Medicare B CONNECTION

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FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction N Providers

February 2015

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Physician group feeling secure with SPOT love

You've got secure mail.

Since the release of the similarly titled 1998 movie starring Meg Ryan and Tom Hanks, technology has evolved dramatically. For the dozen Medicare billers handling claims for physicians at the University of Florida/Shands Hospital, *First Coast Service Options' secure provider portal, SPOT*, is delivering much more love and happiness than the sappy Hollywood story.

"We have a team of 12 billers. We handle everything Part B and use the SPOT for everything we can. It saves so much time," says Kristin Sierens, Supervisor for the Medicare/Tricare billing team at UF/Shands physician group practice.

The team handles about 11,000 claims each month for more than 120 physicians practicing under the UF/Shands umbrella. In addition to being the team supervisor, Kristin Sierens works claim rejections, follow-ups, and appeals. As the team leader she has seen productivity and efficiency increase greatly with their use of First Coast's SPOT portal.

"With SPOT, we put our information in. BAM, there it is. It's in the system. It's cut down by half the amount of time we were spending on each patient claim. We love SPOT," she said.

In December 2014, First Coast extended SPOT, adding the option for providers to submit correspondence for claim redeterminations and overpayments through the secure mail tool. For Sierens' team and UF/Shands, this has translated into less time spent going to the post office and tracking correspondence with First Coast.

"I spent 30-45 minutes a day logging appeals in a spreadsheet to track where we were in the process. We handle 20-30 appeals each day. This adds up to a lot of time for me and for my team handling appeals. When SPOT added secure mail to handle appeals too, it was like, wow this is so great. SPOT just keeps getting better."

In addition to saving time, the secure mail tool within SPOT also gives Sierens assurance her time spent isn't wasted. "Being able to handle the appeals online is great. We started filing electronic appeals right away. Before SPOT offered secure messaging, we would call the customer service line to check on appeals status. Sometimes there was no record of First Coast receiving the paperwork for the appeal," Sierens said. "With secure messaging it is reassuring. We know when we get the email

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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.

Publication staff:
Terri Drury
Kathleen Cruz Fuentes
Sofia Lennie
Martin Smith
Mark Willett
Robert Petty

Fax comments about this publication to:

Medicare Publications
904-361-0723

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.

Continued use of modifier 59 after January 1, 2015

Provider types affected

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

What you need to know

The Centers for Medicare & Medicaid Services (CMS) implemented change request (CR) 8863 on January 5, 2015, effective January 1, 2015. This CR established four new HCPCS modifiers (XE, XP, XS, XU) to define specific subsets of the 59 modifier, a modifier used to define a "distinct procedural dervice". These modifiers are collectively referred to as –X {EPSU} modifiers. Please note that providers may continue to use the 59 modifier after January 1, 2015, in any instance in which it was correctly used prior to January 1, 2015. The initial CR establishing the modifiers was designed to inform system developers that healthcare systems would need to accommodate the new modifiers. Additional guidance and education as to the appropriate use of the new –X {EPSU} modifiers will be forthcoming as CMS continues to introduce the modifiers in a gradual and controlled fashion. That guidance will include additional descriptive information about the new modifiers. CMS will identify situations in which a specific –X {EPSU} modifier will be required and will publish specific guidance before implementing edits or audits.

CR 8863 states that providers who wish to use the new modifiers may use them in accordance with their published definitions, and the X modifiers will function within CMS systems in the same manner as the 59 modifier, bypassing procedure-to-procedure (PTP) edits with a modifier indicator of "1," for example. A modifier indicator of "1" indicates that NCCI-associated modifiers may be used to bypass an edit under appropriate circumstances.

Additional information

CR 8863 is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1422OTN.pdf* and a related *MLN Matters*® article is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8863.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.

Inquiries about CR 8863 (Specific Modifiers for Distinct Procedural Services) and any *MLN Matters*® article associated with the new X modifiers, should be sent to the following email address: *NCCIPTPMUE@cms.hhs.gov*.

MLN Matters® Number: SE1503
Related Change Request (CR) #: CR 8863
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Related CR Transmittal #: N/A
Implementation Date: January 5, 2015

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Try our E/M interactive worksheet

First Coast Service Options (First Coast) Inc. is proud of its exclusive E/M interactive worksheet, available at *http://medicare.fcso.com/EM/165590.asp*. This resource was developed to assist providers with identifying the appropriate code to bill for evaluation and management (E/M) services performed during a specific patient visit. This interactive resource is ideal for use as a checklist by physicians or as a quality assurance tool by auditors, billing specialists, and coders. After you've tried the E/M interactive worksheet, send us your thoughts of this resource through our website feedback form, available at *http://medicare.fcso.com/Feedback/160958.asp*.

Drugs and Biologicals

April 2015 quarterly ASP drug pricing files and revisions to prior quarterly pricing files

Provider types affected

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

Provider action needed

Change request (CR) 9084 informs Medicare MACs to download and implement the April 2015 average sales price (ASP) drug pricing files and, if released by the Centers for Medicare & Medicaid Services (CMS), the January 2015, October 2014, July 2014, and April 2014, ASP drug pricing files for Medicare Part B drugs.

Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after April 6, 2015, with dates of service April 1, 2015, through June 30, 2015. MACs will not search and adjust claims that have already been processed unless you bring such claims to their attention. Make sure that your billing staffs are aware of these changes.

Background

The Medicare Modernization Act of 2003 (MMA; Section 303(c)) revised the payment methodology for Part B covered drugs and biologicals that are not priced on a cost or prospective payment basis.

The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply Medicare contractors with the ASP and not otherwise classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the OPPS are incorporated into the outpatient code editor (OCE) through separate instructions that can be located in the *Medicare Claims Processing Manual* (Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)), Section 50 (Outpatient PRICER); see *http://www.cms.gov/manuals/downloads/clm104c04.pdf*)

The following table shows how the quarterly payment files will be applied:

Files	Effective dates of service
April 2015 ASP and ASP NOC	April 1, 2015, through June 30, 2015
January 2015 ASP and ASP NOC	January 1, 2015, through March 31, 2015
October 2014 ASP and ASP NOC	October 1, 2014, through December 31, 2014

Files	Effective dates of service
July 2014 ASP and ASP NOC	July 1, 2014, through September 30, 2014
April 2014 ASP and ASP NOC	April 1, 2014, through June 30, 2014

Note: The absence or presence of a Healthcare Common Procedure Coding System (HCPCS) code and its associated payment limit does not indicate Medicare coverage of the drug or biological. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. The local MAC processing the claim shall make these determinations.

Additional information

The official instruction, CR 9084, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3180CP.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* under - How Does It Work.

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Related Change Request (CR) #: CR 9084
Related CR Release Date: January 30, 2015
Effective Date: April 1, 2015
Related CR Transmittal #: R3180CP
Implementation Date: April 6, 2015

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Laboratory/Pathology

Clinical laboratory fee schedule – Medicare travel allowance fees for collection of specimens

Provider types affected

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

Provider action needed

Change request (CR) 9066 informs MACs about the revisions to the payment of travel allowances when billed on a per mileage basis using Health Care Common Procedure Coding System (HCPCS) code P9603 and when billed on a flat rate basis using HCPCS code P9604 for 2015. These changes are also made to Chapter 16, Section 60.2 of the *Medicare Claims Processing Manual*. Make sure that your billing staffs are aware of these changes.

Background

CR 9066 revises the payment of travel allowances when billed on a per mileage basis using HCPCS code P9603 and when billed on a flat rate basis using HCPCS code P9604 for 2015. Medicare Part B, allows payment for a specimen collection fee and travel allowance, when medically necessary, for a laboratory technician to draw a specimen from either a nursing home patient or homebound patient under Section 1833(h)(3) of the Social Security Act. Payment for these services is made based on the clinical laboratory fee schedule.

Travel allowance

Payment of the travel allowance is made only if a specimen collection fee is also payable. The travel allowance is intended to cover the estimated travel costs of collecting a specimen including the laboratory technician's salary and travel expenses. MACs have the discretion to choose either a mileage basis or a flat rate, and how to set each type of allowance. Many MACs established local policy to pay based on a flat rate basis only.

