Medicare B CONNECTION
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FIRST COAST SERVICE OPTIONS, INC.
A Newsletter for MAC Jurisdiction N Providers
January 2015

In this issue

New timeframe for response to additional documentation requests

***Note**: This article was revised January 8, 2015, to reflect the revised change request (CR) 8583 issued January 7. The article was revised to include a statement that reviewers should not grant providers additional time to respond to additional documentation requests. Also, the CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same. This information was previously published in the November 2014 Medicare B Connection, Pages 14-15.*

Provider types affected

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

What you need to know

This article is based on CR 8583, which instructs MACs and zone program integrity contractors (ZPICs) to produce pre-payment review additional documentation requests (ADRs) that state that providers and suppliers have 45 days to respond to an ADR issued by a MAC or a ZPIC. Failure to respond within 45 days of a pre-payment review ADR will result in denial of the claim(s) related to the ADR. Make sure your billing staffs are aware of these changes.

Background

In certain circumstances, the Centers for Medicare & Medicaid Services (CMS) review contractors (MACs, ZPICs, recovery auditors, the comprehensive error rate testing contractor and the supplemental medical review contractor) may not be able to make a determination on a claim they have chosen for review based upon the information on the claim, its attachments or the billing history found in claims processing system (if applicable) or Medicare's common working file (CWF).

In those instances, the CMS review contractor will solicit documentation from the provider or supplier by issuing an

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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.

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.

Your Feedback Matters

To ensure that our website meets the needs of our provider community, we carefully analyze your feedback and implement changes to better meet your needs. Discover the results of your feedback on our "*Website enhancements*" page. You'll find the latest enhancements to our provider websites and find out how you can share your thoughts and ideas with First Coast's Web team.

Medicare Part B advance beneficiary notices

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

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

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

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

Patient liability notice

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

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

ABN modifiers

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

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

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

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

GA modifier and appeals

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

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

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

Ambulatory Surgical Center

January 2015 update of the ASC payment system

Provider types affected

This *MLN Matters*® article is intended for ambulatory surgical centers (ASCs) submitting claims to Medicare administrative contractors (MACs) for services to Medicare beneficiaries.

Provider action needed

Change request (CR) 9021 informs MACs about changes to and billing instructions for various payment policies implemented in the January 2015 ASC payment system update. As appropriate, this notification also includes updates to the Healthcare Common Procedure Coding System (HCPCS). Make sure that your billing staff are aware of these changes.

Background

Included in this notification are 2015 payment rates for separately payable drugs and biologicals, including descriptors for newly created Level II HCPCS codes for drugs and biologicals (ASC DRUG files), and covered surgical and ancillary services (ASCFS file).

Many ASC payment rates under the ASC payment system are established using payment rate information in the Medicare physician fee schedule (MPFS). The payment files associated with this transmittal reflect the most recent changes to 2015 MPFS payment. Key updates are:

1. New device pass-through category and device offset for payment

Additional payments may be made to the ASC for covered ancillary services, including certain implantable devices with pass-through status under the outpatient prospective payment system (OPPS). Section 1833(t)(6)(B) of the Social Security Act (the Act) requires that, under the OPPS, categories of devices be eligible for transitional pass-through payments for at least 2, but not more than 3 years. Section 1833(t)(6)(B)(ii)(IV) of the Act requires that we create additional categories for transitional pass-through payment of new medical devices not described by current or expired categories of devices. This policy was implemented in the 2008 revised ASC payment system.

The Centers for Medicare & Medicaid Services (CMS) is establishing one new HCPCS device pass-through category as of January 1, 2015 for the OPPS and the ASC payment systems. That HCPCS code is HCPCS code C2624 (Wireless pressure sensor) is assigned ASC payment indicator (PI)=J7 (OPPS pass-through device paid separately when provided integral to a surgical procedure on ASC list; payment contractor-priced). Table 1 below shows more details.

Table 1: New device pass-through code HCPCS

HCPCS	Short	Long descriptor	ASC PI
C2624	Wireless pressure sensor	Implantable wireless pulmonary artery pressure sensor with delivery catheter, including all system components	J7

2. New Service

The Centers for Medicare & Medicaid Services (CMS) is establishing one new HCPCS surgical procedure code for ASC use effective January 1, 2015, as shown in Table 2.

Table 2: New procedure payable under the ASC payment system, effective January 1, 2015

HCPCS	Short	Long descriptor	ASC PI
C9742		Laryngoscopy, flexible fiberoptic, with injection into vocal cord(s), therapeutic, including diagnostic laryngoscopy, if performed	G2

3. Billing for corneal tissue

CMS reminds ASCs that, according to the *Medicare Claims Processing Manual*, Chapter 14, Section 40 - Payment for Ambulatory Surgery (*http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c14.pdf*), corneal tissue is paid based on acquisition cost or invoice. To receive cost based reimbursement for corneal tissue acquisition, ASCs must bill charges for corneal tissue using HCPCS code V2785.

4. Coding guidance for intraocular or periocular injections of combinations of anti-inflammatory drugs and antibiotics

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

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

According to the *Medicare Claims Processing Manual*, Chapter 17," (*http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c17.pdf*) Section 90.2, the compounded drug combinations described above and similar drug combinations should be reported with HCPCS code J3490 (Unclassified drugs), regardless of the site of service of the surgery, and are packaged as surgical supplies in both the hospital outpatient department (HOPD) and the ASC. Although these drugs are a covered part of the ocular surgery, no separate payment will be made. In addition, these drugs and drug combinations may not be reported with HCPCS code C9399.

According to the *Medicare Claims Processing Manual*, Chapter 30, Section 40.3.6, (*http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c30.pdf*) physicians or facilities should not give advance beneficiary notices (ABNs) to beneficiaries for either these drugs or for injection of these drugs because they are fully covered by Medicare. Physicians or facilities are not permitted to charge the patient an extra amount (beyond the standard copayment for the surgical procedure) for these injections or the drugs used in these injections because they are a covered part of the surgical procedure. Also, physicians or facilities cannot circumvent packaged payment in the HOPD or ASC for these drugs by instructing beneficiaries to purchase and bring these drugs to the facility for administration.

5. Drugs, biologicals, and radiopharmaceuticals

a) 2015 HCPCS codes and dosage descriptors for certain drugs, biologicals, and radiopharmaceuticals.

For 2015, several new HCPCS codes have been created for reporting drugs and biologicals in the ASC setting, where there have not previously been specific codes available. These are displayed in Table 3.

Table 3: 2015 HCPCS codes effective for certain drugs, biologicals, and radiopharmaceuticals

HCPCS	Long descriptor	Payment indicator
C9027	Injection, pembrolizumab, 1 mg	K2
C9136	Injection, factor viii, fc fusion protein, (recombinant), per i.u.	K2
C9349	FortaDerm, and FortaDerm Antimicrobial, any type, per square centimeter	K2
C9442	Injection, belinostat, 10 mg	K2
C9443	Injection, dalbavancin, 10 mg	K2
C9444	Injection, oritavancin, 10 mg	K2
C9446	Injection, tedizolid phosphate, 1 mg	K2
C9447	Injection, phenylephrine and ketorolac, 4 ml vial	K2
J7180	Factor XIII anti-hem factor	K2
J7327	Hyaluronan or derivative, Monovisc, for intra-articular injection, per dose	K2

b) Other 2015 HCPCS and *CPT*® code changes for certain drugs, biologicals, and radiopharmaceuticals.

Table 4 notes those separately payable drugs, biologicals, and radiopharmaceuticals that have undergone changes in their HCPCS codes, their long descriptors, or both. Each product's 2014 HCPCS code and 2014 long descriptors are noted in the two left-hand columns. The 2015 HCPCS code and long descriptors are noted in the adjacent right-hand columns.

Table 4 Other 2014 HCPCS and CPT code changes for certain drugs, biologicals, and radiopharmaceuticals

2014 Code	Long descriptor	2015 Code	Long descriptor
J7195	Factor ix	J7195	Injection, Factor ix
C9021	Injection,	J9301	Injection,
C9022	Injection, elosulfase alfa, 1mg	J1322	Injection, elosulfase alfa, 1mg
C9023	Injection, testosterone undecanoate, 1 mg	J3145	Injection, testosterone undecanoate, 1 mg
C9133	Factor ix	J7200	Factor ix
C9134	Factor XIII	J7181	Factor XIII
C9135	Factor ix	J7201	Factor ix

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2014 Code	Long descriptor	2015 Code	Long descriptor
J7335	Capsaicin 8% patch, per 10 square centimeters	J7336	Capsaicin 8% patch, per square centimeter
Q9970	Injection, ferric	J1439	Injection, ferric

c. Drugs and biologicals with payments based on average sales price (ASP), effective January 1, 2015

For 2015, payment for nonpass-through drugs, biologicals and therapeutic radiopharmaceuticals is made at a single rate of ASP plus six percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In 2015, a single payment of ASP + 6 percent for pass-through drugs, biologicals and radiopharmaceuticals is made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items. Payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available.

Effective January 1, 2015, payment rates for many drugs and biologicals have changed from the values published in the 2015 outpatient payment prospective system (OPPS)/ASC final rule with comment period as a result of the new ASP calculations based on sales price submissions from the third quarter of 2014. In cases where adjustments to payment rates are necessary, changes to the payment rates will be incorporated in the January 2015 ASC drug file.

CMS is not publishing the updated payment rates in this CR implementing the January 2015 update of the ASC payment system. The updated payment rates effective January 1, 2015, can be found in the January 2015 ASC Addendum BB at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html*.

d. Skin substitute procedure edits

The payment for skin substitute products that do not qualify for OPPS pass-through status are packaged into the OPPS payment for the associated skin substitute application procedure. This policy is also implemented in the ASC payment system. The skin substitute products are divided into two groups:

1) High cost skin substitute products, and

2) Low cost skin substitute products for packaging purposes.

Table 5 lists the skin substitute products and their assignment as either a high cost or a low cost skin substitute product, when applicable. ASCs should not separately bill for packaged skin substitutes (ASC PI=N1).

High cost skin substitute products should only be utilized

in combination with the performance of one of the skin application procedures described by *CPT®* codes *15271-15278*. Low cost skin substitute products should only be utilized in combination with the performance of one of the skin application procedures described by HCPCS code C5271-C5278. All OPPS pass-through skin substitute products (ASC PI=K2) should be billed in combination with one of the skin application procedures described by *CPT®* codes *15271-15278*.

Table 5 – Skin Substitute Product Assignment to High Cost/Low Cost Status for 2015

2015 code	Short descriptor	ASC PI	Low/ high cost skin
C9349	Fortaderm, fortaderm antimic	N1	High
C9358	SurgiMend, fetal	N1	Low
C9360	SurgiMend, neonatal	N1	Low
C9363	Integra Meshed Bil Wound Mat	N1	High
Q4100	Skin substitute, NOS	N1	Low
Q4101	Apligraf	N1	High
Q4102	Oasis wound matrix	N1	Low
Q4103	Oasis burn matrix	N1	Low
Q4104	Integra BMWD	N1	High
Q4105	Integra DRT	N1	High
Q4106	Dermagraft	N1	High
Q4107	Graftjacket	N1	High
Q4108	Integra Matrix	N1	High
Q4110	Primatrix	N1	High
Q4111	Gammagraft	N1	Low
Q4112	Cymetra injectable	N1	N/A
Q4113	GraftJacket Xpress	N1	N/A
Q4114	Integra Flowable Wound Matrix	N1	N/A
Q4115	Alloskin	N1	Low

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2015 code	Short descriptor	ASC PI	Low/ high cost skin
Q4116	Alloderm	N1	High
Q4117	Hyalomatrix	N1	Low
Q4118	Matristem Micromatrix	N1	N/A
Q4119	Matristem Wound Matrix	N1	Low
Q4120	Matristem Burn Matrix	N1	Low
Q4121	Theraskin	K2	High
Q4122	Dermacell	K2	High
Q4123	Alloskin	N1	High
Q4124	Oasis Tri-layer Wound Matrix	N1	Low
Q4125	Arthroflex	N1	High
Q4126	Memoderm/derma/ tranz/integup	N1	High
Q4127	Talymed	K2	High
Q4128	Flexhd/ Allopatchhd/ matrixhd	N1	High
Q4129	Unite Biomatrix	N1	High
Q4131	Epifix	N1	High
Q4132	Grafix core	N1	High
Q4133	Grafix prime	N1	High
Q4134	HMatrix	N1	High
Q4135	Mediskin	N1	Low
Q4136	EZderm	N1	Low
Q4137	Amnioexcel or Biodexcel, 1cm	N1	High
Q4138	BioDfence DryFlex, 1cm	N1	High
Q4139	Amniomatrix or Biodmatrix, 1cc	N1	N/A
Q4140	Biodfence 1cm	N1	High
Q4141	Alloskin ac, 1 cm	N1	Low
Q4142	Xcm biologic tiss matrix 1cm	N1	Low
Q4143	Repriza, 1cm	N1	Low
Q4145	Epifix, 1mg	N1	N/A
Q4146	Tensix, 1cm	N1	Low
Q4147	Architect ecm px fx 1 sq cm	N1	High
Q4148	Neox 1k, 1cm	N1	High
Q4149	Excellagen, 0.1 cc	N1	N/A
Q4150	Allowrap DS or Dry 1 sq cm	N1	Low
Q4151	AmnioBand, Guardian 1 sq cm	N1	Low
Q4152*	Dermapure 1 square cm	N1	High
Q4153	Dermavest 1 square cm	N1	Low
Q4154	Biovance 1 square cm	N1	High
Q4155	NeoxFlo or ClarixFlo 1 mg	N1	N/A
Q4156	Neox 100 1 square cm	N1	High
Q4157	Revitalon 1 square cm	N1	Low
Q4158	MariGen 1 square cm	N1	Low
Q4159	Affinity 1 square cm	N1	High
Q4160	NuShield 1 square cm	N1	High

*HCPCS code Q4152 was assigned to the low cost group in the 2015 OPPS/ASC final rule with comment period. Upon submission of updated pricing information, Q4152 is assigned to the high cost group for 2015.

6. Drugs and biologicals based on ASP methodology with restated payment rates

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

7. 2015 ASC wage index

As discussed and finalized in the 2015 OPPS/ASC final rule with comment (79 FR 66937), in 2015, CMS is using the new core-based statistical area (CBSA) delineations issued by the Office of Management and Budget (OMB) in OMB Bulletin 13-01, dated February 28, 2013, for the IPPS hospital wage index. Therefore, because the ASC wage indexes are the pre-floor and pre-reclassified IPPS hospital wage indexes, the 2015 ASC wage indexes reflect the new OMB delineations. In 2015, where the 2015 ASC wage index value with the 2015 CBSAs is lower than the 2014 CBSA values, CMS calculates, or blends, the 2015 ASC wage index adjusted payment rates such that it will equal 50 percent of the ASC wage index based on the 2014 CBSA value and 50 percent of the ASC wage index based on the new 2015 CBSA value. The blending of these

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specific wage index values will mitigate any short-term instability to ASC payments. 2015 CBSAs with wage index values that are higher than the 2014 are not transitioned or blended and reflect the full higher wage index value. For additional information on this ASC wage index policy, please refer to page 66937 in the 2015 OPPS/ASC final rule (CMS-1613-FC), which is accessible at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1613-FC.html*.

8. Coverage determinations

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

Additional information

The official instruction, CR 9021, issued to your MAC regarding this change, is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3163CP.pdf*. If you have questions please contact your MAC at their toll-free number. The number is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html* under - How Does It Work?

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Durable Medical Equipment

2015 DMEPOS HCPCS jurisdiction list

Provider types affected

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

Provider action needed

Change request (CR) 9018 notifies suppliers that the spreadsheet containing an updated list of healthcare common procedure coding system (HCPCS) codes for DME MAC or MAC jurisdictions is updated annually to reflect codes that have been added or discontinued (deleted) each year. Changes in Chapter 23, Section 20.3 of the *Medicare Claims Processing Manual* are reflected in the recurring update notification.

The spreadsheet for the 2015 DMEPOS jurisdiction list is an Excel® spreadsheet and is available under the *Coding Category* at *http://www.cms.gov/Center/Provider-Type/Durable-Medical-Equipment-DME-Center.html*. The spreadsheet is also attached to CR 9018.

Additional information

The official instruction for CR 9018 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3148CP.pdf*.

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

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2015 DMEPOS jurisdiction listing

This article is informational and is based on change request (CR) 9018 that notifies providers that the spreadsheet containing an updated list of the healthcare common procedure coding system (HCPCS) codes for durable medical equipment Medicare administrative contractor (DME MAC) and Part B local carrier or A/B MAC jurisdictions is updated annually to reflect codes that have been added or discontinued (deleted) each year. The spreadsheet is helpful to billing staff by showing the appropriate Medicare contractor to be billed for HCPCS appearing on the spreadsheet. The spreadsheet for the 2015 jurisdiction list is attached to CR 9018 at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3148CP.pdf*. Note that deleted codes are valid for dates of service on or before the date of deletion and updated codes are in bold. The jurisdiction list includes codes that are not payable by Medicare. Please consult the Medicare contractor in whose jurisdiction a claim would be filed in order to determine coverage under Medicare.

