching physician who is enrolled in Medicare as the authorized prescriber on a prescription for a Part D drug (assuming this is consistent with state law). Licensed residents have the option to either enroll themselves or use the teaching physician's name on prescriptions for Part D drugs, unless state law specifies which name is to be used. CMS strongly encourages teaching physicians and facilities to ensure that the NPI of the lawful prescriber under state law is included on prescriptions to assist pharmacies in identifying the correct prescriber and

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avoid follow up from the pharmacies, which experience rejected claims from Medicare Part D plans due to missing or wrong prescriber NPIs on the claims.

- The prescriber enrollment requirements also apply to physicians and non-physician practitioners who write prescriptions for Part D drugs and are employed by a Part A institutional provider (e.g., hospital, federally qualified health center (FQHC), rural health center (RHC)). Since Part A institutional providers may bill for services provided by an employed physician or non-physician practitioner, the physician or non-physician practitioner may not have separately enrolled, unless he or she is also billing for Part B services. Therefore, if the physician or non-physician practitioner prescribes Part D drugs as an employee of the institutional provider, he or she must be enrolled in an approved status for their prescriptions to be coverable under Part D beginning June 1, 2016.

"Other authorized prescribers" are exempt from the Medicare Part D prescriber enrollment requirement. In other words, prescriptions written by "other authorized prescribers are still coverable under Part D, even if the prescriber is not enrolled in or opted out of Medicare. For purposes of the Part D prescriber enrollment requirement only, "other authorized prescribers" are defined as individuals other than physicians and eligible professionals who are authorized under state or other applicable law to write prescriptions but are not in a provider category that is permitted to enroll in or opt-out of Medicare under the applicable statutory language. CMS believes "other authorized prescribers" are largely pharmacists who are permitted to prescribe certain drugs in certain states, but based on the applicable statute, pharmacists are not able to enroll in or opt-out of Medicare.

If you believe you are an "other authorized prescriber" and are not a pharmacist, please contact *providerenrollment@cms.hhs.gov*. In addition, CMS strongly recommends that pharmacists in particular make sure that their primary taxonomy associated with their NPI in the National Plan & Provider Enumeration System (NPPES) reflects that they are a pharmacist. To review and update your NPPES information, please go to the National Plan & Provider Enumeration System Web page at *https://nppes.cms.hhs.gov/NPPES/Welcome.do*.

Upon enforcement of the regulation, Part D plans will need to be able to determine if the prescriber is a pharmacist in order to properly adjudicate the pharmacy claim at point-of-sale.

In an effort to prepare the prescribers and Part D sponsors for the June 1, 2016 enforcement date, CMS has made available an enrollment file that identifies physician and eligible professional who are enrolled in Medicare in an approved or opt-out status. However, the file does not specify if a particular prescriber is eligible to prescribe, as prescribing authority is largely determined by state law. The enrollment file is available at *https://data.cms.gov/dataset/Medicare-Individual-Provider-List/u8u9-2upx*.

The file contains production data but is considered a test file since the Part D prescriber enrollment requirement is not yet applicable. An updated enrollment file will be generated every two weeks, with a purposeful goal of providing updates twice a week by the date of enforcement.

The file displays physician and eligible professional eligibility as of and after November 1, 2014, (i.e., currently enrolled, new approvals, or changes from opt-out to enrolled as of November 1, 2014). Any periods, prior to November 1, 2014, for which a physician or eligible professional was not enrolled in an approved or opt-out status will not be displayed on the enrollment file.

