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

In this issue

Local coverage determinations and relevant ICD-10-CM codes

Updated local coverage determinations (LCD) to include ICD-10 diagnosis codes were posted to the Medicare coverage database (MCD) in April 2014.

Since the October 1, 2015, ICD-10 transition date, First Coast has received comments from physicians and allied providers suggesting changes and/or additions to the current ICD-10 LCD code sets.

First Coast appreciates input from the provider community and evaluates comments as they are received. If the evaluation results in a determination that additional ICD-10 diagnosis code(s) should be included in the applicable LCD, the LCD and associated editing will be updated and an article will be published.

First Coast is addressing all inquiries related to ICD-10 LCD codes as a priority. Please include the following information with your comments and submit to: *medical.policy@fcso.com*:

- The name of the LCD and corresponding L number
- The specific indication as stated in the LCD and relevant ICD-10 diagnosis codes recommended for addition in support of the indication
- If deletion of codes are recommended, please provide the rationale

As always, diagnosis codes are only a surrogate for the stated indications/limitations in the LCD and must be supported in the medical record.

Requests for new indications should be addressed per the normal LCD reconsideration process. For more information regarding this process, see: *http://medicare.fcso.com/Coverage_resources/138575.asp.*

Note: If an LCD prior to the ICD-10 implementation date of October 1, 2015, did not include ICD-9 codes then the LCD after this date will not include diagnosis codes.

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.

Ambulance

Ambulance inflation factor for 2016 and productivity adjustment

Provider types affected

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

Provider action needed

Change request (CR) 9412 furnishes the 2016 ambulance inflation factor (AIF) for determining the payment limit for ambulance services. Make sure that your billing staffs are aware of the change.

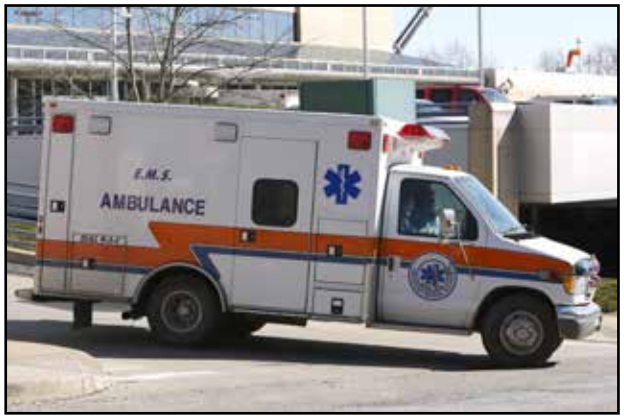
Background

CR 9412 furnishes the 2016 ambulance inflation factor (AIF) for determining the payment limit for ambulance services required by Section 1834(l)(3)(B) of the Social Security Act (the Act). It also clarifies the *Medicare Claims Processing Manual*, Chapter 15 (Ambulance), Section 20.3 (Air Ambulance) and updates Section 20.4 (Ambulance Inflation Factor (AIF)). You will find these updated manual chapters as an attachment to this CR.

Section 1834(l)(3)(B) of the Act provides the basis for an update to the payment limits for ambulance services that is equal to the percentage increase in the consumer price index for all urban consumers (CPI-U) for the 12-month period ending with June of the previous year. Section 3401 of the Affordable Care Act amended Section 1834(l)(3) of the Act to apply a productivity adjustment to this update equal to the 10-year moving average of changes in economy-wide private nonfarm business multi-factor productivity beginning January 1, 2011. The resulting update percentage is referred to as the AIF.

Section 3401 of the Affordable Care Act requires that specific prospective payment system (PPS) and fee schedule (FS) update factors be adjusted by changes in economy-wide productivity. The statute defines the productivity adjustment to be equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity (MFP) (as projected by the Secretary of Health and Human Services for the 10-year period ending with the applicable fiscal year, cost reporting period, or other annual period).

The MFP for 2016 is 0.5 percent and the CPI-U for 2016 is 0.1 percent. According to the Affordable Care Act, the CPI-U is reduced by the MFP, even if this reduction results in a negative AIF update. Therefore, the AIF for 2016 is -0.4 percent.



Part B coinsurance and deductible requirements apply to payments under the ambulance fee schedule. The 2016 ambulance fee schedule file is available in November 2015. It may be retrieved at any time and will reside indefinitely for your access. It may be updated with each quarterly common working file (CWF) update.

Additional information

The official instruction, CR 9412, issued to your MAC regarding this change, is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3380CP.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: MM9412
Related Change Request (CR) #: CR 9412
Related CR Release Date: October 23, 2015
Effective Date: January 1, 2016
Related CR Transmittal #: R3380CP
Implementation Date: January 4, 2016

Ambulatory Surgical Center

Removal of device portion from certain discontinued ASC procedures prior to administration of anesthesia

Provider types affected

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

Provider action needed

Change request (CR) 9297 informs providers that MACs will remove the device portion from certain device intensive ASC procedures when the ASC surgical or ancillary service procedure is terminated prior to anesthesia and modifier 73 is on the claim.

Background

Currently, when an ASC covered surgical procedure or ancillary service is terminated prior to the administration of anesthesia, the ASC adds modifier 73 to the procedure line item on the claim.

The modifier 73 identifies a covered surgical procedure or ancillary service for which anesthesia is planned but discontinued after the patient is prepared and taken to the room where the procedure is to be performed but before anesthesia is administered. Medicare processes these line items by removing one-half of the full program allowance and the beneficiary copayment amounts when processing the 73 modifier.

Key points

In the 2016 outpatient prospective payment system/ ASC) final rule, the Centers for Medicare & Medicaid Services (CMS) finalized a payment policy for device intensive covered surgical procedures which removes the unused device portion of the program payment prior to the program payment reduction when the 73 modifier is appended to the claim.

- This policy does not apply to procedures and services that are discontinued after the administration of anesthesia and include the 74 modifier.
- The MAC will identify and process device intensive procedures and services billed with the 73 modifier, by using the program payment amount appearing in the 'FB Mod Reduced Price' field on the ASC Fee Schedule (FS) record layout as the full program payment, with the device portion removed, prior to processing the 73 modifier payment calculations.
- If there is no payment amount in the FB Mod Reduced Price field of the ASCFS, then the procedure is not device intensive and this new policy would not apply.

To process claims correctly, when device intensive procedures and services are billed with the 73 modifier and FB (full device credit)/FC (partial credit received for replaced device) modifiers, the FB/FC modifier is ignored for this line item unused device, and the line item would continue to be processed as stated above.

For ASCs subject to the ASC quality reporting (QR) program payment reduction, contractors will use the procedure payment amount located in the respective "Penalty FB Mod Reduced Price" field on the ASCFS in place of the payment amount in the "FB Mod Reduced Price" field or the "Penalty Price" field on the ASCFS in place of the payment amount in the "Price" field, as appropriate.

In summary:

1. Effective for dates of service beginning January 1, 2016, when the 73 modifier is included on the ASC claim line, Medicare contractors will edit to determine if the ASCFS "FB Mod Reduced Price" field is zero filled.
2. If the corresponding "FB Mod Reduced Price" field is zero filled on the ASCFS, contractors will continue to apply the value in the ASCFS "Price" field.
3. If the ASC is subject to the ASCQR payment reduction, contractors, as appropriate, will use the payment from the "Penalty Price" field on the ASCFS instead of the "Price" field.
4. If the corresponding "FB Mod Reduced Price" field is not zero filled on the ASCFS, contractors will apply the value contained in the ASCFS "FB Mod Reduced Price" field instead of the value in the ASCFS "Price" field. 5. If the ASC is subject to the ASCQR payment reduction, contractors, as appropriate, will use the payment from the "Penalty FB MOD Reduced Price" field on the ASCFS instead of the "FB MOD Reduced Price" field. 6. Medicare contractors will ignore the FB or FC modifier if submitted on the claim line with the 73 modifier, and allow the claim to process.

Additional information

The official instruction, CR 9297, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1572OTN.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: MM9297
Related Change Request (CR) #: CR 9297
Related CR Release Date: November 6, 2015
Effective Date: January 1, 2016
Related CR Transmittal #: R1572OTN
Implementation Date: April 4, 2016

Cardiac Services

NCD for single chamber and dual chamber permanent cardiac pacemakers

***Note**: This article was revised October 28, 2015, to reflect the revised change request (CR) 9078 issued October 26. The CR was revised to direct the MACs to implement the NCD at the local level until Medicare system instructions are revised and Medicare system changes are implemented. All other information remains unchanged. This information was previously published in the April 2015 Medicare B Connection, Pages 8-11.*

Provider types affected

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

Provider action needed

CR 9078 informs MACs that the Centers for Medicare & Medicaid Services (CMS) issued a national coverage determination (NCD) and concluded that implanted permanent cardiac pacemakers, single chamber or dual chamber, are reasonable and necessary for the treatment of non-reversible symptomatic bradycardia due to sinus node dysfunction and second and/or third degree atrioventricular block. Make sure that your billing staffs are aware of these changes.

Background

Permanent cardiac pacemakers refer to a group of self-contained, battery-operated, implanted devices that send electrical stimulation to the heart through one or more implanted leads. Single chamber pacemakers typically target either the right atrium or right ventricle. Dual chamber pacemakers stimulate both the right atrium and the right ventricle. On August 13, 2013, CMS issued an NCD, in which CMS concluded that implanted permanent cardiac pacemakers, single chamber or dual chamber, are reasonable and necessary for the treatment of non-reversible, symptomatic bradycardia due to sinus node dysfunction and second and/or third degree atrioventricular block. Symptoms of bradycardia are symptoms that can be directly attributable to a heart rate less than 60 beats per minute (for example, syncope, seizures, congestive heart failure, dizziness, or confusion). The following indications are covered for implanted permanent single chamber or dual chamber cardiac pacemakers:

1. Documented non-reversible symptomatic bradycardia due to sinus node dysfunction.
2. Documented non-reversible symptomatic bradycardia due to second degree and/or third degree atrioventricular block.

The following indications are non-covered for implanted permanent single chamber or dual chamber cardiac pacemakers:

1. Reversible causes of bradycardia such as electrolyte abnormalities, medications or drugs, and hypothermia.
2. Asymptomatic first degree atrioventricular block. *(exception)
3. Asymptomatic sinus bradycardia.
4. Asymptomatic sino-atrial block or asymptomatic sinus arrest. *(exception)
5. Ineffective atrial contractions (for example, chronic atrial fibrillation or flutter, or giant left atrium) without symptomatic bradycardia. *(exception)
6. Asymptomatic second degree atrioventricular block of Mobitz Type I unless the QRS complexes are prolonged or electrophysiological studies have demonstrated that the block is at or beyond the level of the His Bundle (a component of the electrical conduction system of the heart).
7. Syncope of undetermined cause. *(exception)
8. Bradycardia during sleep.
9. Right bundle branch block with left axis deviation (and other forms of fascicular or bundle branch block) without syncope or other symptoms of intermittent atrioventricular block. *(exception)
10. Asymptomatic bradycardia in post-myocardial infarction patients about to initiate long-term beta-blocker drug therapy.
11. Frequent or persistent supraventricular tachycardias, except where the pacemaker is specifically for the control of tachycardia. *(exception)
12. A clinical condition in which pacing takes place only intermittently and briefly, and which is not associated with a reasonable likelihood that pacing needs will become prolonged.

MACs will determine coverage under section 1862(a)(1)(A) of the Social Security Act for any other indications for the implantation and use of single chamber or dual chamber cardiac pacemakers that are not specifically addressed in this NCD. **Notes**: MACs shall accept the inclusion of the KX modifier on the claim line(s) as an attestation by the practitioner and/or provider of the service that documentation is on file verifying the patient has non-reversible symptomatic bradycardia (symptoms of bradycardia are symptoms that can be directly attributable to a heart rate less than 60 beats per minute (for example, syncope, seizures, congestive heart failure, dizziness, or confusion)).

Note: The final decision memorandum addresses Medicare policy specific to implanted permanent cardiac pacemakers, single chamber or dual chamber, for the treatment of non-reversible symptomatic bradycardia due to sinus node dysfunction and second and/or third degree

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atrioventricular block. Medicare coverage of removal/replacement of implanted permanent cardiac pacemakers, single chamber or dual chamber, for the above-noted indications, were not addressed in the final decision. Therefore, it is expected that MACs will continue to apply the reasonable and necessary standard in determining local coverage within their respective jurisdictions for removal/replacement of implanted permanent cardiac pacemakers, single chamber or dual chamber.