Note: Deleted codes are valid for dates of service on or before the date of deletion.
Note: Updated codes are in bold.
Note: The jurisdiction list includes codes that are not payable by Medicare. Please consult the Medicare contractor in whose jurisdiction a claim would be filed in order to determine coverage under Medicare.

HCPCS	Description	Jurisdiction
A0021 - A0999	Ambulance services	Local carrier
A4206 - A4209	Medical, Surgical, and Self-Administered Injection Supplies	Local carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A4210	Needle Free Injection Device	DME MAC
A4211	Medical, Surgical, and Self-Administered Injection Supplies	Local carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A4212	Non Coring Needle or Stylet with or without Catheter	Local carrier
A4213 - A4215	Medical, Surgical, and Self-Administered Injection Supplies	Local carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A4216 - A4218	Saline	Local carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A4220	Refill Kit for Implantable Pump	Local carrier
A4221 - A4250	Medical, Surgical, and Self-Administered Injection Supplies	Local carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A4252 - A4259	Diabetic Supplies	DME MAC
A4261	Cervical Cap for Contraceptive Use	Local carrier
A4262 - A4263	Lacrimal Duct Implants	Local carrier
A4264	Contraceptive Implant	Local carrier
A4265	Paraffin	Local carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A4266 - A4269	Contraceptives	Local carrier
A4270	Endoscope Sheath	Local carrier
A4280	Accessory for Breast Prosthesis	DME MAC
A4281 - A4286	Accessory for Breast Pump	DME MAC
A4290	Sacral Nerve Stimulation Test Lead	Local carrier
A4300 - A4301	Implantable Catheter	Local carrier
A4305 - A4306	Disposable Drug Delivery System	Local carrier if incident to a physician's service (not separately payable). If other, DME MAC.

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HCPCS	Description	Jurisdiction
A4310 - A4358	Incontinence Supplies/ Urinary Supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the local carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME MAC.
A4360 - A4435	Urinary Supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the local carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME MAC.
A4450 - A4456	Tape; Adhesive Remover	Local carrier if incident to a physician's service (not separately payable), or if supply for implanted prosthetic device. If other, DME MAC.
A4458 - **A4459**	Enema Bag/ **System**	DME MAC
A4461 - A4463	Surgical Dressing Holders	Local carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A4465 - A4466	Non-elastic Binder and Elastic Garment	DME MAC
A4470	Gravlee Jet Washer	Local carrier
A4480	Vabra Aspirator	Local carrier
A4481	Tracheostomy Supply	Local carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A4483	Moisture Exchanger	DME MAC
A4490 - A4510	Surgical Stockings	DME MAC
A4520	Diapers	DME MAC
A4550	Surgical Trays	Local carrier
A4554	Disposable Underpads	DME MAC
A4555 - A4558	Electrodes; Lead Wires; Conductive Paste	Local carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A4559	Coupling Gel	Local carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A4561 - A4562	Pessary	Local carrier
A4565	Sling	Local carrier
A4570	Splint	Local carrier
A4575	Topical Hyperbaric Oxygen Chamber, Disposable	DME MAC
A4580 - A4590	Casting Supplies & Material	Local carrier
A4595	TENS Supplies	Local carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A4600	Sleeve for Intermittent Limb Compression Device	DME MAC
A4601 - **A4602**	Lithium **Replacement** Batter**ies**	DME MAC
A4604	Tubing for Positive Airway Pressure Device	DME MAC
A4605	Tracheal Suction Catheter	DME MAC
A4606	Oxygen Probe for Oximeter	DME MAC
A4608	Transtracheal Oxygen Catheter	DME MAC
A4611 - A4613	Oxygen Equipment Batteries and Supplies	DME MAC

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HCPCS	Description	Jurisdiction
A4614	Peak Flow Rate Meter	Local carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A4615 - A4629	Oxygen & Tracheostomy Supplies	Local carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A4630 - A4640	DME Supplies	DME MAC
A4641 - A4642	Imaging Agent; Contrast Material	Local carrier
A4648	Tissue Marker, Implanted	Local carrier
A4649	Miscellaneous Surgical Supplies	Local carrier if incident to a physician's service (not separately payable), or if supply for implanted prosthetic device or implanted DME. If other, DME MAC.
A4650	Implantable Radiation Dosimeter	Local carrier
A4651 - A4932	Supplies for ESRD	DME MAC (not separately payable)
A5051 - A5093	Additional Ostomy Supplies	If provided in the physician's office for a "temporary condition, the item is incident to the physician's service & billed to the local carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME MAC.
A5102 - A5200	Additional Incontinence and Ostomy Supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the local carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME MAC.
A5500 - A5513	Therapeutic Shoes	DME MAC
A6000	Non-Contact Wound Warming Cover	DME MAC
A6010 - A6024Z	Surgical Dressing	Local carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other, DME MAC.
A6025	Silicone Gel Sheet	Local carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted "DME. If other, DME MAC."
A6154 - A6411	Surgical Dressing	Local carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other, DME MAC.
A6412	Eye Patch	Local carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other, DME MAC.
A6413	Adhesive Bandage	Local carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other, DME MAC.
A6441 - A6512	Surgical Dressings	Local carrier if incident to a physician's "service (not separately payable), or if supply for implanted prosthetic device or implanted DME. If other, DME MAC.
A6513	Compression Burn Mask	DME MAC
A6530 - A6549	Compression Gradient Stockings	DME MAC

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HCPCS	Description	Jurisdiction
A6550	Supplies for Negative Pressure Wound Therapy Electrical Pump	DME MAC
A7000 - A7002	Accessories for Suction Pumps	DME MAC
A7003 - A7039	Accessories for Nebulizers, Aspirators and Ventilators	DME MAC
A7040 - A7041	Chest Drainage Supplies	Local carrier
A7044 - A7047	Respiratory Accessories	DME MAC
A7048	**Vacuum Drainage Supply**	**Local carrier**
A7501 - A7527	Tracheostomy Supplies	DME MAC
A8000 - A8004	Protective Helmets	DME MAC
A9150	Non-Prescription Drugs	Local carrier
A9152 - A9153	Vitamins	Local carrier
A9155	Artificial Saliva	Local carrier
A9180	Lice Infestation Treatment	Local carrier
A9270	Noncovered Items or Services	DME MAC
A9272	Disposable Wound Suction Pump	DME MAC
A9273	Hot Water Bottles, Ice Caps or Collars, and Heat and/or Cold Wraps	DME MAC
A9274 - A9278	Glucose Monitoring	DME MAC
A9279	Monitoring Feature/Device	DME MAC
A9280	Alarm Device	DME MAC
A9281	Reaching/ Grabbing Device	DME MAC
A9282	Wig	DME MAC
A9283	Foot Off Loading Device	DME MAC
A9284	Non-electric Spirometer	DME MAC
A9300	Exercise Equipment	DME MAC
A9500 - A9700	Supplies for Radiology Procedures	Local carrier
A9900	Miscellaneous DME Supply or Accessory	Local carrier if used with implanted DME. If other, DME MAC.
A9901	Delivery	DME MAC
A9999	Miscellaneous DME Supply or Accessory	Local carrier if used with implanted DME. If other, DME MAC.
B4034 - B9999	Enteral and Parenteral Therapy	DME MAC
D0120 - D9999	Dental Procedures	Local carrier
E0100 - E0105	Canes	DME MAC
E0110 - E0118	Crutches	DME MAC
E0130 - E0159	Walkers	DME MAC
E0160 - E0175	Commodes	DME MAC
E0181 - E0199	Decubitus Care Equipment	DME MAC
E0200 - E0239	Heat/Cold Applications	DME MAC
E0240 - E0248	Bath and Toilet Aids	DME MAC
E0249	Pad for Heating Unit	DME MAC
E0250 - E0304	Hospital Beds	DME MAC
E0305 - E0326	Hospital Bed Accessories	DME MAC
E0328 - E0329	Pediatric Hospital Beds	DME MAC
E0350 - E0352	Electronic Bowel Irrigation System	DME MAC

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HCPCS	Description	Jurisdiction
E0370	Heel Pad	DME MAC
E0371 - E0373	Decubitus Care Equipment	DME MAC
E0424 - E0484	Oxygen and Related Respiratory Equipment	DME MAC
E0485 - E0486	Oral Device to Reduce Airway Collapsibility	DME MAC
E0487	Electric Spirometer	DME MAC
E0500	IPPB Machine	DME MAC
E0550 - E0585	Compressors/ Nebulizers	DME MAC
E0600	Suction Pump	DME MAC
E0601	CPAP Device	DME MAC
E0602 - E0604	Breast Pump	DME MAC
E0605	Vaporizer	DME MAC
E0606	Drainage Board	DME MAC
E0607	Home Blood Glucose Monitor	DME MAC
E0610 - E0615	Pacemaker Monitor	DME MAC
E0616	Implantable Cardiac Event Recorder	Local carrier
E0617	External Defibrillator	DME MAC
E0618 - E0619	Apnea Monitor	DME MAC
E0620	Skin Piercing Device	DME MAC
E0621 - E0636	Patient Lifts	DME MAC
E0637 - E0642	Standing Devices/Lifts	DME MAC
E0650 - E0676	Pneumatic Compressor and Appliances	DME MAC
E0691 - E0694	Ultraviolet Light Therapy Systems	DME MAC
E0700	Safety Equipment	DME MAC
E0705	Transfer Board	DME MAC
E0710	Restraints	DME MAC
E0720 - E0745	Electrical Nerve Stimulators	DME MAC
E0746	EMG Device	Local carrier
E0747 - E0748	Osteogenic Stimulators	DME MAC
E0749	Implantable Osteogenic Stimulators	Local carrier
E0755- E0770	Stimulation Devices	DME MAC
E0776	IV Pole	DME MAC
E0779 - E0780	External Infusion Pumps	DME MAC
E0781	Ambulatory Infusion Pump	Billable to both the Local carrier and the DME MAC. This item may be billed to the DME MAC whenever the infusion is initiated in the physician's office but the patient does not return during the same business day.
E0782 - E0783	Infusion Pumps, Implantable	Local carrier
E0784	Infusion Pumps, Insulin	DME MAC
E0785 - E0786	Implantable Infusion Pump Catheter	Local carrier
E0791	Parenteral Infusion Pump	DME MAC
E0830	Ambulatory Traction Device	DME MAC
E0840 - E0900	Traction Equipment	DME MAC
E0910 - E0930	Trapeze/ Fracture Frame	DME MAC
E0935 - E0936	Passive Motion Exercise Device	DME MAC
E0940	Trapeze Equipment	DME MAC
E0941	Traction Equipment	DME MAC
E0942 - E0945	Orthopedic Devices	DME MAC

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HCPCS	Description	Jurisdiction
E0946 - E0948	Fracture Frame	DME MAC
E0950 - E1298	Wheelchairs	DME MAC
E1300 - E1310	Whirlpool Equipment	DME MAC
E1352 - E1392	Additional Oxygen Related Equipment	DME MAC
E1399	Miscellaneous DME	Local carrier if implanted DME. If other, DME MAC.
E1405 - E1406	Additional Oxygen Equipment	DME MAC
E1500 - E1699	Artificial Kidney Machines and Accessories	DME MAC (not separately payable)
E1700 - E1702	TMJ Device and Supplies	DME MAC
E1800 - E1841	Dynamic Flexion Devices	DME MAC
E1902	Communication Board	DME MAC
E2000	Gastric Suction Pump	DME MAC
E2100 - E2101	Blood Glucose Monitors with Special Features	DME MAC
E2120	Pulse Generator for Tympanic Treatment of Inner Ear	DME MAC
E2201 - E2397	Wheelchair Accessories	DME MAC
E2402	Negative Pressure Wound Therapy Pump	DME MAC
E2500 - E2599	Speech Generating Device	DME MAC
E2601 - E2633	Wheelchair Cushions and Accessories	DME MAC
E8000 - E8002	Gait Trainers	DME MAC
G0008 - G0329	Misc. Professional Services	Local carrier
G0333	Dispensing Fee	DME MAC
G0337 - G0365	Misc. Professional Services	Local carrier
G0372	Misc. Professional Services	Local carrier
G0378 - G**9472**	Misc. Professional Services	Local carrier
J0120 - J3570	Injection	Local carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.
J3590	Unclassified Biologicals	Local carrier
J7030 - J7131	Miscellaneous Drugs and Implant	Local carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.
J7178	Fibrinogen	Local carrier
J7180 - J7195	Antihemophilic Factor	Local carrier
J7196 - J7197	Antithrombin III	Local carrier
J7198	Anti-inhibitor; per I.U.	Local carrier
J7199 - **J7201**	Other Hemophilia Clotting Factors	Local carrier
J7300 - J7307	Contraceptives	Local carrier
J7308 - J7309	Aminolevulinic Acid HCL	Local carrier
J7310	Ganciclovir, Long-Acting Implant	Local carrier
J7311 - J7316	Ophthalmic Drugs	Local carrier
J7321 - J7327	Hyaluronan	Local carrier
J7330	Autologous Cultured Chondrocytes, Implant	Local carrier

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HCPCS	Description	Jurisdiction
J7336	Capsaicin	Local carrier
J7500 - J7599		Local carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.
J7604 - J7699	Inhalation Solutions	Local carrier if incident to a physician's service. If other, DME MAC.
J7799	NOC, Other than Inhalation Drugs through DME	Local carrier if incident to a physician's service. If other, DME MAC
J8498	Anti-emetic Drug	DME MAC
J8499	Prescription Drug, Oral, Non	Local carrier if incident to a physician's service. If other, DME MAC.
J8501 - J8999	Oral Anti-Cancer Drugs	DME MAC
J9000 - J9999	Chemotherapy Drugs	Local carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.
K0001 - K0108	Wheelchairs	DME MAC
K0195	Elevating Leg Rests	DME MAC
K0455	Infusion Pump used for Uninterrupted Administration of Epoprostenal	DME MAC
K0462	Loaner Equipment	DME MAC
K0552	External Infusion Pump Supplies	DME MAC
K0601 - K0605	External Infusion Pump Batteries	DME MAC
K0606 - K0609	Defibrillator Accessories	DME MAC
K0669	Wheelchair Cushion	DME MAC
K0672	Soft Interface for Orthosis	DME MAC
K0730	Inhalation Drug Delivery System	DME MAC
K0733	Power Wheelchair Accessory	DME MAC
K0738	Oxygen Equipment	DME MAC
K0739	Repair or Nonroutine Service for DME	Local carrier if implanted DME. If other, DME MAC
K0740	Repair or Nonroutine Service for Oxygen Equipment	DME MAC
K0743 - K0746	Suction Pump and Dressings	DME MAC
K0800 - K0899	Power Mobility Devices	DME MAC
K0900	Custom DME, other than Wheelchair	DME MAC
K0901 - K0902	**Knee Orthoses**	**DME MAC**
L0112 - L4631	Orthotics	DME MAC
L5000 - L5999	Lower Limb Prosthetics	DME MAC
L6000 - L7499	Upper Limb Prosthetics	DME MAC
L7510 - L7520	Repair of Prosthetic Device	Local carrier if repair of implanted prosthetic device. If other, DME MAC.
L7600	Prosthetic Donning Sleeve	DME MAC
L7900 - L7902	Vacuum Erection System	DME MAC
L8000 - L8485	Prosthetics	DME MAC
L8499	Unlisted Procedure for Miscellaneous Prosthetic Services	Local carrier if implanted prosthetic device. If other, DME MAC.
L8500 - L8501	Artificial Larynx; Tracheostomy Speaking Valve	DME MAC