However, any gaps in enrollment after November 1, 2014, for which a physician or eligible professional was not enrolled in an approved or opt-out status will be reflected on the file with its respective effective and end dates for that given provider. For opted out providers, the opt-out flag will display a Y/N (Yes/No) value to indicate the periods the provider was opted out of Medicare. The file will include the provider's:

- (NPI);
- First and last names;
- Effective and end dates; and
- Opt-out flag

Example 1 – Dr. John Smith's effective date of enrollment is January 1, 2014. Since he was enrolled prior to the generation of the test file, his effective date will display as November 1, 2014. Dr. Smith submits an enrollment application to voluntarily withdraw from Medicare effective December 15, 2014. Dr. Smith will appear on the applicable file as:

NPI	First	Last	Eff date	End date	Opt-out flag
123456789	John	Smith	11/1/14	12/15/14	N

Example 2 – Dr. Mary Jones submits an affidavit to opt-out of Medicare, effective December 1, 2014. Since she has opted out after the generation of the test file, her effective date will display as December 1, 2014. After the two year opt-out period expires, Dr. Jones decides she wants to enroll in Medicare to bill, order, and certify, or to write prescriptions. The enrollment application is received on January 31, 2017, and the effective date issued is January 1, 2017. Dr. Jones will display on the applicable file as:

NPI	First	Last	Eff date	End date	Opt-out flag
987654321	Mary	Jones	12/1/14	12/1/16	Y
987654321	Mary	Jones	1/1/17		N

After the enforcement date of June 1, 2016, the applicable effective dates on the file will be adjusted to June 1, 2016, and it will no longer be considered a test file. All inactive periods prior to June 1, 2016, will be removed from the

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file and it will only contain active and inactive enrollment or opt-out periods as of June 1, 2016, and after. The file will continue to be generated every two weeks, with a purposeful goal of providing updates twice a week by the date of enforcement. Part D sponsors may utilize the file to determine a prescriber's Medicare enrollment or opt-out status when processing Part D pharmacy claims. The file will not validate the provider's ability to prescribe under applicable laws. Please submit questions or issues encountered in accessing the file to *providerenrollment@cms.hhs.gov*.

Additional information

For more information on the enrollment requirements, visit *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html*.

If you have questions and need to speak with the Part B contractor that handles your enrollment, you may find their toll-free number at MAC List on the CMS website.

For a list of frequency asked questions (FAQs) refer to *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/CMS-4159_FAQs.pdf*.

Document history

- This article was revised on December 5, 2014, to add language to emphasize that form CMS-855O is appropriate for use by prescribers.
- This article was revised on October 20, 2015, to communicate changes to and the delayed enforcement of the Part D prescriber enrollment requirement until June 1, 2016, and to provide clarifying information regarding the enrollment process.

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Related Change Request (CR) #: N/A
Related CR Release Date: N/A
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Implementation Date: N/A

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

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

Effective and notice dates

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

Electronic notification

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

More information

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

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

Looking for LCDs?

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

Advance beneficiary notice

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

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

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

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

"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

Evaluation and management services in a nursing facility – new LCD

LCD ID number: L 36230
(Florida, Puerto Rico/U.S. Virgin Islands)

This new local coverage determination (LCD) was developed based on data analysis by the Program Safeguards Communication Group (PSCG), as well as issues identified in medical review related to excessive utilization of evaluation and management (E/M) services in a skilled nursing facility/nursing facility setting in Florida.

Data demonstrated a marked increase in the number of daily or every other day visits in the absence of documented medical necessity.

In addition, many Florida providers continue to bill E/M services (across one or more place of service) in medically unbelievable daily patterns. Data analysis continues to identify providers who were allowed services in excess of 16 hours per day, and some who were allowed services in excess of 24 hours per day.

This LCD has been developed to outline indications and limitations of coverage and/or medical necessity, *CPT*® codes, documentation guidelines, and utilization guidelines for evaluation and management services in a nursing facility.

Effective date

The LCD revision is effective for services rendered **on or after November 15, 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*.

Special histochemical stains and immunohistochemical stains – New Part A-B LCD

LCD ID number: L36234
(Florida, Puerto Rico/U.S. Virgin Islands)

This local coverage determination (LCD) is based on issues identified by Palmetto GBA in their administration of molecular pathology services in several jurisdictions.