Cardiac pacemaker healthcare common procedure coding system (HCPCS) and *Current Procedural Terminology* (*CPT*®) codes

Professional claims

Effective for claims with dates of service on or after August 13, 2013, MACs shall pay for implanted permanent cardiac pacemakers, single chamber or dual chamber, for one of the following *CPT*® codes if the claim contains at least one of the designated diagnosis codes in addition to the KX modifier:

- *33206* Insertion or replacement of permanent pacemaker with transvenous electrode(s) – atrial
- *33207* Insertion or replacement of permanent pacemaker with transvenous electrode(s) – ventricular
- *33208* Insertion or replacement of permanent pacemaker with transvenous electrode(s) – atrial and ventricular

Institutional claims

Effective for claims with dates of service on or after August 13, 2013, MACs shall pay for implanted permanent cardiac pacemakers, single chamber or dual chamber, for the following HCPCS codes if the claim contains at least one of the designated *CPT*® codes, and at least one of the designated diagnosis codes, in addition to the KX modifier:

- C1785 Pacemaker, dual chamber, rate-responsive (implantable)
- C1786 Pacemaker, single chamber, rate-responsive (implantable)
- C2619 Pacemaker, dual chamber, nonrate-responsive (implantable)
- C2620 Pacemaker, single chamber, nonrate-responsive (implantable)
- *33206* Insertion or replacement of permanent pacemaker with transvenous electrode(s) – atrial
- *33207* Insertion or replacement of permanent pacemaker with transvenous electrode(s) – ventricular
- *33208* Insertion or replacement of permanent pacemaker with transvenous electrode(s) – atrial and ventricular

MACs have discretion to cover or not cover the following *CPT*® codes:

- *33227* Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; single lead system
- *33228* Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; dual lead system

Cardiac pacemaker ICD-9/ICD-10 diagnosis codes

Professional claims

Claims with dates of service on and after August 13, 2013, for implanted permanent cardiac pacemakers, single chamber or dual chamber, are covered if submitted with one of the following *CPT*® codes: *33206, 33207*, or *33208*, and that contain at least one of the following ICD-9/ICD-10 diagnosis codes (upon ICD-10 implementation) listed below in addition to the KX modifier:

- 426.0 Atrioventricular block, complete/ I44.2 Atrioventricular block, complete;
- 426.12 Mobitz (type) II atrioventricular block/ I44.1 Atrioventricular block, second degree;
- 426.13 Other second degree atrioventricular block/ I44.1 Atrioventricular block, second degree;
- 427.81 Sinoatrial node dysfunction/ I49.5 Sick sinus syndrome; or
- 746.86 Congenital heart block/ Q24.6 – Congenital heart block.

The following diagnosis codes can be covered at your MACs discretion if submitted with at least one of the *CPT*® codes and diagnosis codes listed above in addition to the KX modifier:

- 426.10 Atrioventricular block, unspecified/ I44.30 Unspecified atrioventricular block;
- 426.11 First degree atrioventricular block/ I44.0 Atrioventricular block first degree;
- 426.4 Right bundle branch block/ I45.10 Unspecified right bundle-branch block/ I45.19 Other right bundle-branch block;
- 427.0 Paroxysmal supraventricular tachycardia/ I47.1 Supraventricular tachycardia;
- 427.31 Atrial fibrillation/ I48.1 Persistent atrial fibrillation/ I48.91, Unspecified atrial fibrillation;
- 427.32 Atrial flutter/ I48.3 Typical atrial flutter/ I48.4 Atypical atrial flutter or I48.91 Unspecified atrial fibrillation; or
- 780.2 Syncope and collapse/R55 Syncope and collapse (R55 is the ICD-10 dx code but is not payable upon implementation of ICD-10 and is only included here for information purposes).

Institutional claims

For coverage of claims with dates of service on and after August 13, 2013, for implanted permanent cardiac pacemakers, single chamber or dual chamber, using HCPCS codes: *C1785, C1786, C2619, C2620, 33206, 33207*, or *33208*, the claim must contain at least one of the following procedure codes:

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- 37.81 Initial insertion of single chamber device, not specified as rate responsive
- 37.82 Initial insertion of single chamber device, rate responsive
- 37.83 Initial insertion of single chamber device

and at least one of the following diagnosis codes in addition to the KX modifier:

- 426.0 Atrioventricular block, complete;
- 426.12 Mobitz (type) II atrioventricular block;
- 426.13 Other second degree atrioventricular block;
- 427.81 Sinoatrial node dysfunction; or
- 746.86 Congenital heart block.

The following diagnosis codes can be covered, at the MAC's discretion, if submitted with at least one of the diagnosis codes listed above in addition to the KX modifier:

- 426.10 Atrioventricular block, unspecified/ I44.30 Unspecified atrioventricular block;
- 426.11 First degree atrioventricular block/ I44.0 Atrioventricular block first degree;
- 426.4 Right bundle branch block/ I45.10 Unspecified right bundle-branch block/ I45.19 Other right bundle-branch block;
- 427.0 Paroxysmal supraventricular tachycardia/ I47.1 Supraventricular tachycardia;
- 427.31 Atrial fibrillation/ I48.1 Persistent atrial fibrillation/ I48.91, Unspecified atrial fibrillation;
- 427.32 Atrial flutter/ I48.3 Typical atrial flutter/ I48.4 Atypical atrial flutter or I48.91 Unspecified atrial fibrillation; or
- 780.2 Syncope and collapse/R55 Syncope and collapse (R55 is the ICD-10 dx code but is not payable upon implementation of ICD-10 and is only included here for information purposes).

Professional claims

MACs shall return claims lines for implanted permanent cardiac pacemakers, single chamber or dual chamber, containing one of the following *CPT*® codes: *33206, 33207*, or *33208*, as unprocessable when the KX modifier is not present. When returning such claims, MACs shall use the following messages:

- **Claim adjustment reason code (CARC) 4** - The procedure code is inconsistent with the modifier used or a required modifier is missing.
- **Remittance advice remarks code (RARC) N517** - Resubmit a new claim with the requested information.

Institutional claims

MACs shall return to providers claims for implanted permanent cardiac pacemakers, single chamber or dual chamber, when any of the following are not present on the claim: At least one HCPCS code: C1785, C1786, C2619, or C2620, at least one *CPT*® code: *33206, 33207, 33208*, *33227, 33228*, at least one diagnosis code: 426.0/I44.2, 426.12/I44.1, 426.13/I44.1, 427.81/I49.5, 746.86/Q24.6, at least one procedure code: 37.81/0JH604Z, 0JH634Z, 0JH804Z, 0JH834Z, 37.82/0JH605Z, 0JH635Z, 0JH805Z, 0JH835Z, 38.83/0JH606Z, 0JH636Z, 0JH806Z, 0JH836Z, and the KX modifier is not present on the claim.

Cardiac pacemaker non-covered ICD-ICD-10 diagnosis code

For claims with dates of service on or after implementation of ICD-10, for implanted permanent cardiac pacemakers, single chamber or dual chamber, using one of the following HCPCS and/or *CPT*® codes: C1785, C1786, C2619, C2620, *33206, 33207*, or *33208*, ICD-10 diagnosis code R55 is not covered even if the claim contains one of the valid diagnosis codes listed above.

MACs will use the following messages when denying claims for implanted permanent cardiac pacemakers, single chamber or dual chamber, containing one of the following HCPCS and/or *CPT*® codes: C1785, C1786, C2619, C2620, *33206*, *33207*, or *33208*, and ICD-10 diagnosis code R55 with the following messages:

- **CARC 96**: Non-covered charge(s).
- **RARC N569**: Not covered when performed for the reported diagnosis.
- **Group code CO** assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed advance beneficiary notice (ABN) is on file.
- **Group code PR** assigning financial liability to the beneficiary, if a claim is received with occurrence code 32 indicating a signed ABN is on file, or occurrence code 32 is present with modifier GA.

Additional information

The official instruction, CR 9078, was issued to your MAC via two transmittals. The first transmittal updates the *Medicare Claims Processing Manual* and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3384CP.pdf*. The second updates the *Medicare National Coverage Determination Manual* and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R186NCD.pdf*.

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

Document history

- This article was revised May 26, 2015, to add a reference to *MLN Matters*® article MM8525 which allows payment for nationally covered implanted permanent cardiac pacemakers, single chamber or dual chamber, for the indications outlined in the

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Drugs and Biologicals

Update to the list of compendia used off-label in an anti-cancer chemotherapeutic regimen

Provider types affected

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

What you need to know

This article is based on change request (CR) 9386 which announces that effective for services on or after August 12, 2015, the Centers for Medicare & Medicaid Services (CMS) is adding Wolters Kluwer Lexi-Drugs® to the list of authoritative compendia for use in the determination of a medically-accepted indication of drugs and biologicals used off-label in an anti-cancer chemotherapeutic regimen.

Background

The Social Security Act (Section 1861(t)(2)(B)(ii)(I); as amended by the Deficit Reduction Act of 2005 (Pub. Law 109-171; Section 6001(f)(1)), recognized the following three compendia as authoritative sources for use in the determination of a "medically accepted indication" of drugs and biologicals used off-label in an anti-cancer chemotherapeutic regimen:

1. American Medical Association Drug Evaluations (AMA-DE);
2. United States Pharmacopoeia-Drug Information (USP-DI) or its successor publication; and
3. American Hospital Formulary Service-Drug Information (AHFS-DI).

These authoritative sources could be used in the determination of a "medically-accepted indication" of drugs and biologicals used off-label in an anti-cancer chemotherapeutic regimen, unless:

- The Secretary of Health and Human Services (HHS) determined that the use is not medically appropriate; or
- The use is identified as not indicated in one or more such compendia.

This provision was implemented through instructions to the MACs in the *Medicare Benefit Policy Manual* (Chapter 15, Section 50.4.5).

Due to changes in the pharmaceutical reference industry:

- The AHFS-DI was the only remaining statutorily-named compendia available for CMS reference;
- The AMA-DE and USP-DI are no longer published;
- Thomson Micromedex designated drug points was the successor to USP-DI; but
- Drug points has since been deleted from the list of recognized compendia.

In January 2008, CMS established, via the physician fee schedule final rule for 2008:

- A process for revising the list of compendia, as authorized under the Social Security Act (Section 1861(t)(2)), and
- A definition for "compendium."

This sub-regulatory process for revising the list of compendia is described in the *Medicare Benefit Policy Manual* (Chapter 15, Section 50.4.5.1).

Based on this process, CMS updated the list in 2008 to include the following four compendia:

1. **Existing** – American Hospital Formulary Service-Drug Information (AHFS-DI),
2. **Effective June 5, 2008** – National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium,
3. **Effective June 10, 2008** – Truven Health Analytics Micromedex DrugDex, and
4. **Effective July 2, 2008** – Elsevier/Gold Standard

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- *Medicare National Coverage Determinations Manual*.
- This article was revised October 28, 2015 to reflect the revised CR 9078 issued October 26. The CR was revised to direct the MACs to implement the NCD at the local level until Medicare system instructions are revised and Medicare system changes are implemented.

MLN Matters® Number: MM9078
Related Change Request (CR) #: CR 9078
Related CR Release Date: October 26, 2015

Effective Date: August 13, 2013
Related CR Transmittal #: R3384CP and R186NCD
Implementation Date: July 6, 2015

Laboratory/Pathology

New waived tests approved by the FDA

Provider types affected

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

Provider action needed

This article is based on change request (CR) 9416 which informs your MACs of new Clinical Laboratory Improvement Amendments of 1988 (CLIA) waived tests approved by the Food and Drug Administration (FDA). Since these tests are marketed immediately after approval, the Centers for Medicare & Medicaid Services (CMS) must notify its contractors of the new tests so that MACs can accurately process claims. CR 9416 informs MACs of the newly added waived complexity tests. See the *Background* and *Additional information* sections of this article for further details, and make sure that your billing staff is aware of these changes.

Background

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

Note: CR 8871 mentioned that effective for services performed on or after June 2, 2014, the HCPCS G0472, HCV screening, will be recognized as a covered service. The HCPCS code G0472QW describes the hepatitis C antibody test performed using the OraQuick HCV Rapid Antibody Test and OraQuick Visual Reference. The OraQuick HCV Rapid Antibody Test and OraQuick Visual Reference test was mentioned as a new waived test in CR 8054. The related *MLN Matters*® articles for CR 8871 and CR 8054 may be viewed at *MM8871* and *MM8054*.

