

C Medicare B CONNECTION

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A Newsletter for MAC Jurisdiction N Providers

December 2015



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Smooth the way to compliance with First Coast's Web tools

In a day's work, any number of things set Sarah Scott to action. As a Clinical Coding Auditor in Corporate Compliance with St. Vincent's HealthCare, how she responds to a call to action is critical for their St. Vincent's patients and the health system to ensure compliant billing and coding practices.

Scott is responsible for reviewing and auditing medical documentation for nearly 200 physicians and residents who provide care for patients covered by Medicare. She says Medicare claims represent a central focus in St. Vincent's compliance plans. Her work with physicians involves annual coding audits and ongoing education. She evaluates medical documentation and other patient data to ensure the assigned procedure and diagnosis codes reflect current Medicare policy and correct billing standards.

"I provide education to our providers on various topics. However, my primary focus is on evaluation and management services," Scott said. Helping providers stay on top of changes is a critical task for the health system getting reimbursed. "We educate our providers based on internal prospective and retrospective audits," Scott said.

To help physicians and residents understand Medicare rules and regulations, Scott turns to First Coast Service Options' Web tools.

"The First Coast tools are right at your fingertips. We use most of them on a regular basis. With our compliance program, the evaluation and management worksheet is perhaps the most used tool," she said. "We look at cases for accuracy and use the E/M worksheet with the providers and medical staff to help them arrive at the level of care based on the documentation."

The E/M interactive worksheet is a helpful checklist and interactive tool that aids providers in identifying the E/M code that best reflects the level of E/M services performed based on the 1995 and 1997 coding guidelines. Providers complete the online form, and the worksheet automatically calculates a suggested E/M code based on their entries.

"Medicare pays physicians based on diagnostic and procedure codes derived from medical documentation. We work closely with our EMR (emergency room) team and providers to improve their workflow, and stress the importance of documenting pertinent data. Proper medical

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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. *CPT® five-digit codes, descriptions, and other data only are copyright 2014 by American Medical Association (or such other date of publication of CPT®). All Rights Reserved. Applicable FARS/DFARS apply. No fee schedules, basic units, relative values or related listings are included in CPT®. AMA does not directly or indirectly practice medicine or dispense medical services. AMA assumes no liability for data contained or not contained herein. ICD-10-CM codes and its descriptions used in this publication are copyright 2015 Optum360, LLC. All rights reserved. This document contains references to sites operated by third parties. Such references are provided for your convenience only. Florida Blue and/or First Coast Service Options Inc. do not control such sites and are not responsible for their content. The inclusion of these references within this document does not suggest any endorsement of the material on such sites or any association with their operators. All stock photos used are obtained courtesy of a contract with www.shutterstock.com.*

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 (waiver 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.

April update to the correct coding initiative edits

Provider types affected

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

Provider action needed

Change request (CR) 9377 informs MACs about the release of the latest package of NCCI edits, version 22.1, which will be effective April 1, 2016. Make sure that your billing staffs are aware of these changes.

Background

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

The latest package of CCI edits, version 22.1, effective April 1, 2016, will be available via the CMS data center (CDC). A test file will be available on or about January 31, 2016, and a final file will be available on or about February 14, 2016.

Version 22.1 will include all previous versions and updates from January 1, 1996, to the present. In the past, CCI was organized in two tables:

- Column 1/column 2 correct coding edits and
- Mutually exclusive code (MEC) edits

In order to simplify the use of NCCI edit files (two tables), on April 1, 2012, CMS consolidated these two edit files into the column one/column two correct coding edit file. Separate consolidations have occurred for the two-practitioner NCCI edit files and the two NCCI edit files used for OCE. It will only be necessary to search the column one/column two correct coding edit file for active or previously deleted edits.

Reporting place of service (POS) codes

Physicians are required to report the place of service (POS) on all health insurance claims they submit to Medicare Part B contractors. The POS code is used to identify where the procedure is furnished. Physicians are paid for services according to the Medicare physician fee schedule (MPFS). This schedule is based on a payment system that includes three major categories, which drive the reimbursement for physician services:

- Practice expense (reflects overhead costs involved in providing service(s))
- Physician work
- Malpractice insurance

To account for the increased practice expense physicians incur by performing services in their offices, Medicare reimburses physicians a higher amount for services performed in their offices (POS code 11) than in an outpatient hospital (POS 22-23) or an ambulatory surgical center (ASC) (POS 24). Therefore, it is important to know the POS also plays a factor in the reimbursement.

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

Additional information

The official instruction, CR 9377, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3408CP.pdf>.

The CMS NCCI Web page has additional information at <https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html>.

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

MLN Matters[®] Number: MM9377
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 Implementation Date: April 4, 2016

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Note: Check with individual payers (e.g., Medicare, Medicaid, other private insurance) for reimbursement policies regarding POS codes.

Important facts when filing a claim to Medicare

- The POS is a required field, entered in the 2400 place of service code loop (segment SV105) of the 837P electronic claim or Item 24B on the CMS-1500 paper claim.
- The name, address and zip code of where the service(s) were actually performed is required for all POS codes, and is entered in Item 32 on the CMS 1500 claim form or in the corresponding loop on its electronic equivalent.
 - Must specify the correct location where the service(s) is performed and billed on the claim, since both the POS and the locality address are components of the MPFS.
- If the POS is missing, invalid or inconsistent with

See **REPORTING**, next page

New and revised place of service codes for outpatient hospitals

Note: This article was revised December 9, 2015, to clarify the effective date of place of service (POS) 19. POS 19 will be accepted for any claims processed on or after January 1, 2016. That is, POS code 19 is valid for any claim, regardless of the date of service, when it is processed on or after January 1, 2016. The title of the table was also changed for clarification. All other information is unchanged. This information was previously published in the [August 2015 Medicare B Connection, Pages 5-6](#).

Provider types affected

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

Provider action needed

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

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

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

Background

As a Health Insurance Portability and Accountability Act of 1996 (HIPAA) covered entity, Medicare must comply with HIPAA’s standards and their implementation guides.

The currently adopted professional implementation guide for the Accredited Standards Committee (ASC) X12N 837 standard requires that each electronic claim transaction include a POS code from the POS code set that the Centers for Medicare & Medicaid Services (CMS) maintains.

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

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

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

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

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procedure code on claim form it will be returned as unprocessable (RUC).

- For example, POS 21 (inpatient hospital) is not compatible with procedure code 99211 (Establish patient office or other outpatient visit).

Helpful hints for POS codes for professional claims

- Implement internal control systems to prevent incorrect billing of POS codes.
- Keep informed on Medicare coverage and billing requirements.
 - For example, billing physician’s office (POS 11) for a minor surgical procedure that is actually

performed in a hospital outpatient department (POS 22) and collecting a higher payment is inappropriate billing and may be viewed as program abuse.

- Check these links frequently for revisions to the listing and validate that you are coding according to the most current version.
 - A complete set of the national POS code set and instructions is provided in CMS Internet-only Manual (IOM) Publication 100-04, Chapter 26, Section 10.5 at: <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf>.
 - Additional information is available at: <https://www.cms.gov/Medicare/Coding/place-of-service-codes/index.html>.

CODES

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

CR 9231 also:

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

Additional information related to POS codes 19 and 22

- Payments for services provided to outpatients who are later admitted as inpatients within three days (or, in the case of non-IPPS hospitals, one day) are bundled when the patient is seen in a wholly-owned or wholly-operated physician practice. The three-day payment window applies to diagnostic and nondiagnostic services that are clinically related to the reason for the patient's inpatient admission, regardless of whether the inpatient and outpatient diagnoses are the same. The three-day payment rule will also apply to services billed with POS code 19.
- Claims for covered services rendered in an off campus-outpatient hospital setting (or in an on campus-outpatient hospital setting, if payable by Medicare) will be paid at the facility rate. The payment policies that currently apply to POS 22 will continue to apply to this POS, and will now also apply to POS 19 unless otherwise stated.



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

Additional information

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

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

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Durable Medical Equipment

Implementation of adjusted DMEPOS fee schedule amounts using information from the national competitive bidding program

Provider types affected

This *MLN Matters*[®] article is intended for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers submitting claims to durable medical equipment Medicare administrative contractors (DME MACs) for services provided to Medicare beneficiaries.

Provider action needed

Stop – impact to you

The adjusted fee schedule amounts for the applicable Healthcare Common Procedure Coding System (HCPCS) codes will be used to pay claims with dates of service on or after January 1, 2016, and will be included in the DMEPOS fee schedule files beginning January 1, 2016.

Caution – what you need to know

Section 1834(a)(1)(F) of the Act mandates adjustments to the fee schedule amounts for DME furnished on or after January 1, 2016, based on information from the competitive bidding program (CBP). Section 1842(s)(3)(B) of the Social Security Act (the Act) provides authority for making adjustments to the fee schedule amounts for enteral nutrients, equipment, and supplies (enteral nutrition) based on information from the competitive bidding program (CBP). Change request (CR) 9239 implements the adjusted DMEPOS fees schedule from the CBP.

Go – what you need to do

Make sure that your billing staffs are aware of the adjusted DMEPOS fee schedule amounts from the CBP.

Background

Medicare payment for most DMEPOS is based on either fee schedules or single payment amounts (SPAs) established under the CBP in certain specified geographic areas, as mandated by 1847(a) and (b) the Act.

Competitive bidding was phased in with the round 1 rebid contracts beginning January 1, 2011, in nine competitive bid areas (CBAs). Contracts for the round 1 rebid expired December 31, 2013. The Centers for Medicare & Medicaid Services (CMS) is required by law to recompetete contracts for the DMEPOS CBP at least once every three years. The same nine CBAs were rebid under the round 1 recompetete with the contracts and process claims with date of service beginning January 1, 2014. Competitive bidding was phased in with the round 2 contracts beginning July 1, 2013, in 100 additional CBAs. Beginning with the round 2 recompetete scheduled to take effect July 1, 2016, CBAs covering more than one state will be subdivided into CBAs that do not cross state lines, resulting in an increase in the

total number of CBAs.

The product categories and HCPCS codes included in each round of the CBP are available at <http://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home>.

Section 1834(a)(1)(F) of the Act mandates adjustments to the fee schedule amounts for DME furnished on or after January 1, 2016, based on information from the CBP. Section 1842(s)(3)(B) of the Act provides authority for making adjustments to the fee schedule amounts for enteral nutrients, equipment, and supplies (enteral nutrition) based on information from the CBP. The methodologies for using information from the CBP to adjust the fee schedule amounts for DME and enteral nutrition are set forth in regulations at *42 Code of Federal Regulations (CFR) 414.210(g)*. There are three general methodologies:

- Adjustment of fee schedule amounts for areas within the contiguous United States, with a special rule for rural areas;
- Adjustment of fee schedule amounts for areas outside the contiguous United States; and
- Adjustment of fee schedule amounts for certain items for all areas in cases where the items have been included in competitive bidding programs in 10 or fewer CBAs.