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HCPCS	Description	Jurisdiction
L8505	Artificial Larynx Accessory	DME MAC
L8507	Voice Prosthesis, Patient Inserted	DME MAC
L8509	Voice Prosthesis, Inserted by a Licensed Health Care Provider	Local carrier for dates of service on or after 10/01/2010. DME MAC for dates of service prior to 10/01/2010
L8510	Voice Prosthesis	DME MAC
L8511 - L8515	Voice Prosthesis	Local carrier if used with tracheoesophageal voice prostheses inserted by a licensed health care provider. If other, DME MAC
L8600 - L8699	Prosthetic Implants	Local carrier
L9900	Miscellaneous Orthotic or Prosthetic Component or Accessory device	Local carrier if used with implanted prosthetic. If other, DME MAC.
M00**75** - M0301	Medical Services	Local carrier
P2028 - P9615	Laboratory Tests	Local carrier
Q0035	Influenza Vaccine; Cardio-kymography	Local carrier
Q0081	Infusion Therapy	Local carrier
Q0083 - Q0085	Chemotherapy Administration	Local carrier
Q0091	Smear Preparation	Local carrier
Q0092	Portable X-ray Setup	Local carrier
Q0111 - Q0115	Miscellaneous Lab Services	Local carrier
Q0138 - Q0139	Ferumoxytol Injection	Local carrier
Q0144	Azithromycin Dihydrate	Local carrier if incident to a physician's service. If other, DME MAC.
Q0161 - Q0181	Anti-emetic	DME MAC
Q0478 - Q0509	Ventricular Assist Devices	Local carrier
Q0510 - Q0514	Drug Dispensing Fees	DME MAC
Q0515	Sermorelin Acetate	Local carrier
Q1004 - Q1005	New Technology IOL	Local carrier
Q2004	Irrigation Solution	Local carrier
Q2009	Fosphenytoin	Local carrier
Q2017	Teniposide	Local carrier
Q2026 - Q2028	Injectable Dermal Fillers	Local carrier
Q2034 - Q2039	Influenza Vaccine	Local carrier
Q2043	Sipuleucel-T	Local carrier
Q2049 - Q2050	Doxorubicin	Local carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.
Q3001	Supplies for Radiology Procedures	Local carrier
Q3014	Telehealth Originating Site Facility Fee	Local carrier
Q3027 - Q3028	Vaccines	Local carrier
Q3031	Collagen Skin Test	Local carrier
Q4001 - Q4051	Splints and Casts	Local carrier
Q4074	Inhalation Drug	Local carrier if incident to a physician's service. If other, DME MAC.
Q4081	Epoetin	Local carrier
Q4082	Drug Subject to Competitive Acquisition Program	Local carrier
Q4100 - Q41**60**	Skin Substitutes	Local carrier
Q5001 - Q5010	Hospice Services	Local carrier

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HCPCS	Description	Jurisdiction
Q9951 - Q9954	Imaging Agents	Local carrier
Q9955 - Q9957	Microspheres	Local carrier
Q9958 - Q9969	Imaging Agents	Local carrier
R0070 - R0076	Diagnostic Radiology Services	Local carrier
V2020 - V2025	Frames	DME MAC
V2100 - V2513	Lenses	DME MAC
V2520 - V2523	Hydrophilic Contact Lenses	Local carrier if incident to a physician's service. If other, DME MAC.
V2530 - V2531	Contact Lenses, Scleral	DME MAC
V2599	Contact Lens, Other Type	Local carrier if incident to a physician's service. If other, DME MAC.
V2600 - V2615	Low Vision Aids	DME MAC
V2623 - V2629	Prosthetic Eyes	DME MAC
V2630 - V2632	Intraocular Lenses	Local carrier
V2700 - V2780	Miscellaneous Vision Service	DME MAC
V2781	Progressive Lens	DME MAC
V2782 - V2784	Lenses	DME MAC
V2785	Processing--Corneal Tissue	Local carrier
V2786	Lens	DME MAC
V2787 - V2788	Intraocular Lenses	Local carrier
V2790	Amniotic Membrane	Local carrier
V2797	Vision Supply	DME MAC
V2799	Miscellaneous Vision Service	DME MAC
V5008 - V5299	Hearing Services	Local carrier
V5336	Repair/ Modification of Augmentative Communicative System or Device	DME MAC
V5362 - V5364	Speech Screening	Local carrier

Source: CR 9018

Laboratory/Pathology

2015 update for clinical laboratory fee schedule and laboratory services

Provider types affected

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

Provider action needed

Change request (CR) 9028 provides instructions for the 2015 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), as amended by Section 628 of the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003, and further amended by Section 3401 of the Affordable Care Act of 2010, the annual update to the local clinical laboratory fees for 2015 is (-0.25) percent. The annual update to local clinical laboratory fees for 2015 reflects an additional multi-factor productivity adjustment and a (-1.75) percentage point reduction as described by the Affordable Care Act.

The annual update to payments made on a reasonable charge basis for all other laboratory services for 2015 is 2.10 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).

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 (described below). However, for a cervical or vaginal smear test (Pap smear), payment may

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also not exceed the actual charge. The Part B deductible and coinsurance do not apply for services paid under the clinical laboratory fee schedule.

Key Points of CR 9028

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. Also, payment may not exceed the actual charge. The 2015 national minimum payment amount is $14.38 ($14.42 plus (-0.25) percent update for 2015).

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 2015 clinical laboratory fee schedule data file is available at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.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 2015 clinical laboratory fee schedule; available in multiple formats, including Excel, text, and comma delimited.

Public comments

On July 14, 2014, CMS hosted a public meeting to solicit input on the payment relationship between 2014 codes and new 2015 *Current Procedural Terminology CPT*® codes. Notice of the meeting was published in the *Federal Register* on March 25, 2014, and on the CMS website approximately April 1, 2014. 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?redirect=/ClinicalLabFeeSched*.

Additional written comments from the public were accepted until October 30, 2014. 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/CY2015-CLFS-Codes-Final-Determinations.pdf*.

Pricing information

The 2015 clinical laboratory fee schedule includes separately payable fees for certain specimen collection methods (codes 36415, P9612, and P9615). The fees are established in accordance with Section 1833(h)(4)(B) of the Act.

The fees for clinical laboratory travel codes P9603 and P9604 are updated annually. 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 2015, CMS will issue a separate instruction on the clinical laboratory travel fees.

The 2015 clinical laboratory fee schedule also includes codes that have a "QW" modifier to both identify codes and to 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

As in prior years, the 2015 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

Existing code *83516*QW is priced at the same rate as code *83516*.

New code *80163* is priced at the same rate as *80162*.

New code *80165* is priced at the same rate as *80164*.

New codes to be gap filled are *81161, 81246, 81287, 81288, 81313, 81410, 81411, 81415, 81416, 81417, 81420, 81425, 81426, 81427, 81430, 81431, 81435, 81436, 81440, 81445, 81450, 81455, 81460, 81465, 81470*, and *81471*.

New code *83006* is priced at the same rate as *82777*.

New code *87505* is priced at the same rate as *87631*.

New code *87506* is priced at the same rate as *87632*.

New code *87507* is priced at the same rate as *87633*.

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New code *87623* is priced at the same rate as *87621*.
New code *87624* is priced at the same rate as *87621*.
New code *87625* is priced at the same rate as *87621*.
New code 87806 is priced at the same rate as *87389*.
New code G6030 is priced at the same rate as *80152*.
New code G6031 is priced at the same rate as *80154*.
New code G6032 is priced at the same rate as *80160*.
New code G6034 is priced at the same rate as *80166*.
New code G6035 is priced at the same rate as *80172*.
New code G6036 is priced at the same rate as code *80174*.
New code G6037 is priced at the same rate as code *80182*.
New code G6038 is priced at the same rate as code *80196*.
New code G6039 is priced at the same rate as code *82003*.
New code G6040 is priced at the same rate as code *82055*.
New code G6041 is priced at the same rate as code *82101*.
New code G6042 is priced at the same rate as code *82145*.
New code G6043 is priced at the same rate as code *82205*.
New code G6044 is priced at the same rate as code *82520*.
New code G6045 is priced at the same rate as code *82646*.
New code G6046 is priced at the same rate as code *82649*.
New code G6047 is priced at the same rate as code *82651*.
New code G6048 is priced at the same rate as code *82654*.
New code G6049 is priced at the same rate as code *82666*.
New code G6050 is priced at the same rate as code *82690*.
New code G6051 is priced at the same rate as code *82742*.
New code G6052 is priced at the same rate as code *83805*.
New code G6053 is priced at the same rate as code *83840*.
New code G6054 is priced at the same rate as code *83858*.
New code G6055 is priced at the same rate as code *83887*.
New code G6056 is priced at the same rate as code *83925*.
New code G6057 is priced at the same rate as code *84022*.
New code G6058 is priced at the same rate as code *80102*.
New code G0464 is priced at the same rate as sum of codes *81315, 81275*, and *82274*.

The following existing codes are to be deleted: *80440*, *82000*, *82055*, *82055QW*, *82953, 82975, 82980, 83008, 83055, 83071, 83634, 83866, 84127, 87001, 87620, 87621, 87622, 80102, 80152, 80154, 80160, 80166, 80172, 80174, 80182, 80196, 82003, 82101, 82145, 82205, 82520, 82646, 82649, 82651, 82654, 82666, 82690, 82742, 83805, 83840, 83858, 83887, 83925*, and *84022*.

Laboratory costs subject to reasonable charge payment in 2011

For outpatients, the following codes are paid under a reasonable charge basis. 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 2015 is 2.1 percent.

Manual instructions for determining the reasonable charge payment can be found in Publication 100-4, *Medicare Claims Processing Manual*, Chapter 23, Section 80 through 80.8, available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf*. 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, the *Medicare Claims Processing Manual*, Chapter 8, Section 60.3, which is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c08.pdf*, instructs that the reasonable charge basis applies. 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 codes P9010, 9016, P9021, P9022, P9038, P9039, P9040, P9051, P9054, P9056, P9057, and P9058 should be applied to the blood deductible as instructed in the *Medicare General Information, Eligibility and Entitlement Manual*, Chapter 3, Section 20.5 through 20.5.4 (available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ge101c03.pdf*):

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 procedures

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*.

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

Additional information

The official instruction, CR 9028, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3152CP.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: MM9028
Related Change Request (CR) #: CR 9028
Related CR Release Date: December 19, 2014
Effective Date: January 1, 2015
Related CR Transmittal #: R3152CP
Implementation Date: January 5, 2015

Medicare Physician Fee Schedule

Emergency update to the 2015 Medicare physician fee schedule database

Provider types affected

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

Provider action needed

This article is based on change request (CR) 9081, to announce an emergency update to payment files issued to contractors based on the 2015 Medicare physician fee schedule database (MPFSDB) final rule. CR 9081 amends those payment files, including an updated conversion factor of $35.7547 for services furnished between January 1, 2015, and March 31, 2015, consistent with the Protecting Access to Medicare Act of 2014 that provides for a zero percent update from 2014 rates. Make sure that your billing staffs are aware of these changes.

Background

Payment files were issued to contractors based upon the 2015 MPFS final rule, displayed on October 31, 2014 (and published in the *Federal Register* on November 13, 2014). CR 9081 amends those payment files in order to correct technical errors to the MPFS update files, including an updated conversion factor of $35.7547 for services furnished between January 1, 2015, and March 31, 2015, consistent with the Protecting Access to Medicare Act of 2014 that provides for a zero percent update from the 2014 rate.

In preparing the 2015 final rates, errors were made in work, practice expense and malpractice RVUs. In correcting these errors and making adjustments to reflect the policies in the 2015 final rule with comment period, relativity adjustments were required across the fee schedule, and the conversion factor was adjusted from that published in the final rule. The amended payment files reflect all these changes and a conversion factor of $35.7547 for services furnished on or after January 1, 2015, and on or before March 31, 2015.

Under current law, a new conversion factor will be required for services furnished on or after April 1, 2015. These files will be provided with the April quarterly update.

Additional information

The official instruction, CR 9081, issued to your MAC regarding this change, is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3166CP.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: MM9081
Related Change Request (CR) #: CR 9081
Related CR Release Date: January 16, 2015
Effective Date: January 1, 2015
Related CR Transmittal #: R3166CP
Implementation Date: January 5, 2015

Posting the limiting charge after applying the EHR and PQRS negative adjustments

Provider types affected

This *MLN Matters*® article is intended for Medicare eligible professionals (EPs) submitting professional claims to Medicare administrative contractors (MACs) for services to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 8667, whose purpose is to place the electronic health record (EHR) and physician quality reporting system (PQRS) negative adjustment limiting charge amounts on MAC websites and hard copy disclosure reports. EPs under the Medicare EHR incentive program include: Doctor of medicine or osteopathy, Doctor of oral surgery or dental medicine, Doctor of podiatry, Doctor of optometry, and Chiropractor. Be sure your billing staffs are aware of these changes.

Background

Electronic health record (EHR)

Beginning January 1, 2015, Section 1848(a)(7) of the Social Security Act as amended by Section 4101(b) of the HITECH Act, requires that EPs that are not meaningful EHR users are subject to the EHR negative adjustment.

Specifically, Section 1848(a)(7) of the Act states that: "If the eligible professional is not a meaningful EHR user (as determined under Subsection (o)(2)) for an EHR reporting period for the year, the fee schedule amount for such services furnished by such professional during the year (including the fee schedule amount for purposes of determining a payment based on such amount) shall be equal to the applicable percent of the fee schedule amount that would otherwise apply to such services under this subsection (determined after application of paragraph (3) but without regard to this paragraph)."

Physician quality reporting system (PQRS)

Beginning on January 1, 2015, Section 1848(a)(8) of the Social Security Act, as added by Section 3002(b) of the Affordable Care Act, requires that EPs who do not satisfactorily report data on quality measures for covered professional services for the quality reporting period of the year are subject to the PQRS negative adjustment.

Specifically, Section 1848(a)(8) of the Act states that: "If the eligible professional does not satisfactorily submit data on quality measures for covered professional services for the quality reporting period for the year (as determined under Subsection (m)(3)(A)), the fee schedule amount for such services furnished by such professional during the year (including the fee schedule amount for purposes of determining a payment based on such amount) shall be equal to the applicable percent of the fee schedule amount that would otherwise apply to such services under this subsection (determined after application of paragraphs (3), (5), and (7), but without regard to this paragraph)."

The negative payment adjustment applies to all EPs, regardless of whether the EP elects to be "participating" or "non-participating" for purposes of Medicare payments.

Non-participating (non-par) EPs in the Medicare program may choose either to accept or not accept assignment on Medicare claims on a claim-by-claim basis. If EPs choose not to accept assignment, they may not charge the beneficiary more than the Medicare limiting charge for unassigned claims for Medicare services. The limiting charge is 115 percent of the MPFS amount. The beneficiary is not responsible for billed amounts in excess of the limiting charge for a covered service.

Non-participating EPs that do not accept assignment on a claim may choose to collect the entire limiting charge amount up front from the beneficiary at the time of service.

Submission of a non-par, non-assigned Medicare physician fee schedule (MPFS) service with a charge in excess of the Medicare limiting charge amount constitutes a violation of the limiting charge. A physician or supplier who violates the limiting charge is subject to a civil monetary penalty of not more than $10,000, an assessment of not more than three times the amount claimed for each item or service, and possible exclusion from the Medicare program. Therefore, it is crucial that EPs are provided with the correct limiting charge they may bill for a MPFS service.

Your MAC will list and display the limiting charge amount after applying the EHR and PQRS negative adjustment on their website. Specifically, they will add the following to their website:

- EHR limiting charge;
- PQRS limiting charge;
- EHR/2014 eRx limiting charge;
- EHR + PQRS limiting charge; and
- EHR/2014 eRx + PQRS limiting charge.

Examples

Non-par non-assigned claim no EHR/PQRS adjustment:

Original fee schedule amount: $100

5 percent non-PAR status: $5 (100 x .05)

Adjustment total $5.00

MPFS allowed amount $100-$5.00= $95.00

Limiting charge allowed= $95.00 x 115 percent= $109.25

Non-par non-assigned claim with EHR adjustment:

Original fee schedule amount: $100

5 percent non-PAR status: $5 (100 x .05)

1 percent EHR negative adjustment $.95 (95 x.01)

Adjustment total $5.95

MPFS allowed amount $100-$5.95= $94.05

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Limiting charge allowed= $94.05 x 115 percent= $108.16

Non-par non-assigned claim with PQRS adjustment:

Original fee schedule amount: $100

5 percent non-PAR status: $5 (100 x .05)

1.5 percent PQRS negative adjustment $1.43 (95 x.015)

Adjustment total $ 6.43

MPFS allowed amount $100-$6.43= $93.57

Limiting charge allowed= $93.57 x 115 percent= $107.61

Non-par non-assigned claim with EHR + e-prescribing:

Original fee schedule amount: $100

5 percent non-PAR status: $5 (100 x .05)

2 percent EHR negative adjustment $1.90 (95 x.02)

Adjustment total $ 6.90

MPFS allowed amount $100-$6.90= $93.10

Limiting charge allowed= $93.10 x 115 percent= $107.07

Non-par non-assigned claim with EHR without 2014 e-Prescribing adjustment + PQRS:

Original fee schedule amount: $100

5 percent non-PAR status: $5 (100 x .05)

1 percent EHR negative adjustment $.95 (95 x .01)

EHR adjustment Total $5.95

MPFS allowed amount $100-$5.95= $94.05

1.5 percent PQRS negative adjustment $1.41 ($94.05 x .015)

PQRS adjustment total $94.05-$1.41=$92.64

MPFS allowed amount $92.64

Limiting charge allowed= $92.64 x 115 percent= $106.54

Non-par non-assigned claim with EHR with 2014 e-Prescribing adjustment + PQRS:

Original fee schedule amount: $100

5 percent non-PAR status: $5 (100 x .05)

2 percent EHR negative adjustment $1.90 (95 x .02)

EHR adjustment total $6.90

MPFS allowed amount $100-$6.90= $93.10

1.5 percent PQRS negative adjustment $1.40 (93.10 x .015)

PQRS adjustment total $93.10-$1.40=$91.70

MPFS allowed amount $91.70

Limiting charge allowed= $91.70 x 115 percent= $105.46

Additional information

Information about the EHR incentive programs is available at *http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html*.