The Palmetto draft was discussed in a national contractor medical director (CMD) workgroup and adopted by jurisdiction N (JN) and other Medicare administrative contractors (MACs), as a draft and posted for a 45-day comment period.

This LCD outlines indications and limitations of coverage and/or medical necessity, *CPT*® code, ICD-10-CM diagnosis codes, documentation guidelines, and utilization guidelines.

Effective date

This LCD revision for ICD-9 diagnosis codes is effective **for services rendered on or after December 6, 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.

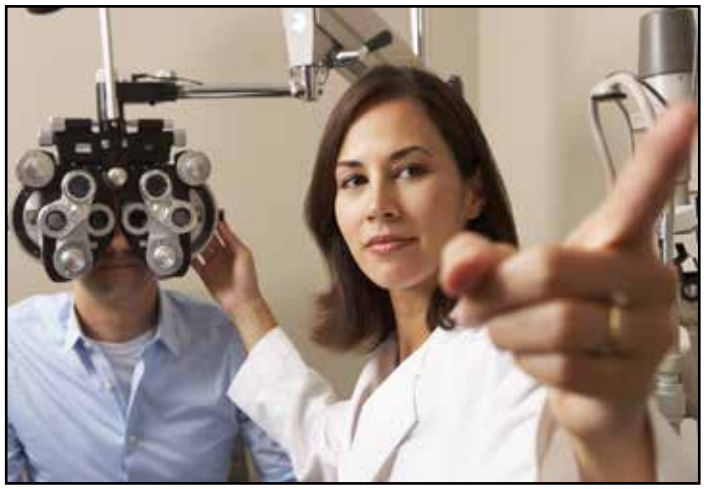
Note: To review active, future, and retired LCDs, please *click here*.

Diagnostic evaluation and medical management of moderate-severe dry eye disease (DED) – new LCD

LCD ID number: L36232 (Florida/Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for diagnostic evaluation and medical management of moderate-severe DED has been created to address the limited indications for a rapid point-of-care (POC) diagnostic test and to further clarify providers eligible to perform this procedure. *Current Procedural Terminology*® (*CPT*®) code *83516* [Immunoassay analysis (MMP-9)] is billed for a rapid POC diagnostic test to aid in the diagnosis of DED.

In addition, data analysis identified an increase in utilization of microfluidic analysis (tear osmolarity), *CPT*® code *83861*. The Medicare Part B Extraction Summary System (BESS) statistical medical data obtained for dates of service July 01, 2014 through December 31, 2014 indicated a carrier to nation atio for Florida at 2.32 for procedure code *83861* (between 100-150 percent above the national average)



(**Note**: data for Puerto Rico and the U.S. Virgin Islands was below the national average for the applicable code). Due to the risk for a high dollar claim payment error the limited indications of *CPT*® code *83861* was also addressed in the LCD.

Furthermore, First Coast took this opportunity to incorporate the current lacrimal punctal plugs LCD in the new LCD to address both the diagnostic evaluation and medical management of moderate–severe DED. Therefore, the lacrimal punctal plugs LCD will be retired November 22, 2015, when the new LCD is implemented.

This LCD outlines indications and limitations of coverage and/or medical necessity, *CPT*® code, ICD-10-CM diagnosis codes, documentation guidelines, and utilization guidelines for diagnostic evaluation and medical management of moderate-severe DED. In addition, an article was created and attached to the LCD to provide instructions on coding and billing.

Though stakeholders for both emerging diagnostic tests (both tear osmolarity test *CPT*® code *83861* and MMP-9 protein *CPT*® code *83516*) addressed in this LCD for DED have adequate support given analytical and clinical validity, the clinical utility, the likelihood that the test, (by implementing an intervention), will result in improved health outcome, has not been well established in the Medicare population.

If future peer reviewed literature suggests alternative approaches to the evaluation of moderate to severe DED, these tests will be evaluated for added limitations or non-coverage.