Fee schedule amounts for areas within the contiguous United States

This methodology for adjusting the fee schedule amounts uses the average of SPAs from CBPs located in eight different regions of the contiguous United States to adjust the fee schedule amounts for the states located in each of the eight regions. These regional SPAs or RSPAs are also subject to a national ceiling (110 percent of the average of the RSPAs for all contiguous states plus the District of Columbia) and a national floor (90 percent of the average of the RSPAs for all contiguous states plus the District of Columbia). This methodology applies to enteral nutrition and most DME items furnished in the contiguous United States (that is, those included in more than 10 CBAs).

There is also a special rule for areas within the contiguous United States that are designated as rural areas. The fee schedule amounts for these areas will be adjusted to equal the national ceiling amounts described above. Regulations at §414.202 define a rural area to be a geographical area represented by a postal ZIP Code where at least 50 percent of the total geographical area of the ZIP code is estimated to be outside any metropolitan statistical area (MSA). A rural area also includes any ZIP code within an MSA that is excluded from a competitive bidding area

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BIDDING

From previous page established for that MSA.

As a result of these adjustments, the national fee schedule amounts for enteral nutrition will transition to statewide fee schedule amounts.

Fee schedule amounts for areas outside the contiguous United States

Areas outside the contiguous United States (noncontiguous areas such as Alaska, Guam, Hawaii) are subject to a different methodology that adjusts the fee schedule amounts so that they are equal to the higher of the average of SPAs for CBAs in areas outside the contiguous United States (currently only applicable to Honolulu, Hawaii) or the national ceiling amounts described above and calculated based on SPAs for areas within the contiguous United States.

Fee schedule amounts for items included in 10 or fewer CBAs

DME items included in 10 or fewer CBAs are subject to a different methodology that adjusts the fee schedule amounts so that they are equal to 110 percent of the average of the SPAs for the 10 or fewer CBAs. This methodology applied to all areas (non-contiguous and contiguous).



Phasing in and updating fee schedule amounts

The adjustments to the fee schedule amounts will be phased in for claims with dates of service January 1, 2016, through June 30, 2016, so that the fee schedule amount is based on a blend of 50 percent of the current fee schedule amounts (the fee schedule amounts that would have gone into effect on January 1, 2016, if they had not been adjusted based on information from the CBP) and 50 percent of the adjusted fee schedule amount.

For claims with dates of service on or after July 1, 2016, the fee schedule is based on 100 percent of the adjusted fee schedule amount.

In most cases, the adjusted fee schedule amounts will not be subject to the annual DMEPOS covered item update and will only be updated when SPAs from the CBP are updated. Updates to the SPAs may occur at the end of a contract period, as additional items are phased into the CBP, or as new CBPs in new areas are phased in. In cases where SPAs from CBPs no longer in effect are used to adjust fee schedule amounts, the SPAs will be increased by an inflation adjustment factor that corresponds to the year in which the adjustment is made

(for example, 2016) and for each subsequent year (for example, 2017, 2018).

The DME MAC and Part B MAC DMEPOS fee schedule file shall be adjusted to include the rural fee and rural fee indicator and these changes will be reflected in the file format and data requirements specified in [Chapter 23](#),

Section 60.1 of the *Medicare Claims Processing Manual*. Similarly, the fiscal intermediary (FI) DMEPOS fee schedule file format, outlined in [Chapter 23](#), Section 50.2 of the *Medicare Claims Processing Manual* will be updated to include the rural fee and rural fee indicator. Beginning January 1, 2016, the DMEPOS fee schedule file will contain HCPCS codes that are subject to the adjusted payment amount methodology as well as codes that are not subject to the adjustments. The DMEPOS fee schedule file will continue to be updated and available for download on a quarterly basis as necessary.

The parenteral and enteral nutrition (PEN) fee schedule file will accommodate adjusted fees for the enteral HCPCS codes that are state specific. The PEN file layout is outlined in [Chapter 23](#), Section 70.1 of the *Medicare Claims Processing Manual*.

Additional information

The official instruction, CR 9239, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3350CP.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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2016 update for DMEPOS fee schedule

Provider types affected

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

Provider action needed

Change request (CR) 9431 provides the 2016 annual update for the Medicare DMEPOS fee schedule. The instructions include information on the data files, update factors, and other information related to the update of the fee schedule. Make sure your billing staffs are aware of these updates.

Background

The Centers for Medicare & Medicaid Services (CMS) updates the DMEPOS fee schedule on an annual basis in accordance with statute and regulations. The update process for the DMEPOS fee schedule is located in the *Medicare Claims Processing Manual*, Chapter 23, Section 60.

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

The Act mandates adjustments to the fee schedule amounts for certain items furnished on or after January 1, 2016, in areas that are not competitive bid areas for the items, based on information from the National Competitive Bidding Program (CBP). The Act provides authority for making adjustments to the fee schedule amounts for enteral nutrients, equipment, and supplies (enteral nutrition) based on information from the CBP.

CMS issued a final rule November 6, 2014 (79 FR 66223) on the methodologies for adjusting DMEPOS fee schedule amounts using information from competitive bidding programs. Program instructions on these changes are also available in Transmittal 3350, CR 9239 September 11, 2015. The CBP product categories, HCPCS codes and single payment amounts (SPAs) included in each round of the CBP are available on the competitive bidding implementation contractor (CBIC) website.

There are three general methodologies used in adjusting the fee schedule amounts:

1. Adjusted fee schedule amounts for areas within the contiguous United States

The average of SPAs from CBPs located in eight different regions of the contiguous United States are used to adjust the fee schedule amounts for the states located in each of the eight regions. These regional SPAs or RSPAs are also subject to a national ceiling (110 percent of the average

of the RSPAs for all contiguous states plus the District of Columbia) and a national floor (90 percent of the average of the RSPAs for all contiguous states plus the District of Columbia). This methodology applies to enteral nutrition and most DME items furnished in the contiguous United States (i.e., those included in more than 10 CBAs).

Also, the fee schedule amounts for areas within the contiguous United States that are designated as rural areas are adjusted to equal the national ceiling amounts described above. Regulations at §414.202 define a rural area to be a geographical area represented by a postal ZIP code where at least 50 percent of the total geographical area of the ZIP code is estimated to be outside any metropolitan statistical area (MSA). A rural area also includes any ZIP code within an MSA that is excluded from a competitive bidding area established for that MSA.

2. Adjusted fee schedule amounts for areas outside the contiguous United States

Areas outside the contiguous United States (i.e., noncontiguous areas such as Alaska, Guam, Hawaii) receive adjusted fee schedule amounts so that they are equal to the higher of the average of SPAs for CBAs in areas outside the contiguous United States (currently only applicable to Honolulu, Hawaii) or the national ceiling amounts described above and calculated based on SPAs for areas within the contiguous United States.

3. Adjusted fee schedule amounts for items included in 10 or fewer areas

DME items included in 10 or fewer CBAs receive adjusted fee schedule amounts so that they are equal to 110 percent of the straight average of the SPAs for the 10 or fewer CBAs. This methodology applies to all areas (i.e., non-contiguous and contiguous).

Phasing in fee schedule amounts

The adjustments to the fee schedule amounts will be phased in for claims with dates of service January 1, 2016, through June 30, 2016, so that each fee schedule amount is based on a blend of 50 percent of the fee schedule amount that would have gone into effect on January 1, 2016, if not adjusted based on information from the CBP, and 50 percent of the adjusted fee schedule amount.

For claims with dates of service on or after July 1, 2016, the July quarterly update files will include the fee schedule amounts based on 100 percent of the adjusted fee schedule amounts.

Fee schedule amounts that are adjusted using SPAs will not be subject to the annual DMEPOS covered item update and will only be updated when SPAs from the CBP are updated. Updates to the SPAs may occur at the end of a contract period, as additional items are phased in to the CBP, or as new CBPs in new areas are phased in. In cases where the SPAs from CBPs no longer in effect are

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used to adjust fee schedule amounts (§414.210(g)(4)), the SPAs will be increased by an inflation adjustment factor that corresponds to the year in which the adjustment would go into effect (for example, 2016 for this update) and for each subsequent year (such as 2017 or 2018) claims with dates of service on or after July 1, 2016, the fee schedule amount on the DMEPOS file is based on 100 percent of the adjusted fee schedule amount.

Fee schedule and rural ZIP code files

The DMEPOS fee schedule file will contain HCPCS codes that are subject to the adjusted payment amount methodologies discussed above as well as codes that are not subject to the fee schedule CBP adjustments taking effect January 1, 2016. In order to apply the rural payment rule for areas within the contiguous United States, the DMEPOS fee schedule file has been updated to include rural payment amounts for those HCPCS codes where the adjustment methodology is based on average regional SPAs. Also, on the PEN file the national fee schedule amounts for enteral nutrition will transition to statewide fee schedule amounts. For parenteral nutrition, the national fee schedule amount methodology will remain unchanged. The DMEPOS and PEN fee schedules and the Rural ZIP code file public-use files (PUFs) will be available for state Medicaid agencies, managed care organizations, and other interested parties after October 29, 2015 at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched.

New codes added effective January 1, 2016

The HCPCS codes A4337, E1012, E0465, E0466, and L8607. are being added to the HCPCS effective January 1, 2016. Codes E1012, E0465, E0466, and L8607 will be added to the DMEPOS fee schedule file effective January 1, 2016.

Codes deleted

The following codes will be deleted from the DMEPOS fee schedule files effective January 1, 2016: E0450, E0460, E0461, E0463, and E0464.

Shoe modification codes

Effective January 1, 2016, CMS is also adjusting the fee schedule amounts for shoe modification codes A5503 through A5507 as part of this update in order to reflect more current allowed service data. The fee schedule amounts for shoe modification codes A5503 through A5507 are being revised to reflect this change, effective January 1, 2016. Section 1833(o)(2)(C) of the Act required that the payment amounts for shoe modification codes A5503 through A5507 be established in a manner that prevented a net increase in expenditures when substituting these items for therapeutic shoe insert codes (A5512 or A5513). To establish the fee schedule amounts for the shoe modification codes, the base fees for codes A5512 and A5513 were weighted based on the approximated total allowed services for each code for items furnished during the second quarter of 2004. For 2016, CMS is updating

the weighted average insert fees used to establish the fee schedule amounts for the shoe modification codes with more current allowed service data for each insert code. The base fees for A5512 and A5513 will be weighted based on the approximated total allowed services for each code for items furnished during 2014.

Update to CR 8566 — wheelchair accessory

Also as part of CR 9431, CMS is adding HCPCS code E1012 (wheelchair accessory, addition to power seating system, center mount power elevating leg rest/platform, complete system, any type). Code E1012 is eligible for payment on a purchase basis when furnished for use with a complex rehabilitative power wheelchair, effective January 1, 2016.