Under either method, when one trip is made for multiple specimen collections (for example, at a nursing home), the travel payment component is prorated based on the number of specimens collected on that trip, for both Medicare and non-Medicare patients, either at the time the claim is submitted by the laboratory or when the flat rate is set by the MAC.

Per mile travel allowance (P9603)

The per mile travel allowance is to be used in situations where the average trip to the patients' homes is longer than 20 miles round trip, and is to be prorated in situations where specimens are drawn from non-Medicare patients in the same trip.

The allowance per mile was computed using the federal mileage rate of $0.575 per mile plus an additional $0.45 per mile to cover the technician's time and travel costs. MACs have the option of establishing a higher per mile rate in excess of the minimum $1.03 per mile if local conditions warrant it (actual total of $1.025 rounded up to reflect systems capabilities). Medicare reviews and updates the minimum mileage rate throughout the year, as well as in conjunction with the clinical laboratory fee schedule (CLFS), as needed. At no time may a laboratory bill for more miles than are reasonable, or for miles that are not actually traveled by the laboratory technician.

Per flat-rate trip basis travel allowance (P9604)

The per flat-rate trip basis travel allowance is $10.30.

Additional information

The Internal Revenue Service (IRS) determines the standard mileage rate for businesses based on periodic studies of the fixed and variable costs of operating an automobile.

The official instruction, CR 9066 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3189CP.pdf*.

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

MLN Matters® Number: MM9066
Related Change Request (CR) #: CR 9066
Related CR Release Date: February 5, 2015
Effective Date: January 1, 2015
Related CR Transmittal #: R3189CP
Implementation Date: As soon as possible, but not later than April 24, 2015

Codes subject to and excluded from CLIA edits

Provider types affected

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

Provider action needed

Change request (CR) 9035 informs MACs about the Healthcare Common Procedure Coding System (HCPCS) codes for 2015 that are both subject to and excluded from clinical laboratory Improvement Amendments (CLIA) edits. CR 9035 also includes the HCPCS codes discontinued as of December 31, 2014.

Make sure that your billing staffs are aware of these CLIA-related changes for 2015 and that you remain current with CLIA certification requirements.

Background

CLIA regulations require a facility to be appropriately certified for each test performed. To ensure that the Centers for Medicare & Medicaid Services (CMS) only pay for laboratory tests performed in certified facilities, each claim for a HCPCS code that is considered a CLIA laboratory test is currently edited at the CLIA certificate level.

The HCPCS codes that are considered a laboratory test under CLIA change each year, and your Medicare contractors need to be informed about the new HCPCS codes that are both subject to CLIA edits and excluded from CLIA edits.

Discontinued HCPCS codes

The HCPCS codes listed in Table 1 below were discontinued on December 31, 2014.

Table 1: HCPCS codes discontinued December 31, 2014

HCPCS code	Descriptor
G0417	Surgical pathology, gross and microscopic examination, for prostate needle biopsy, any method, 21-40 specimens
G0418	Surgical pathology, gross and microscopic examination, for prostate needle biopsy, any method, 41-60 specimens
G0419	Surgical pathology, gross and microscopic examination, for prostate needle biopsy, any method, >60 specimens
80100	Drug screen, multiple drugs
80101	Drug screen
80102	Drug confirmation test
80103	Tissue preparation for drug analysis
80104	Drug screen, multiple drugs
80152	Amitriptyline (antidepressant) level
80154	Benzodiazepines level
80160	Desipramine level
80166	Assay of doxepin
80172	Gold level
80174	Imipramine level
80182	Nortriptyline level
80196	Salicylate (aspirin) level
80440	Thyrotropin releasing hormone (TRH) (hypothalamus hormone) stimulation panel
82000	Acetaldehyde blood test
82003	Acetaminophen level
82055	Alcohol (ethanol) level
82101	Urine alkaloids level
82145	Amphetamine or methamphetamine level
82205	Barbiturates level
82520	Cocaine (drug) level
82646	Dihydrocodeinone (drug) measurement
82649	Dihydromorphinone (drug) level
82651	Dihydrotestosterone (DHT) level
82654	Dimethadione (drug) level
82666	Epiandrosterone (synthetic hormone) level
82690	Ethchlorvynol (drug) level
82742	Flurazepam (drug) level
82953	Glucose (sugar) tolerance test
82975	Glutamine (amino acid by product) level
82980	Glutethimide (drug) level
83008	Guanosine monophosphate (cellular chemical) level
83055	Sulfhemoglobin (hemoglobin) analysis
83071	Hemosiderin (hemoglobin breakdown product) level
83634	Urine lactose (carbohydrate) analysis
83805	Meprobamate (sedative) level
83840	Methadone level
83858	Methsuximide (drug) level
83866	Mucopolysaccharides (protein) screening test
83887	Nicotine level
83925	Opiates (drug) measurement
84022	Phenothiazine (drug) level
84127	Stool porphyrins (metabolism substance) analysis

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HCPCS code	Descriptor
87001	Animal inoculation, small animal with observation
87620	Detection test for human papillomavirus (HPV)
87621	Detection test for human papillomavirus (HPV)
87622	Detection test for human papillomavirus (HPV)
88343	Immunohistochemistry or immunocytochemistry, each separately identifiable antibody per block, cytologic preparation, or hematologic smear each additional separately identifiable antibody per slide (list separately in addition to code for primary procedure)
88349	Assessment using electron microscopy

New HCPCS codes for 2015

The HCPCS codes listed in Table 2 below are new for 2015 and are subject to CLIA edits. The list does not include new HCPCS codes for waived tests or provider-performed procedures. The HCPCS codes listed in Table 2 require a facility to have either a:

1. CLIA certificate of registration (certificate type code 9);
2. CLIA certificate of compliance (certificate type code 1); or
3. CLIA certificate of accreditation (certificate type code 3).

The following facilities are not permitted to be paid for these tests:

1. A facility without a valid, current, CLIA certificate;
2. A facility with a current CLIA certificate of waiver (certificate type code 2); or
3. A facility with a current CLIA certificate for provider-performed microscopy procedures (certificate type code 4).

Note: The HCPCS code *89337* [Frozen preservation of mature eggs] is new for 2015, is excluded from CLIA edits and does not require a facility to have any CLIA certificate.

Table 2: New HCPCS codes subject to CLIA edits for 2015

Note: Does not include new HCPCS codes for waived tests or provider-performed procedures.

HCPCS code	Descriptor
G0464	Colorectal cancer screening; stool-based dna and fecal occult hemoglobin (e.g., kras, ndrg4 and bmp3)
G6030	Amitriptyline
G6031	Benzodiazepines
G6032	Desipramine
G6034	Doxepin
G6035	Gold
G6036	Assay of imipramine
G6037	Nortriptyline
G6038	Salicylate
G6039	Acetaminophen
G6040	Alcohol (ethanol) any specimen except breath
G6041	Alkaloids, urine, quantitative
G6042	Amphetamine or methamphetamine
G6043	Barbiturates, not elsewhere specified
G6044	Cocaine or metabolite
G6045	Dihydrocodeinone
G6046	Dihydromorphinone
G6047	Dihydrotestosterone
G6048	Dimethadione
G6049	Epiandrosterone
G6050	Ethchlorvynol
G6051	Flurazepam
G6052	Meprobamate
G6053	Methadone
G6054	Methsuximide
G6055	Nicotine
G6056	Opiate(s), drug and metabolites, each procedure
G6057	Phenothiazine
G6058	Drug confirmation, each procedure
80163	Digoxin level
80165	Valproic acid level
80300	Drug screen
80301	Drug screen
80302	Drug screen
80303	Drug screen
80304	Drug screen
80320	Alcohols levels
80321	Alcohols levels
80322	Alcohols levels
80323	Alkaloids levels
80324	Amphetamines levels
80325	Amphetamines levels
80326	Amphetamines levels
80327	Anabolic steroids levels
80328	Anabolic steroids levels
80329	Analgesics levels

