

C Medicare B CONNECTION

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A Newsletter for MAC Jurisdiction N Providers

March 2015



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Overview and implementation of the value-based modifier program

Provider types affected

This *MLN Matters*® special edition is intended for physicians and non-physician practitioners (nurse practitioners, physician assistants, and clinical nurse specialists), occupational therapists, physical therapists, speech-language pathologists, and audiologists submitting claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

Provider action needed

Stop – impact to you

This special edition article provides an overview of the physician feedback and value-based modifier program. Under the value modifier program, performance on quality and cost measures

can translate into payment incentives for providers who provide high quality, efficient care, while providers who underperform may be subject to a downward adjustment.



Caution – what you need to know

Beginning January 1, 2015, the Centers for Medicare & Medicaid Services (CMS) began applying a value-based payment modifier (value modifier) to physician payments under the Medicare physician fee schedule for physicians in groups with 100 or more eligible professionals (EPs). EPs consist of physicians, practitioners, physical or occupational therapists, qualified speech-language pathologists, and

qualified audiologists. A group is defined by its Medicare-enrolled taxpayer identification number (TIN). The value

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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.

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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).

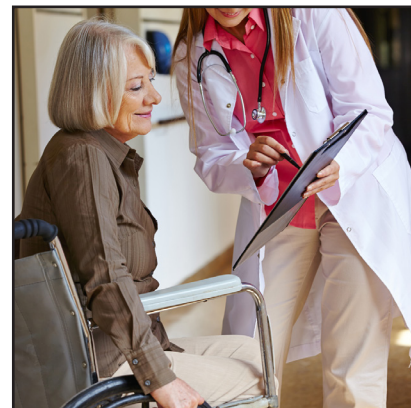
If the provider believes that the service or item may not be covered as medically reasonable and necessary, the patient must be given an acceptable advance notice of Medicare's possible denial of payment if the provider does not want to accept financial responsibility for the service or item. Advance 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 (waiver of liability statement on file).

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

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

Annual Medicare B Connection hardcopy registration form

To receive free editions of the Part B publication in hardcopy or email format, you must complete this registration form. To receive a hardcopy or email of future issues of the Part B publication, **your form must be faxed to 1-904-361-0723 by June 19, 2014.** Providers currently receiving hardcopy publications must renew by using this form. **Providers who do not renew by the June 19 deadline will no longer receive free hardcopy versions after the September 2015 issue.** The publication cycle begins every year on October 1 and concludes September 30.

If you miss the registration deadline, you still have the ability to receive a hard copy through subscription. The annual cost for a hardcopy subscription is \$33. Please note that you are not obligated to complete this form to access information contained in the Part B publication. Issues dating back to 1997 are available free on First Coast Service Options' provider website: http://medicare.fcso.com/Publications_B/index.asp.

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City, state, ZIP code:

Contact person/title:

Telephone number:

Fax number:

E-mail address:

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Fax your completed form to:

Medicare Publications

1-904-361-0723

Please share your questions and/or concerns regarding this initiative with us.

Additional questions or concerns may be submitted via the Medicare provider education website at <http://medicare.fcso.com/Feedback/index.asp>. You also may fax your questions or comments to 1-904-361-0723. **Our Provider Contact Center will not be able to respond to inquiries about this form.**

Clinical laboratory new waived tests

Provider types affected

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

Provider action needed

Change request (CR) 9072 informs MACs about the changes in the new Clinical Laboratory Improvement Amendments of 1988 (CLIA) waived tests approved by the Food and Drug Administration (FDA). Since these tests are marketed immediately after approval, Centers for Medicare & Medicaid Services (CMS) must notify its MACs of the new tests to allow MACs to accurately process claims.

CLIA requires that for each test it performs, a laboratory facility must be appropriately certified. The *Current Procedural Terminology CPT*[®] codes that CMS considers to be laboratory tests under CLIA (and thus requiring certification) change each year. Make sure your billing staffs are aware of these changes.

Background

The Clinical Laboratory Improvement Amendments of 1988 (CLIA) regulations require a facility to be appropriately certified for each test performed. To ensure that Medicare & Medicaid only pay for laboratory tests categorized as waived complexity under CLIA in facilities with a CLIA certificate of waiver, laboratory claims are currently edited at the CLIA certificate level.