The 2015 deflation factors for gap-filling purposes

For gap-filling pricing purposes, the 2015 deflation factors by payment category are: 0.459 for oxygen, 0.462 for capped rental, 0.463 for prosthetics and orthotics, 0.588 for surgical dressings, 0.639 for parental and enteral nutrition, 0.978 for splints and casts and 0.962 for intraocular lenses.

Ventilators

Fee schedules are being added for the following ventilator HCPCS codes:

- E0465 Home ventilator, any type, used with invasive interface (e.g., tracheostomy tube); and
- Code E0466 Home ventilator, any type, used with non-invasive interface (e.g., mask, chest shell).

Code E0465 is added to the HCPCS for billing Medicare claims previously submitted under E0450 and E0463. Code E0466 is added to the HCPCS for billing Medicare claims previously submitted under E0460, E0461, and E0464. The fee schedule amounts for codes E0465 and E0466 are established using the Medicare fee schedule amounts for HCPCS code E0450, based on updated average reasonable charges for ventilators from July 1, 1986, through June 30, 1987.

Diabetic testing supplies (DTS)

The fee schedule amounts for non-mail order DTS (without KL modifier) for codes A4233, A4234, A4235, A4236, A4253, A4256, A4258, A4259 are not updated by the covered item update. In accordance with the American Taxpayer Relief Act of 2012, the fee schedule amounts for these codes were adjusted in 2013 so that they are equal to the single payment amounts for mail order DTS established in implementing the national mail order CBP under the Act.

The non-mail order payment amounts on the fee schedule file will be updated each time the single payment amounts are updated. The CBP for mail order diabetic supplies is effective July 1, 2013–June 30, 2016. The program instructions reviewing these changes are Transmittal 2709, CR 8325, dated May 17, 2013, and Transmittal 2661, CR 8204, dated February 22, 2013. (See related *MLN Matters*® articles MM8325 and MM8204.)

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Although for payment purposes the single payment amounts replace the fee schedule amounts for mail order DTS (KL modifier), the fee schedule amounts remain on the DMEPOS fee schedule file as reference data only for establishing bid limits for future rounds of competitive bidding programs. The mail order DTS fee schedule amounts will be updated annually by the covered item update factor adjusted for multi-factor productivity. The mail order DTS fee schedule amounts are not used in determining the Medicare allowed payment amounts for mail order DTS. The single payment amount Public Use File (PUF) for the national mail order CBP is available at <http://www.dmecompetitivebid.com/palmetto/cbicrd2.nsf/DocsCat/Single%20Payment%20Amounts>.

The Northern Mariana Islands are not considered an area eligible for inclusion under a national mail order competitive bidding program. However, in accordance with The Act, the fee schedule amounts for mail order DTS furnished in the Northern Mariana Islands are adjusted to equal 100 percent of the single payment amounts established under the national mail order competitive bidding program (79 FR 66232).

Because the Northern Mariana Islands adjustment is subject to the six-month phase-in period, the adjusted Northern Mariana Island DTS mail order fees, which are based on 50 percent of the un-adjusted mail order fee schedule amounts and 50 percent of the adjusted mail order single payment amounts, will be provided on the DMEPOS fee schedule file in the Hawaii column of the mail order (KL) DTS (A4233, A4234, A4235, A4236, A4253, A4256, A4258, A4259) codes for dates of service January 1, 2016, through June 30, 2016. Beginning July 1, 2016, the fully adjusted mail order fees (the SPAs) will apply for mail order DTS furnished in the Northern Mariana Islands. The Northern Mariana Island DTS mail order payment amounts will no longer appear in the Hawaii column and the DTS mail order (KL) fee schedules for all states and territories will be removed from the DMEPOS fee schedule file as of July 1, 2016.

2016 fee schedule update factor of -0.4 percent

For 2016, an update factor of 0.1 percent is applied to certain DMEPOS fee schedule amounts. For the majority of fee schedule amounts, in accordance with the statutory Sections 1834(a)(14) and 1886(b)(3)(B)(xi)(II) of the Act, the DMEPOS fee schedule amounts are to be updated for 2016 by the percentage increase in the consumer price index for all urban consumers (United States city average) or CPI-U for the 12-month period ending with June 2015, adjusted by the change in the economy-wide productivity equal to the 10-year moving average of changes in annual economy-wide private non-farm business multi[AG5] -factor productivity (MFP). The MFP adjustment is 0.5 percent and the CPI-U percentage increase is 0.1 percent. Thus, the 0.1 percentage increase in the CPI-U is reduced by the 0.5 percentage increase in the MFP resulting in a

net decrease of -0.4 percent for the update factor.

2016 update labor payment rates for HCPCS codes K0739, L4205, and L7520 January 1, 2016, through December 31, 2016.

The 2016 labor payment amounts are effective for claims submitted using HCPCS codes K0739, L4205, and L7520 with dates of service from January 1, 2016, through December 31, 2016. Those amounts are as follows:

State	K0739	L4205	L7520
AK	\$28.01	\$31.91	\$37.54
AL	\$14.87	\$22.16	\$30.08
AR	\$14.87	\$22.16	\$30.08
AZ	\$18.39	\$22.13	\$37.01
CA	\$22.81	\$36.38	\$42.39
CO	\$14.87	\$22.16	\$30.08
CT	\$24.83	\$22.65	\$30.08
DC	\$14.87	\$22.13	\$30.08
DE	\$27.38	\$22.13	\$30.08
FL	\$14.87	\$22.16	\$30.08
GA	\$14.87	\$22.16	\$30.08
HI	\$18.39	\$31.91	\$37.54
IA	\$14.87	\$22.13	\$36.01
ID	\$14.87	\$22.13	\$30.08
IL	\$14.87	\$22.13	\$30.08
IN	\$14.87	\$22.13	\$30.08
KS	\$14.87	\$22.13	\$37.54
KY	\$14.87	\$28.37	\$38.47
LA	\$14.87	\$22.16	\$30.08
MA	\$24.83	\$22.13	\$30.08
MD	\$14.87	\$22.13	\$30.08
ME	\$24.83	\$22.13	\$30.08
MI	\$14.87	\$22.13	\$30.08
MN	\$14.87	\$22.13	\$30.08
MO	\$14.87	\$22.13	\$30.08
MS	\$14.87	\$22.16	\$30.08
MT	\$14.87	\$22.13	\$37.54
NC	\$14.87	\$22.16	\$30.08
ND	\$18.53	\$31.84	\$37.54
NE	\$14.87	\$22.13	\$41.94
NH	\$15.97	\$22.13	\$30.08
NJ	\$20.06	\$22.13	\$30.08
NM	\$14.87	\$22.16	\$30.08
NV	\$23.69	\$22.13	\$41.00
NY	\$27.38	\$22.16	\$30.08
OH	\$14.87	\$22.13	\$30.08
OK	\$14.87	\$22.16	\$30.08
OR	\$14.87	\$22.13	\$43.25
PA	\$15.97	\$22.79	\$30.08

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State	K0739	L4205	L7520
PR	\$14.87	\$22.16	\$30.08
RI	\$17.72	\$22.81	\$30.08
SC	\$14.87	\$22.16	\$30.08
SD	\$16.62	\$22.13	\$40.22
TN	\$14.87	\$22.16	\$30.08
TX	\$14.87	\$22.16	\$30.08
UT	\$14.91	\$22.13	\$46.84
VA	\$14.87	\$22.13	\$30.08
VI	\$14.87	\$22.16	\$30.08
VT	\$15.97	\$22.13	\$30.08
WA	\$23.69	\$32.47	\$38.57
WI	\$14.87	\$22.13	\$30.08
WV	\$14.87	\$22.13	\$30.08
WY	\$20.73	\$29.53	\$41.94

2016 national monthly fee schedule amounts for stationary oxygen equipment

CMS is implementing the 2016 national monthly fee schedule payment amount for stationary oxygen equipment (HCPCS codes E0424, E0439, E1390 and E1391), effective for claims with dates of service from January 1, 2016, through June 2016. The updated national 2016 monthly payment amount of \$180.10 for the stationary oxygen equipment codes will not appear on the 2016 DMEPOS fee schedule. Instead, for dates of service January 1, 2016, through June 30, 2016, the 2016 fee schedule rate of \$180.10 blends with the stationary oxygen regional SPAs based on 50 percent of the un-adjusted stationary oxygen fee schedule amounts and 50 percent of the adjusted oxygen regional SPAs.

Beginning July 1, 2016, the stationary oxygen equipment fee schedule amounts on the quarterly update to the 2016 DMEPOS fee schedule file will reflect 100 percent of the adjusted oxygen regional SPAs.

When updating the stationary oxygen equipment amounts, corresponding updates are made to the fee schedule amounts for HCPCS codes E1405 and E1406 for oxygen and water vapor enriching systems. Since 1989, the payment amounts for codes E1405 and E1406 have been established based on a combination of the Medicare payment amounts for stationary oxygen equipment and nebulizer codes E0585 and E0570, respectively.

2016 maintenance and servicing payment amount for certain oxygen equipment

Also updated for 2016 is the payment amount for

maintenance and servicing for certain oxygen equipment. Payment for claims for maintenance and servicing of oxygen equipment was instructed in Transmittal 635, change request (CR) 6792, dated February 5, 2010, and Transmittal 717, CR 6990, dated June 8, 2010. (See related *MLN Matters*® articles MM6792 and MM6990.) To summarize, payment for maintenance and servicing of certain oxygen equipment can occur every six months beginning six months after the end of the 36th month of continuous use or end of the supplier's or manufacturer's warranty, whichever is later for either HCPCS code E1390, E1391, E0433, or K0738, billed with the "MS" modifier. Payment cannot occur more than once per beneficiary, regardless of the combination of oxygen concentrator equipment and/or transfilling equipment used by the beneficiary, for any 6-month period.

Per 42 CFR §414.210(5)(iii), the 2010 maintenance and servicing fee for certain oxygen equipment was based on 10 percent of the average price of an oxygen concentrator. For 2011 and subsequent years, the maintenance and servicing fee is adjusted by the covered item update for DME as set forth in §1834(a)(14) of the Act. Thus, the 2016 maintenance and servicing fee is adjusted by the -0.4 percent MFP-adjusted covered item update factor to yield a 2016 maintenance and servicing fee of \$69.48 for oxygen concentrators and transfilling equipment.

Additional information

The official instruction, CR 9431, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3416CP.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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Laboratory/Pathology

2016 annual update for clinical laboratory fee schedule and laboratory services subject to reasonable charge payment

Provider types affected

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

Provider action needed

Change request (CR) 9465 provides instructions for the 2016 clinical laboratory fee schedule, mapping for new codes for clinical laboratory tests, and updates for laboratory costs subject to the reasonable charge payment. Make sure your billing staffs are aware of these updates.