Information about "Physician Quality Reporting System (PQRS) Payment Adjustment Information" is available at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Payment-Adjustment-Information.html*.

The official instruction, CR 8667, issued to your MAC regarding this change, may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1384OTN.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. You can also find a link to your MAC's website at this page.

MLN Matters® Number: MM8667 *Revised*
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Related CR Release Date: May 16, 2014
Effective Date: January 1, 2015
Related CR Transmittal #: R1384OTN
Implementation Date: October 6, 2014

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

2015 MPFS policies and telehealth originating site facility fee payment amount

Provider types affected

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

Provider action needed

This article is based on change request (CR) 9034 which provides a summary of the policies in the 2015 MPFS final rule and announces the telehealth originating site facility fee payment amount. Make sure that your billing staff are aware of these updates for 2015.

Background

The Social Security Act (Section 1848(b)(1); (see *http://www.ssa.gov/OP_Home/ssact/title18/1848.htm*) requires the Centers for Medicare & Medicaid Services (CMS) to establish a fee schedule of payment amounts for physicians' services for the subsequent year. CMS issued a final rule with comment period October 13, 2014 (see *https://www.federalregister.gov/articles/2014/11/13*), that updates payment policies and Medicare payment rates for services furnished by physicians and non-physician practitioners (NPPs) that are paid under the MPFS in 2015.

The final rule also addresses public comments on Medicare payment policies that were described in the proposed rule earlier this year: "Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare & Medicaid Innovation Models & Other Revisions to Part B for 2015; Proposed Rule" was published in the *Federal Register* July 11, 2014. (See *http://www.gpo.gov/fdsys/pkg/FR-2014-07-11/pdf/2014-15948.pdf*).

The final rule also addresses interim final values established in the 2014 MPFS final rule with comment period. (See *http://www.gpo.gov/fdsys/pkg/FR-2013-12-10/pdf/2013-28737.pdf*). The final rule assigns interim final values for new, revised, and potentially misvalued codes for 2015 and requests comments on these values. CMS will accept comments on those items open to comment in the final rule with comment period until December 30, 2014.

Sustainable growth rate (SGR)

The Protecting Access to Medicare Act of 2014 (see *http://www.gpo.gov/fdsys/pkg/BILLS-113hr4302enr/pdf/BILLS-113hr4302enr.pdf*) provides for a zero percent update from the 2014 rates for services furnished between January 1, 2015, and March 31, 2015. Adjusting by .06 percent to achieve required budget neutrality, the conversion factor for this period is $35.8013.

Under current law, the conversion factor will be adjusted April 1, 2015. In the final rule CMS announced a conversion factor of $28.2239 for this period, resulting in an average reduction of 21.2 percent from the 2014 rates. In most prior years, Congress has taken action to avert large across-the-board reductions in PFS rates before they went into effect. The Administration supports legislation to permanently change SGR to provide more stability for Medicare beneficiaries and providers while promoting efficient, high quality care.

Screening and diagnostic digital mammography

To ensure that the higher resources needed for 3D mammography are recognized, Medicare will pay for 3D mammography using add-on codes that will be reported in addition to the 2D mammography codes when 3D mammography is furnished. See *MLN Matters*® article MM8874 (*http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8874.pdf*) for more information.

Primary care and chronic care management

Medicare continues to emphasize primary care by making payment for chronic care management (CCM) services – non-face-to-face services to Medicare beneficiaries who have two or more chronic conditions – beginning January 1, 2015. CCM services include regular development and revision of a plan of care, communication with other treating health professionals, and medication management. CCM can be billed once per month per qualified beneficiary, provided the minimum level of services is furnished.

CMS is finalizing its proposal to allow greater flexibility in the supervision of clinical staff providing CCM services. The proposed application of the "incident to" supervision rules was widely supported by the commenters.

Payment for CCM is only one part of a multi-faceted CMS initiative to improve Medicare beneficiaries' access to primary care. Models being tested through the Innovation Center will continue to explore other primary care innovations.

Finally, CMS will require that in order to bill CCM, a practitioner must use a certified electronic health record (EHR) that meets the requirements for the EHR incentive program as of December 31 of the prior calendar year.

Application of beneficiary cost sharing to anesthesia related to screening colonoscopies

The Medicare statute waives the Part B deductible and coinsurance applicable to screening colonoscopy. In the 2015 final rule, CMS revised the definition of a "screening colonoscopy" to include separately provided anesthesia as part of the screening service so that the coinsurance and deductible do not apply to anesthesia for a screening colonoscopy, reducing beneficiaries' cost-sharing obligations under Part B. For more information, review *MLN Matters*® article MM8874 (*http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8874.pdf*).

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Enhanced transparency in setting PFS rates

Since the beginning of the physician fee schedule in 1992, CMS adopted rates for new and revised codes for the following calendar year in the final rule on an interim basis subject to public comment. This policy was necessary because CMS did not receive the codes in time to include in the PFS proposed rule. Until recently, the only services that were affected by this policy were services with new and revised codes. In recent years, CMS began receiving new and revised codes and revaluing existing services under the misvalued codes initiative. Establishing payment in the final rule for misvalued codes often led to implementation of payment reductions before the public had the opportunity to comment. CMS finalized its proposal to change the process for valuing new, revised and potentially misvalued codes for 2016, so that payment for the vast majority of these codes goes through notice and comment rulemaking prior to being adopted. After a transition in 2016, the process will be fully implemented in 2017.

Potentially misvalued services

Consistent with amendments to the Affordable Care Act (see *http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf*), CMS has been engaged in a vigorous effort over the past several years to identify and review potentially misvalued codes, and to make adjustments where appropriate.

The following are major misvalued code decisions for 2015:

- **Radiation therapy and gastroenterology**: Consistent with the final rule policy and in response to public comments, CMS is not adopting the *CPT*® coding changes for 2015 for gastroenterology and radiation therapy services so that CMS can propose and obtain comments on the revised coding prior to using them for payment. As a result, CMS will not recognize some new *CPT*® codes, and created G-codes in place of changed and new *CPT*® codes.
- **Radiation treatment vault**: CMS proposed to refine the way it accounts for the infrastructure costs associated with radiation therapy equipment, specifically to remove the radiation treatment vault as a direct expense when valuing radiation therapy services. After considering public comments, CMS did not finalize this proposal.
- **Epidural pain injections**: CMS reduced payment for these services in 2014 under the misvalued code initiative. In response to concerns from pain physicians regarding the accuracy of the valuation, CMS proposed to raise the values in 2015 based on their prior resource inputs before adopting further changes after considering RUC recommendations. However, because the inputs for these services included those related to image guidance, CMS also proposed to prohibit separate billing for image guidance for 2015. CMS finalized the policy as proposed to avoid duplicate payment for image guidance. CMS has asked the RUC to further review this issue and make recommendations to us on how to value epidural pain injections.
- **Film to digital substitution**: CMS finalized its proposal to update the practice expense inputs for X-ray services to reflect that X-rays are currently done digitally rather than with analog film.

Global surgery

The U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG) has identified a number of surgical procedures that include more visits in the global period than are being furnished. CMS is also concerned that post-surgical visits are valued higher than visits that were furnished and billed separately by other physicians such as general internists or family physicians.

CMS finalized a proposal to transform all 10-day and 90-day globals to zero-day globals, beginning with 10-day global services in 2017 and following with the 90-day global services in 2018. As CMS revalues these services as zero-day global periods, CMS will actively assess whether there is a better construction of a bundled payment for surgical services that incentivizes care coordination and care redesign across an episode of care.

Access to telehealth services

CMS is adding the following services to the list of services that can be furnished to Medicare beneficiaries under the telehealth benefit:

- Annual wellness visits
- Psychoanalysis
- Psychotherapy
- Prolonged evaluation and management services

For the list of telehealth services, visit: *http://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index.html*.

Telehealth origination site facility fee payment amount update

The Social Security Act (Section 1834(m)(2)(B) (see *http://www.ssa.gov/OP_Home/ssact/title18/1834.htm*) establishes the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001, through December 31 2002, at $20.

For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased by the percentage increase in the Medicare economic index (MEI) as defined in the Social Security Act (Section 1842(i)(3) (see *http://www.ssa.gov/OP_Home/ssact/title18/1842.htm*).

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The MEI increase for 2015 is 0.8 percent. Therefore, for 2015, the payment amount for HCPCS code Q3014 (Telehealth originating site facility fee) is 80 percent of the lesser of the actual charge, or $24.83. (The beneficiary is responsible for any unmet deductible amount and Medicare coinsurance.)

Revisions to malpractice relative value units (RVUs)

As required by the Medicare law, CMS conducted a five-year review and updated the resource-based malpractice RVUs based on updated professional liability insurance premiums, largely paralleling the methodology used in the 2010 update. The final rule indicated that anesthesia RVUs will be updated in 2016.

Revisions to geographic practice cost indices (GPCIs)

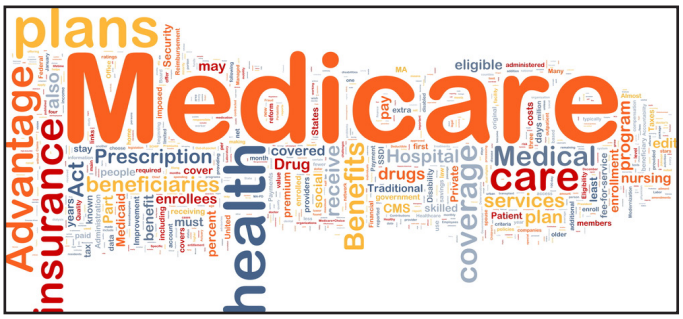
As required by the Medicare law, CMS adjusts payments under the PFS to reflect local differences in the cost of operating a medical practice. For 2015, CMS is using territory-level wage data to calculate the work GPCI and employee wage component of the PE GPCI for the Virgin Islands.

The 2015 GPCIs also reflect the application of the statutorily mandated of 1.5 work GPCI floor in Alaska, and 1.0 work GPCI floor for all other physician fee schedule areas, and the 1.0 PE GPCI floor for frontier states (Montana, Nevada, North Dakota, South Dakota, and Wyoming).

However, given that the statutory 1.0 work GPCI floor is scheduled to expire under current law on March 31, 2015, the GPCIs reflect the elimination of the 1.0 work GPCI floor from April 1, 2015, through December 31, 2015.

Services performed in off-campus provider-based departments

CMS will collect data on services furnished in off-campus provider-based departments by requiring hospitals to report a modifier for those services furnished in an off-campus provider-based department of the hospital and by requiring physicians and other billing practitioners to report these services using a new place of service code on professional claims.



Data collection will be voluntary for hospitals in 2015 and required beginning January 1, 2016. The new place of service codes will be used for professional claims as soon as it is available, but not before January 1, 2016.

The official instruction, CR 9034, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3157CP.pdf*.

For more information about the EHR program, go to *http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html*.

The final rule, published on November 13, 2014, is available at *http://www.gpo.gov/fdsys/pkg/FR-2014-11-13/pdf/2014-26183.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-Net work-MLN/MLNMattersArticles/index.html*.

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Related CR Transmittal #: R3157CP
Implementation Date: January 5, 2015

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Preventive Services

Modifications to coverage of pneumococcal vaccinations

Provider types affected

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

Provider action needed

Change request (CR) 9051 provides an update to the Medicare pneumococcal vaccine coverage requirements, to align with new Advisory Committee on Immunization Practices (ACIP) recommendations. Make sure your billing staffs are aware of these updates.

Background

Medicare Part B covers certain vaccinations including pneumococcal vaccines. Specifically, Section 1861(s)(10)(A) of the Social Security Act, which is available at *http://www.ssa.gov/OP_Home/ssact/title18/1861.htm*, and regulations at 42 CFR 410.57 (*http://www.ecfr.gov/cgi-bin/text-idx?SID=85dbd4cb66820b751ffe58a6c58988df&node=se42.2.410_157&rgn=div8*) authorize Medicare coverage under Part B for pneumococcal vaccine and its administration. For services furnished on or after May 1, 1981, through September 18, 2014, the Medicare Part B program covered pneumococcal pneumonia vaccine and its administration when furnished in compliance with any applicable state law by any provider of services or any entity or individual with a supplier number. Coverage included an initial vaccine administered only to persons at high risk of serious pneumococcal disease (including all people 65 and older; immunocompetent adults at increased risk of pneumococcal disease or its complications because of chronic illness; and individuals with compromised immune systems), with revaccination administered only to persons at highest risk of serious pneumococcal infection and those likely to have a rapid decline in pneumococcal antibody levels, provided that at least five years had passed since the previous dose of pneumococcal vaccine.

However, ACIP updated its guidelines regarding pneumococcal vaccines; now recommending the administration of two different pneumococcal vaccinations.

The Centers for Medicare & Medicaid Services (CMS) is updating the Medicare coverage requirements to align with the updated ACIP recommendations. Effective for dates of service on or after September 19, 2014, (and upon implementation of CR 9051), Medicare will cover:

- An initial pneumococcal vaccine to all Medicare beneficiaries who have never received the vaccine under Medicare Part B; and
- A different, second pneumococcal vaccine one year after the first vaccine was administered (that is, 11 full months have passed following the month in which the last pneumococcal vaccine was administered).

Since the updated ACIP recommendations are specific to vaccine type and sequence of vaccination, prior pneumococcal vaccination history should be taken into consideration. For example, if a beneficiary who is 65 years or older received the 23-valent pneumococcal polysaccharide vaccine (PPSV23) a year or more ago, then the 13-valent pneumococcal conjugate vaccine (PCV13) should be administered next as the second in the series of the two recommended pneumococcal vaccinations. Receiving multiple vaccinations of the same vaccine type is not generally recommended. Ideally, providers should readily have access to vaccination history, such as with electronic health records, to ensure reasonable and necessary pneumococcal vaccinations.

Medicare does not require that a doctor of medicine or osteopathy order the vaccine; therefore, the beneficiary may receive the vaccine upon request without a physician's order and without physician supervision.

Note that MACs will not search for and adjust any claims for pneumococcal vaccines and their administration, with dates of service on and after September 19, 2014. However, they may adjust such claims that you bring to their attention.

Additional information

The official instruction, CR 9051, issued to your MAC includes two transmittals. The first updates the *Medicare Benefit Policy Manual*, Chapter 15 (Covered Medical and Other Health Services), Section 50.4.4.2 (Immunizations) and *Medicare Claims Processing Manual*, Chapter 18 (Preventive and Screening Services), Section 10.1.1 (Pneumococcal Vaccine) as attachments to that transmittal. It is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R202BP.pdf*. The second transmittal updates the *Medicare Claims Processing Manual* and that transmittal is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3159CP.pdf*.

The Centers for Disease Control and Prevention (CDC) recommends that providers use two pneumococcal vaccines for adults aged ≥ 65. These vaccinations are 13-Valent Pneumococcal Conjugate Vaccine (PCV13)

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Preventive and screening services update

***Note**: This article was revised January 8, 2015, to reflect the revised change request (CR) 8874 issued January 7. In the article, the CR release date, transmittal number, and the Web address for accessing CR 8874 are revised. All other information remains the same. This information was previously published in the December 2014 Medicare B Connection, Pages 12-15.*

Provider types affected

This *MLN Matters*® article is intended for Medicare practitioners providing preventive and screening services to Medicare beneficiaries and billing Medicare administrative contractors (MACs) for those services.

Provider action needed

CR 8874 is an update from the Centers for Medicare & Medicaid Services (CMS) to ensure accurate program payment for three screening services. The coinsurance and deductible for these services are currently waived, but due to coding changes and additions, the payments for 2015 would not be accurate without updated CR 8874 for intensive behavioral group therapy for obesity, digital breast tomosynthesis, and anesthesia associated with screening colonoscopy. Make sure billing staffs are aware of these updates. The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 8865 to alert providers and suppliers that CMS issued instructions updating the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) fee schedule payment amounts, effective October 1, 2014. Make sure your billing staffs are aware of these changes.

Background

The following outlines the CMS updates:

Intensive behavioral therapy for obesity

Intensive behavioral therapy for obesity became a covered preventive service under Medicare, effective November 29, 2011. It is reported with HCPCS code G0447 (Face-to-face behavioral counseling for obesity, 15 minutes). Coverage requirements are in the *Medicare National Coverage Determinations (NCDs) Manual*, Chapter 1, Section 210.