As clearly outlined in the LCD, test results must be used for individual patient treatment decisions as a predictive marker (patient likely to respond to a given therapy). And, testing of patients without signs or symptoms is screening and not a covered service.

Effective date

This LCD is effective for services rendered **on or after November 22, 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*. Articles 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.

Revisions to LCDs

Bone mineral density studies – revision to the Part A/B LCD

LCD ID number: L36356 (Florida, Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for bone mineral density studies was revised to include the Centers for Medicare & Medicaid Services (CMS) nationally covered diagnoses.

Although these national diagnoses were not included in the LCD, they were included in the system editing. The revised LCD will be visible to the provider community within the next couple of weeks.

Effective date

This LCD revision 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*.

Biofeedback – revision to the Part A and Part B LCD

LCD ID number: L 33615 (Florida, Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for biofeedback was revised to add ICD-9-CM diagnosis codes 564.00, 564.01, 564.02, 564.09 and 564.6 for procedure code *90911* to the "ICD-9 Codes that Support Medical Necessity" section of the LCD.

The ICD-10-CM diagnosis codes were also revised to include K59.00, K59.01, K59.02, K59.09 and K59.4 for procedure code *90911* to the "ICD-10 Codes that Support Medical Necessity" section of the LCD.

Effective date

This LCD revision for ICD-9 diagnosis codes is effective **for services rendered on or after April 1, 2015**. This LCD revision for ICD-10 diagnosis codes 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*.

Doxorubicin HCl – revision to the Part A/B LCD

LCD ID number: L33990 (Florida, Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for doxorubicin HCl was revised to add ICD-10-CM diagnosis codes C82.00-C82.99, C85.10-C85.99, C91.40-C91.42, C96.0, C96.2, C96.4, C96.A, C96.Z, and C96.9 to the "ICD-10 Codes that Support Medical Necessity" section of the LCD. In addition, diagnosis code range C84.60-C84.79 was changed to diagnosis range C84.00-C84.99 and diagnosis range C86.5-C86.6 was changed to diagnosis range C86.0-C86.6 in the "ICD-10 Codes that Support Medical Necessity" section of the LCD.

Effective date

The LCD revision 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*.

Rituximab (Rituxan®) – revision to the Part A-B LCD

LCD ID number: L33746 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for rituximab (Rituxan®) was revised to add ICD-10-CM diagnosis codes C83.00-C83.99 to the "ICD-10 Codes that Support Medical Necessity" section of the LCD.

Effective date

The LCD revision 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*.

Visual field examination – revision to the Part A-B LCD

LCD ID number: L33766 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for visual field examination was revised to add ICD-10-CM diagnosis codes H40.001-H40.009, H40.011, H40.012, H40.013, H40.021, H40.022, H40.023, H40.031, H40.032, H40.033, H40.041, H40.042, H40.043, H40.051, H40.052, H40.053, H40.061, H40.062, and H40.063 to the "ICD-10 Codes that Support Medical Necessity" section of the LCD.

Effective date

The LCD revision 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*.

Destruction of malignant skin lesions – revision to the Part B LCD

LCD ID number: L33813 (Florida/Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for destruction of malignant skin lesions was revised to add ICD-10-CM diagnosis codes C44.01, C44.02, C44.09, C44.112, C44.119, C44.122, C44.129, C44.192, C44.199, C44.212, C44.219, C44.222, C44.229, C44.292, C44.299, C44.311, C44.319, C44.321, C44.329, C44.391, C44.399, C44.41, C44.42, C44.49, C44.510 - C44.519, C44.520 - C44.529, C44.590 - C44.599, C44.612, C44.619, C44.622, C44.629, C44.692, C44.699, C44.712, C44.719, C44.722, C44.729, C44.792, C44.799, C44.81, C44.82, and C44.89 to the "ICD-10 Codes that Support Medical Necessity" section of the LCD.

Effective date

The revision of this LCD 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*.