Background

In accordance with Section 1833(h)(2)(A)(i) of the Social Security Act (the Act), the annual update to the local clinical laboratory fees for 2016 is 0.10 percent. The annual update to payments made on a reasonable charge basis for all other laboratory services for 2016 is 0.10 percent (See *42 CFR 405.509(b)(1)*). Section 1833(a)(1)(D) of the Act provides that payment for a clinical laboratory test is the lesser of the actual charge billed for the test, the local fee, or the national limitation amount (NLA). The Part B deductible and coinsurance do not apply for services paid under the clinical laboratory fee schedule.

Key points of CR 9465

National minimum payment amounts

For a cervical or vaginal smear test (pap smear), Section 1833(h)(7) of the Act requires payment to be the lesser of the local fee or the NLA, but not less than a national minimum payment amount. Further, payment may not exceed the actual charge. The 2016 national minimum payment amount is \$14.39 (\$14.38 times 0.10 percent update for 2016). The affected codes for the national minimum payment amount are *88142, 88143, 88147, 88148, 88150, 88152, 88153, 88154, 88164, 88165, 88166, 88167, 88174, 88175, G0123, G0143, G0144, G0145, G0147, G0148, and P3000*.

National limitation amounts (maximum)

For tests for which NLAs were established before January 1, 2001, the NLA is 74 percent of the median of the local fees. For tests for which the NLAs are first established on or after January 1, 2001, the NLA is 100 percent of the median of the local fees in accordance with Section 1833(h)(4)(B)(viii) of the Act.

Access to data file

Internet access to the 2016 clinical laboratory fee schedule data file is available at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/clinlab.html>. Other interested parties, such as the Medicaid

state agencies, the Indian Health Service, the United Mine Workers, and the Railroad Retirement Board may use the Internet to retrieve the 2016 clinical laboratory fee schedule; available in multiple formats: Excel, text, and comma delimited.

Public comments and final payment determinations

On July 16, 2015, CMS hosted a public meeting to solicit input on the payment relationship between 2015 codes and new 2016 CPT[®] codes. Recommendations were received from many attendees, including individuals representing laboratories, manufacturers, and medical societies. CMS posted a summary of the meeting and the tentative payment determinations on the website at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html>. Additional written comments from the public were accepted until October 26, 2015. CMS has posted a summary of the public comments and the rationale for the final payment determinations at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Downloads/CY2016-CLFS-Codes-Final-Determinations.pdf>.

Pricing information

The 2016 clinical laboratory fee schedule includes separately payable fees for certain specimen collection methods (codes *36415, P9612, and P9615*). The fees have been established in accordance with Section 1833(h)(4)(B) of the Act.

The fees for clinical laboratory travel codes *P9603 and P9604* are updated on an annual basis. The clinical laboratory travel codes are billable only for traveling to perform a specimen collection for either a nursing home or homebound patient. If there is a revision to the standard mileage rate for 2016, CMS will issue a separate instruction on the clinical laboratory travel fees.

The 2016 clinical laboratory fee schedule also includes codes that have a "QW" modifier to both identify codes and determine payment for tests performed by a laboratory having only a certificate of waiver under the Clinical Laboratory Improvement Amendments (CLIA).

Organ or disease oriented panel codes

Similar to prior years, the 2016 pricing amounts for certain organ or disease panel codes and evocative/suppression test codes were derived by summing the lower of the clinical laboratory fee schedule amount or the NLA for each individual test code included in the panel code. The NLA field on the data file is zero-filled.

Mapping Information

New code *G0477* is priced at the same rate as 0.75 times code *G0434*.

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New code G0478 is priced at the same rate as code G0434.

New code G0479 is priced at the same rate as 4.00 times code G0434.

New code G0480 is priced at the same rate as 3.25 times code 82542.

New code G0481 is priced at the same rate as 5.00 times code 82542.

New code G0482 is priced at the same rate as 6.75 times code 82542.

New code G0483 is priced at the same rate as 8.75 times code 82542.

New code 87651QW is priced at the same rate as code 87651.

New code 87806QW is priced at the same rate as code 87806.

New code 87502QW is priced at the same rate as code 87502.

New code 86780QW is priced at the same rate as code 86780.

New code 87650QW is priced at the same rate as code 87650.

New code 87389QW is priced at the same rate as code 87389.

New code 86850 is priced at the same rate as code 86902.

New code 80081 is priced at the same rate as the sum of codes 85025, 87340, 87389, 86762, 86592, 86850, 86900, and 86901.

New code 80055 is priced at the same rate as the sum of codes 85025, 87340, 86762, 86592, 86850, 86900, and 86901.

New code G0472 is priced at the same rate as code 86803.

New code G0472QW is priced at the same rate as code 86803.

New code 81162 is priced at the same rate as the sum of 0.90 times code 81211, and 0.90 times code 81213.

New code 81170 is priced at the same rate as code 81235.

New code 81218 is priced at the same rate as code 81235.

New code 81219 is priced at the same rate as code 81245.

New code 81272 is priced at the same rate as code 81235.

New code 81273 is priced at the same rate as code 81270.

New code 81276 is priced at the same rate as code 81275.

New code 81311 is priced at the same rate as 1.50 times code 81275.

New code 81314 is priced at the same rate as code 81235.

New code 81528 is priced at the same rate as the sum of codes 81315, 81275, and 82274.

New code 81535 is priced at the same rate as the sum of

2.00 times code 88239 and code 87900.

New code 81536 is priced at the same rate as code 87900.

New codes to be gap filled are: 81412, 81432, 81433, 81434, 81437, 81438, 81442, 81490, 81493, 81525, 81538, 81540, 81545, 81595, 0009M, and 0010M.

The following existing codes are to be deleted: G0431, G0434, G0434QW, G0464, G6030, G6031, G6032, G6034, G6035, G6036, G6037, G6038, G6039, G6040, G6041, G6042, G6043, G6044, G6045, G6046, G6047, G6048, G6049, G6050, G6051, G6052, G6053, G6054, G6055, G6056, G6057, G6058, 82486, 82487, 82488, 82489, 82491, 82492, 82541, 82543, 82544, and 83788.

Laboratory costs subject to reasonable charge payment in 2011

For outpatients, the following codes are paid under a reasonable charge basis (See Section 1842(b)(3) of the Act). In accordance with 42 CFR 405.502 through 42 CFR 405.508, the reasonable charge may not exceed the lowest of the actual charge or the customary or prevailing charge for the previous 12-month period ending June 30, updated by the inflation-indexed update. The inflation-indexed update is calculated using the change in the applicable consumer price index for the 12-month period ending June 30 of each year as set forth in 42 CFR 405.509(b)(1). The inflation-indexed update for 2016 is 0.1 percent.

Manual instructions for determining the reasonable charge payment are available in the *Medicare Claims Processing Manual, Chapter 23* (Fee Schedule Administration and Coding Requirements), Sections 80 through 80.8. If there is sufficient charge data for a code, the instructions permit considering charges for other similar services and price lists.

When services described by the Healthcare Common Procedure Coding System (HCPCS) in the following list are performed for independent dialysis facility patients, *Medicare Claims Processing Manual, Chapter 8* (Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims), Section 60.3, instructs that the reasonable charge basis applies. However, when these services are performed for hospital-based renal dialysis facility patients, payment is made on a reasonable cost basis. Also, when these services are performed for hospital outpatients, payment is made under the hospital outpatient prospective payment system (OPPS).

Blood product codes

Blood product codes are: P9010, P9011, P9012, P9016, P9017, P9019, P9020, P9021, P9022, P9023, P9031, P9032, P9033, P9034, P9035, P9036, P9037, P9038, P9039, P9040, P9044, P9050, P9051, P9052, P9053, P9054, P9055, P9056, P9057, P9058, P9059, and P9060.

Also, payment for the following codes should be applied to the blood deductible as instructed in the *Medicare General Information, Eligibility and Entitlement Manual, Chapter 3* (Deductibles, Coinsurance Amounts, and Payment Limitations), Sections 20.5 through 20.5.4: P9010, P9016, P9021, P9022, P9038, P9039, P9040, P9051, P9054, P9056, P9057, and P9058.

See CLFS, next page

CLFS

From previous page

Note: Biologic products not paid on a cost or prospective payment basis are paid based on Section 1842(o) of the Act. The payment limits based on Section 1842(o), including the payment limits for codes P9041, P9045, P9046, and P9047, should be obtained from the Medicare Part B drug pricing files.

Transfusion medicine codes

Transfusion medicine codes are: 86850, 86860, 86870, 86880, 86885, 86886, 86890, 86891, 86900, 86901, 86902, 86904, 86905, 86906, 86920, 86921, 86922, 86923, 86927, 86930, 86931, 86932, 86945, 86950, 86960, 86965, 86970, 86971, 86972, 86975, 86976, 86977, 86978, and 86985.

Reproductive medicine procedure codes

Reproductive medicine procedure codes are: 89250, 89251, 89253, 89254, 89255, 89257, 89258, 89259, 89260, 89261, 89264, 89268, 89272, 89280, 89281, 89290, 89291, 89335, 89342, 89343, 89344, 89346, 89352, 89353, 89354, and 89356.

Your MAC will not search their files to either retract payment or retroactively pay claims; however, should adjust claims that you bring to their attention.

Additional information

The official instruction, CR 9465, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3420CP.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: MM9465

Related Change Request (CR) #: CR 9465

Related CR Release Date: December 11, 2015

Effective Date: January 1, 2016

Related CR Transmittal #: R3420CP

Implementation Date: January 4, 2016

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Calculate the possibilities ...

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.

Medicare Physician Fee Schedule Database

October update in the Medicare physician fee schedule database

Note: This article was revised November 25, 2015, to reflect the revised change request (CR) 9266 issued November 18. In the article, several codes were removed from the list of codes with bilateral surgery indicator changes. The CR release date, transmittal number, and the Web address for CR 9266 are also revised. This information was previously published in the November 2015 Medicare B Connection, Page 14.

Provider types affected

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

What you need to know

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

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

Background

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

values for physicians' services.

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

Additional information

The official instruction, CR 9266 issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3407CP.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

- On September 29, 2015, additional codes (G0105 and G0121) were added in the "What you need to know" section listing RVU changes.
- On November 25, the "What you need to know" section listing RVU changes was revised to remove several codes (76641, 76641-TC, 76641-26, 76642, 76642-TC, 76642-26) that had been listed with bilateral surgery indicator changes.

MLN Matters® Number: MM9266 *Revised*

Related CR Release Date: November 18, 2015

Related Transmittal #: R3407CP

Change Request (CR) #: CR 9266

Implementation Date: January 1, 2015

Effective Date: October 5, 2015

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Preventive Services

New influenza virus vaccine code

Provider types affected

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

Provider action needed

Change request (CR) 9357 provides instructions for Medicare systems to be updated to include influenza virus vaccine code 90630 (Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use) for claims with dates of service on or after August 1, 2015. Make sure your billing staffs are aware of this code change.