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HCPCS code	Descriptor
80330	Analgesics levels
80331	Analgesics levels
80332	Antidepressants levels
80333	Antidepressants levels
80334	Antidepressants levels
80335	Antidepressants levels
80336	Antidepressants levels
80337	Antidepressants levels
80338	Antidepressants levels
80339	Antiepileptics levels
80340	Antiepileptics levels
80341	Antiepileptics levels
80342	Antipsychotics levels
80343	Antipsychotics levels
80344	Antipsychotics levels
80345	Barbiturates levels
80346	Benzodiazepines levels
80347	Benzodiazepines levels
80348	Buprenorphine level
80349	Cannabinoids levels
80350	Cannabinoids levels
80351	Cannabinoids levels
80352	Cannabinoids levels
80353	Cocaine level
80354	Fentanyl level
80355	Gabapentin level nonblood
80356	Heroin metabolite level
80357	Ketamine and norketamine levels
80358	Methadone level
80359	Methylenedioxyamphetamines levels
80360	Methylphenidate level
80361	Opiates levels
80362	Opioids levels
80363	Opioids levels
80364	Opioids levels
80365	Oxycodone levels
80366	Pregabalin level
80367	Propoxyphene level
80368	Sedative hypnotics (nonbenzodiazepines) levels
80369	Skeletal muscle relaxants levels
80370	Skeletal muscle relaxants levels
80371	Synthetic stimulants levels
80373	Tramadol level
80374	Stereoisomer (enantiomer) drug analysis
80375	Drugs or substances measurement
80376	Drugs or substances measurement
80377	Drugs or substances measurement
81246	Test for detecting genes associated with blood cancer
81288	Test for detecting genes associated with colon cancer
81313	Test for detecting genes associated with prostate cancer
81410	Test for detecting genes associated with heart disease
81411	Test for detecting genes associated with heart disease
81415	Test for detecting genes associated with diseases
81416	Test for detecting genes associated with disease
81417	Reevaluation test for detecting genes associated with disease
81420	Test for detecting genes associated with fetal disease
81425	Test for detecting genes associated with disease
81426	Test for detecting genes associated with disease
81427	Reevaluation test for detecting genes associated with disease
81430	Test for detecting genes causing hearing loss
81431	Test for detecting genes causing hearing loss
81435	Test for detecting genes associated with colon cancer
81436	Test for detecting genes associated with colon cancer
81440	Test for detecting genes associated with cancer of body organ
81445	Test for detecting genes associated with cancer of body organ
81450	Test for detecting genes associated with blood related cancer
81455	Test for detecting genes associated with cancer
81460	Test for detecting genes associated with disease
81465	Test for detecting genes associated with disease
81470	Test for detecting genes associated with intellectual disability

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HCPCS code	Descriptor
81471	Test for detecting genes associated with intellectual disability
81519	Test for detecting genes associated with breast cancer
87505	Detection test for digestive tract pathogen;
87506	Detection test for digestive tract pathogen;
87507	Detection test for digestive tract pathogen
83006	Test for detecting genes associated with growth stimulation
87623	Detection test for human papillomavirus (hpv)
87624	Detection test for human papillomavirus (hpv)
87625	Detection test for human papillomavirus (hpv)
87806	Detection test for HIV1
88341	Special stained specimen slides to examine tissue
88344	Special stained specimen slides to examine tissue
88364	Cell examination
88366	Cell examination
88369	Microscopic genetic examination manual
88373	Microscopic genetic examination using computerassisted technology
88374	Microscopic genetic examination using computerassisted technology
88377	Microscopic genetic examination manual.

On November 19, 2014, CMS released CR 8871 which mentioned that effective for services performed on or after June 2, 2014, the new HCPCS G0472, HCV screening, will be recognized as a covered service. G0472 is a code that:

- Is considered a test under CLIA;
- Is subject to CLIA edits; and
- Would require a facility to have either:
  - A CLIA certificate of registration (certificate type code 9),
  - A CLIA certificate of compliance (certificate type code 1), or
  - A CLIA certificate of accreditation (certificate type code 3).

You may want to review the related *MLN Matters*® article for CR 8871 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8871.pdf*.

Additional information

The official instruction, CR 9035, issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3182CP.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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Medicare Physician Fee Schedule

2015 MPFS policies and telehealth originating site facility fee payment amount

***Note**: This article was revised January 18, 2015, to provide a link to a related MLN Matters® article MM9081 at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9081.pdf . This article announced an emergency update to payment files issued to contractors based on the 2015 MPFS final rule. The update 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. All other information is unchanged. This article was previously published in the January 2015 Medicare B Connection, Pages 24-26.*

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 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 is 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 CY 2015; Proposed Rule* was published in the *Federal Register* on 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

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 on 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

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(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*).

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 0-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 0-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

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- 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*).

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.

Additional information

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-Network-MLN/MLNMattersArticles/index.html*.

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Implementation Date: January 5, 2015

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Surgery

Percutaneous image-guided lumbar decompression for lumbar spinal stenosis

Provider types affected

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

What you need to know

Change request (CR) 8954 is a follow-up to change request (CR) 8757, Transmittal 2959 and Transmittal 167 (Percutaneous Image-guided Lumbar Decompression (PILD) for Lumbar Spinal Stenosis (LSS)). CR 8757 was effective January 9, 2014, and provided for percutaneous image-guided decompression (PILD) when provided in a clinical study through coverage with evidence development (CED) for beneficiaries with LSS.

Background

CR 8954 provides additional direction specifically for PILD, procedure code G0276, when performed in a randomized, blinded clinical trial ONLY, for claims with dates of service on or after January 1, 2015. Healthcare Common Procedure Coding System (HCPCS) G0276 - Blinded procedure for lumbar stenosis, percutaneous image-guided lumbar decompression (PILD), or placebo control, performed in an approved coverage with evidence development (CED) clinical trial, is to be used only when the CED PILD trial is blinded, randomized, and controlled and contains a placebo procedure control arm. It appears in the January 2015 updates of the Medicare physician fee schedule database and the integrated outpatient code editor (IOCE).

Payment for HCPCS G0276 under the hospital outpatient prospective payment system (OPPS) is available in the latest OPPS Addendum B at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html*.

All PILD for LSS claims with dates of service December 31, 2014, and earlier, should be processed with procedure code *0275T* **only** and are not subject to reprocessing regardless of the type of trial in which the services were rendered.

Note: Beginning with PILD for LSS claims with dates of service on and after January 1, 2015, there are two distinct procedure codes that are to be used: G0276 for clinical trials that are blinded, randomized, and controlled, and contain a placebo procedure control arm (use this CR 8954 for claim processing instructions), and *0275T* for all other clinical trials (use CR 8757 for claim processing instructions).

CR 8954 does not replace but rather is in addition to CR 8757. The *MLN Matters*® article related to CR 8757 is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8757.pdf*.

Billing requirements

Medicare will accept HCPCS code G0276 for PILD for LSS claims received with dates of service on and after January 1, 2015, when those services are provided in a blinded, randomized, controlled trial with a placebo procedure control arm under CED only.

Claims for PILD for LSS with dates of service on and after January 1, 2015, will be accepted when billed in a place of service (POS) 22 (outpatient) or 24 (ambulatory surgical center), using HCPCS G0276, along with:

- ICD-9 diagnosis range 724.01-724.03, or,
- ICD-10 diagnosis range M48.05-M48.07 (when ICD-10 is implemented)

Only when billed with:

- Diagnosis code ICD-9 V70.7 (ICD-10 Z00.6) (once ICD-10 is implemented) either in the primary/secondary positions;
- Modifier -Q0; and
- An eight-digit clinical trial identifier number listed on the CMS CED website.

Medicare will return claims for PILD for LSS claims, HCPCS G0276, as unprocessable when billed with a diagnosis code other than 724.01-724.03 (ICD-9), or, M48.05-M48.07 (ICD-10) (when ICD-10 is implemented) using:

- **Claim adjustment reason code (CARC) B22** – "This payment is adjusted based on the diagnosis."
- **Remittance advice remark code (RARC) N704** – "Alert: You may not appeal this decision but can resubmit this claim/service with corrected information if warranted."
- **Group code** – contractual obligation (CO).