CR 9416 Updates

The latest tests approved by the FDA as waived tests under CLIA are listed in the Tables 1 and 2. The *Current Procedural Terminology* (*CPT*®) codes for these new tests in Table 1 must have the modifier 'QW' to be recognized as a waived test.

Table 1: TESTS GRANTED WAIVED STATUS UNDER CLIA (Requires QW Modifier)

CPT® code(s)	Effective date	Description
*86308*QW	January 21, 2015	Medline Mono Test Cassette {Whole Blood)
G0434QW	June 5, 2015	AssureTech Co. LTD, AssureTech Oxycodone Strip {OTC}
G0434QW	June 5, 2015	AssureTech Co. Ltd, AssureTech Secobarbital Strip {OTC};
G0434QW	June 5, 2015	AssureTech Co. Ltd, AssureTech Secobarbital/ Oxycodone Panel Dip {OTC}
G0434QW	June 5, 2015	AssureTech Co. Ltd, AssureTech Secobarbital/ Oxycodone Quick Cup {OTC}
G0434QW	June 5, 2015	AssureTech Co. Ltd, AssureTech Secobarbital/Oxycodone Turn Key-Split Cup {OTC}

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Clinical Pharmacology.

On August 12, 2015, CMS announced the addition of Wolters Kluwer Lexi-Drugs® to the above list of four compendia used by the Medicare program in the determination of a "medically-accepted indication" for off-label drugs and biologics used in an anticancer chemotherapeutic treatment regimen. This is effective for services on or after August 12, 2015.

Further details on this issue are in the revised Chapter 15, Section 50.4.5.1 of the *Medicare Benefit Policy Manual*, which is an attachment to CR 9386.

Additional information

The official instruction, CR 9386, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R212BP.pdf*.

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

MLN Matters® Number: MM9386
Related Change Request (CR) #: CR 9386
Related CR Release Date: November 6, 2015
Effective Date: August 12, 2015
Related CR Transmittal #: R212BP
Implementation Date: February 10, 2016

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CPT® code(s)	Effective date	Description
*82274*QW, G0328QW	June 26, 2015	Medline iFOB Test
G0434QW	July 16, 2015	Noble Medical Inc. Noble 1 Step + Cup
*82274*QW, G0328QW	July 28, 2015	Sekisui Diagnostics, LLC OSOM iFOB Test
*86318*QW	August 19, 2015	Alere Clearview H. pylori Whole Blood Only {Whole Blood};
*86318*QW	August 19, 2015	Alere Signify H. pylori Whole Blood Only {Whole Blood}
*87880*QW	August 21, 2015	LABSCO Advantage Strep A
G0434QW	August 31, 2015	UCP Biosciences, Inc. UCP Drug Test Mini Cups
G0434QW	Sept. 22, 2015	American Screening Corporation, Reveal Mini Drug Test Cups
G0434QW	October 13, 2015	Assure Tech Co., Ltd AssureTech Buprenorphine Strip;
G0434QW	October 13, 2015	Assure Tech Co., Ltd AssureTech Methadone Strip;
G0434QW	October 13, 2015	Assure Tech Co., Ltd AssureTech Buprenorphine/ Methadone Panel Dip;
G0434QW	October 13, 2015	Assure Tech Co., Ltd AssureTech Buprenorphine/ Methadone Quick Cup; and
G0434QW	October 13, 2015	Assure Tech Co., Ltd AssureTech Buprenorphine/ Methadone Turn Key-Split Cup

However, the tests referenced in the attachment of CR 9416 titled, "TESTS GRANTED WAIVED STATUS UNDER CLIA", do not require a 'QW' modifier to be recognized as a waived test. These tests have been extracted from that document and are listed in Table 2.

Table 2: TESTS GRANTED WAIVED STATUS UNDER CLIA (Do not require QW Modifier)

CPT®	Test name	Use
81002	Dipstick or tablet reagent urinalysis – non-automated for bilirubin, glucose, hemoglobin, ketone, leukocytes, nitrite, pH, protein, specific gravity, and urobilinogen	Screening of urine to monitor/diagnose various diseases/ conditions, such as diabetes, the state of the kidney or urinary tract, and urinary tract infections
81025	Urine pregnancy tests by visual color comparison	Diagnosis of pregnancy
82270, *82272* *Contact your*	Fecal occult blood	Detection of blood in feces from whatever cause, benign or malignant (colorectal cancer screening)
82962	Blood glucose by glucose monitoring devices cleared by the FDA for home use	Monitoring of blood glucose levels
83026	Hemoglobin by copper sulfate – non-automated	Monitors hemoglobin level in blood
84830	Ovulation tests by visual color comparison for human luteinizing hormone	Detection of ovulation (optimal for conception)
85013	Blood count; spun microhematocrit	Screen for anemia
85651	Erythrocyte sedimentation rate – non-automated	Nonspecific screening test for inflammatory activity, increased for majority of infections, and most cases of carcinoma and leukemia

Note: MACs will not search their files to either retract payment or retroactively pay claims processed prior to the implementation of CR 9416. However, your MAC should adjust claims if you bring such claims to their attention.

Additional information

The official instruction, CR 9416, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3406CP.pdf*.

MLN Matters® Number: MM9416
Related Change Request (CR) #: CR 9416
Related CR Release Date: November 13, 2015
Effective Date: January 1, 2016
Related CR Transmittal #: R3406CP
Implementation Date: January 4, 2016

January changes to the laboratory NCD edit software

***Note**: This article was revised November 6, 2015, to reflect the revised change request (CR) 9352 issued November 5, 2015. The CR was revised to change the effective date. In addition, the transmittal number, CR release date, and the Web address for accessing CR 9352 are revised. All other information remains the same. This information was previously published October 2015 Medicare B Connection, Page 15.*

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

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 claim 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 October 1, 2015.

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/R3396CP.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.

Document history

Date	Description
November 6, 2015	This article was revised November 6, 2015, to reflect the revised CR 9352 issued November 5, 2015. The CR was revised to change the effective date. In addition, the transmittal number, CR release date, and the Web address for accessing CR 9352 are revised.

MLN Matters® Number: MM9352 *Revised*
Related Change Request (CR) #: CR 9352
Related CR Release Date: November 5, 2015
Effective Date: October 1, 2015
Related CR Transmittal #: R3396CP
Implementation Date: January 4, 2016

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Compliance tips for laboratory services

The Centers for Medicare & Medicaid Services (CMS) implemented the comprehensive error rate testing (CERT) program to measure improper payments in the Medicare fee-for-service (FFS) program. CERT selects a random sampling of claim types, including clinical laboratory services, to request and review medical documentation to determine if the services were paid appropriately. If the criteria for coverage are not met or the provider fails to submit medical documentation to support the claim, the payment is recouped from the provider and an error is assessed to the contractor for that paid claim. First Coast is receiving errors for clinical laboratory services at both the national and contractor level in the CERT program.

Clinical laboratory tests had a national improper payment rate of 36 percent during the 2014 reporting period for the CERT program. Insufficient documentation caused more than 93 percent of the CERT review contractor identified improper payments. Insufficient documentation could be a missing order and/or documentation that support the intent to order the laboratory test(s), which are the highest errors in this category.

Tips for responding to documentation requests

If you receive a documentation request from a Medicare review contactor, you will need, at a minimum, to check for the following in your documentation and submit it to the requesting review contractor:

- Procure all pertinent documentation from the ordering provider, if necessary, and ensure all documentation (including the order) is authenticated according to Medicare requirements
  - If the documentation is not authenticated in compliance with Medicare's legibility rules, obtain a signature attestation, signature log or any other documentation to authenticate the ordering provider
- Confirm authenticated order or documentation showing intent to order is submitted
  - If you cannot provide a copy of the order, contact the ordering practitioner and request that they send you a copy of the order
  - If the ordering practitioner cannot provide a copy of the order, request they send the progress notes, plan of care or another medical record entry prior to the lab tests, such as medical history or physical examination, documenting the intent to order the test(s) or why the test is needed

- Audit documentation prior to submission to ensure all requirements are met and requested documents are included in response
- Certify the documentation submitted supports medical necessity for services billed
  - Refer to all available local coverage determinations (LCDs) for guidance on services being rendered and billed

Note: A best practice suggestion was received from a Florida laboratory. Their suggestion is to include information to support medical necessity for tests in the remarks section of the requisition or order that is received by the laboratory from the ordering/referring provider. This suggestion may not be sufficient in supplying medical necessity for **all** laboratory tests. Please review medical necessity guidelines for the laboratory test being rendered to evaluate the effectiveness of this suggestion.

Sources: *Clinical Laboratory Specialty Web page*
Medical Documentation Web page
Medicare Coverage Database
MLN Matters® MM6698 Signature Guidelines for Medical Review Purposes
IOM Pub. 100-08, Chapter 3 Verifying Potential Errors and Taking Corrective Actions

Calculate the possibililtes ...

Whether you're estimating the amount of a Medicare payment, the length of an ESRD coordinating period, or the deadlines for sending an appeals request or responding to an additional development request, try the easy way to calculate the possibilities. Find everything you need to "do it yourself" in our Tool center.

Preventive Services

Medicare coverage of screening for lung cancer with low-dose computed tomography

Provider types affected

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

Provider action needed

Change request (CR) 9246 informs MACs that Medicare covers lung cancer screening with low-dose computed tomography (LDCT) if all eligibility requirements listed in the national coverage determination (NCD) are met. Make sure that your billing staffs are aware of these changes.

Background

Section 1861(ddd)(1) of the *Social Security Act (the Act)* authorizes the Centers for Medicare & Medicaid Services (CMS) to add coverage of "additional preventive services" through the NCD process. The "additional preventive services" must meet all of the following criteria:

- Be reasonable and necessary for the prevention or early detection of illness or disability;
- Be recommended with a grade of A or B by the United States Preventive Services Task Force (USPSTF); and
- Be appropriate for individuals entitled to benefits under Part A or enrolled under Part B.

CMS reviewed the evidence for lung cancer screening with low dose computed tomography (LDCT) and determined that the criteria listed above were met, enabling CMS to cover this "additional preventive service" under Medicare Part B.

CMS issued NCD 210.14 on August 21, 2105, that provides for Medicare coverage of screening for lung cancer with LDCT. Effective for claims with dates of service on and after February 5, 2015, Medicare beneficiaries must meet all of the following criteria:

- Be 55–77 years of age
- Be asymptomatic (no signs or symptoms of lung cancer)
- Have a tobacco smoking history of at least 30 pack-years (one pack-year = smoking one pack per day for one year; 1 pack = 20 cigarettes)
- Be a current smoker or one who has quit smoking within the last 15 years
- Receive a written order for lung cancer screening with LDCT that meets the requirements described in the NCD

Written orders for lung cancer LDCT screenings must be appropriately documented in the beneficiary's medical record, and must contain the following information:

- Date of birth
- Actual pack–year smoking history (number)
- Current smoking status, and for former smokers, the number of years since quitting smoking
- A statement that the beneficiary is asymptomatic (no signs or symptoms of lung cancer)
- The national provider identifier (NPI) of the ordering practitioner

Counseling and shared decision-making visit

Before the first lung cancer LDCT screening occurs, the beneficiary must receive a written order for LDCT lung cancer screening during a lung cancer screening counseling and shared decision-making visit that includes the following elements and is appropriately documented in the beneficiary's medical records:

- Must be furnished by a physician (as defined in section 1861(r)(1) of the Act) or qualified non-physician practitioner (meaning a Physician Assistant (PA), Nurse Practitioner (NP), or Clinical Nurse Specialist (CNS) as defined in section1861(aa)(5) of the Act); and
- Must include all of the following elements:
  - Determination of beneficiary eligibility including age, absence of signs or symptoms of lung cancer, a specific calculation of cigarette smoking pack-years; and if a former smoker, the number of years since quitting;
  - Shared decision-making, including the use of one or more decision aids, to include benefits and harms of screening, follow-up diagnostic testing, over-diagnosis, false positive rate, and total radiation exposure;
  - Counseling on the importance of adherence to annual lung cancer LDCT screening, impact of co-morbidities, and ability or willingness to undergo diagnosis and treatment;
  - Counseling on the importance of maintaining cigarette smoking abstinence if former smoker; or the importance of smoking cessation if current smoker and, if appropriate, furnishing of information about tobacco cessation interventions; and,
  - If appropriate, the furnishing of a written order for lung cancer screening with LDCT.