Listed below are the latest tests approved by FDA as waived tests under CLIA. The *CPT*[®] codes for the following new tests must have the modifier QW to be recognized as a waived test. The *CPT*[®] code, effective date, and description for the latest tests approved by the FDA as waived tests under CLIA are the following:

- G0434QW, September 18, 2014, CLIA waived Inc. rapid drug test cup {cassette dip card format};
- 86308QW, September 23, 2014, AimStep Mono {whole blood};
- G0434QW, September 26, 2014, Polymed Therapeutics FaStep marijuana panel dip;
- G0434QW, September 26, 2014, Polymed Therapeutics FaStep marijuana quick cup;
- G0434QW, September 26, 2014, Polymed Therapeutics FaStep marijuana strip;
- G0434QW, September 26, 2014, Polymed Therapeutics FaStep marijuana turn-key split cup;
- G0434QW, September 26, 2014, Polymed Therapeutics FaStep methamphetamine panel dip;
- G0434QW, September 26, 2014, Polymed Therapeutics FaStep methamphetamine quick cup;
- G0434QW, September 26, 2014, Polymed Therapeutics FaStep methamphetamine strip;
- G0434QW, September 26, 2014, Polymed Therapeutics FaStep methamphetamine turn-key split cup;
- G0434QW, October 9, 2014, Chemtron Biotech, Inc. Chemtrue single/multi-panel drug screen dip card tests;
- G0434QW, October 9, 2014, Chemtron Biotech, Inc. Chemtrue single/multi-panel drug screen cassette tests;
- G0434QW, October 9, 2014, Chemtron Biotech, Inc. Chemtrue multi-panel drug screen dip card tests;
- G0434QW, October 9, 2014, Chemtron Biotech, Inc. Chemtrue multi-panel drug screen dip card with OPI 2000 test;
- G0434QW, October 17, 2014, Healgen oxazepam test strip;
- G0434 QW, October 17, 2014, Healgen oxazepam test dip card;
- G0434QW, October 17, 2014, Healgen oxazepam test cup;
- G0434QW, October 17, 2014, Healgen oxazepam test cassette;
- G0434QW, October 17, 2014, Healgen morphine test strip;
- G0434QW, October 17, 2014, Healgen morphine test dip card;
- G0434QW, October 17, 2014, Healgen morphine test cup;
- G0434QW, October 17, 2014, Healgen morphine test cassette;
- G0433QW, October 29, 2014, Chembio diagnostic systems, Inc. DPP HIV 1/2 assay {oral fluid}; and
- 87389QW [from December 5, 2014, to December 31, 2014], Orogenics, Alere Determine HIV-1/2 Ag/Ab Combo {fingerstick whole blood}; and
- 87806QW [on and after January 1, 2015] , Orogenics, Alere Determine HIV-1/2 Ag/Ab combo {fingerstick whole blood};



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WAIVED

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- G0434QW, December 10, 2014, Transmetron Invitro pro drug test cups;
- G0434QW, December 10, 2014, Coastline Medical Management Coastline explorer cup {cassette dip card format};
- 86780QW, December 15, 2014, Diagnostics Direct LLC Syphilis Health Check {finger stick whole blood};
- G0434QW, December 19, 2014, On-site testing specialists, Inc. on-site testing specialist single/multi-panel drug screen dip card tests;
- G0434QW, December 19, 2014, On-Site testing specialists, Inc. On-site testing specialist single/multi-panel drug screen dip card with OPI 2000 tests; and
- 87502QW, January 5, 2015, Alere i Influenza A & B Test {direct nasal swab only}.

From December 5, 2014, to December 31, 2014, the CPT® code 87389QW has been assigned for the detection of antigen to HIV-1, and antibodies to HIV-1 and HIV-2 performed using the Oregenis, Alere Determine HIV-1/2 Ag/Ab combo {fingerstick whole blood}. On and after January 1, 2015, the CPT® code assigned to Oregenis, Alere Determine HIV-1/2 Ag/Ab combo {fingerstick whole blood} will be 87806QW.

The new CPT® code 86780QW has been assigned for the immunochromatographic assay for the detection of

Treponema pallidum (syphilis) antibodies in whole blood performed using the Diagnostics Direct LLC syphilis health check {finger stick whole blood}.

The new CPT® code 87502QW has been assigned for the differential and qualitative detection of influenza A and influenza B viral nucleic acids using isothermal nucleic acid amplification technology performed using the Alere i influenza A & B test {direct nasal swab only}.