Medicare will return PILD for LSS claims, HCPCS G0276, as unprocessable when billed in a POS other than 22 or 24 using:

- **CARC 58** – "Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service."
- **RARC N704** – "Alert: You may not appeal this decision but can resubmit this claim/service with corrected information if warranted."
- **Group code** – CO.

Medicare will return PILD for LSS claims, HCPCS G0276, as unprocessable if they do not contain the required

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clinical trial diagnosis code V70.7 (ICD-9) or Z00.6 (ICD-10) (once ICD-10 is implemented) in either the primary/secondary positions with the following:

- **CARC B22** – "This payment is adjusted based on the diagnosis."
- **RARC M76** – "Missing/incomplete/invalid diagnosis or condition"
- **RARC N704** – "Alert: You may not appeal this decision but can resubmit this claim/service with corrected information if warranted."
- **Group code** – CO

Medicare will return PILD for LSS claims, HCPCS G0276, as unprocessable when billed without a -Q0 modifier with the following:

- **CARC 4** – "The procedure code is inconsistent with the modifier used or a required modifier is missing."
- **RARC N657** – "This should be billed with the appropriate code for these services."
- **RARC N704** – "Alert: You may not appeal this decision but can resubmit this claim/service with corrected information if warranted."
- **Group code** – CO

Also, remember that you must submit the numeric, eight-digit clinical trial identifier number in the electronic 837P in Loop 2300 REF02 (REF01=P4) or preceded by "CT" when placed in Field 19 of paper claim form CMS-1500. This requirement is further discussed in *MLN Matters*® article MM8401 available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8401.pdf*.

For hospital outpatient procedures on type of bill (TOB) 13x or 85x, on or after January 1, 2015, Medicare will allow payment for PILD for LSS, HCPCS G0276, along with:

- ICD-9 diagnosis range 724.01-724.03; or,
- ICD-10 diagnosis range M48.05-M48.07 (once ICD-10 is implemented)

Only when billed with:

- Diagnosis code ICD-9 V70.7 (ICD-10 Z00.6) (once ICD-10 is implemented) and condition code 30 either in the primary/secondary positions;
- Modifier -Q0; and
- An eight-digit clinical trial identifier number listed on the CMS CED website.

For hospital outpatient procedures on TOB 13x or 85x, on or after January 1, 2015, MACs will line-level deny claims for PILD for LSS, HCPCS G0276, along with:

- ICD-9 diagnosis range 724.01-724.03; or,
- ICD-10 diagnosis range M48.05-M48.07 (once ICD-10 is implemented);

When billed without diagnosis code ICD-9 V70.7 (ICD-10

Z00.6) (once ICD-10 is implemented) and condition code 30 either in the primary/secondary positions, Modifier -Q0, or an eight-digit clinical trial identifier number listed on the CMS CED website, with the following:

- **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

Additional information

You can review the list of approved clinical studies related to PILD for LSS at *http://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/PILD.html*.

The official instruction, CR 8954 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3175CP.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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New timeframe for response to additional documentation requests

***Note**: This article was revised February 9, 2015, to reflect the revised change request (CR) 8583 issued February 4. In the article, 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 on the front page of the January 2015 Medicare B Connection.*

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, 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 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/R567PI.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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Extension of provider enrollment moratoria for home health agencies and Part B ambulance suppliers

***Note**: This article was revised January 30, 2015, to reflect an extension of the moratoria for another six months, as noted in the article. This information was previously published in the August 2014 Medicare B Connection, Pages 34-35.*

Provider types affected

This *MLN Matters*® article is intended for home health agencies (HHAs), HHA sub-units, and Part B ambulance suppliers in parts of Florida, Illinois, Michigan, Texas and New Jersey that provide services to Medicare, Medicaid and CHIP beneficiaries.

Provider action needed

Stop – impact to you

Effective January 29, 2015, the temporary moratoria on new HHAs, HHA sub-units, and Part B ambulance suppliers are being extended for an additional six months in certain geographic locations.

Caution – what you need to know

During the six-month temporary moratorium, initial provider enrollment applications and change of information applications to add additional practice locations, received from HHAs, HHA sub-units, and Part B ambulance suppliers in the listed counties will be denied. Application fees that are paid for applications that are denied due to this temporary moratorium will be refunded.

Go – what you need to do

Effective January 29, 2015, HHAs, HHA sub-units, and Part B ambulance suppliers should not submit initial enrollment applications or change of information applications to add additional practice locations until the six-month moratoria has expired. CMS will announce in the *Federal Register* when the moratorium has been lifted or if it will be extended.

Background

In accordance with 42 CFR §424.570(c), the Centers for Medicare & Medicaid Services (CMS) may impose a moratorium on the enrollment of new Medicare providers and suppliers of a specific type or the establishment of new practice locations in a particular geographic area.

On January 29, 2015, CMS announced, in a *Federal Register* notice (*https://s3.amazonaws.com/public-inspection.federalregister.gov/2015-01696.pdf*), the extension of temporary moratoria on the enrollment of new HHAs, HHA sub-units, and Part B ambulance suppliers in designated geographic locations.

The moratoria initially became effective January 30, 2014, and its implementation was announced in the *Federal Register*, which may be accessed at *https://www.federalregister.gov/articles/2014/02/04/2014-02166/medicare-medicaid-and-childrens-health-insurance-programs-announcement-of-new-and-extended-temporary#page-6475*.

Moratoria extension

Effective January 29, 2015, the temporary moratoria on new HHAs, HHA sub-units is being extended for an additional six months in the areas stated in Table 1.

See **ENROLLMENT**, next page

SPOT

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zconfirmation from SPOT, our appeals have been received by First Coast and they are in the system."

In addition to the secure mail tool, Sierens found love at first sight when First Coast added the ability to reopen claims. "Reopenings has drastically cut down the amount of time we spend on claims. My team was so happy when reopenings came out in SPOT We can go in and change an incorrect diagnosis code and cut the time in half in what it takes for us to handle that claim," Sierens said.

"We might have a charge go out with an incorrect modifier. With reopenings, we can make the correction online. With the IVR, we could do a reopening, but we would have to wait two weeks before we received a new EOB to find out if we keyed in the correct information."

For her peers in medical billing offices throughout Florida, Sierens says if the office doesn't have SPOT they should get it right away. "SPOT will increase your staff accuracy and productivity. It is also a lot easier to track what you have done with the email confirmations. And, wow, it's free. Why wouldn't you get SPOT."

> **"When SPOT added secure mail to handle appeals too, it was like, Wow this is so great. SPOT just keeps getting better."**
>
> **-Kristin Sierens,**
> **UF/Shands Supervisor**
> ***/Medicare/Tricare Payors***
> ***(Photo Courtesy: Kristin Sierens, UF/Shands)***

ENROLLMENT

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Table 1: HHAs and HHA sub-units under temporary moratorium

City and state	Counties
Fort Lauderdale, FL	Broward
Miami, FL	Miami-Dade, Monroe
Detroit, MI	Macomb, Monroe, Oakland, Washtenaw Wayne
Dallas, TX	Collin, Dallas, Denton Ellis, Kaufman, Rockwall, Tarrant
Houston, TX	Brazoria, Chambers, Fort Bend, Galveston Harris, Liberty, Montgomery, Waller
Chicago, IL	Cook, DuPage, Kane Lake, McHenry, Will

In addition, the temporary moratorium on new Part B ambulance suppliers is being extended for an additional six months in the areas stated in Table 2.

Table 2: Part B ambulance suppliers under six-month temporary moratoria

City and state	Counties
Houston, TX	Harris, Brazoria, Chambers, Fort Bend, Galveston, Liberty, Montgomery, Waller
Philadelphia, PA	Bucks (PA), Delaware (PA), Montgomery (PA), Philadelphia (PA), Burlington (NJ), Camden (NJ), Gloucester (NJ)

Initial provider enrollment applications and change of information applications to add additional practice locations received from HHAs, HHA sub-units, and Part B ambulance suppliers in the above listed counties will

be denied in accordance with 42 CFR §424.570(c). Application fees that are paid for applications that are denied due to this temporary moratorium will be refunded.