Background

CR 9357 provides that (effective for claims with dates of service on or after August 1, 2015, processed on or after April 4, 2016) Medicare will pay for vaccine *Current Procedural Terminology (CPT)*[®] code 90630 (Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use).

Your MAC will add influenza virus vaccine *CPT*[®] code 90630 to existing influenza virus vaccine edits and accept it for claims with dates of service on or after August 1, 2015.

Effective for dates of service on and after August 1, 2015, MACs will:

- Pay for vaccine code 90630 on institutional claims as follows:
 - **Hospitals** – types of bill (TOB) 12x and 13x, skilled nursing facilities (SNFs) – TOB 22x and 23x, home health agencies (HHAs) – TOB 34x, hospital-based renal dialysis facilities (RDFs) – TOB 72x, and critical access hospitals (CAHs) – TOB 85x, based on reasonable cost;
 - **Indian health service (IHS) hospitals** – TOB 12x, and 13x and IHS CAHs – TOB 85x, based on the lower of the actual charge or 95 percent of the average wholesale price (AWP); and
 - **Comprehensive outpatient rehabilitation facility (CORF)** – TOB 75x, and independent RDFs – TOB 72x, based on the lower of actual charge or 95 percent of the AWP.
- Pay for code 90630 on professional claims using the CMS Seasonal Influenza Vaccines Pricing Web page at <https://www.cms.gov/Medicare/Medicare-Fee-for->



[Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html](http://www.cms.gov/Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html) to determine the payment rate for influenza virus vaccine code 90630.

Note: In all of the above instances, annual Part B deductible and coinsurance do not apply.

In addition, until Medicare system changes are implemented, MACs will hold institutional claims containing influenza virus vaccine *CPT*[®] codes 90630 (with dates of service on or after August 1, 2015) that they receive before April 4, 2016. Once the system changes described in CR 9357 are implemented, these institutional claims will be processed and paid.

Additional information

The official instruction, CR 9357, issued to your MAC regarding this change is available at <http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3403CP.pdf>.

MLN Matters[®] Number: MM9357

Related Change Request (CR) #: CR 9357

Related CR Release Date: November 9, 2016

Effective Date: August 1, 2015

Related CR Transmittal #: R3403CP

Implementation Date: April 4, 2016

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Therapy Services

Therapy services cap values for 2016

Provider types affected

This *MLN Matters*[®] article is intended for physicians, therapists, and other providers, submitting claims to Medicare administrative contractors (MACs), including home health & hospice MACs, for outpatient therapy services provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 9448, from which this article was developed, describes the amounts and the policy for outpatient therapy caps for 2016. For physical therapy and speech-language pathology combined, the 2016 therapy cap will be \$1,960. For occupational therapy, the cap for 2016 will be \$1,960. Please make sure your billing staffs are aware of these updates.

Background

The Balanced Budget Act of 1997, P.L. 105-33, Section 4541(c) applies, per beneficiary, annual financial limitations on expenses considered incurred for outpatient therapy services under Medicare Part B, commonly referred to as “therapy caps.” The therapy caps are updated each year based on the Medicare Economic Index. An exceptions process to the therapy caps for reasonable and medically necessary services was required by Section 5107 of the Deficit Reduction Act of 2005. The exceptions process for the therapy caps has been continuously extended several times through subsequent legislation. Most recently, Section 202 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) extended the therapy cap exceptions

process through December 31, 2017.

Additional information

The official instruction, CR 9448, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3417CP.pdf>.

For more information on the therapy caps and other issues related to outpatient therapy services, please see the Therapy Services Web page at <https://www.cms.gov/Medicare/Billing/TherapyServices/index.html>.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning->

[Network-MLN/MLNMattersArticles/index.html](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html) under - How Does It Work.

MLN Matters[®] Number: MM9448
Related Change Request (CR) #: CR 9448
Related CR Release Date: November 25, 2015
Effective Date: January 1, 2016
Related CR Transmittal #: R3417CP
Implementation Date: January 4, 2016

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Correct your claims on the 'SPOT'

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

Remittance advice remark and claim adjustment reason code and MREP and PC Print update

Provider types affected

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

Provider action needed

Change request (CR) 9374 updates the claim adjustment reason code (CARC) and remittance advice remark code (RARC) lists. It also instructs Medicare system maintainers to update Medicare Remit Easy Print (MREP) and PC Print software. Make sure your billing staffs are aware of these changes and obtain the updated MREP or PC Print software if you use it.

Background

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

The Centers for Medicare & Medicaid Services (CMS) instructs the MACs to conduct updates based on the code update schedule that results in publication three times a year – around March 1, July 1, and November 1.

CR 9374 is a code update notification indicating when updates to CARC and RARC lists are made available on the Washington Publishing Company (WPC) website. Shared system maintainers (SSMs) have the responsibility to implement code deactivation, making sure that any deactivated code is not used in original business messages, but the deactivated code in derivative messages is allowed. MACs make necessary program changes so that deactivated reason and remark codes are allowed in derivative messages after the deactivation implementation date per CR 9374 or as posted on the WPC website when:

- Medicare is not primary;
- The COB claim is received after the deactivation effective date; and
- The date in DTP03 in Loop 2430 or 2330B in COB 837 transaction is less than the deactivation effective date as posted on the WPC website.

MACs make necessary programming changes so that deactivated reason and remark codes are allowed even after the deactivation implementation date in a reversal and correction situation, when a value of 22 in CLP02 identifies the claim to be a corrected claim, and in Medicare secondary payer (MSP) claims, when forwarded

to Medicare by primary payers before the deactivation date and Medicare adjudication is done after the deactivation date.

SSMs must make sure that Medicare does not report any deactivated code on or before the effective date for deactivation as posted on the WPC website, found at <http://wpc-edi.com/Reference/>. If any new or modified code has an effective date past the implementation date specified in CR 9374, MACs must implement on the date specified on the WPC website.

The discrepancy between the dates may arise because the WPC website gets updated only three times per year and may not match the CMS systems release schedule. For this recurring CR, MACs and SSMs must get the complete list for both CARC and RARC from the WPC website to obtain the comprehensive lists for both code sets and determine the changes that are included on the code list since the last code update CR (CR 9278, with a related *MLN Matters*[®] article available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9278.pdf>.)

In accordance with HIPAA Legislation Published in the Federal Register (45 CFR Part 162), covered entities are required to comply with established standards and code set regulations. Furthermore, the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) further defines the requirements for the 835 transaction by specifying phase III operating rules, the 835 transaction (health care claim payment/advice) and standard paper remittance advice which require the use of CARCs and RARCs.

Additional information

The official instruction, CR 9374, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3418CP.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: MM9374
 Related Change Request (CR) #: CR 9374
 Related CR Release Date: November 25, 2015
 Effective Date: April 1, 2016
 Related CR Transmittal #: R3418CP
 Implementation Date: April 4, 2016

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Claim status category and claim status code update

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

Change request (CR) 9427 informs MACs about the changes to claim status category and claim status codes.

Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all covered entities to use only claim status category and claim status codes approved by the National Code Maintenance Committee (NCMC) in the Accredited Standards Committee (ASC) X12 276/277 health care claim status request and response transaction standards adopted under HIPAA for electronically submitting health care claims status requests and responses. These codes explain the status of submitted claim(s).

Proprietary codes may not be used in the ASC X12 276/277 transactions to report claim status.

The NCMC meets at the beginning of each ASC X12 trimester meeting (January/February, June, and September/October) and makes decisions about additions, modifications, and retirement of existing codes. The NCMC has decided to allow the industry six months for implementation of newly added or changed codes.

The code sets are available at <http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-category-codes/> and <http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-codes>. Included in the code lists are specific details, including the date when a code was added, changed, or deleted.

All code changes approved during the January 2016 committee meeting shall be posted on these sites on or about February 1, 2016. MACs must complete entry of all applicable code text changes and new codes, and terminate use of deactivated codes, by the implementation date of CR 9427.

These code changes are to be used in editing of all ASC X12 276 transactions processed on or after the date of implementation and to be reflected in the ASC X12 277 transactions issued on and after the date of implementation of CR 9427.

CMS and the MACs must comply with the requirements contained in the current standards adopted under HIPAA for electronically submitting certain health care transactions, among them the ASC X12 276/277 health care claim status request and response. These contractors must use valid claim status category and claim status codes when sending ASC X12 277 health care claim status responses and when sending ASC X12 277 healthcare claim acknowledgments. References in this CR to “277 responses” and “claim status responses” encompass both the ASC X12 277 health care claim status response and the ASC X12 277 healthcare claim acknowledgment transactions.

Patient:	01608034780	
Claim Number:	06/09/10	
Date Claim Received:		
DATES OF SERVICE	PROCEDURE CODE	
05/21/10-05/21/10	82272	PULM
05/21/10-05/21/10	94010	PULM
05/21/10-05/21/10	94375	CARDIOVASCULAR SERV
05/21/10-05/21/10	93000	VENIPUNCTURE
05/21/10-05/21/10	36410	Total:

Additional information

The official instruction, CR 9427, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3413CP.pdf>.

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

MLN Matters[®] Number: MM9427
 Related Change Request (CR) #: CR 9427
 Related CR Release Date: November 20, 2015
 Effective Date: April 1, 2016
 Related CR Transmittal #: R3413CP
 Implementation Date: April 4, 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.

Implement operating rules - phase III ERA EFT: CORE 360 uniform use of claim CARC and RARC rule - update from CAQH CORE

Provider types affected

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

Provider action needed

Change request (CR) 9350 instructs MACs and Medicare's shared system maintainers (SSMs) to update systems based on the Committee on Operating Rules for Information Exchange (CORE) 360 uniform use of claim adjustment reason codes (CARC) and remittance advice remark codes (RARC) rule publication. These system updates are based on the CORE code combination list to be published on or about February 1, 2016.

Background

The Department of Health & Human Services (HHS) adopted the Phase III Council for Affordable Quality Healthcare (CAQH) CORE electronic funds transfer (EFT) & electronic remittance advice (ERA) operating rule set that must be implemented by January 1, 2014, under the Patient Protection and Affordable Care Act of 2010.

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

Through the Affordable Care Act, Congress sought to promote implementation of electronic transactions and achieve cost reduction, and efficiency improvements, by creating more uniformity in the implementation of standard transactions. This was done by mandating the adoption of a set of operating rules for each of the HIPAA transactions. The Affordable Care Act defines operating rules and specifies the role of operating rules in relation to the standards.

CR 9350 deals with the regular update in CAQH CORE defined code combinations per operating rule 360 - uniform use of claim adjustment reason codes and remittance advice remark codes (835) rule.

CAQH CORE will publish the next version of the code combination list on or about February 1, 2016. This update



is based on the CARC and RARC updates as posted at the Washington Publishing Company (WPC) website on or about November 1, 2015.