Written orders for subsequent annual LDCT screens may be furnished during any appropriate visit with a physician or qualified non-physician practitioner (PA, NP, or CNS)

There is also specific criteria that the reading radiologist and radiology imaging facility must meet. The radiology imaging facility must collect and submit data to a CMS-approved registry for each LDCT lung cancer screening performed. The data collected and submitted to a CMS-approved registry must include specific elements.

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Information regarding CMS-approved registries is posted at: *http://www.cms.gov/Medicare/Medicare-General-Information/MedicareApprovedFacilitie/Lung-Cancer-Screening-Registries.html*.

Coinsurance and deductibles

Medicare coinsurance and Part B deductible are waived for this preventive service.

Health care common procedure coding system (HCPCS) codes

Effective for claims with dates of service on and after February 5, 2015, the following HCPCS codes are used for lung cancer screening with LDCT:

- **G0296** – Counseling visit to discuss need for lung cancer screening (LDCT) using low dose CT scan (service is for eligibility determination and shared decision making)
- **G0297** – Low dose CT scan (LDCT) for lung cancer screening

In addition to the HCPCS code, these services must be billed with ICD-10 diagnosis code Z87.891 (personal history of tobacco use/personal history of nicotine dependence), ICD-9 diagnosis code V15.82.

Note: **Contractors shall apply contractor-pricing to claims containing HCPCS G0296 and G0297 with dates of service February 5 through December 31, 2015.**

Institutional billing requirements

Effective for claims with dates of service on and after February 5, 2015, providers may use the following types of bill (TOBs) when submitting claims for lung cancer screening, HCPCS codes G0296 and G0297: 12x, 13x, 22x, 23x, 71x (G0296 only), 77x (G0296 only), and 85x.

Medicare will pay for these services as follows:

- **Outpatient hospital departments** – TOBs 12x and 13x - based on outpatient prospective payment system (OPPS)
- **Skilled nursing facilities (SNFs)** – TOBs 22x and 23x – based on the Medicare physician fee schedule (MPFS)
- **Critical access hospitals (CAHs)** – TOB 85x – based on reasonable cost
- **CAH Method II** – TOB 85x with revenue code 096x, 097x, or 098x based on the lesser of the actual charge or the MPFS (115 percent of the lesser of the fee schedule amount and submitted charge) for HCPCS G0296 only;
- **Rural health clinics (RHCs)** – TOB 71x – based on the all-inclusive rate for HCPCS G0296 only; and
- **Federally qualified health centers (FQHCs)** – TOB 77x – based on the PPS rate for HCPCS G0296 only.

Note: For outpatient hospital settings, as in any other setting, services covered under this NCD must be ordered by a primary care provider within the context of a primary care setting and performed by an eligible Medicare provider for these services.

Claim adjustment reason codes (CARCs), remittance advice remark codes (RARCs), group codes

MACs will use the following CARCs, RARCs, and group codes when denying payment for LDCT lung cancer screening, HCPCS G0296 and G0297:

Submitted on a TOB other than 12x, 13x, 22x, 23x, 71x, 77x, or 85x:

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

Note: For modifier GZ, MACs will use CARC 50.

For TOBs 71x and 77x when HCPCS G0296 is billed on the same date of service with another visit (this does not apply to initial preventive physical exams for 71x TOBs):

- **CARC 97** – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- **RARC M15** – Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.

Note: 77x TOBs will be processed through the integrated outpatient code editor under the current process.

- **Group code CO** assigning financial liability to the provider.

Where a previous HCPCS G0297 is paid in history in a 12-month period (at least 11 full months must elapse from the date of the last screening):

- **CARC 119** – Benefit maximum for this time period or occurrence has been reached.
- **RARC N386** – This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.
- **Group code CO** assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

Note: For modifier GZ, MACs will use CARC 50.

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Because the beneficiary is not between the ages of 55 and 77 at the time the service was rendered (line-level):

- **CARC 6**: – The procedure/revenue code is inconsistent with the patient's age. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- **Group code CO** (contractual obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

Note: For modifier GZ, MACs will use CARC 50.

Because the claim line was not billed with ICD-10 diagnosis Z87.891:

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

Note: For modifier GZ, MACs will use CARC 50.

Additional information

The official instruction, CR 9246, consists of two transmittals:

1. *Transmittal R3374CP* updates the *Medicare Claims Processing Manual*

2. *Transmittal R185NCD* updates the *Medicare NCD Manual*

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

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Implementation Date: January 4, 2016

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Radiology

Billing transportation fee by portable X-ray suppliers

Provider types affected

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

Provider action needed

This article is based on change request (CR) 9354 which removes the word "Medicare" before "patient" in the *Medicare Claims Processing Manual* (Publication 100-04, Chapter 13, Section 90.3) and clarifies guidance when more than one patient is X-rayed at the same location. Make sure that your billing staff are aware of these changes.

Background

Portable X-ray suppliers receive a transportation fee for transporting portable X-ray equipment to the location where portable X-rays are taken. If more than one patient at the same location is X-rayed, the portable X-ray transportation fee is allocated among the patients. The Centers for Medicare & Medicaid Services (CMS) believes it would be more appropriate to allocate the transportation fee among all patients who receive portable X-ray services in a single trip. Medicare should not pay for more than its share of the transportation costs for portable X-ray services.

CMS has revised the *Medicare Claims Processing Manual* to remove the word "Medicare" before "patient" in Section 90.3. Also, CMS is clarifying the guidance for the billing of the transportation fee of portable X-ray suppliers. The revised part of Section 90.3 is as follows:

90.3 – Transportation Component (HCPCS Codes R0070-R0076)

"*This component represents the transportation of the equipment to the patient. Establish local RVUs for the transportation R codes based on* ***Medicare Administrative Contractor (MAC)*** *knowledge of the nature of the service furnished. The MACs shall allow only a single transportation payment for each trip the portable X-ray supplier makes to a particular location. When more than one patient is X-rayed at the same location, the single transportation payment under the Physician Fee Schedule is to be prorated among all patients (****Medicare Parts A and B, and non-Medicare) receiving portable X-ray services during that trip, regardless of their insurance status. For example, for portable X-ray services furnished at a SNF, the transportation fee should be allocated among all patients receiving***

portable X-ray services at the same location in a single trip irrespective of whether the patient is in a Part A stay, a Part B patient, or not a Medicare beneficiary at all. If the patient is in a Part A SNF stay, payment for the allocated portion of the transportation fee (and the X-ray) would be the SNF's responsibility. For a privately insured patient, it would be the responsibility of that patient's insurer. For a Medicare Part B patient, payment would be made under Part B for the share of the transportation fee attributable to that patient."…

Additional information

The official instruction, CR 9354, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3387CP.pdf*.

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

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Related Change Request (CR) #: CR 9354
Related CR Release Date: October 30, 2015
Effective Date: January 1, 2016
Related CR Transmittal #: R3387CP
Implementation Date: January 1, 2016

Payment reduction for computed tomography diagnostic imaging services

Provider types affected

This *MLN Matters*® article is intended for providers submitting claims for computed tomography (CT) diagnostic imaging services to Medicare administrative contractors (MACs), including durable medical equipment MACs (DME MACs).

Provider action needed

Stop – impact to you

The Centers for Medicare & Medicaid Services (CMS) is creating the modifier "CT" (Computed tomography services furnished using equipment that does not meet each of the attributes of the National Electrical Manufacturers Association (NEMA) XR-29-2013 standard). Beginning in 2016, claims for CT scans described by related *Current Procedural Terminology* (*CPT*®) codes that are furnished on non-NEMA Standard XR-29-2013-compliant CT scans must include modifier "CT" that will result in the applicable payment reduction.

Caution – what you need to know

Change request (CR) 9250 informs providers that effective January 1, 2016, a payment reduction of five percent applies to CT services furnished using equipment that is inconsistent with the CT equipment standard and for which payment is made under the physician fee schedule. The payment reduction increases to 15 percent in 2017 and subsequent years.

Go – what you need to do

Make sure that your billing staffs are aware of the NEMA standards and the payment reductions related to CT services furnished on equipment inconsistent with the CT equipment standard.

Background

Section 218(a) of the Protecting Access to Medicare Act of 2014 (PAMA) is titled, "Quality Incentives to Promote Patient Safety and Public Health in Computed Tomography Diagnostic Imaging." It amends the Social Security Act (SSA) by reducing payment for the technical component (and the technical component of the global fee) of the physician fee schedule service (five percent in 2016 and 15 percent in 2017 and subsequent years) for CT services identified by the following *CPT*® codes:

70450-70498	*72191-72194*	*74150-74178*
71250-71275	*73200-73206*	*74261-74263*
72125-72133	*73700-73706*	*75571-75574*

This applies when the services identified by these codes are furnished using equipment that does not meet each of the attributes of the NEMA Standard XR-29-2013, entitled, "Standard Attributes on CT Equipment Related to Dose Optimization and Management."

The statutory provision requires that information be provided and attested to by a supplier and a hospital outpatient department that indicates whether an applicable CT service was furnished that was not consistent with the NEMA CT equipment standard, and that such information may be included on a claim and may be a modifier. The statutory provision also provides that such information shall be verified, as appropriate, as part of the periodic accreditation of suppliers under SSA Section 1834(e) and hospitals under SSA Section 1865(a). Any reduced expenditures resulting from this provision are not budget neutral.

To implement this provision, CMS will create modifier "CT." Beginning in 2016, claims for CT scans described by above-listed *CPT*® codes (and by successor codes) that are furnished on non-NEMA Standard XR-29-2013-compliant CT scans must include modifier "CT" that will result in the applicable payment reduction.

Beginning January 1, 2016, a payment reduction of 5 percent applies to the technical component (and the technical component of the global fee) for CT services furnished using equipment that is inconsistent with the CT equipment standard and for which payment is made under the physician fee schedule. This payment reduction becomes 15 percent for 2017 and succeeding years.

When such payment reductions are made, MACs will supply:

- **Claim adjustment reason code 237**: Legislated/ Regulatory Penalty. 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.)
- **Remittance advice remark code N759**: Payment adjusted based on the National Electrical Manufacturers Association (NEMA) Standard XR-29-2013; and
- **Group code**: CO (contractual obligation).

Additional information

The official instruction, CR 9250 issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3402CP.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: MM9250
Related Change Request (CR) #: CR 9250
Related CR Release Date: November 6, 2015
Effective Date: January 1, 2016
Related CR Transmittal #: R3402CP
Implementation Date: January 4, 2016

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Surgery

New values for incomplete colonoscopies billed with modifier 53

Provider types affected

This *MLN Matters*® article is intended for providers submitting claims to Medicare administrative contractors (MACs) for services to Medicare beneficiaries related to incomplete colonoscopies billed with modifier *53*.

Provider action needed

Stop – impact to you

Change request (CR) 9317, from which this article is taken, revises the method for calculating payment for discontinued procedures. New payment rates will apply when modifier *53* (discontinued procedure) is appended to codes *44388*, *45378*, G0105, and G0121.

Caution – what you need to know

Effective for services performed on or after January 1, 2016, the Medicare physician fee schedule (MPFS) database will have specific values for *Current Procedural Terminology* (*CPT*®) codes *44388-53*; *45378-53*; G0105-*53*; and G0121-*53*.

Go – what you need to do

Make sure that your billing staffs are aware of these revisions for calculating payments for discontinued procedures using modifier *53*. Incomplete colonoscopies are reported with modifier *53*. Medicare will pay for the interrupted colonoscopy at a rate that is calculated using one-half the value of the inputs for the codes.

Background

According to *CPT*® instruction, prior to 2015, an incomplete colonoscopy was defined as a colonoscopy that did not evaluate the colon past the splenic flexure (the distal third of the colon). Physicians were previously instructed to report an incomplete colonoscopy with *45378* and append modifier *53* (discontinued procedure), which is paid at the same rate as a sigmoidoscopy.

In 2015, the *CPT*® instruction changed the definition of an incomplete colonoscopy to a colonoscopy that does not evaluate the entire colon. The 2015 *CPT*® manual states:

"When performing a diagnostic or screening endoscopic procedure on a patient who is scheduled and prepared for a total colonoscopy, if the physician is unable to advance the colonoscope to the cecum or colon-small intestine anastomosis due to unforeseen circumstances, report *45378* (colonoscopy) or *44388* (colonoscopy through stoma) with modifier *53* and provide appropriate documentation."