Note: HHAs, HHA sub-units, and Part B ambulance suppliers are afforded appeal rights. However, the scope of review will be limited to whether the temporary moratorium applies to the provider or supplier appealing the denial. CMS' basis for imposing a temporary moratorium is not subject to review.

Additional information

For more information regarding CMS' use of temporary moratoriums, please review *MLN Matters*® article MM7350 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7350.pdf*.

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

MLN Matters® Number: SE1425 *Revised*
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

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.

Background fingerprints – check status online

The fingerprint-based background requirement was implemented August 6, 2014; details released in *special edition article SE1427*.

Accurate Biometrics is the Centers for Medicare & Medicaid Services (CMS) contractor responsible for processing fingerprints for CMS. Providers can find all of the information necessary to complete the provider fingerprinting requirement, which now includes the ability to authenticate and check the status of fingerprint submission online. If at any time during this process you have a question, please call 1-866-361-9944 for assistance.

ICD-10 limited end-to-end testing with submitters for 2015

Provider types affected

This *MLN Matters*® article is intended for providers and clearinghouses wishing to submit test claims with International Classification of Diseases, Tenth Revision (ICD-10) codes to Medicare administrative contractors (MACs).

What you need to know

Change request (CR) 8867 directs MACs to test with a limited number of providers and clearinghouses to ensure claims with ICD-10 codes can be processed from submission to remittance. This additional testing effort will help ensure a successful transition to International Classification of Disease, Tenth Revision, (ICD-10).

The Centers for Medicare & Medicaid Services (CMS) defines successful end-to-end testing as being able to demonstrate that:

- Testing entities are able to successfully submit ICD-10 claims to the shared systems,
- Software changes made to support ICD-10 result in appropriately adjudicated claims based on the pricing data employed for testing purposes; and
- Remittance advices are produced.

Make sure your billing staffs are aware of this update.

Background

The ICD-10 must be implemented by October 1, 2015. While system changes to implement this project have been completed and tested in previous releases, the industry has requested the opportunity to test with CMS.

CR 8867 will allow a small subset of submitters to test with MACs and the common electronic data interchanges (CEDIs) in three testing periods to demonstrate to the industry that CMS systems are ready for the ICD-10 implementation. MACs and CEDI shall conduct three limited end-to-end testing weeks with a small subset of submitters.

To facilitate this testing, CR 8867 requires MACs to do the following:

- Conduct limited end-to-end testing with submitters in three testing periods; January 2015, April 2015 and July 2015. Test claims will be submitted January 26-30, 2015, April 27-May 1, 2015, and July 20-24, 2015.
- Each MAC (and CEDI with assistance from DME MACs) will select 50 submitters for each MAC jurisdiction supported to participate in the end-to-end testing. The Railroad Retirement Board (RRB) contractor will also select 50 submitters. Testers will be selected randomly from a list of volunteers. At least five, but not more than fifteen of the testers will be a clearinghouse, and submitters should be a mix of provider types.
- MACs and CEDIs will post a volunteer form to their website to collect volunteer information with which to select volunteers.
    - Form verifies testers are ready to test, meet the requirements to test, and collect data about the tester. (How they submit claims, what types of claims they will submit, and so forth.)
    - MACs and CEDIs will post the form to its website by March 13, 2015, for the July 2015 testing.
    - Volunteers must submit completed forms to the MACs and CEDIs by April 17, 2015, for the July 2015 testing.
- By May 8, 2015, for the July 2015 testing, the MACs and CEDIs (for the DME MACs) will notify the volunteers that they have been selected to test and provide them with the information needed for the testing, such as:
    - How to submit test claims (for example, what test indicators should be set);
    - What dates of service may be used for testing;
    - How many claims may be submitted for testing (Test claims volume is limited to a total of 50 claims for the entire testing week, submitted in no more than three files);
    - Request for national provider identifiers (NPIs) and health insurance claim numbers (HICNs) that will be used in testing (no more than five NPIs and 10 HICNs per submitter);
    - Notice that if more than 50 claims are submitted, they may not be processed;
    - Notice that claims submitted with NPIs or HICNs not previously submitted for testing, likely will not be completed; and
    - Notice of potential protected health information (PHI) on test remittances not submitted (and instructions to report PHI found to the MAC).
- MACs and CEDIs (for the DME MACs) will collect information from the testers after they have been notified of their selection, using a form provided by CMS. This form will specifically request the HICNs, provider transaction access number (PTANs), and NPIs the tester will use during testing. Testers shall submit these forms back to the MAC/CEDI by February 20, 2015, for the April 2015 testing, and by May 29, 2015, for the July 2015 testing. Notification will warn testers that if forms are not received timely, they may lose their opportunity to test.
- Testers selected in the January 2015 testing may participate in the April 2015 testing, and may submit an additional 50 test claims using the same HICNs and NPIs provided previously. MACs shall send a reminder to the January 2015 testers of this option 30 days prior to the start of the April 2015 testing, using language provided by CMS.
- Testers selected in the January 2015 and April 2015 Testing may participate in the July 2015 testing, and may submit an additional 50 test claims using the

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same HICNs and NPIs provided previously. MACs shall send a reminder to the January 2015 and April 2015 testers of this option 30 days prior to the start of the July 2015 testing, using language provided by CMS.

- MACs and CEDI will work with the testers selected to ensure they are prepared to test, and understand the requirements for testing.
- MACs and CEDI will instruct the testers to submit up to a total of 50 test claims during the testing period. This may be submitted in one to three files, but the total number of test claims cannot exceed 50.
- CEDI will instruct suppliers to submit claims with ICD-10 code with dates of service October 1, 2015, through October 15, 2015. They may also submit claims with ICD-9 codes with dates of service before October 1, 2015.
    - MACs will instruct testers to submit test claims with ICD-10 code with dates of service on or after October 1, 2015. They may also submit test claims with ICD-9 codes with dates of service before October 1, 2015.
    - MACs and CEDIs will be prepared to support increased call volume from testers during the testing window, and up to 2 weeks following the receipt of the ERAs from testing.
    - MACs and CEDIs will provide information to the testers on who to contact for testing questions. This may be separate contacts for front end questions and remittance questions.
    - MACs and CEDIs will post an announcement about the testing to its websites. The announcement will be provided by CMS.

Additional information

The official instruction, CR 8867, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1451OTN.pdf*.

You may also want to review *MLN Matters*® article SE1409, which discusses ICD-10 testing. That article is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1409.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number, as well as your MAC's website address, 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: MM8867
Related Change Request (CR) #: CR 8867
Related CR Release Date: January 20, 2015
Related CR Transmittal #: R1451OTN
Effective dates: September 12, 2014 - for MACs and CEDI (non-systems change requirements) (**Note**: This is the due date of the first MAC and CEDI requirement); January 26, 2015, for FISS and CEDI coding for January testing week; April 27, 2015, for FISS and CEDI coding for April testing week; July 20, 2015, for FISS and CEDI coding for July testing week.
Implementation dates: January 5, 2015, for FISS and CEDI coding for January testing week; February 16, 2015, for MAC requirements for the January 15 testing. This is the due date of the last MAC deliverable. April 6, 2015, for FISS and CEDI coding for April testing week; May 18, 2015, for MAC requirements for the April 15 testing. This is the due date of the last MAC deliverable.; July 6, 2015, for FISS and CEDI coding for July testing week; August 10, 2015, for MAC requirements for the July 15 testing. This is the due date of the last MAC deliverable.