To improve payment accuracy, in *2015 Physician Fee Schedule (PFS) Proposed Rule*, CMS created a new HCPCS code for the reporting and payment of behavioral group counseling for obesity – HCPCS codes G0473 (Face-to-face behavioral counseling for obesity, group (2-10), 30 minutes).

For coverage requirements of intensive behavioral therapy for obesity, see the NCD for Intensive Behavioral Therapy for Obesity.

The same claims editing that applies to G0447 applies to G0473. Therefore, effective for claims with dates of service on or after January 1, 2015, MACs will recognize HCPCS code G0473, but only when billed with one of the ICD-9 codes for body mass index (BMI) 30.0 and over (V85.30,-V85.39, V85.41-V85.45). (Once ICD-10 is effective, the related ICD-10 codes are Z68.30-Z68.39 and Z68.41-Z68.45.) When claims for G0473 are submitted without a required diagnosis code, they will be denied using the following remittance codes:

- **Claim adjustment reason code (CARC) 167**: This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- **Remittance advice remarks 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. A copy of this policy is available at *www.cms.mcd.search.asp*. If you do not have web access, you may contact the contractor to request a copy of the NCD.

Effective for claims with dates of service on or after January 1, 2015, beneficiary coinsurance and deductible do not apply to claim lines with HCPCS code G0473.

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and 23-Valent Pneumococcal Polysaccharide Vaccine (PPSV23). For more information on these recommendations, visit *http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6337a4.htm*.

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

MLN Matters® Number: MM9051
Related Change Request (CR) #: CR 9051

Related CR Release Date: December 31, 2014
Effective Date: September 19, 2014
Related CR Transmittal #: R202BP and R3159CP
Implementation Date: February 2, 2015

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Note that Medicare pays claims with code G0473 only when submitted by the following provider specialty types as found on the provider's Medicare enrollment record:

- 01 – General practice
- 08 – Family practice
- 11 – Internal medicine
- 16 – Obstetrics/gynecology
- 37 – Pediatric medicine
- 38 – Geriatric medicine
- 50 – Nurse practitioner
- 89 – Certified clinical nurse specialist
- 97 – Physician assistant

Claim lines submitted with G0473, but without an appropriate provider specialty will be denied with the following remittance codes:

- **CARC 8**: The procedure code is inconsistent with the provider type/specialty (taxonomy). Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- **RARC N95**: This provider type/provider specialty may not bill this service.
- **Group code CO** (if GZ modifier present) or PR (if modifier GA is present).

Further, effective for dates of service on or after January 1, 2015, claim lines with G0473 are only payable for the following places of service (POS) codes:

- 11 – Physician's office
- 22 – Outpatient hospital
- 49 – Independent clinic
- 71 – State or local public health clinic

Claim lines for G0473 will be denied without an appropriate POS code using the following remittance codes:

- **CARC 5**: The procedure code/bill type is inconsistent with the place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- **RARC M77**: Missing/incomplete/invalid place of service.
- **Group code CO** (if GZ modifier present) or PR (if modifier GA is present).

Remember that Medicare will deny claim lines billed for HCPCS codes G0447 and G0473 if billed more than 22 times in a 12-month period using the following codes:

- **CARC 119**: Benefit maximum for this time period or occurrence has been reached.
- **RARC N362**: The number of days or units of service exceeds our acceptable maximum.
- **Group code CO** (if GZ modifier present) or PR (if modifier GA is present).

Note: MACs will display the next eligible date for obesity counseling on all MAC provider inquiry screens.

MACs will allow both a claim for the professional service and a claim for a facility fee for G0473 when that code is billed on type of bill (TOB) 13x or on TOB 85x when revenue code 096x, 097x, or 098x is on the TOB 85x. Payment on such claims is based on the following:

- TOB 13x paid based on the OPPS:
- TOB 85x in critical access hospitals based on reasonable cost; except
- TOB 85x Method II hospitals based on 115 percent of the lesser of the fee schedule amount or the submitted charge.

Institutional claims submitted on other than TOB 13x or 85x will be denied using:

- **CARC 171**: Payment is denied when performed by this type of provider on this type of facility. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 service payment information REF), if present.
- **RARC N428**: Not covered when performed in this place of service.
- **Group code CO** (if GZ modifier present) or PR (if modifier GA is present).

Digital breast tomosynthesis

In the 2015 PFS final rule with comment period, CMS established a payment rate for the newly created *Current Procedural Terminology®* (*CPT®*) code *77063* for screening digital breast tomosynthesis mammography. The same policies that are applicable to other screening mammography codes are applicable to *CPT®* code *77063*. In addition, since this is an add-on code it should only be paid when furnished in conjunction with a 2D digital mammography.

Effective January 1, 2015, HCPCS code *77063* (Screening digital breast tomosynthesis, bilateral (list separately in addition to code for primary procedure)), must be billed in conjunction with the screening mammography HCPCS code G0202 (Screening mammography, producing direct digital image, bilateral, all views, 2D imaging only. Effective January 1, 2015, beneficiary coinsurance and deductible does not apply to claim lines with *77063* (Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary procedure).

Payment for *77063* is made only when billed with an ICD-9 code of V76.11 or V76.12 (and when ICD-10 is effective with ICD-10 code Z12.31). When denying claim lines for *77063* that are submitted without the appropriate diagnosis code, the claim lines are denied using the following messages:

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- **CARC 167**: This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- **RARC N386**: This decision was based on a national coverage determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *www.cms.mcd.search.asp*. If you do not have web access, you may contact the contractor to request a copy of the NCD.
- **Group code C**O (if GZ modifier present) or PR (if modifier GA is present).

On institutional claims:

- MACs will pay for tomosynthesis, HCPCS code *77063*, on TOBs 12x, 13x, 22x, 23x based on MPFS, and TOB 85x with revenue code other than 096x, 097x, or 098x based on reasonable cost. TOB 85x claims with revenue code 096x, 097x, or 098x are paid based on MPFS (115 percent of the lesser of the fee schedule amount and submitted charge).
- MACs will pay for tomosynthesis, HCPCS code *77063* with revenue codes 096x, 097x, or 098x when billed on TOB 85x method II based on 115 percent of the lesser of the fee schedule amount or submitted charge.
- MACs will return to the provider any claim submitted with tomosynthesis, HCPCS code *77063* when the TOB is not 12x, 13x, 22x, 23x, or 85x.
- MACs will pay for tomosynthesis, HCPCS code *77063*, on institutional claims TOBs 12x, 13x, 22x, 23x, and 85x when submitted with revenue code 0403 and on professional claims TOB 85x when submitted with revenue code 096x, 097x, or 098x.
- Effective for claims with dates of service on or after January 1, 2015, MACs will RTP claims for HCPCS code *77063* that are not submitted with revenue code 0403, 096x, 097x, or 098x.

Anesthesia furnished in conjunction with colonoscopy

Section 4104 of the Affordable Care Act defined the term "preventive services" to include "colorectal cancer screening tests" and as a result it waives any coinsurance that would otherwise apply under Section 1833(a)(1) of the Act for screening colonoscopies. In addition, the Affordable Care Act amended Section 1833(b)(1) of the Act to waive the Part B deductible for screening colonoscopies. These provisions are effective for services furnished on or after January 1, 2011.

In the *2015 PFS Proposed Rule*, CMS proposed to revise the definition of "colorectal cancer screening tests" to include anesthesia separately furnished in conjunction with screening colonoscopies; and in the *2015 PFS Final Rule* with comment period, CMS finalized this proposal. The definition of "colorectal cancer screening tests" includes anesthesia separately furnished in conjunction with screening colonoscopies in the Medicare regulations at Section 410.37(a)(1)(iii). As a result, beneficiary coinsurance and deductible does not apply to anesthesia services associated with screening colonoscopies.

As a result, effective for claims with dates of service on or after January 1, 2015, anesthesia professionals who furnish a separately payable anesthesia service in conjunction with a screening colonoscopy (HCPCS code *00810* performed in conjunction with G0105 and G0121) shall include the following on the claim for the services that qualify for the waiver of coinsurance and deductible:

- **Modifier** *33* – Preventive services: when the primary purpose of the service is the delivery of an evidence based service in accordance with a USPSTF A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory), the service may be identified by adding 33 to the procedure. For separately reported services specifically identified as preventive, the modifier should not be used.

Additional information

The official instruction, CR 8874 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3160CP.pdf*.

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

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Related Change Request (CR) #: CR 8874
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Effective Date: January 1, 2015
Related CR Transmittal #: R3160CP
Implementation Date: January 5, 2015

Radiology

Fluorodeoxyglucose positron emission tomography (PET) for solid tumors

***Note**: This article was revised January 12, 2015, to reflect the revised change request (CR) 8739 issued January 8. In the article, reference to an attachment in the "Background" section has been replaced with a Web link to the list of appropriate diagnosis codes. Note that 793.11 has been added to that list. Also, the CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same. This information was previously published in the May 2014 Medicare B Connection, Pages 12-14.*

Provider types affected

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

Provider action needed

This article is based on CR 8739, which advises MACs, effective for dates of service on or after June 11, 2013, to cover three FDG PET scans when used to guide subsequent management of anti-tumor treatment strategy after completion of initial anti-cancer therapy for the same cancer diagnosis. Coverage of any additional FDG PET scans (that is, beyond three) used to guide subsequent management of anti-tumor treatment strategy after completion of initial anti-cancer therapy for the same diagnosis will be determined by your MAC. Make sure your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) has reconsidered Section 220.6, of the *National Coverage Determinations (NCD) Manual* to end the prospective data collection requirements across all oncologic indications of FDG PET in the context of CR 8739. The term FDG PET includes PET/computed tomography (CT) and PET/magnetic resonance (MRI).

CMS is revising the *NCD Manual*, Section 220.6, to reflect that CMS has ended the coverage with evidence development (CED) requirement for (2-[F18] fluoro-2-deoxy-D-glucose) FDG PET, PET/CT, and PET/MRI for all oncologic indications contained in Section 220.6.17 of the *NCD Manual*. This removes the current requirement for prospective data collection by the National Oncologic PET Registry (NOPR) for oncologic indications for FDG (Healthcare Common Procedure Coding System (HCPCS) code A9552) only.

Note: For clarification purposes, as an example, each different cancer diagnosis is allowed one (1) initial treatment strategy (-PI modifier) FDG PET Scan and three (3) subsequent treatment strategy (-PS modifier) FDG PET scans without the -KX modifier.

The fourth FDG PET scan and beyond for subsequent treatment strategy for the same cancer diagnosis will always require the -KX modifier. If a different cancer diagnosis is reported, whether reported with a -PI modifier or a -PS modifier, that cancer diagnosis will begin a new count for subsequent treatment strategy for that beneficiary. A beneficiary's file may or may not contain a claim for initial treatment strategy with a -PI modifier. The existence or non-existence of an initial treatment strategy claim has no bearing on the frequency count of the subsequent treatment strategy (-PS) claims.

Providers may refer to *http://cms.gov/medicare/coverage/determinationprocess/downloads/petforsolidtumorsoncologicdxcodesattachment_NCD220_6_17.pdf* for a list of appropriate diagnosis codes.

Effective for claims with dates of service on or after June 11, 2013, Medicare will accept and pay for FDG PET oncologic claims billed to inform initial treatment strategy or subsequent treatment strategy for suspected or biopsy proven solid tumors for all oncologic conditions without requiring the following:

- **Q0 modifier**: Investigational clinical service provided in a clinical research study that is in an approved clinical research study (institutional claims only);:
- **Q1 modifier**: routine clinical service provided in a clinical research study that is in an approved clinical research study (institutional claims only);
- **V70.7**: Examination of participant in clinical research; or
- **Condition code 30** (institutional claims only).

Effective for dates of service on or after June 11, 2013, MACs will use the following messages when denying claims in excess of **three** for PET FDG scans for subsequent treatment strategy when the –KX modifier is not included, identified by *CPT*® codes *78608*, *78811*, *78812*, *78813*, *78814*, *78815*, or *78816*, modifier –PS, HCPCS A9552, and the same cancer diagnosis code:

- **Claim adjustment reason code (CARC) 96**: "Non-Covered Charge(s). **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
- **Remittance advice remarks code (RARC) N435**: "Exceeds number/frequency approved/allowed within time period without support documentation."
- **Group code PR** assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file.
- **Group code CO** assigning financial liability to the

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provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

MACs will not search their files to adjust claims processed prior to implementation of CR 8739. However, if you have such claims and bring them to the attention of your MAC, the MAC will adjust such claims if appropriate.

Synopsis of coverage of FDG PET for oncologic conditions

Effective for claims with dates of service on and after June 11, 2013, the chart below summarizes national FDG PET coverage for oncologic conditions:

FDG PET for cancers tumor type	Initial treatment strategy (formerly "diagnosis" & "staging")	Subsequent treatment strategy (formerly "restaging" & "monitoring response to treatment"
Colorectal	Cover	Cover
Esophagus	Cover	Cover
Head and neck (not thyroid, CNS)	Cover	Cover
Lymphoma	Cover	Cover
Non-small cell lung	Cover	Cover
Ovary	Cover	Cover
Brain	Cover	Cover
Cervix	Cover with exceptions *	Cover
Small cell lung	Cover	Cover
Soft tissue sarcoma	Cover	Cover
Pancreas	Cover	Cover
Testes	Cover	Cover
Prostate	Non-cover	Cover
Thyroid	Cover	Cover
Breast (male and female)	Cover with exceptions *	Cover
Melanoma	Cover with exceptions *	Cover
All other solid tumors	Cover	Cover
Myeloma	Cover	Cover

*__Cervix__: Nationally non-covered for the initial diagnosis of cervical cancer related to initial anti-tumor treatment strategy. All other indications for initial anti-tumor treatment strategy for cervical cancer are nationally covered.

*__Breast__: Nationally non-covered for initial diagnosis and/or staging of axillary lymph nodes. Nationally covered for initial staging of metastatic disease. All other indications for initial anti-tumor treatment strategy for breast cancer are nationally covered.

*__Melanoma__: Nationally non-covered for initial staging of regional lymph nodes. All other indications for initial anti-tumor treatment strategy for melanoma are nationally covered.

Additional information

The official instruction, CR 8739, issued to your MAC regarding this change, is available at in two transmittals at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3162CP.pdf and http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R168NCD.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: MM8739 *Revised*
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Related CR Release Date: January 8, 2015
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Related CR Transmittal #: R3162CP, R168NCD
Implementation Dates: May 19, 2014 - MAC Non-Shared System Edits; July 7, 2014 - CWF development/testing, FISS requirement development; October 6, 2014 - CWF, FISS, MCS Shared System Edits

Surgery

Transcatheter mitral valve repair national coverage determination

Provider types affected

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

Provider action needed

Effective for claims with dates of service furnished on or after August 7, 2014, the Centers for Medicare & Medicaid Services (CMS) will reimburse claims for TMVR for mitral regurgitation (MR) when furnished under coverage with evidence development (CED).

TMVR is non-covered for the treatment of MR when not furnished under CED according to the above-noted criteria. TMVR used for the treatment of any non-MR indications are non-covered by Medicare.

Background

TMVR is a new technology for use in treating MR. MR occurs when the leaflets of the mitral valve do not close properly and blood flows from the left ventricle back into the left atrium, causing the heart to work harder to pump. This, in turn, causes enlargement of the left ventricle and can lead to potential heart failure.

Abbott's MitraClip, the only U.S. Food and Drug Administration (FDA)-approved TMVR device, involves clipping together a portion of the mitral valve leaflets. This is performed under general anesthesia, with delivery of the device typically through a percutaneous transvenous approach, via echocardiographic and fluoroscopic guidance.

The procedure is performed in a cardiac catheterization laboratory or hybrid operating room/cardiac catheterization laboratory with advanced quality imaging. TMVR is covered for uses not listed as an FDA-approved indication when performed in approved clinical studies which meet certain study question requirements. The TMVR procedure must be performed by an interventional cardiologist or cardiac surgeon, or they may jointly participate in the intraoperative technical aspects, as appropriate.

On August 7, 2014, CMS issued a final decision memorandum covering TMVR for MR under CED for the treatment of MR when furnished for an FDA-approved indication with an FDA-approved device as follows:

- Treatment of significant, symptomatic, degenerative MR when furnished according to an FDA-approved indication, and all CMS coverage criteria are met; and
- TMVR for MR uses not expressly listed as FDA-approved indications but only within the context of an FDA-approved, randomized clinical trial that meets all CMS coverage criteria.

CED requires that each patient be entered into a qualified national registry. In addition, prior to receiving TMVR, face-to-face examinations of the patient are required by a cardiac surgeon and a cardiologist experienced in mitral valve surgery to evaluate the patient's suitability for TMVR and determination of prohibitive risk, with documentation of their rationale.

The NCD lists the criteria that must be met prior to beginning a TMVR program and after a TMVR program is established. No NCD existed for TMVR for MR prior to August 7, 2014, and TMVR is non-covered outside CED or for non-MR indications. The Web address for accessing the NCD transmittal is available in the *Additional information* section at the end of this article.