Additional information

The official instruction, CR 9072, issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3207CP.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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 Effective Date: April 1, 2015
 Related CR Transmittal #: R3207CP
 Implementation Date: April 6, 2015

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Mandatory payment adjustment of 2 percent extended for Medicare FFS claims (sequestration)

For the Medicare fee-for-service (FFS) program claims with dates of service or dates of discharge on or after April 1, 2013, will continue to incur a 2 percent reduction in Medicare payment through March 31, 2016 (sequestration). Claims for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), including claims under the DMEPOS Competitive Bidding Program, will continue to be reduced by 2 percent based upon whether the date-of-service, or the start date for rental equipment or multi-day supplies, is on or after April 1, 2013. The claims payment adjustment will continue to be applied to all claims after determining coinsurance, any applicable deductible, and any applicable Medicare

secondary payment adjustments.

Although beneficiary payments for deductibles and coinsurance are not subject to the 2 percent payment reduction, Medicare's payment to beneficiaries for unassigned claims is subject to the 2 percent reduction. CMS encourages Medicare physicians, practitioners, and suppliers who bill claims on an unassigned basis to continue discussions with beneficiaries on the impact of sequestration on Medicare's reimbursement. Questions about reimbursement should be directed to your Medicare administrative contractor (<http://go.usa.gov/3xtCC>).

Ambulatory Surgical Center

April 2015 update of the ASC payment system

Provider types affected

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

Provider action needed

Change request (CR) 9100 describes changes to and billing instructions for various payment policies implemented in the April 2015 ASC payment system update and includes updates to the Healthcare Common Procedure Coding System (HCPCS). Make sure your billing staffs are aware of these changes.

Key points of CR 9100

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

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

CMS is establishing one new HCPCS device pass-through category as of April 1, 2015, for the OPPS and the ASC payment systems. The table, below, provides a listing of new coding and payment information concerning the new device category for transitional pass-through payment. HCPCS code C2623 (Catheter, transluminal angioplasty, drug-coated, non-laser) is assigned ASC PI= J7 (OPPS pass-through device paid separately when provided integral to a surgical procedure on ASC list; payment contractor-priced).

New device pass-through code HCPCS

HCPCS	Short descriptor	Long descriptor	ASC PI
C2623	Cath, translumin, drug-coat	Catheter, transluminal angioplasty, drug-coated, nonlaser	J7

a. Device offset from payment

The C2623 device should always be billed with CPT® code 37224 (*Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty*), or CPT® code 37226 (*Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed*). The Centers for Medicare & Medicare Services (CMS) has determined that a portion of the OPPS payment associated with the cost of HCPCS code C2623 is reflected in the OPPS payment for CPT® codes 37224 and 37226.



The ASC code pair file will be used to establish the reduced ASC payment amount for CPT® codes 37224 and 37226, only when billed with HCPCS code C2623.

b. Billing instructions for CPT® codes 37224 and 37226

Pass-through category C2623 (Catheter, transluminal angioplasty, drug-coated, nonlaser), is to be billed, and paid for, as a pass-through device only when provided with CPT® code 37224 (*Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty*), or CPT® code 37226 (*Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed*) beginning on and after C2623's effective date of April 1, 2015.

2. New services

No new services have been assigned for payment in the ASC payment system effective April 1, 2015.

3. Drugs, biologicals, and radiopharmaceuticals

a. New April 2015 HCPCS codes for certain drugs, biologicals, and radiopharmaceuticals

For April 2015, six new HCPCS codes, shown in the table below, have been created for reporting drugs and biologicals in the ASC setting, where there have not previously been specific codes available.

New April 2015 HCPCS codes effective for certain drugs, biologicals, and radiopharmaceuticals

HCPCS code ¹	Long descriptor	ASC PI
C9445	Injection, c-1 esterase inhibitor (recombinant), Ruconest, 10 units	K2

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ASC

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HCPSC code ¹	Long descriptor	ASC PI
C9448	Netupitant 300mg and palonosetron 0.5 mg, oral	K2
C9449	Injection, blinatumomab, 1 mcg	K2
C9450 ²	Injection, fluocinolone acetonide intravitreal implant, 0.01 mg	K2
C9451	Injection, peramivir, 1 mg	K2
C9452	Injection, ceftolozane 50 mg and tazobactam 25 mg	K2



Notes:

- HCPSC codes listed in the above table are new codes effective April 1, 2015.
- HCPSC code C9450 is associated with Iluvien® and should not be used to report any other fluocinolone acetonide intravitreal implant (e.g., Retisert®). ASCs should note that the dosage descriptor for Iluvien is 0.01 mg. Because each implant is a fixed dose containing 0.19 mg of fluocinolone acetonide, ASCs should report 19 units of C9450 for each implant.