Visit <http://www.wpc-edi.com/reference> for CARC and RARC updates and <http://www.caqh.org/CORECodeCombinations.php> for CAQH CORE defined code combination updates.

Additional information

The official instruction, CR 9350, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3411CP.pdf>.

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

MLN Matters[®] Number: MM9350

Related Change Request (CR) #: CR 9350

Related CR Release Date: November 20, 2015

Effective Date: April 1, 2016

Related CR Transmittal #: R3411CP

Implementation Date: April 4, 2016

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

Note: This article was revised December 3, 2015, to reflect an updated CR that: 1) Removed invalid TOB 52x from NCD250.5; 2) Removed invalid TOB 25c from NCD80.11 and added TOB 85c; and 3) included complete history in NCD 160.18. In the article, the change request (CR) release date, transmittal number, and the Web address for accessing CR 9252 are revised. All other information remains the same. This information was previously published in the [October 2015 Medicare B Connection, Page 22](#).

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

See **ICD-10**, next page

ICD-10

From previous page

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/R1580OTN.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
December 3, 2015	Article was revised to reflect new CR that: 1) Removed invalid TOB 52x from NCD250.5, 2) Removed invalid TOB 25X from NCD 80.11 and added TOB 85X and, 3) Included complete history in NCD160.18.
October 6, 2015	Article was revised to reflect new CR issued October 5, 2015. In the article, the CR release date, transmittal number, and the Web address for accessing CR 9252 are revised.



MLN Matters® Number: MM9252 *Revised*
 Related Change Request (CR) #: CR 9252
 Related CR Release Date: December 3, 2015
 Effective Date: October 1, 2015
 Related CR Transmittal #: R1580OTN
 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

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Quarterly provider update

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

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

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

TOOLS

From front page

record documentation is critical to receiving accurate and timely reimbursement for furnished services,” Scott said.

Once she has reviewed ways for providers to improve the accuracy of their coding or documentation, Scott also helps them proactively prevent denied claims by showing them how to use other First Coast Web tools.

“With the LCD look up tool, we stress its use before services are rendered. We suggest that our providers and medical staff become familiar with the LCD to determine medical necessity and if an advanced beneficiary notice will be needed,” Scott said”

Scott cited the use of the LCD look up tool prior to rendering an EKG test for pre-op clearance as an example of how she shares the advantages of using First Coast’s Web tools with medical staff, physicians and residents.

“As we demonstrate the LCD tool, we may ask questions like ‘Are you doing an EKG as part of a routine pre-op clearance with no risk factors, or does the patient have some other underlying condition such as uncontrolled diabetes ,hypertension that will put the patient at risk for surgery’” Scott said. “If they are not familiar with the LCD, the physician may link the EKG to the pre-op clearance diagnosis when there were other diagnoses or risk factors on the patient record which would necessitate the test. We want to ensure the correct diagnosis is billed based on the documentation.”

Her use of the LCD lookup also extends to other administrative uses. “First Coast’s LCD tool is helpful for our practice administrators to determine if medical necessity is supported before the service is rendered,” Scott explained. “Often we have sales reps marketing services to our providers indicating the services are a covered Medicare benefit; however, they haven’t checked to see if there is a local coverage determination.”

In conjunction with the LCD look up, Scott says the First Coast fee schedule look up offers helpful information for evaluating new procedures. She assists the finance department and practice administrators with research using First Coast tools. “With the fee schedule look up, we can assess the Medicare allowable amounts to determine reimbursement, policy indicators, global days, RVUs and identify if an LCD is associated with the procedure code.”

Scott has stayed informed about new additions to the First Coast website by serving on the First Coast Provider Outreach and Education Advisory Group and attending Medicare Speaks conferences for the past eight years.

“Participating in all of the First Coast activities allows me to network with peers and build relationships in the community,” she said. “In this, I am able to offer firsthand information back to our providers. I believe being that voice not only benefits our ministry but helps other health systems and First Coast to hear the concerns and suggestions from the providers. We are all one team, working for the same common goal for our patients.”

“ The First Coast tools are right at your fingertips. We use most of them on a regular basis. With our compliance program, the evaluation and management worksheet is perhaps the most used tool. ”



-Sarah Scott
Clinical Coding Auditor
St. Vincent’s HealthCare
(Photo Courtesy: Sarah Scott,
St. Vincent’s HealthCare)



Learn the secrets to billing Medicare correctly

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

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

2016 Medicare deductible, coinsurance and premium rates

Provider types affected

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

Provider action needed

Change request (CR) provides instruction for MACs to update the claim processing system with the new 2016 Medicare deductible, coinsurance, and premium rates. Make sure your billing staffs are aware of these changes.

Background

Beneficiaries who use covered Part A services may be subject to deductible and coinsurance requirements. A beneficiary is responsible for an inpatient hospital deductible amount, which is deducted from the amount payable by the Medicare program to the hospital, for inpatient hospital services furnished in a spell of illness. When a beneficiary receives such services for more than 60 days during a spell of illness, he or she is responsible for a coinsurance amount equal to one-fourth of the inpatient hospital deductible per day for the 61st-90th day spent in the hospital. An individual has 60 lifetime reserve days of coverage, which they may elect to use after the 90th day in a spell of illness. The coinsurance amount for these days is equal to one-half of the inpatient hospital deductible. A beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible per day for the 21st through the 100th day of skilled nursing facility (SNF) services furnished during a spell of illness.

Most individuals age 65 and older, and many disabled individuals under age 65, are insured for Health Insurance (HI) benefits without a premium payment. The Social Security Act provides that certain aged and disabled persons who are not insured may voluntarily enroll, but are subject to the payment of a monthly premium. Since 1994, voluntary enrollees may qualify for a reduced premium if they have 30-39 quarters of covered employment. When voluntary enrollment takes place more than 12 months after a person's initial enrollment period, a 10 percent penalty is assessed for two years for every year they could have enrolled and failed to enroll in Part A.

Under Part B of the Supplementary Medical Insurance (SMI) program, all enrollees are subject to a monthly premium. Most SMI services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay), which are set by statute. When Part B enrollment takes place more than 12 months after a person's initial enrollment period, there is a permanent 10 percent increase in the premium for each year the beneficiary could have enrolled and failed to enroll. In

addition, some beneficiaries may pay higher Part B premiums, based on their income.

2016 Part A - Hospital insurance (HI)

- Deductible: \$1,288.00
- Coinsurance
 - \$322.00 a day for 61st-90th day
 - \$644.00 a day for 91st-150th day (lifetime reserve days)
 - \$161.00 a day for 21st-100th day (skilled nursing facility coinsurance)
- Base premium (BP): \$411.00 a month
- BP with 10 percent surcharge: \$452.10 a month
- BP with 45 percent reduction: \$226.00 a month (for those who have 30-39 quarters of coverage)
- BP with 45 percent reduction and 10 percent surcharge: \$248.60 a month

2016 Part B - Supplementary medical insurance (SMI)

- Standard premium: \$121.80 a month
- Deductible: \$166.00 a year
- Pro rata data amount
 - \$118.86 1st month
 - \$47.14 2nd month
- Coinsurance: 20 percent

Additional information

The official instruction, CR 9410, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R96GI.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: MM9410
 Related Change Request (CR) #: CR 9410
 Related CR Release Date: November 25, 2015
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 Related CR Transmittal #: R96GI
 Implementation Date: January 4, 2016

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Processing Issues

Processing issue for reference laboratory and anti-markup payment limitation services

Issue

A claim processing issue affecting claims for reference lab services and services subject to the anti-markup payment limitation, which were billed on or after October 1, 2015, has been resolved.

Resolution

Medicare administrative contractors (MACs) are reprocessing these claims. If you are holding claims pending a resolution to this issue, please submit the claims to your MAC for processing.

Status/date resolved

Open.

Provider action

None; **Reminder:** For all claims received on or after October 1, 2015, billing physicians/suppliers must submit the national provider identifiers (NPIs) of performing physicians/suppliers that furnish reference lab tests or services subject to the anti-markup payment limitation,



even if the performing physician/suppliers are located outside of the biller's jurisdiction. The NPI should be included in Item 32a of the CMS-1500 claim form (or the electronic equivalent.)

Current processing issues

Here is a link to a table of [current processing issues](#) for both Part A and Part B.

Guidelines for unsolicited/voluntary refunds

Medicare contractors receive unsolicited/voluntary refunds (i.e., monies received not related to an open account receivable).

Part A contractors generally receive unsolicited/voluntary refunds in the form of an adjustment bill, but may receive some unsolicited/voluntary refunds as checks.

Part B contractors generally received checks. Substantial funds are returned to the trust funds each year through such unsolicited/voluntary refunds.

The Centers for Medicare & Medicaid Services reminds providers that:

The acceptance of a voluntary refund as repayment for the claims specified in no way affects or limits the rights of the federal government, or any of its agencies or agents, to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims.

Source: CMS Pub. 100-06, Chapter 5, Section 410.10



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Retired LCD

Chiropractic Services – retired LCD

LCD ID number: L33840 (Florida, Puerto Rico/ U.S. Virgin Islands)

Medicare coverage of chiropractic service is specifically limited by statute with the requirements explicitly outlined in Centers for Medicare & Medicaid services (CMS) publications and manuals. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Chiropractic_Services_Booklet_ICN906143.pdf.

Medicare administrative contractors (MACs) have historically implemented chiropractic services local coverage determination (LCD) as an educational tool to further emphasize requirements for the diagnosis, treatment, documentation, and billing of chiropractic services. Given the implementation of ICD-10 diagnoses coding effective October 1, 2015, and the focus of CMS and its contractors on aligning education tools used to improve the documentation of services by a chiropractor described as means of manual manipulation of the spine to correct a subluxation of an individual, MAC JN is retiring its LCD with plans to implement an updated LCD in the February policy cycle.

There is no change in billing, coding, and documentation

requirements. As always, a diagnosis code is only a surrogate for what is documented in the patient's medical record. Though ICD-10 code range M99.0-M99.09 that describes segmental and somatic dysfunction based on anatomic location will be acceptable diagnoses, currently this category (biomechanical lesions, not elsewhere classified) is not to be used alone if a condition is classified elsewhere. Given no LCD is in play, there is not a required set of ICD-10 codes that support medical necessity. On audit, the documentation must support the reasonable and necessary threshold for coverage as well as the other Medicare requirements for the chiropractic service.

Effective date

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

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

Note: To review active, future and retired LCDs, please [click here](#).

Revisions to LCDs

B-scan – LCD revised to include additional ICD-10 codes

LCD ID number: L33904 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for b-scan was revised to add ICD-10-CM diagnosis code range H47.311-H47.399 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 December 10, 2015.

Effective date

This LCD revision is effective for claims processed **on or after December 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, [click here](#).