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

Parenteral iron supplementation for patients receiving ESA therapy for anemia of chronic kidney disease or iron deficiency anemia –Part B LCD retired

LCD ID number: L29174 (Florida)
LCD ID number: L29426 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for parenteral iron supplementation for patients receiving erythropoiesis stimulating agents (ESA) therapy for anemia of chronic kidney disease or iron deficiency anemia is retired effective February 24, 2015. The LCD is outdated given the varying approved indications for the drugs in the class. Please refer to LCD L32094 (label and off-label coverage of outpatient drugs and biologicals) for guidance on drug coverage. Based on national coverage determination (NCD) 110.10 (intravenous iron therapy), the following dual diagnosis requirement must be met when sodium ferric gluconate complex or iron sucrose injections are administered intravenously to patients undergoing chronic hemodialysis who are receiving supplemental erythropoietin therapy:

One of the following chronic kidney disease, ICD-9-CM diagnosis codes 585.4, 585.5, or 585.6 and one of the secondary ICD-9-CM diagnosis codes for iron deficiency anemia 280.0, 280.1, 280.8 or 280.9).

Generally, off label use (non-Food and Drug Administration (FDA) approved indication) is not a covered service for drugs used in a non- cancer episode of care. For the FDA approved use in patients with iron deficiency anemia who have intolerance to oral iron or have had unsatisfactory response to oral iron, the medical record documentation must support the need for the IV drug by addressing the specific issues with intolerance to oral iron and the details of previous oral iron use leading up to the decision that there is unsatisfactory response to oral iron.

Use of these drugs in the outpatient hospital setting or incident to in the physician's office may be subject to pre or post payment medical review. Should the contractor request documentation to support the billing of these drugs, providers should submit a relevant history and physical, physician progress notes, any results of pertinent diagnostic tests or procedures, a physician's order, the name of the drug, the route of administration, the dosage (e.g., mgs, mcgs, ccs or IUs), the duration of administration and any wastage of the drug.

Effective date

This LCD retirement is effective for services rendered **on or after February 24, 2015**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Injectafer® (ferric carboxymaltose) injection – claims that may have been denied in error

Claims submitted for procedure code J1439 (Injection, ferric carboxymaltose) between **January 1 and February 5, 2015**, may have been denied incorrectly with the following denial message: "These are non-covered services because this is not deemed a 'medical necessity' by the payer".

This error was corrected February 5, 2015. Claims processed on or after February 6, 2015, were adjudicated correctly.

No action required by providers

Providers whose claims were incorrectly denied due to this error do not need to take any action. First Coast Service Options Inc. will perform adjustments to correct the error on all the affected claims. We apologize for any inconvenience this may have caused.

Revisions to LCDs

Bortezomib (Velcade®) – revision to the Part B LCD

LCD ID number: L29087 (Florida)
LCD ID number: L29102 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for Bortezomib (Velcade®) was most recently revised April 10, 2014. Since that time, a revision was made under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD to add the off-labeled indications of Waldenström's Macroglobulinemia/Lymphoplasmacytic Lymphoma, Non-Hodgkin's lymphoma (NHL) - Adult T-Cell Leukemia/Lymphoma, NHL - Peripheral T-Cell Lymphoma, and NHL - Primary Cutaneous CD30+ T-Cell Lymphoproliferative Disorders. Also, under the "ICD-9 Codes that Support Medical Necessity" section of the LCD, diagnosis codes 200.60-200.68, 200.80-200.88, 204.80, 204.82, 273.3, and V10.79 and descriptors were added. In addition, the "Sources of Information and Basis for Decision" section of the LCD was updated.

Effective date

This LCD revision is effective for services rendered **on or after January 30, 2015**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Diagnostic colonoscopy – revision to the Part B LCD

LCD ID number: L29152 (Florida)
LCD ID number: L29332 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for diagnostic colonoscopy has been revised based on 2015 Healthcare Common Procedural Coding System (HCPCS) Annual Update. Under the "*CPT*®/HCPCS Codes" section of the LCD, *Current Procedural Terminology* (*CPT*®) codes *44401, 44402, 44403, 44404, 44405, 44406, 44407, 44408, 45388, 45389, 45390, 45393*, and *45398* were added.

Effective date

This LCD revision is effective for claims processed **on or after February 24, 2015**, for services rendered **on or after January 1, 2015**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Implantable miniature telescope (IMT) – revision to the Part B LCD

LCD ID number: L32822 (Florida/Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for implantable miniature telescope (IMT) was revised to decrease the age of eligibility from 75 and older to 65 and older based on the Food and Drug Administration's (FDA's) approval (PMA P050034 S013). The "Indications and Limitations of Coverage and /or Medical Necessity" section of the LCD was revised to change the age of eligibility. In addition, the "Sources of Information and Basis of Decision" section of the LCD was updated.

Effective date

The LCD revision is effective for claims processed **on or after February 11, 2015**, for services rendered **on or after October 8, 2015**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Noncovered services – revision to the Part B LCD

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

The Medical Policy & Procedures Department evaluated the following services and determined that they are not considered medically reasonable and necessary at this time based on current available published evidence (e.g., peer-reviewed medical literature, and published studies). Therefore, the following procedure codes have been added to the *Noncovered Services* local coverage determination (LCD). After a draft LCD becomes effective/active, any stakeholder may request a revision to the LCD, by following the reconsideration process as outlined on our website.

- *0008M: Oncology (breast), mRNA analysis of 58 genes using hybrid capture, on formalin-fixed paraffin-embedded (FFPE) tissue, prognostic algorithm reported as a risk score*
- *0347T: Placement of interstitial device(s) in bone for radiostereometric analysis (RSA)*
- *0348T-0350T:* Radiologic examination, radiostereometric analysis (rsa)
- *0351T-0352T:* Optical coherence tomography of breast or axillary lymph node, excised tissue, each specimen
- *0353T-0354T:* Optical coherence tomography of breast, surgical cavity
- *0355T: Gastrointestinal tract imaging, intraluminal (eg,capsule endoscopy), colon, with interpretation and report*
- *0356T: Insertion of drug-eluting implant (including punctual dilation and implant removal when performed) into lacrimal canaliculus, each*
- *0358T: Bioelectrical impedance analysis whole body composition assessment, supine position, with interpretation and report*
- *0359T: Behavior identification assessment, by the physician or other qualified health care professional, face-to-face with patient and caregiver(s), includes administration of standardized and non-standardized tests, detailed behavioral history, patient observation and caregiver interview, interpretation of test results, discussion of findings and recommendations with the primary guardian(s)/caregiver(s), and preparation of report*
- *0360T: Observational behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by one technician; first 30 minutes of technician time, face-to-face with the patient*
- *0361T: Observational behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by one technician; each additional 30 minutes of technician time, face-to-face with the patient (List separately in addition to code for primary service)*
- *0362T: Exposure behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by physician or other qualified health care professional with the assistance of one or more technicians; first 30 minutes of technician(s) time, face-to-face with the patient*
- *0363T: Exposure behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by physician or other qualified health care professional with the assistance of one or more technicians; each additional 30 minutes of technician(s) time, face-to-face with the patient (List separately in addition to code for primary procedure)*
- *0364T-0365T:* Adaptive behavior treatment by protocol, administered by technician, face-to-face with one patient
- *0366T-0367T:* Group adaptive behavior treatment by protocol, administered by technician, face-to-face with two or more patients
- *0368T-0369T:* Adaptive behavior treatment with protocol modification administered by physician or other qualified health care professional with one patient
- *0370T: Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present)*
- *0371T: Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present)*
- *0372T: Adaptive behavior treatment social skills group, administered by physician or other qualified health care professional face-to-face with multiple patients*
- *0373T-0374T:* Exposure adaptive behavior treatment with protocol modification requiring two or more technicians for severe maladaptive behavior(s)

In determining if a service or procedure reaches the threshold for coverage, this contractor addresses the quality of the evidence per the *Program Integrity Manual*. When addressing the articles and related information in the public domain, the jurisdiction N (JN) Medicare administrative contractor (MAC) reached the determination that available evidence was of moderate to low quality, consisting of small case series, retrospective studies, and review articles reporting limited safety and efficacy data for these procedures. Due to the unavailability of high quality evidence, the JN MAC reiterates that there is insufficient scientific evidence to support these procedures, and therefore they are not considered reasonable and necessary under section 1862(a)(1)(a) of the Social Security Act.