Therefore, in accordance with the change in *CPT*® manual language, the Centers for Medicare and Medicaid Services (CMS) has applied specified values in the MPFS database for the following codes:

- *44388-53* (colonoscopy through stoma);
- *45378-53* (colonoscopy);
- G0105-*53* (colorectal cancer screening; colonoscopy on individual at high risk; and
- G0121-*53* (colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk).

Effective for services performed on or after January 1, 2016, the MPFS database will have specific values for the codes listed above. Given that the new *CPT*® definition of an incomplete colonoscopy also include colonoscopies where the colonoscope is advanced past the splenic flexure but not to the cecum, CMS has established new values for incomplete diagnostic and screening colonoscopies performed on or after January 1, 2016. Incomplete colonoscopies are reported with modifier *53*. Medicare will pay for the interrupted colonoscopy at a rate that is calculated using one-half the value of the inputs for the codes.

Note: Chapters 12, Section 30.1 and Chapter 18, Section 60.2 of the *Medicare Claims Processing Manual* have been revised to reflect the information contained in CR 9317.

Additional information

The official instruction, CR 9317 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3368CP.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: MM9317
Related Change Request (CR) #: CR 9317
Related CR Release Date: October 9, 2015
Effective Date: January 1, 2016
Related CR Transmittal #: R3368CP
Implementation Date: January 1, 2016

General Coverage

ICD-10-CM diagnosis codes for bone mass measurement

Provider types affected

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

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) will implement change request (CR) 9252 January 4, 2016, effective October 1, 2015. (See related *MLN Matters*® article MM9252.) This CR establishes the list of covered conditions and corresponding ICD-10-CM diagnosis codes approved for bone mass measurement studies according to the requirements set forth in national coverage determination (NCD) 150.3. CR 9252 and accompanying spreadsheet inadvertently omitted the condition of osteopenia and the ICD-10-CM codes that describe it which are classified to subcategory M85.8- Other specified disorders of bone density and structure. The codes and conditions identified within this subcategory are considered covered indications for bone mass measurement under NCD 150.3 and providers should report these appropriately according to medical documentation. Additional guidance and education as to the updated complete list of covered indications will be forthcoming as CMS continues to review this issue and the systems updates required.

Background

Under ICD-9-CM, the term "Osteopenia" was indexed to ICD-9-CM diagnosis code 733.90 (Disorder of bone and cartilage). This code was listed as a covered condition under the business requirement 5521.1.1 for CR 5521/ NCD 150.3, dated May 11, 2007, when reported with *CPT*® code *77080*. (See related *MLN Matters*® article MM5521.) The accompanying *Benefit Policy Manual*, Publication 100-02, Chapter 15, Section 80.5.6, Beneficiaries Who May Be Covered, includes: 2. An individual with vertebral abnormalities as demonstrated by an X-ray to be indicative of osteoporosis, osteopenia, or vertebral fracture.

Under ICD-10-CM, the term "Osteopenia" is indexed to ICD-10-CM subcategory M85.8- Other specified disorders of bone density and structure, within the ICD-10-CM Alphabetic Index. The codes within this subcategory were inadvertently omitted from the CMS spreadsheet that accompanied CR 9252 containing the list of covered conditions and corresponding diagnosis codes. These are considered covered for NCD 150.3 indications.

Below is the list of ICD-10-CM diagnosis codes within subcategory M85.8- that providers may report as covered indications in addition to the current list provided in CR 9252 and its accompanying CMS spreadsheet.

- M85.80 Other specified disorders of bone density and structure, unspecified site
- M85.811 Other specified disorders of bone density and structure, right shoulder
- M85.812 Other specified disorders of bone density and structure, left shoulder
- M85.821 Other specified disorders of bone density and structure, right upper arm
- M85.822 Other specified disorders of bone density and structure, left upper arm
- M85.831 Other specified disorders of bone density and structure, right forearm
- M85.832 Other specified disorders of bone density and structure, left forearm
- M85.841 Other specified disorders of bone density and structure, right hand
- M85.842 Other specified disorders of bone density and structure, left hand
- M85.851 Other specified disorders of bone density and structure, right thigh
- M85.852 Other specified disorders of bone density and structure, left thigh
- M85.861 Other specified disorders of bone density and structure, right lower leg
- M85.862 Other specified disorders of bone density and structure, left lower leg
- M85.871 Other specified disorders of bone density and structure, right ankle and foot
- M85.872 Other specified disorders of bone density and structure, left ankle and foot
- M85.88 Other specified disorders of bone density and structure, other site
- M85.89 Other specified disorders of bone density and structure, multiple sites

Additional information

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

MLN Matters® Number: SE1525
Related Change Request (CR) #: CR 9252
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

ICD-10 conversion/coding infrastructure revisions to NCDs–3rd maintenance CR

Note: This article was revised October 6, 2015, to reflect the revised change request (CR) 9252 issued October 5. In the article, the CR release date, transmittal number, and the Web address for accessing CR 9252 are revised. This information was previously published in the October 2015 Medicare B Connection, Page 15.

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

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/R1547OTN.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: MM9252 *Revised*
Related Change Request (CR) #: CR 9252
Related CR Release Date: October 5, 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 #: R1547OTN

Reporting principal and interest amounts when refunding previously recouped money on the remittance advice

Provider types affected

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

Provider action needed

Change request (CR) 9168 explains to providers who received a favorable appeals decision that it will be easier and consequently more transparent to identify the claim and/or the refund of principal and interest paid by Medicare. Your MAC will make sure that the remittance advices are reporting the refunded principal and interest amounts separately, and provide individual claim information. CR 9168 applies to electronic remittance advice (ERA) only.

Background

Currently reporting of refunded principal and interest amounts for all related claims on the Remittance Advice (RA) is shown as one lump sum amount. This practice creates problems for the provider community as this is not conducive to posting payment properly. Providers have the money but are not able to identify the claim and/or the refund of principal and interest paid by Medicare.

CR 9168 instructs MACs to report the principal and interest separately and also to provide individual claim information. Specifically, the reporting will be in the provider level balance (PLB) segment of the 835 as follows:

PLB details – reporting principal refunds

PLB03-1: WW to report overpayment recovery (negative sign for the amount in PLB04) being refunded

PLB03-2: Positions 1 – 25: Account payable (AP) invoice number

PLB03-2: Positions 26 – 50: Claim adjustment account receivable (AR) number

PLB 04: Refund amount (principal refund amount)

PLB details – reporting interest refunds

PLB03-1: RU to report interest paid (negative sign for the amount in PLB04)

PLB03-2: Positions 1 – 25: AP Invoice number

PLB03-2: Positions 26 – 50: Claim adjustment AR number

PLB04: Interest amount on refund

Additional information

The official instruction, CR 9168 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1570OTN.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: MM9168
Related Change Request (CR) #: CR 9168
Related CR Release Date: November 6, 2015
Effective Date: July 1, 2016
Related CR Transmittal #: R1570OTN
Implementation Date: July 5, 2016

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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.

Medicare Remit Easy Print upgrade

Provider types affected

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

What you need to know

Change request (CR) 9291 contains upgrades to Medicare Remit Easy Print (MREP) software based on enhancement requests received through the Medicare administrative contractors (MACs) and/or the Centers for Medicare & Medicaid Services (CMS) website.

This software is available free of charge from the CMS website and now offers a number of special reports that users can view and download in addition to the remittance advice. Make sure that your billing staffs are aware of these changes.

Background

MREP software was developed by CMS to help providers to transition to electronic remittance advice (ERA) by offering to translate the ERA into a humanly readable format. CMS introduced the software in October 2005, and has continuously enhanced the software based on feedback from the end users.

CMS offers free software - MREP - to view and print Health Insurance Portability and Accountability Act (HIPAA) compliant ERA, transaction 835 - Health Care Claim Payment/Advice. The software gets enhanced on a regular basis to meet the changing needs of providers/suppliers to help them transition to ERA.

A key change in this version of the MREP application is an upgrade so that when a user prints the claim detail with the "Glossary" option selected, the glossary will begin on the same page of the last claim if there are available print lines on the page, rather than always printing on a new page.

Another upgrade to the MREP application is that the claim adjustment reason code (CARC) is added as a new criteria option for the existing search functionality. The search scope will be limited to a single selected remit, as it is today.

Additional information

The official instruction, CR 9291, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1552OTN.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: MM9291
Related CR Release Date: November 5, 2015
Related Transmittal #: R1552OTN
Change Request (CR) #: CR 9291
Implementation Date: April 4, 2016
Effective Date: April 1, 2016

Online Medicare refreshers

The *Medicare Learning Network*® (MLN) Products Web-Based Training (WBT) courses are designed for self-paced training via the Internet.

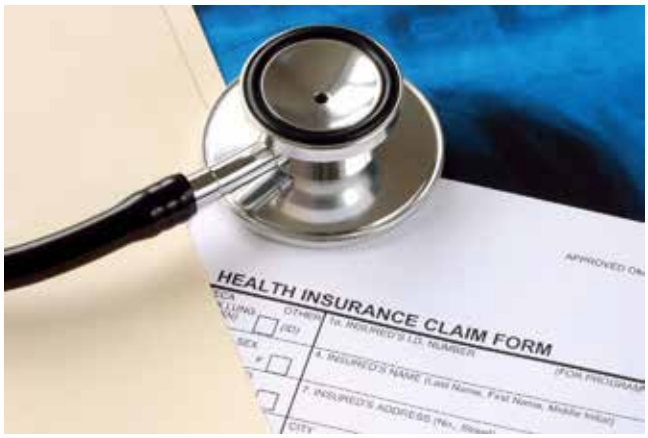
These WBT courses provide information on a broad range of Medicare topics for health care professionals and their staff. Many of these courses offer continuing education credits.

Click here to explore the wide away of training opportunities.

When not to show patient paid amounts on claims

Some providers who accept assignment have a concern that Medicare issues partial checks to beneficiaries. Such checks are generally issued because of a patient paid amount in item 29 of the CMS-1500 (02/12) claim form. Here are a few notes concerning this situation:

- When assignment is accepted, Medicare Part B recommends:
- Since it is difficult to predict when deductible/coinsurance amounts will be applicable (and over-collection is considered program abuse), it is recommended that providers do not collect these amounts until Medicare Part B payment is received.
- If you believe you can accurately predict the coinsurance amount and wish to collect it before Medicare Part B payment is received, note the amount collected for coinsurance on your claim form. It is recommended that providers do not collect the deductible prior to receiving payment from Medicare Part B because, as noted above, over-collection is considered program abuse. In addition, this practice can cause a portion of the provider's check to be issued to beneficiaries on assigned claims.
- Do not show any amounts collected from patients if the service is never covered by Medicare Part B or you believe, in a particular case, the service will be denied payment. Where patient paid amounts are shown for services that are denied payment, a portion of the provider's check may go to the beneficiary.
- There is no need to show a patient paid amount in item 29 of form CMS-1500 (or electronic equivalent) when assignment is not accepted.



Source: The Centers for Medicare & Medicaid Services (CMS) Internet-only manual (IOM) *Publication 100-04, Chapter 1, Section 30.3.1.1 and 30.3.3.B*; *Chapter 26, Section 10.4*

Update to NCD 210.3 colorectal cancer screening

Issue

Due to an increase in inappropriate denials, the Centers for Medicare & Medicaid Services (CMS) expedited an update to national coverage determination (NCD) 210.3, colorectal cancer screening tests. CMS is taking action to correct inappropriate denials of procedure code G0105 with ICD-10 code Z86.010 where they exist, and appropriate payment will be made for these procedures.

Resolution

No action is needed by providers. As outlined in change request (CR) 9252 for ICD-10 conversion/coding infrastructure revisions to NCDs published October 6, 2015, Medicare will cover Z86.010 as well as a host of other codes for G0105 or G0120. For more information, please refer to *MLN Matters*® number MM9252: *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9252.pdf*.

Status/date resolved

Open.

Provider action

No action is needed by providers. CMS is taking action to correct inappropriate denials of procedure code G0105 with ICD-10 code Z86.010 where they exist, and appropriate payment will be made for these procedures.

Current processing issues

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

First Coast Service Options (First Coast) strives to ensure that the information available on our provider website is accurate, detailed, and current. Therefore, this is a dynamic site and its content changes daily. It is best to access the site to ensure you have the most current information rather than printing articles or forms that may become obsolete without notice.