CR 9002 revises the *Medicare Claims Processing Manual*, Chapter 32, Section 340 (Transcatheter Mitral Valve Repair (TMVR)), and the *National Coverage Determinations* (NCD) Manual, Chapter 20, Section 20.33 (Transcatheter Mitral Valve Repair (TMVR) which are included in CR 9002.

Based on the NCD, TMVR must be furnished in a hospital with the appropriate infrastructure that includes but is not limited to:

- On-site active valvular heart disease surgical program with >two hospital-based cardiothoracic surgeons experienced in valvular surgery;
- Cardiac catheterization lab or hybrid operating room/catheterization lab equipped with a fixed radiographic imaging system with flat-panel fluoroscopy, offering catheterization laboratory-quality imaging;
- Non-invasive imaging expertise including transthoracic/transesophageal/3D echocardiography, vascular studies, and cardiac CT studies;
- Sufficient space, in a sterile environment, to

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accommodate necessary equipment for cases with and without complications;

- Post-procedure intensive care facility with personnel experienced in managing patients who have undergone open-heart valve procedures;
- Adequate outpatient clinical care facilities; and
- Appropriate volume requirements per the applicable qualifications below.

There are institutional and operator requirements for performing TMVR. The hospital must have the following:

- A surgical program that performs =25 total mitral valve surgical procedures for severe MR per year of which at least 10 must be mitral valve repairs;
- An interventional cardiology program that performs =1000 catheterizations per year, including =400 percutaneous coronary interventions (PCIs) per year, with acceptable outcomes for conventional procedures compared to National Cardiovascular Data Registry (NCDR) benchmarks;
- The heart team must include:

1. An interventional cardiologist(s) who:
   - performs =50 structural procedures per year including atrial septal defects (ASD), patent foramen ovale (PFO) and trans-septal punctures; and,
   - must receive prior suitable training on the devices to be used; and,
   - must be board-certified in interventional cardiology or board-certified/eligible in pediatric cardiology or similar boards from outside the United States;
2. Additional members of the heart team, including cardiac echocardiographers, other cardiac imaging specialists, heart valve and heart failure specialists, electrophysiologists, cardiac anesthesiologists, intensivists, nurses, nurse practitioners, physician assistants, data/research coordinators, and a dedicated administrator.
   - All cases must be submitted to a single national database;
   - Ongoing continuing medical education (or the nursing/technologist equivalent) of 10 hours per year of relevant material; and
   - The cardiothoracic surgeon(s) must be board-certified in thoracic surgery or similar foreign equivalent.
   - The heart team's interventional cardiologist or a cardiothoracic surgeon must perform the TMVR. Interventional cardiologist(s) and cardiothoracic surgeon(s) may jointly participate in the intra-operative technical aspects of TMVR as appropriate.

The heart team and hospital must be participating in a prospective, national, audited registry that: 1) consecutively enrolls TMVR patients; 2) accepts all manufactured devices; 3) follows the patient for at least one year; and, 4) complies with relevant regulations relating to protecting human research subjects, including 45 *Code of Federal Regulations* (CFR) Part 46 and 21 CFR Parts 50 & 56. For complete details on the outcomes that must be tracked by the registry and the data that must be provided to the registry, see the CR 9002 NCD transmittal. The Web address for that transmittal is in the *Additional information* section at the end of this article.

Coding requirements/claims processing requirements

Coding requirements for TMVR for MR claims furnished on or after August 7, 2014

The *Current Procedural Terminology*® (*CPT*®) codes for TMVR for MR claims are:

- ***0343T*** – Transcatheter mitral valve repair percutaneous approach including transseptal puncture when performed; initial prosthesis. (**Note**: *0343T* will be replaced by *CPT*® code *33418* effective January 1, 2015.)
- ***0344T*** – Transcatheter mitral valve repair percutaneous approach including transseptal puncture when performed; additional prosthesis(es) during same session (List separately in addition to code for primary procedure). (**Note**: *0344T* will be replaced by *CPT*® code *33419* effective January 1, 2015.)
- ***0345T*** – Transcatheter mitral valve repair percutaneous approach via the coronary sinus
- ***33418*** – Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; initial prosthesis. (**Note**: *CPT*® code *33418* is effective January 1, 2015.)
- ***33419*** – Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; additional prosthesis(es) during same session. (List separately in addition to code for primary procedure.) (**Note**: *CPT*® code *33419* is effective January 1, 2015.)

ICD-9/ICD-10 codes for TMVR for MR claims

The ICD-9 (and upon ICD-10 implementation)/ICD-10 codes are:

- ICD-9 procedure code 35.97 – Percutaneous mitral valve repair with implant and ICD-10 procedure code is 02UG3JZ – Supplement mitral valve with synthetic substitute, percutaneous approach
- ICD-9 diagnosis code for TMVR for MR claims is 424.0 – Mitral valve disorder and ICD-10 diagnosis codes are I34.0 – Nonrheumatic mitral (valve) insufficiency or I34.8 – Other nonrheumatic mitral valve disorders

Professional claims place of service (POS) codes for TMVR for MR claims

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Effective for claims with dates of service on and after August 7, 2014, place of service (POS) code 21 is valid for use for TMVR for MR services. All other POS codes will be denied. MACs will supply the following messages when MACs denying TMVR for MR claims for invalid POS:

- **Claim adjustment reason code (CARC) 58**: "Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
- **Group code CO** (contractual obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed advance beneficiary notice (ABN) is on file.)

Professional claims modifiers for TMVR for MR claims

Effective for claims with dates of service on or after August 7, 2014, MACs will pay TMVR for MR claim lines billed with *CPT*® codes *0343T, 0344T*, and *00345T* when billed for two surgeons/co-surgeons only when the claim includes modifier -62. (Effective January 1, 2015, *CPT*® codes *33418* and *33419* replace *CPT*® codes *0343T* and *0344T*, respectively.) Claim lines for two surgeons/co-surgeons billed without modifier -*62* shall be returned as unprocessable.

MACs will supply the following messages when returning TMVR for MR claim lines for two surgeons/co-surgeons billed without modifier -*62* as unprocessable:

- **CARC 4**: "The procedure code is inconsistent with the modifier used or a required modifier is missing. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
- **Remittance advice remarks code (RARC) N517**: "Resubmit a new claim with the requested information."
- **Group code**: CO

Effective for claims with dates of service on or after August 7, 2014, MACs will pay claim lines for TMVR for MR billed with *CPT*® codes *0343T, 0344T*, and *0345T* in a clinical trial when billed with modifier -Q0. (Effective January 1, 2015, *CPT*® codes *33418* and *33419* replace *CPT*® codes *0343T* and *0344T*, respectively.) TMVR for MR claim lines in a clinical trial billed without modifier -Q0 will be returned as unprocessable. MACs will supply the following messages when returning TMVR for MR claim lines in a clinical trial billed without modifier -Q0 as unprocessable:

- **CARC 4**: "The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
- **RARC N517**: "Resubmit a new claim with the requested information."
- **Group code**: CO

Professional clinical trial diagnostic coding for TMVR for MR claims

Effective for claims with dates of service on or after August 7, 2014, MACs will pay claim lines for TMVR for MR billed with *CPT*® codes *0343T, 0344T*, and *0345T* in a clinical trial when billed with ICD-9 diagnosis code 424.0 (ICD-10 I34.0 or I34.8) and secondary ICD-9 diagnosis code V70.7 (ICD-10=Z00.6). (Effective January 1, 2015, *CPT*® codes *33418* and *33419* replace *CPT*® codes *0343T* and *0344T*, respectively.) TMVR for MR claim lines in a clinical trial billed without ICD-9 diagnosis code 424.0 (ICD-10 I34.0 or I34.8) and secondary ICD-9 diagnosis code V70.7 (ICD-10=Z00.6) will be denied.

MACs will supply the following messages when denying TMVR for MR claim lines in a clinical trial billed without secondary ICD-9 diagnosis code V70.7(ICD-10=Z00.6) as unprocessable:

- **CARC 50**: "These are non-covered services because this is not deemed a 'medical necessity' by the payer."
- **RARC N386**: "This decision was based on a national coverage determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *http://www.cms.hhs.gov/mcd/search.asp*. If you do not have web access, you may contact the contractor to request a copy of the NCD."
- **Group code**: CO

Claims processing requirements for TMVR for MR on inpatient hospital claims

Inpatient hospitals shall bill for TMVR for MR on a 11x type of bill (TOB) effective for discharges on or after August 7, 2014. In addition to the ICD-9/10 procedure and diagnosis codes mentioned above, inpatient hospital discharges for TMVR for MR shall be covered when billed with the following clinical trial coding:

- Secondary ICD-9 diagnosis code V70.7/ICD-10 diagnosis code Z00.6;
- Condition code 30; and
- An eight-digit NCT Number assigned by the National Library of Medicine (NLM) and displayed at *https://clinicaltrials.gov/*.

Inpatient hospital discharges for TMVR for MR will be rejected when billed without the ICD-9/10 diagnosis and procedure codes and clinical trial coding mentioned above. Claims that do not include these required codes shall be rejected with the following messages:

- **CARC 50**: "These are non-covered services because this is not deemed a "medical necessity" by the payer."
- **RARC N386**: "This decision was based on a national coverage determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *http://www.cms.hhs.gov/mcd/search.asp*. If you

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General Coverage

Certifying patients for the Medicare home health benefit

Provider types affected

This *MLN Matters*® special edition (SE) 1436 is intended for Medicare-enrolled physicians who certify patient eligibility for home health care services and submit claims to Medicare administrative contractors (MACs) for those services provided to Medicare beneficiaries.

What you need to know

This *MLN Matters*® SE1436 article gives Medicare-enrolled providers an overview of the Medicare home health services benefit, including patient eligibility requirements and certification/recertification requirements of covered Medicare home health services.

Key points

To be eligible for Medicare home health services a patient must have Medicare Part A and/or Part B per Section 1814(a)(2)(C) and Section 1835(a)(2)(A) of the Social Security Act (the Act):

- Be confined to the home;
- Need skilled services;
- Be under the care of a physician;
- Receive services under a plan of care established and reviewed by a physician; and
- Have had a face-to-face encounter with a physician or allowed non-physician practitioner (NPP).

Care must be furnished by or under arrangements made by a Medicare-participating home health agency (HHA).

Patient eligibility – confined to home

Section 1814(a) and Section 1835(a) of the Act specify that an individual is considered "confined to the home" (homebound) if the following two criteria are met:

First criteria ONE of the following must be met:	Second criteria BOTH of the following must be met:
Because of illness or injury, the individual needs the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person to leave their place of residence.	There must exist a normal inability to leave home.
Have a condition such that leaving his or her home is medically contraindicated.	Leaving home must require a considerable and taxing effort.

The patient may be considered homebound (that is, confined to the home) if absences from the home are:

- Infrequent;
- For periods of relatively short duration;
- For the need to receive health care treatment;
- For religious services;
- To attend adult daycare programs; or
- For other unique or infrequent events (for example, funeral, graduation, trip to the barber).

Some examples of persons confined to the home are:

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do not have web access, you may contact the contractor to request a copy of the NCD."

- **Group code**: Contractual obligation (CO)

Additional information

The official instruction, CR 9002, issued to your MAC regarding this change consists of two transmittals. The first updates the *Medicare Claims Processing Manual* and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3142CP.pdf*.

The second updates the *NCD Manual* and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R178NCD.pdf*.

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

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Related Change Request (CR) #: CR 9002
Related CR Release Date: December 5, 2014
Effective Date: August 7, 2014
Related CR Transmittal #: R178NCD and R3142CP
Implementation Date: April 6, 2015

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- A patient who is blind or senile and requires the assistance of another person in leaving their place of residence;
- A patient who has just returned from a hospital stay involving surgery, who may be suffering from resultant weakness and pain and therefore their actions may be restricted by their physician to certain specified and limited activities such as getting out of bed only for a specified period of time or walking stairs only once a day; and
- A patient with a psychiatric illness that is manifested, in part, by a refusal to leave home or is of such a nature that it would not be considered safe for the patient to leave home unattended, even if they have no physical limitations.

Patient eligibility – need skilled services

According to Section 1814(a)(2)(C) and Section 1835(a)(2)(A) of the Act, the patient must be in need of one of the following services:

- Skilled nursing care on an intermittent basis (furnished or needed on fewer than seven days each week or less than eight hours each day for periods of 21 days or less, with extensions in exceptional circumstances when the need for additional care is finite and predictable per Section 1861(m) of the Act);
- Physical therapy (PT);
- Speech-language pathology (SLP) services; or
- Continuing occupational therapy (OT)

Patient eligibility – under the care of a physician and receiving services under a plan of care

Section 1814(a)(2)(C) and Section 1835(a)(2)(A) of the Act require that the patient must be under the care of a Medicare-enrolled physician, defined at 42 *Code of Federal Regulations* (*CFR*) 424.22(a)(1)(iii) as follows:

- Doctor of medicine;
- Doctor of osteopathy; or
- Doctor of podiatric medicine (may perform only plan of treatment functions that are consistent with the functions he or she is authorized to perform under state law).

According to Section 1814(a)(2)(C) and Section 1835(a)(2)(A) of the Act, the patient must receive home health services under a plan of care established and periodically reviewed by a physician. Based on 42 *CFR* 424.22(d)(1) a plan of care may not be established and reviewed by any physician who has a financial relationship with the HHA.

Physician certification of patient eligibility

As a condition for payment, according to the regulations at 42 CFR 424.22(a)(1):

- A physician must certify that a patient is eligible for Medicare home health services according to 42 *CFR* 424.22(a)(1)(i)(v); and
- The physician who establishes the plan of care must sign and date the certification.

The Centers for Medicare & Medicaid Services (CMS) does not require a specific form or format for the certification as long as a physician certifies that the following five requirements, outlined in 42 *CFR* Section 424.22(a)(1), are met:

1. The patient needs intermittent SN care, PT, and/or SLP services;
2. The patient is confined to the home (that is, homebound);
3. A plan of care has been established and will be periodically reviewed by a physician;
4. Services will be furnished while the individual was or is under the care of a physician; and
5. A face-to-face encounter:
   a. Occurred no more than 90 days prior to the home health start of care date or within 30 days of the start of the home health care;
   b. Was related to the primary reason the patient requires home health services; and
   c. Was performed by a physician or allowed non-physician practitioner.

Note: The certifying physician must also document the date of the face-to-face encounter.

According to the regulations at 42 *CFR* 424.22(a)(2) physicians should complete the certification when the plan of care is established or as soon as possible thereafter. The certification must be complete prior to when an HHA bills Medicare for reimbursement.

Certification requirements – who can perform a face-to-face encounter

According to 42 *CFR* 424.22(a)(1)(v)(A), the face-to-face encounter can be performed by:

- The certifying physician;
- The physician who cared for the patient in an acute or post-acute care facility (from which the patient was directly admitted to home health);

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- A nurse practitioner or a clinical nurse specialist who is working in collaboration with the certifying physician or the acute/post-acute care physician; or
- A certified nurse midwife or physician assistant under the supervision of the certifying physician or the acute/post-acute care physician.

According to 42 *CFR* 424.22(d)(2), the face-to-face encounter cannot be performed by any physician or allowed NPP (listed above) who has a financial relationship with the HHA.

Certification requirements – management and evaluation narrative

According to 42 *CFR* 424.22(a)(1)(i) if a patient's underlying condition or complication requires a registered nurse (RN) to ensure that essential **non-skilled** care is achieving its purpose and a RN needs to be involved in the development, management and evaluation of a patient's care plan, the physician will include a brief narrative describing the clinical justification of this need.

If the narrative is part of the certification form then the narrative must be located immediately prior to the physician's signature. If the narrative exists as an addendum to the certification form in addition to the physician's signature on the certification form, the physician must sign immediately following the narrative in the addendum.

For skilled nursing care to be reasonable and necessary for management and evaluation of the patient's plan of care, the complexity of the necessary unskilled services that are a necessary part of the medical treatment must require the involvement of a registered nurse to promote the patient's recovery and medical safety in view of the patient's overall condition.

For more information about SN for management and evaluation refer to Section 40.1.2.2, Chapter 7 of the *Medicare Benefit Policy Manual* at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf*.

Certification requirements – supporting documentation

- Documentation in the certifying physician's medical records and/or the acute/post-acute care facility's medical records (if the patient was directly admitted to home health) shall be used as the basis for certification of home health eligibility. If the documentation used as the basis for the certification of eligibility is not sufficient to demonstrate that the patient is or was eligible to receive services under the Medicare home health benefit, payment will not be rendered for home health services provided.
- According to the regulations at 42 *CFR* 424.22(c), Certifying physicians and acute/post-acute care facilities must provide, upon request, the medical

record documentation that supports the certification of patient eligibility for the Medicare home health benefit to the home health agency, review entities, and/or CMS. Certifying physicians who show patterns of non-compliance with this requirement, including those physicians whose records are inadequate or incomplete for this purpose, may be subject to increased reviews, such as provider-specific probe reviews.