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NONCOVERED

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Any denied claim would have Medicare's appeal rights. The second level of appeal (qualified independent contractor) requires review by a clinician to uphold any denial. Providers should submit for review all the relevant medical documentation and case specific information of merit and/or new information in the public domain.

An interested stakeholder can request a reconsideration of an LCD after the notice period has ended and the draft becomes active. In the case of the noncovered services LCD, the stakeholder may request the list of the articles and related information in the public domain that were considered by the Medical Policy department in making the noncoverage decision. If the stakeholder has new information based on the evaluation of the list of articles and related information, an LCD reconsideration can be initiated. It is the responsibility of the interested stakeholder to request the evidentiary list from the contractor and to submit the additional articles, data, and related information in support of their request for coverage. The request must meet the LCD reconsideration requirements outlined on the website.

Also, any interested party could request the Centers for Medicare & Medicaid Services (CMS) to consider developing a national coverage determination (NCD). Of note, if the evidence is not adequate for coverage under section 1862(a)(1)(A), an item or service may be considered for coverage under the CMS Coverage with Evidence Development (CED) policy in which "reasonable and necessary" is established under 1862(a)(1)(E) of the Act. Under the authority of section 1862(a)(1)(E), the NCD process may result in coverage if the item or service is covered only when provided within a setting in which there is a pre-specified process for gathering additional data, and in which that process provides additional protections and safety measures for beneficiaries, such as those present in certain clinical trials.

Effective date

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

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

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

Peripheral nerve blocks – revision to the Part B LCD

LCD ID number: L29258 (Florida)
LCD ID number: L29466 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for peripheral nerve blocks has been revised based on a reconsideration request. Under the "ICD-9 Codes that Support Medical Necessity" section of the LCD, ICD-9-CM diagnosis code 355.5 (Tarsal tunnel syndrome) was added for *Current Procedural Terminology* (*CPT*®) code *64450*.

Effective date

This LCD revision is effective for services rendered **on or after January 30, 2015**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Widespread probe notification for modifier 24

First Coast Service Options Inc. (First Coast) conducted a widespread probe (WSP) in response to an aberrant billing pattern identified for *Current Procedural Terminology* (*CPT*®) codes *99223* (Initial hospital care); *99233* (Subsequent hospital care) and *99291* (Critical care, evaluation and management) in 2012. The results of the WSP probe yielded a 66.95 percent error rate. First Coast plans to complete an additional WSP of hospital evaluation and management services for dates of service June 1, 2014, to November 30, 2014, to determine the effectiveness of provider outreach and education activities. The widespread probe will include *CPT*® codes *99223, 99233* and *99291*.

Additional Information

Adjustment of gastric band outside the 90-day global period of laparoscopic gastric band placement

This article was developed to address recent inquires related to the adjustment of gastric lap band outside of the 90-day global period. Laparoscopic placement of an adjustable gastric band (LAGB) (*Current Procedural Terminology* (*CPT*®) code *43770*) is a covered procedure for surgical treatment of morbid obesity, when appropriate, based on the criteria outlined in the *Medicare National Coverage Determination (NCD) for Bariatric Surgery for Treatment of Morbid Obesity* (NCD 100.1) and local coverage determination (LCD) for *Surgical Management of Morbid Obesity* (L29317/L29477).

Adjustment of the gastric band after LAGB consists of an injection or withdrawal of saline. Adjustments to the LAGB should not be billed during the 90-day global period of the laparoscopic placement of an adjustable gastric band, as it is included in the primary procedure and is not separately payable during the global period.

Currently, adjustment of a LAGB does not have a unique *CPT*® code. After the 90-day global period, it should be billed using *CPT*® code *43659* (Unlisted laparoscopy procedure, stomach) with the statement "adjustment of gastric band" in Item 19 of the CMS-1500 or its electronic equivalent.

An evaluation and management (E&M) code and adjustment of LAGB will only be allowed on the same date of service if a significant separately identifiable and medically necessary service is provided. Modifier 25 should be appended to the E&M code only if it does not apply to the evaluation and adjustment of the LAGB.

New HCPCS modifiers to define subsets of the 59 modifier

Based on the Centers for Medicare and Medicaid Services (CMS) change request (CR) 8863, four new HCPCS modifiers have been established to define subsets of the 59 modifier, a modifier used to define a "distinct procedural service."

- XE: Separate encounter, a service that is distinct because it occurred during a separate encounter,
- XP: Separate practitioner, a service that is distinct because it was performed by a different practitioner,
- XS: Separate structure, a service that is distinct because it was performed on a separate organ/structure, and
- XU: Unusual non-overlapping service, the use of a service that is distinct because it does not overlap usual components of the main service.

The following local coverage determinations (LCDs) and/or associated coding guidelines were revised to reflect the new X (EPSU) modifiers.

- Destruction of Internal Hemorrhoid(s) by Infrared Coagulation (IRC), L30862 (Florida and Puerto Rico/U.S. Virgin Islands)
- Diagnostic Laryngoscopy, L29153 (Florida), L29334 (Puerto Rico/U.S. Virgin Islands)
- Fundus Photography, L29179 (Florida), L29341 (Puerto Rico/U.S. Virgin Islands)
- Intensity Modulated Radiation Therapy (IMRT), L29200 (Florida), L29352 (Puerto Rico/U.S. Virgin Islands)
- Mohs Micrographic Surgery (MMS), L29230 (Florida), L29366 (Puerto Rico/U.S. Virgin Islands)
- Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI), L29276 (Florida), L29473 (Puerto Rico/U.S. Virgin Islands)
- Vertebroplasty, Vertebral Augmentation, Percutaneous, L29209 (Florida), L29454 (Puerto Rico/U.S. Virgin Islands)
- Wound Debridement Services, L29128 (Florida), L29146 (Puerto Rico/U.S. Virgin Islands)

Effective date

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

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

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

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 29, 2015

MLN Connects™ Provider eNews for January 29, 2015

View this edition as a PDF

In this edition:

MLN Connects™ National Provider Calls

- Payment of Chronic Care Management Services Under CY 2015 Medicare PFS – Registration Now Open
- ICD-10 Implementation and Medicare Testing – Registration Now Open
- New MLN Connects™ National Provider Call Audio Recording and Transcript

CMS Events

- Special Open Door Forum: Prior Authorization of Non-Emergent Hyperbaric Oxygen Therapy
- Special Open Door Forum: Understanding Dialysis Facility Compare-Driving Informed Decision Making
- Special Open Door Forum: Adding Star Ratings to the Home Health Compare Website

Announcements

- Influenza Updates from CDC
- Pneumococcal Vaccinations Update from CMS
- CMS Launches Dialysis Facility Compare Star Ratings
- HHS Sets Clear Goals and Timeline for Shifting Medicare Reimbursements from Volume to Value
- EHR Incentive Program: Eligible Professional 2014 Attestation Deadline on February 28
- EHR Incentive Programs: New Stage 2 Summary of Care FAQ Provides Guidance on Measure #3

- Comparative Billing Report on Modifiers 24 & 25: Specialty Surgeons
- ICD-10 Resources

Claims, Pricers, and Codes

- Payment for HCPCS Code Q0091 as an RHC or FQHC Billable Visit under the All-Inclusive Rate System

Medicare Learning Network® Educational Products

- "Continued Use of Modifier 59 after January 1, 2015" *MLN Matters*® Article – Released
- "Telehealth Services" Fact Sheet – Revised
- "Medicare Part B Immunization Billing" Educational Tool – Revised
- New *Medicare Learning Network*® Provider Compliance Fast Fact
- *Medicare Learning Network*® Products Available In Electronic Publication Format

Medicare Learning Network®

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

MLN Connects™ Provider eNews for February 5, 2015

MLN Connects™ Provider eNews for February 5, 2015

View this edition as a PDF

In this edition:

MLN Connects™ National Provider Calls

- Payment of Chronic Care Management Services under CY 2015 Medicare PFS – Register Now
- ICD-10 Implementation and Medicare Testing – Register Now
- New MLN Connects™ National Provider Call Audio Recordings and Transcripts