CMS corrects errors in Internet manuals for claims processing and beneficiary eligibility

Provider types affected

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

Provider action needed

The purpose of change request (CR) 9336 is to update the Medicare manuals to correct various minor technical errors and omissions. These changes are intended only to clarify the existing content and no policy, processing, or system changes are anticipated.

Background

CR 9336 revises the following Medicare manuals:

- *Medicare General Information, Eligibility, and Entitlement Manual* (Publication 100-01);
- *Medicare Benefit Policy Manual* (Pub 100-02); and
- *Medicare Claims Processing Manual* (Pub 100-04).

Medicare General Information, Eligibility, and Entitlement Manual Revision Summary

Chapter 1: General Overview

In Section 10.1, the final paragraph's discussion about tracking the utilization of Part A benefit days (as added previously by CR 8044) is clarified by removing the inappropriate reference to utilization of home health services, which is actually measured in terms of visits rather than benefit days.

Chapter 4: Physician Certification and Recertification of Services

Section 10.6 is revised to explain more completely the reference to "alternate placement" days that CRs 8044 and 8669 had previously added to the fifth paragraph of Section 20.1 of the *Medicare Benefit Policy Manual*. The revised section now reads:

- "A physician who certifies or recertifies to the need for continued inpatient stay should use the same criteria that apply to the hospital's utilization review committee. These criteria include not only medical necessity, but also the availability of out-of-hospital facilities and services which will assume continuity of care. In accordance with the regulations at 42 CFR 424.13(c), a physician should certify or recertify need for continued hospitalization if the physician finds that the patient could receive treatment in a SNF but no bed is available in the participating SNF. Where the basis for the certification or recertification is the need for continued inpatient care because of the lack of SNF accommodations, the certification or recertification should so state. The physician is expected to continue efforts to place the patient in a participating SNF as soon as the bed becomes available. Coverage of these additional, 'alternate placement' days in the hospital can continue until the earliest of the following events occurs:
  - A bed becomes available in a participating SNF;
  - The beneficiary's care needs drop below SNF-level; or
  - The beneficiary has exhausted all of the available days of Part A inpatient hospital benefits in that benefit period."

Medicare Benefit Policy Manual revision summary

Chapter 8: Coverage of Extended Care (SNF) Services Under Hospital Insurance

In Section 20.1, the fourth paragraph's reference (as added previously by CR 8044) to the limitation of liability policy discussed in the *Medicare Claims Processing Manual*, Chapter 30, Section 130.2.A. is clarified to reflect the referenced policy more accurately. Specifically, Chapter 8, Section 20.1 now clarifies that in some instances, the limitation of beneficiary liability for a hospital stay may apply to only a portion of the hospital stay, so that it would still be possible for the remainder of the hospital stay to count toward a "qualifying," medically necessary 3-day stay for SNF benefit purposes.

Medicare Claims Processing Manual revision summary

Chapter 6: Inpatient Part A Billing and SNF Consolidated Billing

Sections 20.1.2 and 20.1.2.1 are each revised by removing a parenthetical reference to revenue codes (originally added in CR 3070) that has become obsolete.

In Section 20.4 (Screening and Preventive Services), the description of screening services in the first paragraph (as added by CR 8044) is revised for greater clarity. Also, for a phrase (under Part B) that appears near the end of the sixth paragraph of that section, the emphasized font that was inadvertently removed in the course of manualizing CR 8669 is now restored. The updated paragraph now reads as follows:

Paragraph six: "Further, it is worth noting that unlike preventive services covered under Part B, those preventive vaccines covered under Part D are not subject to SNF CB, even when furnished to an SNF's Part A resident. This is because Section 1862(a)(18) of the Act specifies that SNF CB applies to '. . . covered skilled nursing facility services described in Section 1888(e)(2)(A)(i) . . . .' Section 1888(e)(2)(A)(i) of the Act, in turn, defines 'covered skilled nursing facility services' specifically in terms of (I) Part A SNF services, along with (II) those non-excluded services that (if not for the enactment of SNF CB) would be types of services '. . . for which payment may be made under **Part B** . . .'

Additional information

The official instruction, CR 9336, issued to your MAC

See **MANUALS**, next page

Medicare fee-for-service claims processing guidance for implementing International Classification of Diseases, 10th Edition (ICD-10) – A re-issue of MM7492

***Note**: This article was revised October 30, 2015, to add language to Table A under "Claims that span the ICD-10 implementation date" regarding inpatient psychiatric facilities (IPFs) and long term care hospital (LTCH) PPS. All other information remains the same. This information was previously published in the August 2014 Medicare B Connection, Pages 25-28.*

Provider types affected

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

Provider action needed

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

The HIPAA standard health care claim transactions are among those for which ICD-10 codes must be used for dates of service on and after October 1, 2015. As a result of CR 7492 (and related *MLN Matters*® article MM7492), guidance was provided on processing certain claims for dates of service near the original October 1, 2013, implementation date for ICD-10. **This article updates MM7492 to reflect the October 1, 2015, implementation date**. Make sure your billing and coding staffs are aware of these changes.

Key points of SE1408

General reporting of ICD-10

As with ICD-9 codes today, providers and suppliers are still required to report all characters of a valid ICD-10 code on claims. ICD-10 diagnosis codes have different rules regarding specificity and providers/suppliers are required to submit the most specific diagnosis codes based upon the information that is available at the time.

Please refer to *http://www.cms.gov/Medicare/Coding/ICD10/index.html* for more information on the format of ICD-10 codes. In addition, ICD-10 procedure codes (PCs) will only be utilized by inpatient hospital claims as is currently the case with ICD-9 procedure codes.

General claims submissions information

ICD-9 codes will no longer be accepted on claims (including electronic and paper) with FROM dates of service (on professional and supplier claims) or dates of discharge/through dates (on institutional claims) on or after October 1, 2015. Institutional claims containing ICD-9 codes for services on or after October 1, 2015, will be returned to provider (RTP) as unprocessable. Likewise, professional and supplier claims containing ICD-9 codes for dates of services on or after October 1, 2015, will also be returned as unprocessable. You will be required to re-submit these claims with the appropriate ICD-10 code. A claim cannot contain both ICD-9 codes and ICD-10 codes. Medicare will RTP all claims that are billed with **both** ICD-9 and ICD-10 **diagnosis codes** on the same claim. For dates of service **prior to** October 1, 2015, submit claims with the appropriate ICD-9 diagnosis code. For dates of service on or after October 1, 2015, submit with the appropriate ICD-10 diagnosis code. Likewise, Medicare will also RTP all claims that are billed with **both** ICD-9 and ICD-10 **procedure codes** on the same claim. For claims with dates of service prior to October 1, 2015, submit with the appropriate ICD-9 procedure code. For claims with dates of service on or after October 1, 2015, submit with the appropriate ICD-10 procedure code. Remember that ICD-10 codes may only be used for services provided on or after October 1, 2015. Institutional claims containing

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regarding this change consists of three transmittals. Those are:

- *R3379CP*, which updates the *Medicare Claims Processing Manual*;
- *R211BP*, which updates the *Medicare Benefit Policy Manual*; and
- *R94GI*, which updates the *Medicare General Information, Eligibility, and Entitlement Manual*.

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: MM9336
Related Change Request (CR) #: CR 9336
Related CR Release Date: October 16, 2015
Effective Date: November 16, 2015
Related CR Transmittal #: R3379CP, R211BP, and R94GI
Implementation Date: November 16, 2015

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ICD-10 codes for services prior to October 1, 2015, will be RTP. Likewise, professional and supplier claims containing ICD-10 codes for services prior to October 1, 2015, will be returned as unprocessable. Please submit these claims with the appropriate ICD-9 code.

Will the Centers for Medicare & Medicaid Services (CMS) allow for dual processing of ICD-9 and ICD-10 codes (accept and process both ICD-9 and ICD-10 codes for dates of service on and after October 1, 2015)?

No, CMS will not allow for dual processing of ICD-9 and ICD-10 codes after ICD-10 implementation on October 1, 2015. Many providers and payers, including Medicare have already coded their systems to only allow ICD-10 codes beginning October 1, 2015. The scope of systems changes and testing needed to allow for dual processing would require significant resources and could not be accomplished by the October 1, 2015, implementation date. Should CMS allow for dual processing, it would force all entities with which we share data, including our trading partners, to also allow for dual processing? In addition, having a mix of ICD-9 and ICD-10 codes in the same year would have major ramifications for CMS quality, demonstration, and risk adjustment programs.

Claims that span the ICD-10 implementation date

There may be times when a claim spans the ICD-10 implementation date for institutional, professional, and supplier claims. For example, the beneficiary is admitted as an inpatient in late September, 2015 and is discharged after October 1, 2015. Another example is a DME claim for monthly billing that spans between September and October 2015 (that is, the monthly billing dates are September 15, 2015 – October 14, 2015). The following tables provide further guidance to providers for claims that span the periods where ICD-9 and ICD-10 codes may both be applicable.

Table A – Institutional providers

Bill type	Facility type/ services	Claim processing requirement	Use FROM or THROUGH date
11x	Inpatient hospitals (including TEFRA hospitals, inpatient	If the hospital claim has a discharge and/or through date on or after 10/1/15, then the entire claim is billed using ICD-10.	THROUGH
11x	Inpatient	*Note: If the hospital claim has a discharge and/or through date on or after 10/1/15, and a benefits exhaust occurrence code with a September 2015 date does not exist, the entire claim is billed using ICD-10. If a benefits exhaust occurrence code with a September 2015 date exists, the provider must split bill the claim using the benefits exhaust occurrence code date as the through date on the first claim and bill with ICD-9 codes. The subsequent claim is billed as a no pay claim with appropriate ICD-10 coding.	*See Note
12x	Inpatient Part B hospital services	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM

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Bill type	Facility type/ services	Claim processing requirement	Use FROM or THROUGH date
13x	Outpatient hospital	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
14x	Non-patient laboratory services	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
18x	Swing beds	If the [swing bed or SNF] claim has a discharge and/ or through date on or after 10/1/2015, then the entire claim is billed using ICD-10.	THROUGH
21x	Skilled nursing (Inpatient Part A)	If the [swing bed or SNF] claim has a discharge and/ or through date on or after 10/1/2015, then the entire claim is billed using ICD-10.	THROUGH
22x	Skilled nursing facilities (Inpatient Part B)	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
23x	Skilled nursing facilities	Split claims - require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
32x	Home health (Inpatient Part B)	Allow HHAs to use the payment group code derived from ICD-9 codes on claims which span 10/1/2015, but require those claims to be submitted using ICD-10 codes.	THROUGH
3x2	Home health – request for	*NOTE - RAPs can report either an ICD-9 code or anICD-10 code based on the one (1) date reported. Since these dates will be equal to each other, there is no requirement needed. The corresponding final claim, however, will need to use an ICD-10 code if the HH episode spans beyond 10/1/2015.	*See Note

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Bill type	Facility type/ services	Claim processing requirement	Use FROM or THROUGH date
34x	Home health –	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
71x	Rural health clinics	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
72x	End-stage renal disease (ESRD)	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
73x	Federally qualified health clinics (*prior to 4/1/10*)	N/A – Always ICD-9 code set.	N/A
74x	Outpatient therapy	Split claims - require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
75x		Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
76x		Split claims - require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
77x	Federally qualified health clinics (*effective 4/4/10*)	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM

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Bill type	Facility type/ services	Claim processing requirement	Use FROM or THROUGH date
81x	Hospice-hospital	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
82x	Hospice – non hospital	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
83x	Hospice – hospital-based	N/A	N/A
85x	Critical access hospital	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (dos) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later	FROM

Table B - Special outpatient claims processing circumstances

Scenario	Claim processing requirement	Use FROM or THROUGH Date
3-day /1-day Payment Window	Since all outpatient services (with a few exceptions) are required to be bundled on the inpatient bill if rendered within three (3) days of an inpatient stay; if the inpatient hospital discharge is on or after 10/1/2015, the claim must be billed with ICD-10 for those bundled outpatient services.	THROUGH

Table C – Professional claims

Type of claim	Claim processing requirement	Use FROM or THROUGH date
All	Anesthesia procedures that begin on 9/30/2015 but end on 10/1/2015 are to be billed with ICD-9 diagnosis codes and use 9/30/2015 as both the FROM and THROUGH date.	FROM

Table D –Supplier claims

Supplier type	Claim processing requirement	Use FROM or THROUGH date
DMEPOS	Billing for certain items or supplies (such as capped rentals or monthly supplies) may span the ICD-10 compliance date of 10/1/2015 (i.e., the FROM date of service occurs prior to 10/1/2015 and the TO date of service occurs after 10/1/2015).	FROM

Additional information

You may also want to review SE1239 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1239.pdf*. SE1239 announces the revised ICD-10 implementation date of October 1, 2015.