Fundus photography – revision to the LCD

LCD ID number: L33670 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for fundus photography was revised to add ICD-10-CM diagnosis codes H59.031-H59.039 to the "Indications and Limitations of Coverage and/or Medical Necessity" and "ICD-10 Codes that Support Medical Necessity" sections of the LCD for *Current Procedural Terminology (CPT®)* code 92250.

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](#).

Somatosensory testing – revision to the LCD

LCD ID number: L33958 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for somatosensory testing was revised to add ICD-10-CM diagnosis code range M48.06-M48.07 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 December 10, 2015.

Effective date

Visual field examination – revision to the LCD

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

The local coverage determination (LCD) for visual field examination was revised to add ICD-10-CM diagnosis codes E10.39, E11.39, E13.39, Z09, Z79.3, Z79.891, and Z79.899 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

Strapping – revision to the LCD

LCD ID number: L34023 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for strapping was revised to add numerous ICD-10-CM diagnosis code ranges within the M12, M20, M21, M24, M25, M65, M77, M84, S82, S86, S89, S90, S92, S93, S96, and S99 series of diagnoses and ICD-10 diagnosis code M72.2 to the “ICD-10 Codes that Support Medical Necessity” section of the LCD for *Current Procedural Terminology (CPT®)* codes 29540 and 29550. Also, numerous ICD-10-CM diagnosis code ranges were added within the S86, S93, and S96 series of diagnoses to the “ICD-10 Codes that Support Medical Necessity” section of the LCD for *CPT®* code 29580.

In addition, ICD-10 diagnosis code ranges S86.011A-S86.011S, S86.012A-S86.012S, S93.411A-S93.411S, S93.412A-S93.412S, S93.421A-S93.421S, S93.422A-S93.422S, S93.431A-S93.431S, S93.432A-S93.432S, S93.491A-S93.491S, S93.492A-S93.492S, S93.511A-S93.511S, S93.512A-S93.512S, S93.514A-S93.514S, S93.515A-S93.515S, S93.521A-S93.521S, S93.522A-S93.522S, S93.524A-S93.524S, S93.525A-S93.525S, S93.611A-S93.611S, S93.612A-S93.612S, S93.621A-

This LCD revision is effective for claims processed **on or after December 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, [click here](#).

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, please [click here](#).

S93.621S, S93.622A-S93.622S, S93.691A-S93.691S, S93.692A-S93.692S, S96.011A-S96.011S, S96.012A-S96.012S, S96.111A-S96.111S, S96.112A-S96.112S, S96.199A-S96.199S, S96.211A-S96.211S, S96.212A-S96.212S, S96.811A-S96.811S, and S96.812A-S96.812S were removed from the “ICD-10 Codes that Support Medical Necessity” section of the LCD for *CPT®* codes 29540 and 29550 as these diagnosis code ranges were expanded.

The updated LCD will be available on the Medicare coverage database (MCD) on or after November 26, 2015.

Effective date

This LCD revision is effective for claims processed **on or after November 18, 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](#).

Bone mineral density studies – revision to the LCD based on CR 9252

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

Based on change request (CR 9252), the local coverage determination (LCD) for bone mineral density studies was revised to add ICD-10-CM diagnosis codes Z79.3, Z79.83, and Z87.310 to the “ICD-10 Codes that Support Medical Necessity” section of the LCD.

Effective date

This LCD revision is effective for claims processed on

or after **January 4, 2016**, 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](#).

Ocular photodynamic therapy (OPT) with verteporfin – revision to the LCD

LCD ID number: L33705 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR 9252), the local coverage determination (LCD) for ocular photodynamic therapy (OPT) with verteporfin was revised to add ICD-10-CM diagnosis code B39.5 to the “ICD-10 Codes that Support Medical Necessity” section of the LCD.

Effective date

This LCD revision is effective for claims processed on

or after **January 4, 2016**, 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 has been revised to remove CPT® codes 43206 (*Esophagoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure), with optical endomicroscopy*); 43252 (*esophagogastroduodenoscopy, flexible, transoral, diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure), with optical endomicroscopy*).

Additionally, the following two CPT® codes have been removed from the noncovered services LCD and placed in the recently revised LCD titled, polysomnography and sleep testing (L33405): 95803 (*Actigraphy testing, recording, analysis, interpretation, and report*), and 95806 (*sleep study, unattended, simultaneous recording of heart rate, oxygen saturation, respiratory airflow, and respiratory effort*).

As such, the ‘Procedures for Part A and Procedures for

Part B’ sections of the LCD have been revised.

Removing a service from noncoverage should not be interpreted as a positive coverage statement and coverage by the contractor. It is expected that the procedure will be performed on qualified patients per standards of care for their condition. As always, the medical record must support the reasonable and necessary threshold for coverage and be available for audit if there is a pre or post payment medical review.

Effective date

This LCD revision is effective for claims processed **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, [click here](#).

Additional information

2016 HCPCS local coverage determination changes – Part B

First Coast Service Options Inc. has revised local coverage determinations (LCDs) impacted by the 2016 Healthcare Common Procedure Coding System (HCPCS) annual update. Procedure codes have been added, revised, replaced and deleted accordingly:



LCD Title	Changes
Allergy Testing	Descriptor change for CPT® code 88346
Colorectal Cancer Screening	Deleted HCPCS code G0464 and replaced it with CPT® code 81528
Controlled Substance Monitoring and Drugs of Abuse Testing	Descriptor change for CPT® code 83789 Deleted HCPCS codes G0431, G0434, and G6030-G6058 Added HCPCS codes G0477-G0483
CYP2C19, CYP2D6, CYP2C9, and VKORC1 Genetic Testing	Descriptor change for CPT® code 81355
Diagnostic Colonoscopy	Deleted HCPCS codes G6019, G6020, G6021, G6024, and G6025
Erythropoiesis Stimulating Agents	Deleted HCPCS codes J0886
G-CSF (Neupogen®, Granix™, Zarxio™)	Descriptor change for HCPCS code J1442 Deleted HCPCS code J1446 and replaced it with HCPCS code J1447
Genetic Testing for Lynch Syndrome	Descriptor change for CPT® code 81210
Hemophilia Clotting Factors	Deleted HCPCS codes Q9975 and replaced it with HCPCS code J7205 Removed unlisted HCPCS codes C9399/J7199 and replaced them with HCPCS code J7188
Hepatitis B Surface Antibody and Surface Antigen	Descriptor change for CPT® code 87340
Implantable Infusion Pump for the Treatment of Chronic Intractable Pain (Coding Guidelines only)	Deleted HCPCS code Q9977 and replaced it with HCPCS code J7999

LCD Title	Changes
Implantable Miniature Telescope (IMT)	Descriptor change for CPT® code 03087
Independent Diagnostic Testing Facility (IDTF)	Added HCPCS code G0279 and CPT® codes 47531, 47532, 47544, 72081, 72082, 72083, 72084, 73501, 73502, 73503, 73521, 73522, 73523, 73551, 73552, 74712, 74713, 78265, 78266, 92537, and 92538 Deleted CPT® codes 70373, 72010, 72069, 72090, 73500, 73510, 73520, 73530, 73540, 73550, 74305, 74320, 74327, and 92543 The level of physician supervision was revised for CPT® codes 73562 and 78264. Also, based on change request 9250 language was added related to services that do not meet the National Electrical Manufacturers Association (NEMA) Standard. The effective date of this revision is based on date of service
Intravenous Immune Globulin	Added HCPCS code J1575
Intravitreal Bevacizumab (Avastin®)	Deleted HCPCS code Q9977 and replaced it with HCPCS code J7999
Laser Trabeculoplasty	Descriptor change for CPT® code 65855

See HCPCS, next page

HCPCS

From previous page

LCD Title	Changes
Molecular Pathology Procedures	Descriptor change for CPT® codes 81210, 81275, and 81355 Added CPT® codes 81162, 81170, 81218, 81219, 81272, 81273, 81276, 81311 and 81314
Noncovered Procedures - Endoscopic Treatment of Gastroesophageal Reflux disease (GERD)	Deleted HCPCS code C9724 and replaced it with CPT® code 43210
Noncovered Services	Descriptor change for CPT® codes 87320, 90632, 90633, 90634, 90644, 90647, 90648, 90649, 90650, 90680, 90681, and 0358T. Deleted CPT® code 0099T (replaced with CPT® code 65785), CPT® code 0103T (replaced with unlisted CPT® code 84999), CPT® code 0123T (replaced with unlisted CPT® code 66999), CPT® code 0223T, 0224T, and 0225T (replaced with unlisted CPT® code 93799), CPT® code 0233T (replaced with unlisted CPT® code 88749), CPT® code 0243T and 0244T (replaced with unlisted CPT® code 94799), CPT® code 0262T (replaced with CPT® code 33477), CPT® code 0311T (replaced with CPT® code 93050), HCPCS codes G0627 and G0628 (replaced with CPT® codes 46601 and 46607) and unlisted CPT® code 20999 for Magnetic resonance guided focused ultrasound surgery (MRgFUS) (e.g., ExAblate) (replaced with code CPT® 0398T) Deleted CPT® codes 90645, 90646, 90692, and 90693

LCD Title	Changes
Peripheral Nerve Blocks	Deleted CPT® code 64412
Plerixafor (Mozobil®)	Deleted HCPCS code J1446 and replaced it with HCPCS code J1447
Radiation Therapy for T1 Basal Cell and Squamous Cell Carcinomas of the Skin	Descriptor change for CPT® code 77789 Deleted CPT® codes 77785 and 77786 and replaced with CPT® codes 77767 and 77768 Deleted CPT® code 0182T (referenced in the “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD as a noncovered service) was replaced with CPT® code 0394T. Additionally, CPT® code 0394T was added to the “CPT®/HCPCS Codes” section under ‘Group 2 codes’ as a noncovered service. In addition, the statement containing CPT® code 77787 was removed , as this code was deleted.
Screening and Diagnostic Mammography	Descriptor change for CPT® code 77057
Spinal Cord Stimulation for Chronic Pain	Descriptor change for CPT® code 95972 Deleted CPT® code 95973
Vestibular Function Tests	Deleted CPT® code 92543 and replaced it with CPT® codes 92537 and 92538
	Added HCPCS codes J7328 and Q9980

Percutaneous electrical nerve stimulation (PENS) and percutaneous neuromodulation therapy (PNT)

Due to multiple claims received related to inappropriate billing of percutaneous electrical nerve stimulation (PENS) and percutaneous neuromodulation therapy (PNT), this article is being published to provide clarification. Providers are required to bill procedure codes that exactly describe the service performed and currently there are no specific *Current Procedural Terminology*® (CPT®) codes for PENS or PNT. Therefore, unlisted CPT® code 64999 (Unlisted procedure, nervous system) should be used to report percutaneous electrical nerve stimulation and percutaneous neuromodulation therapy. CPT® codes for percutaneous implantation of neurostimulator electrodes (i.e., CPT® 64553 - 64565) are also not appropriate given PENS and PNT use percutaneously inserted needles and wires rather than percutaneously implanted electrodes. Additionally, the stimulation devices used in PENS and PNT are not implanted, therefore CPT® code 64590 is also not appropriate.