CMS Events

- Special Open Door Forum: Home Health Clinical Templates

Announcements

- HHS Proposes Path to Improve Health Technology and Transform Care
- Extension of Temporary Moratoria on Enrollment of New HHAs, HHA Sub-units and Part B Ambulance Suppliers
- CLIA Individualized Quality Control Plan: Education and Transition Period Ends December 31, 2015
- 2015 PQRS Payment Adjustment and Providers who Rendered Services at RHCs/FQHCs
- Open Payments: Second Year of Data Submission Begins
- CMS Intends to Engage in Rulemaking for EHR Incentive Program Changes for 2015
- Get Started with Hospice CAHPS
- Proposed Decision Memo: Screening for the HIV Infection

Claims, Pricers, and Codes

- Home Health Pricer will be Updated on April 1
- FY 2015 Inpatient PPS PC Pricer Update Available

Medicare Learning Network® Educational Products

- "Payment Codes on Home Health Claims Will Be Matched Against Patient Assessments" *MLN Matters*® Article – Released
- "Extension of Provider Enrollment Moratoria for Home Health Agencies and Part B Ambulance Suppliers" *MLN Matters*® Article – Revised
- "Internet-based PECOS Contact Information" Fact Sheet – Reminder
- *Medicare Learning Network*® Products Available In Electronic Publication Format
- Subscribe to the *MLN Matters*® Electronic Mailing List
- Helpful Tips on *Medicare Learning Network*® Products and Learning Management System – Subscribe Now

February is American Heart Month

Initiatives such as Million Hearts®, a national initiative to prevent a million heart attacks and strokes by 2017, provide health care professionals and other partners with resources that you can use to help enhance your prevention efforts. Medicare provides coverage for a variety of preventive services that can help identify risk factors and provide information and tools that can assist your Medicare patients in making informed decisions about heart-healthy lifestyle choices. Encourage your Medicare patients to take full advantage of their covered services.

MLN Connects™ Provider eNews for February 12, 2015

MLN Connects™ Provider eNews for February 12, 2015

View this edition as a PDF

In this edition:

MLN Connects™ National Provider Calls

- Payment of Chronic Care Management Services under CY 2015 Medicare PFS – Last Chance to Register
- ICD-10 Implementation and Medicare Testing – Register Now
- National Partnership to Improve Dementia Care in Nursing Homes and QAPI – Registration Now Open

CMS Events

- Physician Compare Benchmark Discussion Webinars

Announcements

- DMEPOS Competitive Bidding: Register by Tuesday in Order to Bid
- February is American Heart Month
- IRF Quality Reporting Program: Data Submission Deadline February 15
- LTCH Quality Reporting Program: Data Submission Deadline February 15
- EHR Incentive Program: 2014 Attestation Deadline for Eligible Professionals February 28
- EHR Incentive Programs: Public Health Objectives: Reporting Requirements in Stage 1 and 2
- NCD for Screening for Lung Cancer with Low Dose Computed Tomography
- Background Fingerprints: Check Your Status Online
- Antipsychotic Drug use in Nursing Homes: Trend Update
- CMS is Accepting Suggestions for Potential PQRS Measures

Claims, Pricers, and Codes

- CY 2015 HH PPS PC Pricer and PPS Main Frame Pricer Updates Available

Medicare Learning Network® Educational Products

- "Hospital Outpatient Prospective Payment System" Fact Sheet – Revised
- "DMEPOS Quality Standards" Booklet – Reminder
- "Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Information for Pharmacies" Fact Sheet -- Reminder
- "Screening, Brief Intervention, and Referral to Treatment (SBIRT) Services" Fact Sheet – Reminder

Complying with medical record documentation requirements

A fact sheet was developed November 2014 by the *Medicare Learning Network®* (*MLN*), in conjunction with the comprehensive error rate testing (CERT) Part A and Part B (A/B) and durable medical equipment (DME) Medicare administrative contractor (MAC) Outreach & Education task forces, to provide nationally-consistent education on topics of interest to health care professionals. It is designed to help providers understand how to provide accurate and supportive medical record documentation.

This fact sheet discusses the following:

- Third-party additional documentation requests
- Insufficient documentation errors
  1. Vertebral augmentation procedures
  2. Physical therapy services
  3. Evaluation and management services
  4. DME
  5. Computed tomography scans
  6. Resources

First Coast Service Options Inc. (First Coast) encourages providers to review *MLN Matters® fact sheet MLN ICN 909160* to learn more about reducing medical documentation errors.

Phone numbers

Customer service

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

Education event registration hotline

904-791-8103 (NOT toll-free)

Electronic data interchange (EDI)

888-670-0940

Electronic funds transfers (EFT) (CMS-588)

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

Fax number (for general inquiries)

904-361-0696

Interactive voice response (IVR) system

877-847-4992

Provider enrollment

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

The SPOT help desk

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

Addresses

Claims

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

Redeterminations

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

Redetermination of overpayments

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

Reconsiderations

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

General inquiries

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

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

Provider enrollment

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

Medical policy

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

Medicare secondary payer

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

Electronic data interchange (EDI)

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

Overpayments

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

Medicare Education and Outreach

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

Fraud and abuse

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

Freedom of Information Act requests

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

Overnight mail and/or special courier service

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

Websites

Provider

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

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

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

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

Beneficiaries

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

Phone numbers

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866-454-9007
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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

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

The SPOT help desk

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

Addresses

Claims

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

Redeterminations

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

Redetermination of overpayments

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

Reconsiderations

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

General inquiries

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

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

Provider enrollment

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

Medical policy

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

Medicare secondary payer

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

Electronic data interchange (EDI)

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

Overpayments

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

Medicare Education and Outreach

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

Fraud and abuse

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

Freedom of Information Act requests

FOIA USVI
P.O. Box 45073
Jacksonville, FL 32231-5073

Special courier service

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

Websites

Provider

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

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Centers for Medicare & Medicaid Services

http://www.cms.gov

First Coast University

http://www.fcsouniversity.com/

Beneficiaries

Centers for Medicare & Medicaid Services

http:// www.medicare.gov

Phone numbers

Customer service

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

Education event registration hotline

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

Electronic data interchange (EDI)

888-875-9779

Electronic funds transfers (EFT) (CMS-588)

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

General inquiries

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

Interactive voice response (IVR) system

877-847-4992

Provider enrollment

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

The SPOT help desk

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

Addresses

Claims

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

Redeterminations

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

Redetermination of overpayments

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

Reconsiderations

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

General inquiries

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

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

Provider enrollment

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

Medical policy

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

Medicare secondary payer

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

Electronic data interchange (EDI)

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

Overpayments

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

Medicare Education and Outreach

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

Fraud and abuse

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

Freedom of Information Act requests

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

Special courier service

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

Websites

Provider

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http://www.cms.gov

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

Beneficiaries

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

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

Item	Acct Number	Cost per item	Quantity	Total cost
Part B subscription – The Medicare Part B jurisdiction N publications, in both Spanish and English, are available free of charge online at *http://medicare.fcso.com/Publications_B/index.asp* (English) or *http://medicareespanol.fcso.com/Publicaciones/* (Español). Nonprovider entities or providers who need additional copies may purchase an annual subscription. This subscription includes all issues published from October 2014 through September 2015.	40300260	$33		
2015 fee schedule – The Medicare Part B Physician and Nonphysician Practitioner Fee Schedules, effective for services rendered January 1 through December 31, 2015, are available free of charge online at *http://medicare.fcso.com/Data_files/* (English) or *http://medicareespanol.fcso.com/Fichero_de_datos/* (Español). Additional copies are available for purchase. The fee schedules contain payment rates for all localities. These items do not include the payment rates for injectable drugs, clinical lab services, mammography screening, or DMEPOS items. **Note:** Requests for hard copy paper disclosures will be completed as soon as CMS provides the direction to do so. Revisions to fees may occur; these revisions will be published in future editions of the Medicare Part B publication.	40300270	$12		
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Please write legibly			Subtotal	$
			Tax (***add % for your area***)	$
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City: _____ State: _____ ZIP: _____

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