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

For 2015, payment for non-pass-through drugs, biologicals and therapeutic radiopharmaceuticals is made at a single rate of ASP + 6 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. Additionally, in 2015, a single payment of ASP + 6 percent for pass-through drugs, biologicals and radiopharmaceuticals is made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items.

Payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. Updated payment rates effective April 1, 2015, are available the April 2015 ASC Addendum BB, which is at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html.

Suppliers who think they may have received an incorrect payment for drugs and biologicals impacted by these corrections may request MAC adjustment of the previously processed claims.

a. Revised ASC payment indicator for HCPSC J0365

Effective April 1, 2015, the ASC payment indicator for HCPSC code J0365 (Injection, ap protonin, 10,000 kiu) will change from K2 to Y5. This code is listed in the table below, along with the effective date for the revised status indicator

Drugs and biologicals with revised payment indicators

HCPSC code	Long descriptor	ASC PI	Effective date
J0365	Injection, ap protonin, 10,000 kiu	Y5	4/1/2015

b. Other changes to 2015 HCPSC codes for certain drugs, biologicals, and radiopharmaceuticals

Effective April 1, 2015, HCPSC code Q9975 Factor viii (Eloctate) will replace HCPSC code C9136 Factor viii (Eloctate). The payment indicator for Q9975 will remain K2. Code C9136 has a termination date of March 31, 2015.

The following table describes the HCPSC code change and effective date.

New HCPSC codes for certain drugs and biologicals effective April 1, 2015

HCPSC code	Short descriptor	Long descriptor	ASC PI	Added date
Q9975	Factor VIII FC Fusion Recomb	Injection, factor viii, fc fusion protein,	K2	4/1/2015

5. Billing guidance for corneal allograft tissue

ASCs can bill for corneal allograft tissue used for coverage (CPT® code 66180) or revision (CPT® code 66185) of a glaucoma aqueous shunt with HCPSC code V2785. Contractors pay for corneal tissue acquisition reported with HCPSC code V2785 based on acquisition/invoice cost.

6. Coverage determinations

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

7. Claim adjustment

Your MAC will adjust, as appropriate, claims that you bring to their attention that:

- Have dates of service January 1-March 31, 2015, and were originally processed prior to the installation of the revised January 2015 ASC DRUG file.
- Have dates of service July 1-September 30, 2014, and were originally processed prior to the installation of the revised July 2014 ASC DRUG file.

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Cardiac Services

National coverage determination for single chamber and dual chamber permanent cardiac pacemakers

Provider types affected

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

Provider action needed

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

Background

Permanent cardiac pacemakers refer to a group of self-contained, battery-operated, implanted devices that send electrical stimulation to the heart through one or more implanted leads. Single chamber pacemakers typically target either the right atrium or right ventricle. Dual chamber pacemakers stimulate both the right atrium and the right ventricle.

On August 13, 2013, CMS issued an NCD, in which CMS concluded that implanted permanent cardiac pacemakers, single chamber or dual chamber, are reasonable and necessary for the treatment of non-reversible, symptomatic bradycardia due to sinus node dysfunction and second and/or third degree atrioventricular block. Symptoms of bradycardia are symptoms that can be directly attributable to a heart rate less than 60 beats per minute (for example, syncope, seizures, congestive heart failure, dizziness, or confusion).



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

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

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

1. Reversible causes of bradycardia such as electrolyte abnormalities, medications or drugs, and hypothermia.
2. Asymptomatic first degree atrioventricular block. *(exception)
3. Asymptomatic sinus bradycardia.

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1. Have dates of service October 1-December 30, 2014, and were originally processed prior to the installation of the revised October 2014 ASC DRUG file.

Additional information

The official instruction, CR 9100, issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3214CP.pdf>.

If you have any questions, please contact your MAC at their toll-free number. That number is available

at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html> under - How Does It Work.