Retired LCDs

Qualitative drug screening – Part B LCD retired

LCD ID number: L33938
(Florida, Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for qualitative drug screening is being retired based on the development of a new LCD titled "controlled substance monitoring and drugs of abuse testing" (L36393).

Effective date

The retirement of this 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*.

Additional information

Magnetic resonance angiography and magnetic resonance imaging LCDs – clarification related to ICD-10-CM diagnosis codes

Due to multiple inquires received related to MRA and MRI local coverage determinations (LCDs) not including ICD-10-CM diagnosis codes, this article is being published to provide clarification. .During the ICD-9-CM to ICD-10-CM conversion of the First Coast Service Options (First Coast) (LCDs) for MRA/MRI a determination was made to leave out the ICD-10-CM diagnosis codes from these LCDs.

Moving forward, certain LCDs may be revised to include the appropriate ICD-10-CM diagnosis codes, based on data analysis of these services. If First Coast determines to add the diagnoses, the LCD would be taken through a 45-day comment and 45-notice period, given this would further restrict the LCD by adding diagnosis codes and associated editing.

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 event

Ask-the-contractor Teleconference (ACT): An ICD-10 Update

Wednesday, November 18
Time: Time: 11:00 a.m.-1:00 p.m. **Type of event:** Webcast

http://medicare.fcso.com/Events/0303471.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®

MLN Connects® Provider eNews for September 24, 2015

MLN Connects® Provider eNews for September 24, 2015

View this edition as a PDF

In this edition:

Countdown to ICD-10

- Use ICD-10 to Successfully Bill for Your Services
- Clarifying Questions and Answers Related to the CMS/AMA Joint Announcement and Guidance Regarding ICD-10 Flexibilities – Update
- Access the ICD-10 Code Set
- List of Valid ICD-10-CM Codes
- Claims that Span the ICD-10 Implementation Date
- Coding for ICD-10-CM: Continue to Report *CPT*®/HCPCS Modifiers for Laterality
- Get ICD-10 Answers in One Place

MLN Connects® National Provider Calls and Events

- 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 – Register Now
- New MLN Connects® National Provider Event Audio Recording and Transcript

Other CMS Events

- *Medicare Learning Network*® Webinar: Medicare Basics for New Providers Part Three: Medicare Claim Review Programs, POE, and Protecting the Medicare Trust Fund
- Long-Term Care Hospital Quality Reporting Program Provider Training

Announcements

- September is Prostate Cancer Awareness Month
- Prepare for DMEPOS Competitive Bidding Round 1 2017: Three Steps to Get Ready
- EHR Incentive Program 2016 Payment Adjustment Fact Sheet for Hospitals Available

Medicare Learning Network® Educational Products

- "PECOS for Physicians and Non-Physician Practitioners" Fact Sheet – Revised
- *Medicare Learning Network*® Product Available In Electronic Publication Format

Medicare Learning Network®

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

MLN Connects® Provider eNews for October 1, 2015

MLN Connects® Provider eNews for October 1, 2015

View this edition as a PDF

In this edition:

ICD-10

- Coding around the Compliance Date
- Physician Orders for Lab, Radiology Services, and Other Services after ICD-10 Implementation
- Access the ICD-10 Code Set
- Finding ICD-10 Information Online

MLN Connects® National Provider Calls and Events

- Dialysis Facility Compare: Rollout of Five Star Rating Call – Last Chance to Register
- 2014 Supplemental QRUR Physician Feedback Program Call – Register Now
- Improving Medicare Post-Acute Care Transformation Act – Register Now
- New MLN Connects® Event Video Slideshows, Audio Recordings, and Transcripts

MLN Connects Videos

- Video Available on PQRS and VM: What You Need to Know in 2015

Other CMS Events

- Webinar for Comparative Billing Report on Modifiers 24 and 25: Orthopedic Surgeons