- Information from the HHA, such as the patient's comprehensive assessment, can be incorporated into the certifying physician's and/or the acute/post-acute care facility's medical record for the patient.
  - Information from the HHA must be corroborated by other medical record entries and align with the time period in which services were rendered.
  - The certifying physician must review and sign off on anything incorporated into the patient's medical record that is used to support the certification of patient eligibility (that is, agree with the material by signing and dating the entry).
- The certifying physician's and/or the acute/post-acute care facility's medical record for the patient must contain information that **justifies the referral** for Medicare home health services. This includes documentation that substantiates the patient's:
  1. Need for the skilled services; and
  2. Homebound status.
- The certifying physician's and/or the acute/post-acute care facility's medical record for the patient must contain the **actual clinical note for the face-to-face encounter visit** that demonstrates that the encounter:
  1. Occurred within the required timeframe;
  2. Was related to the primary reason the patient requires home health services; and
  3. Was performed by an allowed provider type.

This information can be found most often in, but is not limited to, clinical and progress notes and discharge summaries.

Please review the following examples included at the end of this article:

1. Discharge summary;

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2. Progress note;
3. Progress note and problem list; or
4. Discharge summary and comprehensive assessment.

Recertification

At the end of the initial 60-day episode, a decision must be made as to whether or not to recertify the patient for a subsequent 60-day episode. According to the regulations at 424.22(b)(1) recertification is required at least every 60 days when there is a need for continuous home health care after an initial 60-day episode and unless there is a:

- Patient-elected transfer; or
- Discharge with goals met and/or no expectation of a return to home health care.

(These situations trigger a new certification, rather than a recertification)

Medicare does not limit the number of continuous episodes of recertification for patients who continue to be eligible for the home health benefit.

Recertification requirements:

1. Must be signed and dated by the physician who reviews the plan of care;
2. Indicate the continuing need for skilled services (the need for OT may be the basis for continuing services that were initiated because the individual needed SN, PT or SLP services); and
3. Estimate how much longer the skilled services will be required.

Physician billing for certification/recertification

Certifying/recertifying patient eligibility can include contacting the home health agency and reviewing of reports of patient status required by physicians to affirm the implementation of the plan of care that meets patient's needs.

1. **Healthcare Common Procedure Coding System (HCPCS) code G0180** − physician certification home health patient for Medicare-covered home health service under a home health plan of care (patient not present).
2. **HCPCS code G0179** − physician recertification home health patient for Medicare-covered home health services under a home health plan of care (patient not present)

Physician claims for certification/recertification of eligibility for home health services (G0180 and G0179 respectively) are not considered to be for "Medicare-covered" home health services if the HHA claim itself was non-covered because the certification/recertification of eligibility was not complete or because there was insufficient documentation to support that the patient was eligible for the Medicare home health benefit.

Additional information

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

More information is available at the Medicare Home Health Agency website at *http://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html*.

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Where do I find...

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ADR. The requirements for additional documentation are as follows:

The Social Security Act, Section 1833(e) - Medicare contractors are authorized to collect medical documentation. The Act states that no payment shall be made to any provider or other person for services unless they have furnished such information as may be necessary in order to determine the amounts due to such provider or other person for the period with respect to which the amounts are being paid or for any prior period.

According to the *Medicare Program Integrity Manual*, Chapter 3, Section 3.2.3.2, (Verifying Potential Errors and Tracking Corrective Actions), when requesting documentation for pre-payment review, the MAC and ZPIC shall notify providers that the requested documentation is to be submitted within 45 calendar days of the request. The reviewer should not grant extensions to the providers who need more time to comply with the request. Reviewers shall deny claims for which the requested documentation was not received by day 46.

Additional information

The official instruction, CR 8583, issued to your MAC regarding this change, is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R566PI.pdf*.

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

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Implementation Date: April 6, 2015

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Prompt payment interest rate revision

Medicare must pay interest on clean claims if payment is not made within the applicable number of calendar days (i.e., 30 days) after the date of receipt. The applicable number of days is also known as the payment ceiling. For example, a clean claim received March 1, 2014, must be paid before the end of business March 31, 2014.

The interest rate is determined by the applicable rate on the day of payment. This rate is determined by the Treasury Department on a six-month basis, effective every January and July 1. Providers may access the Treasury Department Web page *http://fms.treas.gov/prompt/rates.html* for the correct rate. The interest period begins on the day after payment is due and ends on the day of payment.

The new rate of 2.125 percent is in effect through June 30, 2015.

Interest is not paid on:

- Claims requiring external investigation or development by the Medicare contractor
- Claims on which no payment is due
- Claims denied in full
- Claims for which the provider is receiving periodic interim payment
- Claims requesting anticipated payments under the home health prospective payment system.

Note: The Medicare contractor reports the amount of interest on each claim on the remittance advice to the provider when interest payments are applicable.

2015 'Medicare Part B Participating Physician and Supplier Directory'

The *Medicare Part B Participating Physician and Supplier Directory* (MEDPARD) contains names, addresses, telephone numbers, and specialties of physicians and suppliers who have agreed to participate in accepting assignment on all Medicare Part B claims for covered items and services.

The MEDPARD listing will be available no later than January 30 on the First Coast Medicare provider website at *http://medicare.fcso.com/MEDPARD/*.

Source: Pub 100-04, Transmittal 3102, CR 8967

CMS updates provider enrollment policies

Provider types affected

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

What you need to know

Change request (CR) 8901 incorporates into Chapter 15 of the *Program Integrity Manual* (PIM) several provider enrollment policies in the final rule titled, "Medicare Program; Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs."

Key points of CR 8901

The key points of the updated Chapter 15 of the *Medicare Program Integrity Manual* are as follows:

- If a MAC approves a provider's or supplier's Form CMS-855 reactivation application or reactivation certification package (RCP) for a Part B non-certified supplier, the reactivation effective date will be the date the MAC received the application or RCP that was processed to completion. Also, upon reactivating billing privileges for a Part B non-certified supplier, the MAC will issue a new provider transaction access number (PTAN).
- CMS may deny a physician's or eligible professional's Form CMS-855 enrollment application under § 424.530(a)(11) if:
  - The physician's or eligible professional's Drug Enforcement Administration (DEA) Certificate of Registration to dispense a controlled substance is currently suspended or revoked; or
  - The applicable licensing or administrative body for any state in which the physician or eligible professional practices has suspended or revoked the physician's or eligible professional's ability to prescribe drugs, and such suspension or revocation is in effect on the date the physician or eligible professional submits his or her enrollment application to the Medicare contractor.
- CMS may revoke a physician's or eligible professional's Medicare enrollment under § 424.535(a)(13) if:
  - The physician's or eligible professional's DEA certificate of registration is suspended or revoked; or
  - The applicable licensing or administrative body for any state in which the physician or eligible professional practices has suspended or revoked the physician's or eligible professional's ability to prescribe drugs.

- CMS may revoke a physician's or eligible professional's Medicare enrollment under § 424.535(a)(14) if CMS determines that the physician or eligible professional has a pattern or practice of prescribing Part D drugs that falls into one of the following categories:
  - The pattern or practice is abusive or represents a threat to the health and safety of Medicare beneficiaries or both.
  - The pattern or practice of prescribing fails to meet Medicare requirements.

Additional information

The official instruction, CR 8901, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R561PI.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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Opting out of Medicare and/or electing to order and refer services

***Note**: This article was revised January 14, 2015, to add clarifying language, on the "opt-out" process and requirements, especially in regards to the definition of "opt-out." All other information is unchanged. This information was previously published in the August 2013 Medicare B Connection, Pages 35-37.*

Provider types affected

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

What you need to know

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

Background

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

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

Filing an affidavit to opt-out

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

- In general, the law requires that during that two-year period of time, physicians and non-physician practitioners who have filed affidavits opting out of Medicare must sign private contracts with all Medicare beneficiaries to whom they furnish services that would otherwise be covered by Medicare, except those who are in need of emergency or urgently needed care.
- They cannot sign such contracts with beneficiaries in need of emergency or urgent care services.
- Moreover, physicians and non-physician practitioners who opt-out cannot choose to opt-out of Medicare for some Medicare beneficiaries but not others; or for some services and not others.
- Opt-out affidavits are only valid for two years, after which the physician or practitioner may renew an opt-out without interruption by filing an affidavit with each Medicare contractor who has jurisdiction over claims the physician/practitioner would otherwise file with Medicare, provided the affidavits are filed within 30 days after the current opt-out period expires.

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

Otherwise, those physicians and practitioners who wish to opt-out must provide the information mentioned in writing to the MAC within their service jurisdiction. Currently there is not an option to submit an opt-out affidavit online.

- The affidavit must be in writing and signed by the physician/non-physician practitioner.
- It must include various statements to which the physician/non-physician practitioner must agree; for example, the physician/non-physician practitioner must agree not to submit claims to Medicare for any services furnished during the opt-out period, except for emergency or urgent care services furnished to beneficiaries with whom the physician/non-physician practitioner has not previously entered into a private contract.

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- It must identify the physician/non-physician practitioner sufficiently so that the Medicare contractor can ensure that no payment is made to the physician/non-physician practitioner during the opt-out period.
- It must be filed with all Medicare contractors who have jurisdiction over the claims the physician/non-physician practitioner would have otherwise filed with Medicare and must be filed no later than 10 days after entering into the first private contract to which the affidavit applies.

The following specific information must be included in the affidavit:

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

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

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

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

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

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

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

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

- Physicians (doctor of medicine or osteopathy, doctor of dental medicine, doctor of dental surgery, doctor of podiatric medicine, doctor of optometry, optometrists may only order and certify DMEPOS products/services and laboratory and X-ray services payable under Medicare Part B);
- Physician assistants;
- Clinical nurse specialists;
- Nurse practitioners;
- Clinical psychologists;
- Interns, residents, and fellows;
- Certified nurse midwives; and
- Clinical social workers.

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

CMS would like to highlight the following limitations:

- Chiropractors are not eligible to order supplies or services for Medicare beneficiaries. All services ordered by a chiropractor will be denied.

See **OPT-OUT**, next page

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- Home health agency (HHA) services may only be ordered or certified by a doctor of medicine (M.D.), doctor of osteopathy (D.O.), or doctor of podiatric medicine (DPM). Claims for HHA services ordered by any other practitioner specialty will be denied.
- Optometrists may only order and certify DMEPOS products/services, and laboratory and X-ray services payable under Medicare Part B.
- Residents who have provisional licenses from the state and are permitted to enroll in Medicare are also eligible to opt-out of Medicare. However, the opted out resident may only furnish under private contracts the types of services that he or she is specifically authorized to furnish under state law at the direction of his or her teaching institution. Although the opt-out option is available, CMS encourages licensed residents to enroll via the CMS-855O since their employment arrangement could change and the opt-out status lasts for two years and cannot be terminated within that timeframe.

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

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

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

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

Additional information

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

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

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

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Related Change Request (CR) #: Not applicable
Related CR Release Date: N/A
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Implementation Date: N/A

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

Get ready for ICD-10

On October 1, 2015, the health care industry will transition from ICD-9 to ICD-10 codes for diagnoses and inpatient procedures.

This transition is going to change how you do business—from registration and referrals to superbills and software upgrades. But that change doesn't have to be overwhelming.

The Centers for Medicare & Medicaid Services has the following resources to help your practice prepare for the transition.

Online ICD-10 guide

ICD-10 basics for large medical practices

FAQs – ICD-10 acknowledgement and end-to-end testing

Provider types affected

This *MLN Matters*® special edition article is intended for all physicians, providers, suppliers, clearinghouses, and billing agencies who participate in Medicare ICD-10 acknowledgement testing and who are selected to participate in end-to-end testing.

Provider action needed

Physicians, providers, suppliers, clearinghouses, and billing agencies who participate in acknowledgement testing and who are selected to participate in Medicare ICD-10 end-to-end testing should review the following questions and answers before preparing claims for ICD-10 acknowledgement testing and end-to-end testing to gain an understanding of the guidelines and requirements for successful testing. When "you" is used in this publication, we are referring to ICD-10 acknowledgement testers or end-to-end testers.

Question	Acknowledgement testing	End-to-end testing
Do I need to register for testing?	No, you do not need to register for acknowledgement testing.	Yes, end-to-end testing volunteers must register on their Medicare administrative contractor (MAC) website during specific time periods.
Who can participate in testing?	Acknowledgement testing is open to all Medicare fee-for-service (FFS) electronic submitters.	End-to-end testing is open to: ▪ Medicare FFS direct submitters; ▪ Direct data entry (DDE) submitters who receive an electronic remittance advice (ERA);
How many testers will be selected?	All Medicare FFS electronic submitters can acknowledgement test.	50 end-to-end testers will be selected per MAC jurisdiction for each testing round. **You must be selected by the MAC for this testing.**
What will the testing show?	The goal of acknowledgement testing is to demonstrate that: ▪ Providers and submitters can submit claims with valid ICD-10 codes and ICD-10 companion qualifier codes; ▪ Providers submitted claims with valid national provider identifiers (NPIs) ▪ The claims are accepted by the Medicare FFS claims systems; and ▪ Claims receive 277CA or 999	The goal of end-to-end testing is to demonstrate that: ▪ Providers and submitters can successfully submit claims containing ICD-10 codes to the Medicare FFS claims systems; ▪ Software changes the Centers for Medicare & Medicaid Services (CMS) made to support ICD-10 result in appropriately adjudicated claims; and ▪ Accurate remittance advices are produced.
Will the testing test national coverage	No, acknowledgment testing will not test NCDs and LCDs.	Yes, end-to-end test claims will be subject to all NCDs and LCDs.
Will the testing confirm payment and return an ERA to the tester?	No, acknowledgement testing will not confirm payment. Test claims will receive 277CA or 999 acknowledgement, as appropriate, to confirm that the claim was accepted or rejected by Medicare.	Yes, end-to-end testing will provide an ERA based on current year pricing.
How many claims can testers submit?	There is no limit on the number of acknowledgement test claims you can submit.	You may submit 50 end-to-end test claims per test week.

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FAQs

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Question	Acknowledgement testing	End-to-end testing
How do testers submit claims for testing?	You submit acknowledgement test claims directly or through a clearinghouse or billing agency with test indicator "T" in the Interchange Control Structure (ISA) 15 field.	You submit end-to-end test claims directly with test indicator "T" in the ISA15 field or through DDE.
When should testers submit test claims?	You may submit acknowledgement test claims anytime. We encourage you to test during the highlighted testing weeks: ▪ March 2 – 6, 2015; and ▪ June 1 – 5, 2015.	You must submit end-to-end test claims during the following testing weeks: ▪ January 26 – 30, 2015; ▪ April 27 – May 1, 2015; and ▪ July 20 – 24, 2015.
What dates of service do testers use during testing?	You must use current dates of service during acknowledgement testing.	You must use the following future dates of service during end-to-end testing: ▪ **Professional claims** – Dates of service on or after October 1, 2015; ▪ **Inpatient claims** – Discharge dates on or after October 1, 2015; ▪ **Supplier claims** – Dates of service between October 1, 2015, and October 15, 2015; and ▪ **Professional and institutional claims** – Dates up to December 31, 2015. You cannot use dates in 2016 or beyond.

Important note: Remember that you must be selected by the MAC in order to participate in end-to-end testing.

Resources

The chart below provides ICD-10 resource information.

For more information about…	Resource
ICD-10	*http://www.cms.gov/Medicare/Coding/ICD10/index.html*
ICD-10 information for Medicare fee-for-service providers	*http://www.cms.gov/Medicare/Coding/ICD10/Medicare-Fee-For-Service-Provider-Resources.html*
ICD-10 implementation timelines	*http://www.cms.gov/Medicare/Coding/ICD10/ICD-10ImplementationTime.html*
ICD-10 statute and regulations all available *Medicare Learning Network®* (*MLN*) Products	*http://www.cms.gov/Medicare/Coding/ICD10/Statute_Regulations.html*
"*Medicare Learning Network®* Catalog of Products"	Located on the *CMS website* or scan the quick response (QR) code on the right
Provider-specific Medicare information	MLN® publication titled *MLN® Guided Pathways: Provider Specific Medicare Resources* located at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Provider_Specific_Booklet.pdf*
Medicare information for patients	*http://www.medicare.gov*

Additional information

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

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Implementation Date: N/A

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

Provider types affected

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

Provider action needed

Change request (CR) 9004 updates the claim adjustment reason code (CARC) and remittance advice remark code (RARC) lists that are effective April 1, 2015. The CR instructs Medicare system maintainers to update Medicare remit easy print (MREP) and PC print. Make sure that your billing staffs are aware of these changes for 2015 and that they obtain the updated MREP or PC print software if they use that software.