MLN Matters[®] Number: MM9100
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 Related CR Transmittal #: R3214CP
 Implementation Date: April 6, 2015

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

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

Note: The final decision memorandum addresses Medicare policy specific to implanted permanent cardiac pacemakers, single chamber or dual chamber, for the treatment of non-reversible symptomatic bradycardia due to sinus node dysfunction and second and/or third degree atrioventricular block. Medicare coverage of removal/replacement of implanted permanent cardiac pacemakers, single chamber or dual chamber, for the above-noted indications, were not addressed in the final decision. Therefore, it is expected that MACs will continue to apply the reasonable and necessary standard in determining local coverage within their respective jurisdictions for removal/replacement of implanted permanent cardiac pacemakers, single chamber or dual chamber.



Cardiac pacemaker Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT®) codes

Professional claims

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

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

Institutional claims

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

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

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ventricular

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

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

Cardiac pacemaker ICD-9/ICD-10 diagnosis codes

Professional claims

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

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

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

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

here for information purposes).

Institutional claims

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

- 37.81 Initial insertion of single chamber device, not specified as rate responsive
- 37.82 Initial insertion of single chamber device, rate responsive
- 37.83 Initial insertion of single chamber device
- and at least one of the following diagnosis codes in addition to the KX modifier:
 - 426.0 Atrioventricular block, complete;
 - 426.12 Mobitz (type) II atrioventricular block;
 - 426.13 Other second degree atrioventricular block;
 - 427.81 Sinoatrial node dysfunction; or
 - 746.86 Congenital heart block.

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

- 426.10 Atrioventricular block, unspecified/ I44.30 Unspecified atrioventricular block;

The KX modifier is accepted as an attestation by the practitioner and/or provider of the service that documentation is on file verifying the patient has non-reversible symptomatic bradycardia.

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

Professional claims

MACs shall return claims lines for implanted permanent cardiac pacemakers, single chamber or dual chamber,

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containing one of the following *CPT*[®] codes: 33206, 33207, or 33208, as unprocessable when the KX modifier is not present. When returning such claims, MACs shall use the following messages:

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

Institutional claims

MACs shall return to providers claims for implanted permanent cardiac pacemakers, single chamber or dual chamber, when any of the following are not present on the claim: At least one HCPCS code: C1785, C1786, C2619, or C2620, at least one *CPT*[®] code: 33206, 33207, 33208, 33227, 33228, at least one diagnosis code: 426.0/I44.2, 426.12/I44.1, 426.13/I44.1, 427.81/I49.5, 746.86/Q24.6, at least one procedure code: 37.81/OJH604Z, OJH634Z, OJH804Z, OJH834Z, 37.82/OJH605Z, OJH635Z, OJH805Z, OJH835Z, 38.83/OJH606Z, OJH636Z, OJH806Z, OJH836Z, and the KX modifier is not present on the claim.

Cardiac pacemaker non-covered ICD-10 diagnosis code

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

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

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



- **Group code PR** assigning financial liability to the beneficiary, if a claim is received with occurrence code 32 indicating a signed ABN is on file, or occurrence code 32 is present with modifier GA.

Additional information

The official instruction, CR 9078, was issued to your MAC via two transmittals. The first transmittal updates the *Medicare Claims Processing Manual* and it is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3204CP.pdf>. The second updates the *Medicare National Coverage Determination Manual* and it is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R179NCD.pdf>.

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

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Durable Medical Equipment

2015 update for DMEPOS fee schedule

Note: This article was revised February 24, 2015, to reflect the revised change request (CR) 8999 issued February 6. In the article, the CR release date, transmittal number, and the Web address for accessing the CR were updated. All other information remains the same. This information was previously published in the [December 2014 edition, Pages 7-10](#).

Provider types affected

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

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued CR 8999 to advise providers of the 2015 annual update for the Medicare DMEPOS fee schedule. The instructions include information on the data files, update factors, and other information related to the update of the fee schedule. Make sure your staffs are aware of these updates.

Background

CMS updates the DMEPOS fee schedules on an annual basis in accordance with statute and regulations. The update process for the DMEPOS fee schedule is located in the *Medicare Claims Processing Manual*, Chapter 23, Section 60, which is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf>.

Payment on a fee schedule basis is required for durable medical equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by Section 1834(a), (h), and (i) of the Social Security Act (the Act). Also, payment on a fee schedule basis is a regulatory requirement at 42 CFR Section 414.102 for parenteral and enteral nutrition (PEN), splints, casts and intraocular lenses (IOLs) inserted in a physician's office.

Key points

Fee schedule files

The DMEPOS fee schedule file will be available for providers and suppliers, as well as State Medicaid Agencies, managed care organizations, and other interested parties at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/>.