Announcements

- Talk to Your Patients about Mental Illness and Depression
- CMS Proposes New Medicare Clinical Diagnostic Laboratory Tests Fee Schedule
- HHS Announces $685 Million to Support Clinicians Delivering High Quality, Patient-Centered Care
- CMS Awards $110 Million to Continue Improvements in Patient Safety
- 2014 Supplemental Quality and Resource Use Reports Available
- MACRA: New Opportunities for Medicare Providers through Innovative Payment Systems
- Getting Started with the Hospice Item Set: Updated Fact Sheet Available
- Access Ordering and Referring Report through data.cms.gov
- Change in Cost Report Appeals Support Contractor for Part A Providers
- New EHR Web Page for Past Program Requirements and Resources
- Guidance on Switching EHR Vendors
- 2016 PQRS Payment Adjustment and Informal Review Process

Medicare Learning Network® Educational Products

- "Medicare Enrollment and Claim Submission Guidelines" Booklet – Revised
- "Medicare Enrollment for Institutional Providers" Fact Sheet – Revised
- New *Medicare Learning Network*® Educational Web Guides Fast Fact

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.

MLN Connects® Provider eNews for October 8, 2015

MLN Connects® Provider eNews for October 8, 2015

View this edition as a PDF

In this edition:

ICD-10

- Get ICD-10 Answers in One Place
- 5 Ways to Check Your Claim Status

MLN Connects® National Provider Calls and Events

- 2014 Supplemental QRUR Physician Feedback Program Call — Last Chance to Register
- Improving Medicare Post-Acute Care Transformation Act — Register Now
- New MLN Connects National Provider Call Audio Recordings and Transcripts

Other CMS Events

- MACRA Request for Information Webinars

Announcements

- DMEPOS Competitive Bidding Round 1 2017 Bidding Starts October 15
- HHS Issues Rules to Advance Electronic Health Records with Added Simplicity and Flexibility
- Physician Compare Preview Period Open through November 6
- DMEPOS Fee Schedule PUF Formats and Rural Zip Code File
- October Quarterly Provider Update Available
- Technical Correction to FY 2015 IPF Final Rule
- Participation in EHR Incentive Programs: Updated FAQs

Claims, Pricers and Codes

October 2015 OPPS Pricer File Available

Medicare Learning Network® Educational Products

- "How to Access and Use the Medicare Learning Network Learning Management and Product Ordering System (LM/POS)" Fact Sheet — Released
- "Safeguard Your Identity and Privacy Using PECOS" Fact Sheet — Revised
- "DMEPOS Information for Pharmacies" Fact sheet — Revised
- Medicare Learning Network Products Available in Electronic Publication Format

MLN Connects® Provider eNews for October 15, 2015

MLN Connects® Provider eNews for October 15, 2015

View this edition as a PDF

In this edition:

ICD-10

- Use ICD-10 Now
- ICD-10 Ombudsman and ICD-10 Coordination Center Support Your Transition Needs
- Qualifiers for ICD-10 Diagnosis Codes on Electronic Claims

MLN Connects® National Provider Calls and Events

- Improving Medicare Post-Acute Care Transformation Act Call — Last Chance to Register
- Stay Informed about Medicare Program Changes

Other CMS Events

- Long-Term Care Hospital Quality Reporting Program Provider Training

Announcements

- CMS Launches New ACO Dialysis Model
- New Medicare Utilization and Payment Data Available for Medical Equipment, Supplies
- Primary Care Makes Strides in Improving Quality and Costs
- CMS to Release a Comparative Billing Report on Optometry Services in October
- EHR Incentive Program: 2016 Payment Adjustments and Reconsiderations

Medicare Learning Network® Educational Products

- "Medicare Quarterly Provider Compliance Newsletter [Volume 6, Issue 1]" Educational Tool — Released
- Medicare Learning Network Products Available in Hard Copy Format
- Medicare Learning Network Product Available In Electronic Publication Format

MLN Connects® Provider eNews for October 22, 2015

MLN Connects® Provider eNews for October 22, 2015

View this edition as a PDF

In this edition:

ICD-10

- Learn How to Assign an ICD-10-CM Diagnosis Code with MLN Connects Videos
- Video Slideshow from August 27 MLN Connects Call Available
- 5 Ways to Check Your Claim Status
- Contact List for ICD-10 Questions

MLN Connects® National Provider Calls and Events

- Clinical Diagnostic Laboratory Test Payment System Proposed Rule Call — Registration Now Open
- New MLN Connects National Provider Call Audio Recording and Transcript

Other CMS Events

- EHR Incentive Programs: Recording from Final Rule Webinar Available

Announcements

- HHS Awards more than $240 Million to Expand the Primary Care Workforce
- HHS Awards up to $22.9 Million in Planning Grants for Certified Community Behavioral Health Clinics
- 2016 Value Modifier: Informal Review Request Period Open through November 9
- 2016 PQRS Payment Adjustment: Informal Review Request Period Open through November 9
- IRF Quality Reporting Program Data Submission Deadline: November 15
- LTCH Quality Reporting Program Data Submission Deadline: November 15

- MACRA Request for Information: Comments Accepted through November 17
- Dialysis Facility Compare: Submit your Comments through December 4
- New Survey Process for Duodenoscopes/ Endoscopes/ Reusable Medical Devices
- Hospice Quality Reporting Program: New Training Modules Available

Claims, Pricers, and Codes

- Mass Adjustments of IRF PPS Claims that Require a Special Wage Index

Medicare Learning Network® Educational Products

- "Infection Control: Environmental Safety" Web-Based Training Course — Released
- "Infection Control: Injection Safety" Web-Based Training Course — Released
- "PECOS for Provider and Supplier Organizations" Fact Sheet — Revised

Take the time to 'chat' with the website team

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

Phone numbers

Customer service

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

Education event registration hotline

904-791-8103 (NOT toll-free)

Electronic data interchange (EDI)

888-670-0940

Electronic funds transfers (EFT) (CMS-588)

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

Fax number (for general inquiries)

904-361-0696

Interactive voice response (IVR) system

877-847-4992

Provider enrollment

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

The SPOT help desk

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

Addresses

Claims

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

Redeterminations

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

Redetermination of overpayments

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

Reconsiderations

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

General inquiries

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

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

Provider enrollment

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

Medical policy

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

Medicare secondary payer

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

Electronic data interchange (EDI)

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

Overpayments

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

Medicare Education and Outreach

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

Fraud and abuse

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

Freedom of Information Act requests

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

Overnight mail and/or special courier service

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

Websites

Provider

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

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

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

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

Beneficiaries

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

Phone numbers

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

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

Electronic data interchange (EDI)
888-670-0940

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

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

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

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

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

Addresses

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Websites

Provider
First Coast Service Options Inc. (First Coast), your CMS-contracted Medicare administrative contractor

http://medicare.fcso.com

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

Centers for Medicare & Medicaid Services

http://www.cms.gov

First Coast University

http://www.fcsouniversity.com/

Beneficiaries
Centers for Medicare & Medicaid Services

http://www.medicare.gov

Phone numbers

Customer service

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

Education event registration hotline

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

Electronic data interchange (EDI)

888-875-9779

Electronic funds transfers (EFT) (CMS-588)

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

General inquiries

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

Interactive voice response (IVR) system

877-847-4992

Provider enrollment

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

The SPOT help desk

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

Addresses

Claims

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

Redeterminations

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

Redetermination of overpayments

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

Reconsiderations

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

General inquiries

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

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

Provider enrollment

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

Medical policy

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

Medicare secondary payer

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

Electronic data interchange (EDI)

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

Overpayments

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

Medicare Education and Outreach

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

Fraud and abuse

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

Freedom of Information Act requests

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

Special courier service

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

Websites

Provider

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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

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

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Medicare Publications
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Atlanta, GA 30384-6443

Contact Name: _____

Provider/Office Name: _____

Phone: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

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