Background

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

The CARC and RARC changes that affect Medicare are usually requested by the Centers for Medicare & Medicaid Services (CMS) staff in conjunction with a policy change. Medicare contractors and shared system maintainers (SSMs) are notified about these changes in the corresponding instructions from the specific CMS component that implements the policy change, in addition to the regular code update notification. If a modification has been initiated by an entity other than CMS for a code currently used by Medicare, MACs must either use the modified code or another code if the modification makes the modified code inappropriate to explain the specific reason for adjustment.

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. SSMs must make sure that Medicare does not report any deactivated code on or before the effective date for deactivation as posted on the on Washington Publishing Company (WPC) website. If any new or modified code has an effective date past the implementation date specified in CR 9004, MACs will implement on the date specified on the WPC website. The WPC website is available at *http://www.wpcedi.com/Reference*.

CR 9004 lists only the changes that have been approved since the last code update CR 8855, Transmittal 2996, issued on July 25, 2014, with a related *MLN Matters*® article available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8855.pdf*), and does not provide a complete list of codes for these two code sets.

The complete list for both CARC and RARC from the WPC website is updated three times a year – around March 1, July 1, and November 1. The WPC website, which has four listings available for both CARC and RARC, is available at *http://www.wpc-edi.com/Reference.*

Changes in CARC list since CR 8855

These are changes in the CARC database since the last code update in CR 8855.

New codes – CARC:

Code	Current narrative	Effective date
262	Adjustment for delivery cost. Note: To be used for pharmaceuticals only.	11/1/2014
263	Adjustment for shipping cost. **Note**: To be used for pharmaceuticals only.	11/1/2014
264	Adjustment for postage cost. Note: To be used for pharmaceuticals only.	11/1/2014
265	Adjustment for administrative cost. **Note**: To be used for pharmaceuticals only.	11/1/2014
266	Adjustment for compound preparation cost. Note: To be used for pharmaceuticals only.	11/1/2014
267	Claim spans multiple months. Rebill separate claim/service.	11/1/2014
268	Claim spans 2 calendar years. Please resubmit one claim per calendar year.	11/1/2014

Modified codes – CARC:

Code	Modified narrative	Effective date
133	The disposition of the claim/service is pending further review. (Use only with group code OA). This change effective 11/01/2014: The disposition of this service line is pending further review. (Use only with group code OA). **Note**: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	11/1/2014

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Code	Modified narrative	Effective date
201	Patient is responsible for amount of this claim/service through 'set aside arrangement' or other agreement. (Use only with Group Code PR) 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.)	11/1/2014

Deactivated codes – CARC –None

Changes in RARC list since CR 8855

These are changes in the RARC database since the last code update CR 8855.

New codes – RARC:

Code	Narrative	Effective date
N729	Missing patient medical/dental record for this service.	11/1/2014
N730	Incomplete/invalid patient medical/dental record for this service.	11/1/2014
N731	Incomplete/Invalid mental health assessment.	11/1/2014
N732	Services performed at an unlicensed facility are not reimbursable.	11/1/2014
N733	Regulatory surcharges are paid directly to the state.	11/1/2014
N734	The patient is eligible for these medical services only when unable to work or perform normal activities due to an illness or injury.	11/1/2014

Modified codes – RARC:

Code	Modified narrative	Effective date
N42	Missing mental health assessment.	11/1/2014
MA118	Alert: No Medicare payment issued for this claim for services or supplies furnished to a Medicare-eligible veteran through a facility of the Department of Veterans Affairs. Coinsurance and/or deductible are applicable.	11/1/2014
MA09	Claim submitted as unassigned but processed as assigned in accordance with our current assignment/ participation agreement.	11/1/2014

Deactivated Codes – RARC

Code	Current narrative	Effective date
N483	Missing periodontal charts	
N484	Incomplete/invalid periodontal charts.	5/1/2015

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

Additional information

The official instruction, CR 9004, issued to your MAC regarding this change, is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3161CP.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: MM9004
Related Change Request (CR) #: CR 9004
Related CR Release Date: January 9, 2015
Effective Date: April 1, 2015
Related CR Transmittal #: R3161CP
Implementation Date: April 6, 2015

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

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

Effective and notice dates

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

Electronic notification

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

More information

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

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

Looking for LCDs?

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

Advance beneficiary notice

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

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

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

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

Find out first: Subscribe to First Coast eNews

One of the secrets to achieving success as a Medicare provider is access to the right information at the right time. Subscribe to First Coast Service Options *eNews*, to learn the latest Medicare news and critical program changes affecting the provider community. Join as many lists as you wish, in English or Spanish, and customize your subscription to fit your specific needs, line of business, specialty, or topics of interest. So, *subscribe to eNews, and stay informed.*

Retired LCDs

Arthrocentesis – retired LCD

LCD ID number: L29061 (Florida)
LCD ID number: L29079 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for arthrocentesis is retired effective January 27, 2015. New procedure codes and their descriptors are in effect as of January 1, 2015. Absent LCD, assuming all other requirements of the program are met, the medically reasonable and necessary threshold for coverage applies for these procedures including qualifications of the performing provider.

Effective date

This LCD retirement is effective for services rendered **on or after January 27, 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 "LCD Attachments" in the Jump to Section…" drop-down menu at the top of the LCD page.

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

Revised LCD

Cataract extraction – revised Part B LCD

LCD ID number: L29095 (Florida)
LCD ID number: L29110 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) was revised to update the following sections: "Indications and Limitations of Coverage and/or Medical Necessity" and "Documentation Requirements". Language was added to these sections of the LCD to clarify the medical necessity of techniques and protocols for second eye cataract surgery.

Effective date

This LCD revision is effective for services rendered **on or after January 6, 2015**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Additional Information

Psychotherapy probe review findings CPT® code 90834

First Coast Service Options Inc. (First Coast) recently conducted post payment provider specific probes reviews in response to data aberrancies identified for *Current Procedural Terminology®* (*CPT®*) code *90834* (psychotherapy, 45 minutes with patient and/or family member). Post payment medical reviews resulted in high error rates. Services were denied because submitted medical records did not meet documentation requirements as outlined in The Psychiatric Diagnostic Evaluation and Psychotherapy Services Local Coverage Determination (LCD) (L33128). Specifically the medical records were missing one or more of the following documentation requirements for each date of service:

- Documentation of measurable goals on the treatment plan;
- Detailed summary of the psychotherapy sessions, including descriptive documentation of therapeutic interventions;
- Degree of patient participation and interaction with the therapist;
- Reaction of the patient to the therapy sessions;
- Documented progress toward measurable goals since the last sessions; and changes or lack of changes in the patient's symptoms or behavior;
- Documentation of adjustments in the treatment plan that reveal the dynamics of treatment;
- Treatment plan was not updated and did not support the medical necessity of each psychotherapy session.

The documentation for psychotherapy services should include on a periodic basis the patient's capacity to participate and benefit from psychotherapy. Such periodic documentation should include the estimated duration of treatment in terms of number of sessions required and the target symptoms, measurable and objective goals of therapy related to changes in behavior, thought processes and/or medications, methods of monitoring outcome, and why the chosen therapy is an appropriate modality either in lieu of or in addition to another form of psychiatric treatment. For an acute problem, there should be documentation that the treatment is expected to improve the mental health status or function of the patient. For chronic problems, there must be documentation indicating that stabilization of mental health status or function is

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expected. Documentation will reflect adjustments in the treatment plan that reveals the dynamics of treatment.

It is expected that the treatment plan for a patient receiving outpatient psychotherapy (i.e., measurable and objective treatment goals, descriptive documentation of therapeutic intervention, frequency of sessions, and estimated duration of treatment) will be updated on a periodic basis, generally at least every three months.

The medical record documentation maintained by the provider must indicate the medical necessity of each psychotherapy session and include the following:

- The presence of a psychiatric illness and/or the demonstration of emotional or behavioral symptoms sufficient to alter baseline functioning; and
- A detailed summary of the session, including descriptive documentation of therapeutic interventions such as examples of attempted behavior modification, supportive interaction, and discussion of reality; and
- The degree of patient participation and interaction with the therapist, the reaction of the patient to the therapy session, documentation toward goal oriented outcomes and the changes or lack of changes in patient symptoms and/or behavior as a result of the therapy session.
- The rationale for any departure from the plan or extension of therapy should be documented in the medical record. The therapist must document patient/therapist interaction in addition to an assessment of the patient's problem(s).

First Coast recommends providers be familiar with medical necessity indications and documentation requirements for psychotherapy services as indicated in the Psychiatric Diagnostic Evaluation and Psychotherapy Services LCD. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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.

Upcoming provider outreach and educational events

Medicare Part B changes and regulations

When: Wednesday, March 18
Time: 11:30 a.m.-1:00 p.m. **Type of event:** Webcast

http://medicare.fcso.com/Events/276919.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 *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

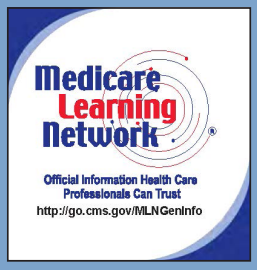
If you or your colleagues were unable to attend one of our past Medicare educational webcasts, you still have the opportunity to learn about the topics covered during the training session. Visit the First Coast Medicare training website, download the recording of the event, and listen to the webcast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

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

MLN Connects™ Provider eNews for January 8, 2015

MLN Connects™ Provider eNews for January 8, 2015
View this edition as a PDF

In this edition:

MLN Connects™ National Provider Calls

- Medicare Quality Reporting Programs: Data Submission Process – Last Chance to Register
- IRF PPS: New IRF-PAI Items Effective October 1, 2015 – Last Chance to Register
- ESRD QIP Payment Year 2017 and 2018 Final Rule – Register Now
- New MLN Connects™ National Provider Call Audio Recordings and Transcripts
- Continuing Education for Participation in MLN Connects™ National Provider Calls

MLN Connects™ Videos

- Monthly Spotlight: The 2-Midnight Benchmark Rule

CMS Events

- Volunteer for ICD-10 End-to-End Testing in April – Deadline Extended to January 21
- Open Payments Question & Answer Session
- Physician Compare Virtual Office Hour Session
- ICD-10 Clinical Documentation Improvement Webinar Recording Available

Announcements

- Get Your Patients Off to a Healthy Start in 2015 with the AWV and the IPPE
- Public Reporting of 2013 Quality Measures on the Physician Compare and Hospital Compare Websites
- FY 2015 Results for the HAC Reduction Program and Hospital VBP Program
- ACOs Moving Ahead: New Participants in Medicare Shared Savings Program
- CMS Updates Open Payments Data
- Open Payments System Unavailable in January
- January Quarterly Provider Update Available
- Teaching Hospitals Receiving FTE Resident Caps Under Section 5506 of the Affordable Care Act
- IRF-PAI Training Manual Updated with Information on New Items Effective October 1, 2015
- CMS is Accepting Suggestions for Potential PQRS

Measures

Claims, Pricers, and Codes

- Hold on Certain CAH Method II Claims for Anesthesiologist and CRNA Services
- Hospice Claims Returned in Error for Edit U5181
- Part A Claims Hold for Select Preventive and Screening Services

Medicare Learning Network® Educational Products

- "Certifying Patients for the Medicare Home Health Benefit" *MLN Matters®* Article – Released
- "Modifications to Medicare Part B Coverage of Pneumococcal Vaccinations" *MLN Matters®* Article – Released
- "The 2013 Physician Quality Reporting System (PQRS)" Booklet – Released
- "FAQs – International Classification of Diseases, 10th Edition (ICD-10) End-to-End Testing" *MLN Matters®* Article – Revised
- "Inpatient Psychiatric Facility Prospective Payment System" Fact Sheet -- Revised
- "Discharge Planning" Booklet – Revised
- "The Basics of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Accreditation" Fact Sheet – Reminder
- "The Basics of Internet-based PECOS for Physicians and Non-Physician Practitioners" Fact Sheet – Reminder
- *Medicare Learning Network®* Products Available In Electronic Publication Format

MLN Connects™ Provider eNews for January 15, 2015

MLN Connects™ Provider eNews for January 15, 2015
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In this edition:
Editor's Note

Thank you for providing feedback about the MLN Connects™ Provider eNews in 2014. We take your feedback seriously and have used it to enhance the eNews throughout the year. It is easier than ever to give us feedback on your eNews experience in 2015. Please continue to let us know how the eNews is helping you or provide us any suggestions you may have. Have a great year.

MLN Connects™ National Provider Calls

- ESRD QIP Payment Year 2017 and 2018 Final Rule – Last Chance to Register

CMS Events

- Volunteer for ICD-10 End-to-End Testing in April – Forms Due January 21
- Webinar for Comparative Billing Report on Modifier 59: Dermatology
- Open Payments Program Overview Video Tutorial Now Available

Announcements

- Help Protect the Vision of Your Medicare Patients – Recommend Annual Glaucoma Screening
- Hospice Providers: Continue to Collect and Submit HIS Data in 2015
- Open Payments System Unavailable through Late January

Claims, Pricers, and Codes

- Adjustment of Some Home Health Claims: Update

Medicare Learning Network® Educational Products

- "FAQs – International Classification of Diseases, 10th Edition (ICD-10) Acknowledgement Testing and End-to-End Testing" *MLN Matters*® Article – Released
- "Ambulance Fee Schedule" Fact Sheet – Revised
- "Medicare Secondary Payer for Providers, Physicians, Other Suppliers, and Billing Staff" Fact Sheet – Revised
- "Avoiding Medicare Fraud and Abuse: A Roadmap for Physicians" Web-Based Training Course – Revised
- *Medicare Learning Network*® Products Available In Electronic Publication Format

MLN Connects™ Provider eNews for January 22, 2015

MLN Connects™ Provider eNews for January 22, 2015
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In this edition:
Editor's Note

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MLN Connects™ National Provider Calls

- National Partnership to Improve Dementia Care in Nursing Homes and QAPI – Upcoming 2015 Calls

CMS Events

- eHealth Webinar: QRDA I Submission for Eligible Hospitals

Announcements

- Bidding Open for the Round 2 Recompete/National Mail-Order Recompete of the DMEPOS Competitive Bidding Program
- Cervical Health Awareness Month
- Major Improvements to the Internet-based PECOS System
- Submission Timeframes for 2014 PQRS Data
- Hospitals Must Start Medicare EHR Participation in 2015 to Earn Incentives
- Updated Information on Reporting Menu Objectives for the EHR Incentive Programs
- January ICD-10 End-to-End Testing Participants Are Pre-Registered For April Testing
- Share Your ICD-10 Story

Claims, Pricers, and Codes

- January 2015 PPS Provider Data Available
- FY 2015 Inpatient PPS PC Pricer Update Available
- FY 2015 Inpatient PPS 2015.3 Mainframe Pricer Update Available
- January 2015 Outpatient Prospective Payment System Pricer File Update
- Part A Claims Hold for Select Preventive and Screening Services – Updated

Medicare Learning Network® Educational Products

- "Medicare Quarterly Provider Compliance Newsletter [Volume 5, Issue 2]" Educational Tool – Released
- "2015 Medicare Part C and Part D Reporting Requirements and Data Validation" Web-Based Training Course – Released
- "Opting out of Medicare and/or Electing to Order and Certify Items and Services to Medicare Beneficiaries" *MLN Matters*® Article – Revised
- New *Medicare Learning Network*® Educational Web Guides Fast Fact
- *Medicare Learning Network*® Product Available In Electronic Publication Format

Phone numbers

Customer service

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

Education event registration hotline

904-791-8103 (NOT toll-free)

Electronic data interchange (EDI)

888-670-0940

Electronic funds transfers (EFT) (CMS-588)

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877-660-1759 (TTY)

Fax number (for general inquiries)

904-361-0696

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877-847-4992

Provider enrollment

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

The SPOT help desk

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

Addresses

Claims

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

Redeterminations

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

Redetermination of overpayments

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

Reconsiderations

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

General inquiries

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

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

Provider enrollment

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

Medical policy

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

Medicare secondary payer

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

Electronic data interchange (EDI)

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

Overpayments

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

Medicare Education and Outreach

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

Fraud and abuse

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

Freedom of Information Act requests

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

Overnight mail and/or special courier service

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

Websites

Provider

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

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

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

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

Beneficiaries

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877-660-1759 (TTY)

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

Addresses

Claims

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

Redeterminations

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

Redetermination of overpayments

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

Reconsiderations

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

General inquiries

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

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

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

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

Medicare secondary payer

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

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Medicare EDI, 4C
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Jacksonville, FL 32231-4071

Overpayments

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

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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.cms.gov

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http://www.fcsouniversity.com/

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http:// www.medicare.gov

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

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904-361-0407 (FAX)

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877-660-1759 (TTY)

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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

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Q2 Administrators, LLC
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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

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Jacksonville, FL 32232-5157

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Jacksonville, FL 32232-5087

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P.O. Box 45092
Jacksonville, FL 32232-5092,

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