Of note, CPT® code 64999 billed for percutaneous neuromodulation using a percutaneous electrode array



(PEA) (e.g., BioWave) has been evaluated by First Coast and added to the noncovered services LCD in 2008. Therefore, there is insufficient evidence to support coverage of Biowave's Deepwave percutaneous neuromodulation pain therapy system at this time.

Note: To review active, future and retired LCDs, [click here](#).

Self-administered drug (SAD) list – Praluent® (alirocumab), repatha™ (evolocumab), and natpara® (parathyroid hormone) J3490/J3590/C9399

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



Effective for services rendered on or after January 18, 2016, the following drugs have been added to the MAC J-N Part A SAD list.

- **J3490/J3590/C9399:** Alirocumab (Praluent®)
- **J3490/J3590/C9399:** Evolocumab (Repatha™)
- **J3490/J3590/C9399:** Parathyroid hormone (Natpara®)

The evaluation of drugs for addition to the self-administered drug (SAD) list is an ongoing process. Providers are responsible for monitoring the SAD list for the addition or deletion of drugs.

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

Upcoming provider outreach and educational event

Oxygen, coverage and documentation requirements: Presented by CGS Administrators, LCC – the DME MAC for JC

Wednesday, January 21

Time: 11:30 a.m.-1:00 p.m. Type of event: Webcast

<http://medicare.fcso.com/Events/0309645.asp>

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

Two easy ways to register

Online – Visit our provider training website at <http://www.fcsouniversity.com>, log on to your account and select the course you wish to register. Class materials are available under “My Courses” no later than one day before the event.

First-time User? Set up an account by completing [Request User Account Form](#) online. Providers who do not have yet a national provider identifier may enter “99999” in the NPI field. You will receive logon information within 72 hours of your request.

Fax – Providers without Internet access may request a fax registration form through our Registration Hotline at 1-904-791-8103. Class materials will be faxed to you the day of the event.

Please Note:

- Pre-registration is required for all teleconferences, webcasts and in-person educational seminars.
- Dates and times are subject to change prior to opening of event registration.

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Provider Address: _____

City, State, ZIP Code: _____

Keep checking our website, medicare.fcso.com, for details and newly scheduled educational events (teleconferences, webcasts, etc.) or call the First Coast Provider Education Registration Hotline at 1-904-791-8103 to learn more about the about our newest training opportunities for providers.

Never miss a training opportunity

If you or your colleagues were unable to attend one of our past Medicare educational webcasts, you still have the opportunity to learn about the topics covered during the training session. Visit the First Coast Medicare training website, download the recording of the event, and listen to the webcast when you have the time.

Take advantage of 24-hour access to free online training

In addition to live training events, we also offer you the advantage of self-paced, free online courses that will allow you and your staff to train when and where it is most convenient for you. In addition, our comprehensive course catalog allows you to find the Medicare training that fits your specific needs, and several of our online courses offer CEUs. Learn more on the First Coast Medicare training website and explore our catalog of online courses.



MLN Connects® Provider eNews for November 25, 2015

MLN Connects® Provider eNews for November 25, 2015

[View this edition as a PDF](#)

In this edition:

MLN Connects® Events

- National Partnership to Improve Dementia Care and QAPI Call — Last Chance to Register
- Medicare Quality Reporting Programs: 2016 Physician Fee Schedule Call — Register Now
- ESRD QIP: Access PY 2016 Performance Score Report and Certificates Call — Register Now
- ESRD QIP: Payment Year 2019 Final Rule Call — Registration Now Open
- New MLN Connects National Provider Call Audio Recording and Transcript

Announcements

- Release of the 2016 DMEPOS Fee Schedules
- December 1 is World AIDS Day: The Time to Act is Now
- Comments on Tobacco Treatment Measures due December 4
- 2016 Value Modifier Informal Review Deadline Extended to December 16
- 2016 PQRS Payment Adjustment: Informal Review



Deadline Extended to December 16

Claims, Pricers, and Codes

- Smoking Cessation Claims Editing Incorrectly
- Home Health Billing Codes Changing January 1

Medicare Learning Network® Educational Products

- Clarification of Patient Discharge Status Codes and Hospital Transfer Policies *MLN Matters*® Article — Revised
- Verify Your Profile Information in the Learning Management/Product Ordering System
- New 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 December 3, 2015

MLN Connects® Provider eNews for December 3, 2015

[View this edition as a PDF](#)

In this edition:

MLN Connects® Events

- National Partnership to Improve Dementia Care and QAPI Call — Last Chance to Register
- Medicare Quality Reporting Programs: 2016 Physician Fee Schedule Call — Register Now
- ESRD QIP: Access PY 2016 Performance Score Report and Certificates Call — Register Now
- ESRD QIP: Payment Year 2019 Final Rule Call — Registration Now Open
- New MLN Connects National Provider Call Audio Recording and Transcript

Other CMS Events

- Comparative Billing Report on Physical Therapy Webinar

Announcements

- CMS Updates Quality Strategy
- CMS Awards \$110 Million in ESRD Network Funding
- Corrections Being Made to 2016 DMEPOS Fee Schedules
- CMS to Release Comparative Billing Report on Home E/M Services in December
- Hospital IQR and Medicare EHR Incentive Programs: Data Submission Deadline Extended
- PQRS Changes in 2016 Physician Fee Schedule Final Rule



- National Influenza Vaccination Week: December 6 through 12

Claims, Pricers, and Codes

- Extracorporeal Photophoresis and PTA Claims Editing Incorrectly

Medicare Learning Network® Educational Products

- Advance Beneficiary Notice of Noncoverage Interactive Tutorial Educational Tool — New
- ICD-10 Website Wheel Educational Tool — Revised
- Hospital Reclassifications Fact Sheet — Revised
- PECOS for DMEPOS Suppliers Fact Sheet – Revised
- Medicare Disproportionate Share Hospital Fact Sheet — Revised
- DMEPOS Quality Standards Booklet — Revised

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 December 10, 2015

MLN Connects® Provider eNews for December 10, 2015

[View this edition as a PDF](#)

In this edition:

MLN Connects® Events

- ESRD QIP: Payment Year 2019 Final Rule Call — Register Now

MLN Connects® Videos

- ICD-10 Post-Implementation: Coding Basics Revisited

Announcements

- CMS Releases 2014 National Health Expenditures
- ICD-10 Specialty Resources Guide
- EHR Incentive Programs: 2015 Program Requirement Resources
- Hospital Compare Website Refresh
- New ST PEPPER Available
- Hospice Item Set Record Submissions: CASPER

Reports Available

- Long-Term Care Facilities: Mandatory Electronic Staffing Data Submission Begins in 2016
- 2016 Value Modifier Informal Review Deadline December 16
- 2016 PQRS Payment Adjustment: Informal Review Deadline December 16
- Corrections Made to 2016 DMEPOS Fee Schedules

Medicare Learning Network® Educational Products

- Diagnosis Coding: Using the ICD-10-CM Web-Based Training Course — Revised
- Health Care Professional Frequently Used Web Pages Educational Tool — Revised
- Inpatient Rehabilitation Facility Prospective Payment System Fact Sheet — Revised
- Reading the Institutional Remittance Advice Fact Sheet — Revised

MLN Connects® Provider eNews for December 17, 2015

MLN Connects® Provider eNews for December 17, 2015

[View this edition as a PDF](#)

In this edition:

Editor's Note

Happy holidays from the eNews staff! The next regular edition of the eNews will be released on Thursday, January 7, 2016.

MLN Connects® Events

- ESRD QIP: Payment Year 2019 Final Rule Call — Register Now
- Collecting Data on Global Surgery as Required by MACRA Listening Session — Registration Now Open
- IMPACT Act: Connecting Post-Acute Care across the Care Continuum Call — Registration Opening Soon
- New Audio Recording and Transcript Available

Announcements

- CMS Expands Quality Data on Physician Compare and Hospital Compare

- CMS Hospital-Acquired Conditions Reduction Program: FY 2016 Results
- Corrections Made to 2016 DMEPOS Fee Schedules

Claims, Pricers, and Codes

- January 2016 Average Sales Price Files Available
- FY 2016 Inpatient PPS PC Pricer Update Available
- Claims Processing Issue for Reference Laboratory and Anti-markup Payment Limitation Services Resolved

MLN Connects® Videos

- CMS Provider Minute: Hospital Discharge Day Management Services Video — New
- What is the HIPAA Privacy Rule? Tips to Protect Your Patients' Privacy Video — New

Medicare Learning Network® Educational Products

- Reading a Professional Remittance Advice Booklet — Revised
- New MLN Provider Compliance Fast Fact

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@fcsso.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@fcsso.com

Medicare secondary payer

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

Electronic data interchange (EDI)

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

Overpayments

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

Medicare Education and Outreach

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

Fraud and abuse

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

Freedom of Information Act requests

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

Overnight mail and/or special courier service

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

Websites

Provider

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

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

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

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

Beneficiaries

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

Phone numbers

Customer service

866-454-9007

877-660-1759 (speech and hearing impaired)

Education event registration hotline

904-791-8103 (NOT toll-free)

Electronic data interchange (EDI)

888-670-0940

Electronic funds transfers (EFT) (CMS-588)

866-454-9007

877-660-1759 (TTY)

Fax number (for general inquiries)

904-361-0696

Interactive voice response (IVR) system

877-847-4992

Provider enrollment

888-845-8614

877-660-1759 (TTY)

The SPOT help desk

855-416-4199

email: FCSOSPOTHelp@FCSO.com

Addresses

Claims

Medicare Part B Claims

P.O. Box 45098

Jacksonville, FL 32232-5098

Redeterminations

Medicare Part B Redetermination

P.O. Box 45024

Jacksonville, FL 32232-5024

Redetermination of overpayments

First Coast Service Options Inc.

P.O. Box 45091

Jacksonville, FL 32232-5091

Reconsiderations

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@fcsso.com

Online form: <http://medicare.fcsso.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@fcsso.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

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<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@fcsso.com
Online form: <http://medicare.fcsso.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@fcsso.com

Medicare secondary payer

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

Electronic data interchange (EDI)

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

Overpayments

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

Medicare Education and Outreach

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

Fraud and abuse

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

Freedom of Information Act requests

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

Special courier service

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

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Provider

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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
<p>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.</p>	40300260	\$33		
<p>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.</p> <p>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.</p>	40300270	\$12		
Language preference: English [] Español []				
<i>Please write legibly</i>			Subtotal	\$
			Tax (add % for your area)	\$
			Total	\$

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P.O. Box 406443
Atlanta, GA 30384-6443

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Phone: _____

Mailing Address: _____

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