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

***Note**: This article was revised October 21, 2015, to add a statement on item c. under "Effect of edits on providers" regarding a legislative change impacting the two year opt-out period. All other information remains the same. This information was previously published in the October 2015 Medicare B Connection, Pages 20-26.*

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.

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You may also want to review SE1410 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1410.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.

Document History

- This article was revised June 27, 2015, to clarify language under "Claims that span the ICD-10 implementation date."
- The article was revised October 30, 2015, to add information in Table A regarding inpatient psychiatric facilities (IPF) and long term care hospital (LTCH) PPS guidance.

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Implementation Date: N/A

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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 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.

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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):

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

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Reason code	This reason code will assign when:
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 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 Iternet-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 two years, and the NPI is required on the affidavit). Note, however, that 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

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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.

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 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 1 (person). Organizations (qualifier 2) 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 1 and 2. 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?

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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.

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.*

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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*.

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

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

Retired LCD

Lacrimal punctal plugs – retired Part B LCD

LCD ID number: L33916 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for lacrimal punctal plugs is being retired as the limited indications for lacrimal punctal plugs have been incorporated into the new LCD diagnostic evaluation and medical management of moderate-severe dry eye disease (DED) (L36232). The new LCD addresses both the diagnostic evaluation and medical management of moderate-severe DED. Therefore, the LCD for lacrimal punctal plugs is being retired.

Effective date

This LCD retirement 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*.

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

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

Revisions to LCDs

Allergen immunotherapy – revision to the LCD

LCD ID number: L33804 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for allergen immunotherapy was revised to remove ICD-10-CM diagnosis codes T63.001A - T63.001S*, T63.004A - T63.004S*, T63.091A - T63.091S*, T63.094A - T63.094S*, T63.301A - T63.301S*, T63.304A - T63.304S, T63.391A - T63.391S, T63.394A - T63.394S*, T63.891A - T63.891S, T63.894A - T63.894S, T63.91XA - T63.91XS, and T63.94XA - T63.94XS from the "ICD-10 Codes that Support Medical Necessity" section of the LCD. In addition, ICD-10-CM diagnosis code range T63.001A-T63.94XS* was added to the "ICD-10 Codes that Support Medical Necessity" section of the LCD for *Current Procedural Terminology* (*CPT*®) codes *95115* and *95117*.

The updated LCD will be available on the Medicare coverage database (MCD) on or after November 19, 2015.

Effective date

This LCD revision is effective for claims processed **on or November 9, 2015**, 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*.

Azacitidine (Vidaza®) – revision to the LCD

LCD ID number: L33266 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for azacitidine (Vidaza®) was revised to add ICD-10-CM diagnosis C93.10-C93.12 to the "ICD-10 Codes that Support Medical Necessity" section of the LCD. The updated LCD will be available on the Medicare coverage database (MCD) on or after November 5, 2015.

Effective date

This LCD revision is effective for claims processed **on or after October 29, 2015**, 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*.

Bone mineral density studies – revision to the LCD

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

Based on direction from the Centers for Medicare & Medicaid Services (CMS), the local coverage determination (LCD) for bone mineral density studies was revised to add ICD-10-CM diagnosis codes M85.80*, M85.811*, M85.812*, M85.821*, M85.822*, M85.831*, M85.832*, M85.841*, M85.842*, M85.851*, M85.852*, M85.861*, M85.862*, M85.871*, M85.872*, M85.88*, and M85.89* to the "ICD-10 Codes that Support Medical Necessity" section of the LCD for *Current Procedural Terminology* (*CPT*®) codes *77080* and *77085*.

The updated LCD will be available on the Medicare coverage database (MCD) on or after November 12, 2015.

Effective date

This LCD revision is effective for claims processed **on or after November 2, 2015**, 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*.

Cardiology-non-emergent outpatient testing: exercise stress test, stress echo, MPI SPECT, and cardiac PET – revision to the Part B LCD

LCD ID number: L36209 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for cardiology-non-emergent outpatient testing: exercise stress test, stress echo, MPI SPECT, and cardiac PET was revised to add ICD-10-CM diagnosis codes I05.0- I05.9, I06.0- I06.9, I07.0- I07.9, I08.0- I08.9, I09.1, I09.81, I09.89, I09.9 , I35.0- I35.9, I36.0- I36.9, and I37.0- I37.9 for *Current Procedural Terminology* (*CPT*®) codes *93350, 93351*, and *93352* to the "ICD-10 Codes that Support Medical Necessity" section of the LCD.

The updated LCD will be available on the Medicare coverage database (MCD) on or after November 5, 2015.

Effective date

This LCD revision is effective for claims processed **on or after November 2, 2015**, 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 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 range D03.0-D03.8 to the "ICD-10 Codes that Support Medical Necessity" section of the LCD.

The updated LCD will be available on the Medicare coverage database (MCD) on or after November 19, 2015.

Effective date

This LCD revision is effective for claims processed **on or after November 9, 2015**, 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*.

Diagnostic colonoscopy – revision to the LCD

LCD ID number: L33671 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for diagnostic colonoscopy was revised to add ICD-10-CM diagnosis codes C45.9, C79.9, D13.2, D13.30, D13.39, D19.1, K57.00 – K57.01, K59.00 – K59.09, and K63.5 to the "ICD-10 Codes that Support Medical Necessity" section of the LCD. In addition, the LCD was revised to expand the ulcerative colitis ICD-10-CM diagnosis range to K51.00–K51.919.

The updated LCD will be available on the Medicare coverage database (MCD) November 12, 2015.

Effective date

This LCD revision is effective for claims processed **on or after November 6, 2015**, 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, *click here*.

Excision of malignant skin lesions – revision to the LCD

LCD ID number: L33818 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for excision of malignant skin lesions was revised to add additional ICD-10-CM diagnosis codes to the "ICD-10 Codes that Support Medical Necessity" section of the LCD. ICD-10-CM diagnosis code ranges D03.51-D03.59, D03.60-D03.62, and D03-70-D03.72 were added for procedure codes *11600-11606*, ICD-10-CM diagnosis code D03.4 and code ranges D03.60-D03.62 and D03.70-D03.72 were added for procedure codes *11620-11626*, and ICD-10-CM diagnosis codes D03.0, D03.10-D03.12, D03.20-D03.22, D03.30-D03.39 and D03.8 were added for procedure codes *11640-11646*. Additionally, ICD-10-CM diagnosis code D04.5 was removed from the ICD-10-CM diagnosis code list for procedure codes *11620-11626* and added to the ICD-10-CM diagnosis code list for procedure codes *11600-11606*, as it was mistakenly added to the diagnosis list for procedure codes *11620-11626*.

The updated LCD will be available on the Medicare coverage database (MCD) on or after November 19, 2015.

Effective date

This LCD revision is effective for claims processed **on or after November 12, 2015**, 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, *click here*.

Fluorescein angiography – revision to the LCD

LCD ID number: L33997 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for fluorescein angiography was revised to add ICD-10-CM diagnosis codes H59.031-H59.039 to the "ICD-10 Codes that Support Medical Necessity" section of the LCD for *Current Procedural Terminology* (*CPT*®) code *92235*.

The updated LCD will be available on the Medicare coverage database (MCD) on or after November 19, 2015.

Effective date

This LCD revision is effective for claims processed **on or after November 19, 2015**, 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, *click here*.

Gemcitabine (Gemzar®) – revision to the LCD

LCD ID number: L33726 (Florida/Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for gemcitabine (Gemzar®) was revised to add ICD-10-CM diagnosis codes C45.1 and C67.0-C67.9 to the "ICD-10 Codes that Support Medical Necessity" section of the LCD.

The updated LCD will be available on the Medicare coverage database (MCD) on or after November 19, 2015.

Effective date

This LCD revision is effective for claims processed **on or after November 5, 2015**, 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*.

Noncovered services – revision to the LCD

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

The local coverage determination (LCD) for noncovered services was revised to remove *Current Procedural Terminology* (*CPT*®) code *0330T* from the "*CPT*®/HCPCS Codes" section of the LCD under the subtitles "Procedures for Part A" and "Procedures for Part B." *CPT*® code *0330T* (tear film imaging, unilateral or bilateral, with interpretation and report) will be added to the new LCD for diagnostic evaluation and medical management of moderate-severe dry eye disease (DED) (L36232) as a noncovered service. The new LCD addresses both the diagnostic evaluation and medical management of moderate – severe DED.

Effective date

This LCD revision 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*.

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*.

Ophthalmoscopy – revision to the LCD

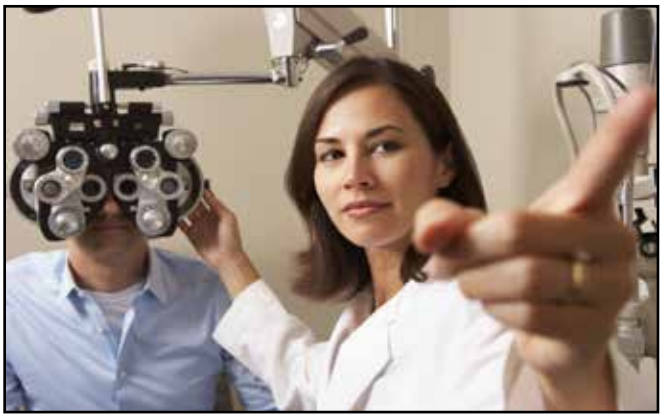
LCD ID number: L34017 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for ophthalmoscopy was revised to add ICD-10-CM diagnosis codes H59.031-H59.039 to the "ICD-10 Codes that Support Medical Necessity" section of the LCD for *Current Procedural Terminology* (*CPT*®) codes *92225* and *92226*.

The updated LCD will be available on the Medicare coverage database (MCD) on or after November 19, 2015.

Effective date

This LCD revision is effective for claims processed **on or after November 19, 2015**, 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, *click here*.

Polysomnography and sleep testing – revision to the LCD

LCD ID number: L33405 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for polysomnography and sleep testing has been revised based on data analysis and claim review that identified repeat sleep study testing within a six month to one year period of time for both initial diagnostic testing and titration of positive airway pressure (PAP) therapy. The indications/ limitations and utilization for such testing was clarified. Additionally, the LCD has been updated given the addition of new codes, as well as to add language related to the limited coverage of the titration of a covered oral appliance for the treatment of obstructive sleep apnea. (The oral appliance must meet the requirements of the durable medical equipment Medicare administrative contractor (DME MAC) LCD.)

Effective date

This LCD is effective for services rendered **on or after December 21, 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*.

Scanning computerized ophthalmic diagnostic imaging (SCODI) – revision to the LCD

LCD ID number: L33751 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for scanning computerized ophthalmic diagnostic imaging (SCODI) was revised to add ICD-10-CM diagnosis codes H43.00-H43.9 to the "ICD-10 Codes that Support Medical Necessity" section of the LCD for *Current Procedural Terminology* (*CPT*®) codes *92133* and *92134*. In addition, ICD-10-CM diagnosis codes H59.031-H59.039 were added to the "Indications and Limitations of Coverage and/or Medical Necessity" and "ICD-10 Codes that Support Medical Necessity" sections of the LCD for *CPT*® codes *92133* and *92134*.

The updated LCD reflecting ICD-10-CM diagnosis codes **H43.00-H43.9** is available on the Medicare coverage database (MCD) on or after November 5, 2015.

The updated LCD reflecting ICD-10-CM diagnosis codes **H59.031-H59.039** will be available on the Medicare coverage database (MCD) on or after November 19, 2015.

Effective date

The LCD revision related to the addition of ICD-10-CM diagnosis codes **H43.00-H43.9** is effective **for claims processed on or after October 29, 2015**, for services rendered **on or after October 1, 2015**.

The LCD revision related to the addition of ICD-10-CM diagnosis codes **H59.031-H59.039** is effective for claims processed **on or after November 19, 2015**, 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*.

Susceptibility studies – revision to the LCD

LCD ID number: L33755 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for susceptibility studies was revised to add ICD-10-CM diagnosis code range B96.0-B96.89 to the "ICD-10 Codes that Support Medical Necessity" section of the LCD. In addition, ICD-10 diagnosis code range M00.10 - M00.19 was removed from the "ICD-10 Codes that Support Medical Necessity" section of the LCD and ICD-10 diagnosis code range M00.00 – M00.89 was added to the "ICD-10 Codes that Support Medical Necessity" section of the LCD.

The updated LCD will be available on the Medicare coverage database (MCD) on or after November 19, 2015

Effective date

This LCD revision is effective for claims processed **on or after November 12, 2015**, 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,*click here*.

3D interpretation and reporting of imaging studies – revision to the LCD

LCD ID number: L33256 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for 3D interpretation and reporting of imaging studies was revised to add ICD-10-CM diagnosis code R93.8 to the "ICD-10 Codes that Support Medical Necessity" section of the LCD.

The updated LCD will be available on the Medicare coverage database (MCD) on or after November 5, 2015.

Effective date

This LCD revision is effective for claims processed **on or after November 2, 2015**, 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*.

Additional information

Erythropoiesis stimulating agents (J0881 and J0885) claims may have been denied in error

Issue

Claims for procedure code J0881 (Injection, darbepoetin alfa, 1 microgram [non-ESRD use]) and J0885 (Injection, darbepoetin alfa, 1 microgram [for ESRD on dialysis]) may have been denied in error with the following message: "These are non-covered services because this is not deemed a "medical necessity' by the payer".

Resolution

The error was corrected October 15, 2015. Claims processed on or after October 15, 2015 were adjudicated correctly. First Coast Service Options Inc. will perform a mass adjustment to correct impacted claims.

Status

Open.

Provider action

None; providers whose claims were incorrectly denied due to this error do not need to take any action.

Current processing issues

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

Widespread probe review for end-stage renal disease services (ESRD)

First Coast Service Options Inc. (First Coast) completed a complex widespread service specific probe review during CLIN 0003 related to the use of monthly end-stage renal disease (ESRD) related services. The widespread probe was conducted to validate the payment error risk related to the end-stage renal disease (ESRD) monthly services.

Specific codes probed included:

Current Procedural Terminology (CPT®) code 90960- End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 4 or more face-to-face visits by a physician or other qualified health care professional per month

CPT® code 90961- End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 2 or 3 face-to-face visits by a physician or other qualified health care professional per month

Overall widespread probe findings for *CPT®* codes *90960* and *90961*

Results of the widespread probe (WSP) for CPT® code 90960

- The overall error rate is six percent: 51 claims reviewed from ten providers
- 35 of 51 claims were allowed
- Seven of 51 claims were recoded to *CPT®* code *90962*
- Nine of 51 claims were recoded to *CPT®* code *90961*
- The majority of the claims were allowed as billed.
- Some claims were recoded to *CPT®* code *90962* or *90961* because the medical record submitted did not support the amount of face to face visits required for the code billed.
- Two of the ten providers drove the error rate
- 21 percent error rate
- With these providers removed the error rate is 1.79 percent
- Follow up action will be determined by First Coast

Results of the WSP for CPT® 90961

- The overall error rate is 29.41 percent: 50 claims reviewed from ten providers
- 33 of 50 claims were allowed
- 12 of 50 claims were denied
- Four of 50 claims were recoded to *CPT®* code *90962*
- One out of 50 claims were recoded to *CPT®* code *90960*
- The majority of the claims were allowed as billed.
- Some claims were recoded to *CPT®* code *90962* because the medical record submitted did not support the amount of face to face visits required for the code billed.
- One claim was upcoded to *CPT®* code *90960* because the medical record submitted support more face to face visit than the code billed required
- Two of the ten providers did not submit the medical record requested
- With these providers removed the error rate is 7.57 percent
- Follow up action will be determined by First Coast

Reference for additional information

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/GlobalSurgery-ICN907166.pdf

Upcoming provider outreach and educational event

Medicare Part B changes and regulations

Wednesday, December 16
Time: Time: 11:30 a.m.-1:00 p.m. **Type of event:** Webcast

http://medicare.fcso.com/Events/0302307.asp

Medicare's documentation guidelines for polysomnography testing (Part A/B)

Thursday, December 17
Time: Time: 11:30 a.m.-12:30 p.m. **Type of event:** Webcast

http://medicare.fcso.com/Events/0306220.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 October 29, 2015

MLN Connects® Provider eNews for October 29, 2015
View this edition as a PDF

In this edition:

Editor's note

If you order or refer items or services for Medicare beneficiaries and do not have a Medicare enrollment record, you need to submit an enrollment application to Medicare. See the revised *MLN Matters® special edition article #SE1305*. Also, see the revised *MLN Matters® special edition article #SE1434* on provider enrollment requirements for writing prescriptions for Medicare Part D drugs. Learn how to enroll to order/refer or prescribe Part D drugs using the 855O and more.

ICD-10

- Qualifiers for ICD-10 Diagnosis Codes on Electronic Claims
- Get ICD-10 Answers in One Place

MLN Connects® National Provider Calls and Events

- Clinical Diagnostic Laboratory Test Payment System Proposed Rule Call — Register Now
- National Partnership to Improve Dementia Care and QAPI Call — Registration Now Open
- New MLN Connects National Provider Call Audio Recording and Transcript

Other CMS Events

- Webinar for Comparative Billing Report on Optometry Services
- Long-Term Care Hospital Quality Reporting Program Provider Training

Announcements

- October is National Breast Cancer Awareness Month
- Protect Your Patients against Influenza and Pneumonia

- Hospital Value-Based Purchasing Program: FY 2016 Results
- DMEPOS Fee Schedule DME and PEN Text File Formats — Revised
- Antipsychotic Drug use in Nursing Homes: Trend Update
- EHR Incentive Programs: New Public Health Reporting FAQ

Claims, Pricers, and Codes

- Claims Processing Issue for non-Pneumococcal and Influenza Vaccines
- Correction of Mammography Claims
- October 2015 OPPS Pricer File Update

Medicare Learning Network® Educational Products

- "Provider Enrollment Requirements for Writing Prescriptions for Medicare Part D Drugs" MLN Matters Article — Revised
- "Full Implementation of Edits on the Ordering/Referring Providers in Me+dicare Part B, DME, and Part A HHA Claims" MLN Matters Article — Revised
- New Medicare Learning Network Educational Web Guides Fast Fact

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 November 5, 2015

MLN Connects® Provider eNews for November 5, 2015

View this edition as a PDF

In this edition:

MLN Connects® National Provider Calls and Events

- Clinical Diagnostic Laboratory Test Payment System Proposed Rule Call — Last Chance to Register
- National Partnership to Improve Dementia Care and QAPI Call — Register Now
- Medicare Quality Reporting Programs: 2016 Physician Fee Schedule Call — Registration Now Open
- ESRD QIP: Access PY 2016 Performance Score Report and Certificates Call — Registration Now Open
- New MLN Connects National Provider Call Audio Recording and Transcript

Announcements

- Physician Fee Schedule: Policy and Payment Changes for CY 2016
- Hospital Outpatient and ASC: Policy and Payment Changes for CY 2016
- ESRD Facilities: Policies and Payment Rates for CY 2016
- HHAs: Payment Changes for CY 2016
- Discharge Planning Proposed Rule Focuses on Patient Preferences
- Final Waivers in Connection with the Shared Savings Program
- DMEPOS Competitive Bidding Round 1 2017: Covered Document Review Date November 16
- Physician Compare Preview Period Extended to November 16
- 2016 Value Modifier: Informal Review Deadline Extended to November 23
- 2016 PQRS Payment Adjustment: Informal Review Deadline Extended to November 23
- Part D Prescribers Must Enroll in Medicare: Submit Your Application by January 1
- Considering Opting Out of Medicare to Meet the Prescriber Enrollment Requirements?
- CMS to Release a Comparative Billing Report on Physical Therapy in November
- November is Home Care and Hospice Month
- Each Office Visit is an Opportunity to Recommend Influenza Vaccination
- Find Information on Medicare-Covered Preventive Services

Claims, Pricers, and Codes

- Colorectal Cancer Screening Claims Processing Issue
- FY 2015 Inpatient PPS PC Pricer Update Available
- FY 2015 HH PPS PC Pricer Update Available

Medicare Learning Network® Educational Products

- Medicare Learning Network Catalog: November 2015 Version Available
- "ICD-10-CM Diagnosis Codes for Bone Mass Measurement" MLN Matters Article — Released
- "Medicare FFS Claims Processing Guidance for Implementing ICD-10" MLN Matters Article — Revised
- Medicare Learning Network Products Available in Electronic Publication Format

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 November 12, 2015

MLN Connects® Provider eNews for November 12, 2015
View this edition as a PDF

In this edition:

MLN Connects® National Provider Calls and Events

- National Partnership to Improve Dementia Care and QAPI Call — Register Now
- Medicare Quality Reporting Programs: 2016 Physician Fee Schedule Call — Register Now
- ESRD QIP: Access PY 2016 Performance Score Report and Certificates Call — Register Now

Other CMS Events

- LTCH Quality Reporting Program: In-Person Provider Training in Baltimore, MD

Announcements

- Three DMEPOS Competitive Bidding Reminders for Round 1 2017
- EHR Incentive Programs Stage 3 Final Rule: Submit Comments by December 15
- New FAQs on Participation in EHR Incentive Programs
- CMS Seeking Comment on MACRA Episode Groups by February 15
- Raising Awareness of Diabetes in November

Claims, Pricers, and Codes

- Pap Smear and PET Scan Claims Editing Incorrectly
- Additional Logic Applied to MDC 14

Medicare Learning Network® Educational Products

- Selecting Home Health Claims for Probe and Educate Review *MLN Matters*® Article — Released
- Clinical Laboratory Improvement Amendments Fact Sheet — Revised
- Inpatient Psychiatric Facility Prospective Payment System Fact Sheet — Revised
- Products Available in an Electronic Publication Format

MLN Connects® Provider eNews for November 19, 2015

MLN Connects® Provider eNews for November 19, 2015
View this edition as a PDF

In this edition:

MLN Connects® Events

- National Partnership to Improve Dementia Care and QAPI Call — Register Now
- Medicare Quality Reporting Programs: 2016 Physician Fee Schedule Call — Register Now
- ESRD QIP: Access PY 2016 Performance Score Report and Certificates Call — Register Now

Announcements

- Registration for DMEPOS Competitive Bidding Round 1 2017 Closes November 20
- CMS Awards Partnership-Driven Special Innovation Projects to QIN-QIOs
- Reducing Improper Payment: A Collaborative Effort
- Comprehensive Care for Joint Replacement Model
- Revised 2014 Annual QRURs Available
- 2016 Value Modifier Informal Review Deadline Ends November 23
- 2016 PQRS Payment Adjustment: Informal Review Deadline Ends November 23
- Comments on Discharge to Community Quality Measure due November 23
- Considering Opting Out of Medicare to Meet the Prescriber Enrollment Requirements? — Updated
- EHR Incentive Programs: New Public Health Reporting FAQs
- Recognizing Lung Cancer Awareness Month and the Great American Smokeout

Claims, Pricers, and Codes

- ICD-10 Transition: Clarifications about NCDs and LCDs
- CY 2013 Referring Provider DMEPOS Data — Updated

Medicare Learning Network® Educational Products

- Complying with Documentation Requirements for Laboratory Services Fact Sheet — New
- Skilled Nursing Facility Prospective Payment System Booklet — Revised
- Product Available in an Electronic Publication Format

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

C2C Innovative Solutions, Inc.
Part B QIC South Operations
ATTN: Administration Manager
P.O. Box 183092
Columbus, Ohio 43218-3092

General inquiries

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

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

Provider enrollment

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

Medical policy

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

Medicare secondary payer

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

Electronic data interchange (EDI)

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

Overpayments

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

Medicare Education and Outreach

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

Fraud and abuse

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

Freedom of Information Act requests

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

Overnight mail and/or special courier service

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

Websites

Provider

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

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

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

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

Beneficiaries

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

Phone numbers

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

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904-791-8103 (NOT toll-free)

Electronic data interchange (EDI)
888-670-0940

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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
C2C Innovative Solutions, Inc.
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

C2C Innovative Solutions, Inc.
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

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532 Riverside Avenue
Jacksonville, FL 32202-4914

Websites

Provider

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

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City: _____ State: _____ ZIP: _____

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