HCPCS codes added/deleted

The following new codes are effective January 1, 2015:

- A4602 in the inexpensive/routinely purchased (IN) payment category.
- The following new codes are in the prosthetics and

orthotics (PO) payment category: A7048, L3981, L6026, L7259, and L8696. (Fee schedule amounts for these codes will be added to the DMEPOS fee schedule, effective January 1, 2015.)

- Also, code A4459 is added.

The base fee for code A4602 will be submitted to CMS by CMS contractors by April 3, 2015, for inclusion in the July 2015 DMEPOS fee schedule update.

The following codes are deleted from the DMEPOS fee schedule files effective January 1, 2015: A7042, A7043, L6025, L7260, and L7261.

For gap-filling purposes, the 2014 deflation factors by payment category are as follows:

Factor	Category
0.459	Oxygen
0.462	Capped rental
0.464	Prosthetics and orthotics
0.588	Surgical dressings
0.640	Parenteral and enteral nutrition
0.963	Intraocular lenses
0.980	Splints and casts

Specific coding and pricing issues

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

For 2015, CMS is updating the weighted average insert fees used to establish the fee schedule amounts for the shoe modification codes with more current allowed service data for each insert code. The base fees for A5512 and A5513 will be weighted based on the approximated total allowed services for each code for items furnished during 2013.

The fee schedule amounts for shoe modification codes A5503 through A5507 are being revised to reflect this change, effective January 1, 2015.

Diabetic testing supplies (DTS)

The fee schedule amounts for non-mail order diabetic testing supplies (DTS) (without KL modifier) for codes A4233, A4234, A4235, A4236, A4253, A4256, A4258, A4259 are not updated by the covered item update for

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2014. In accordance with Section 636(a) of the American Taxpayer Relief Act of 2012, the fee schedule amounts for these codes were adjusted in 2013 so that they are equal to the single payment amounts for mail order DTS established in implementing the national mail order competitive bidding program (CBP) under Section 1847 of the Act.

The non-mail order payment amounts on the fee schedule file will be updated each time the single payment amounts are updated which can happen no less often than every three years as CBP contracts are re-competed. The national competitive bidding program for mail order diabetic supplies is effective July 1, 2013, to June 30, 2016.

The program instructions reviewing the changes are in Transmittal 2661, CR 8204, dated February 22, 2013. The *MLN Matters*[®] article related to CR 8204 is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-NetworkMLN/MLNMattersArticles/downloads/MM8204.pdf>.

Although for payment purposes the single payment amounts replace the fee schedule amounts for mail order DTS (KL modifier), the fee schedule amounts remain on the DMEPOS fee schedule file as reference data such as for establishing bid limits for future rounds of competitive bidding programs. The mail order DTS fee schedule amounts shall be updated annually by the covered item update, adjusted for multi-factor productivity (MFP), which results in update of 1.5 percent for 2015. The single payment amount public use file for the national mail order competitive bidding program is available at <http://www.dmecompetitivebid.com/palmetto/cbicrd2.nsf/DocsCat/Single%20Payment%20Amounts>.

2015 fee schedule update factor of 1.5 percent

For 2015, the update factor of 1.5 percent is applied to the applicable 2014 DMEPOS fee schedule amounts. In accordance with the statutory Sections 1834(a)(14) and 1886(b)(3)(B)(xi)(II) of the Act, the DMEPOS fee schedule amounts are to be updated for 2015 by the percentage increase in the consumer price index for all urban consumers (United States city average) or CPI-U for the 12-month period ending with June of 2014, adjusted by the change in the economy-wide productivity equal to the 10-year moving average of changes in annual economy-wide private non-farm business multi-factor productivity (MFP). The MFP adjustment is 0.6 percent and the CPI-U percentage increase is 2.1 percent. Thus, the 2.1 percentage increase in the CPI-U is reduced by the 0.6 percentage increase in the MFP resulting in a net increase of 1.5 percent for the update factor.

2015 update to the labor payment rates

The table below contains the 2015 allowed payment amounts for HCPCS labor payment codes K0739, L4205 and L7520. Since the percentage increase in the CPI-U for the 12-month period ending with June 30, 2014, is 2.1 percent this change is applied to the 2014 labor payment

amounts to update the rates for 2015.

The 2015 labor payment amounts in the following table are effective for claims submitted using HCPCS codes K0739, L4205 and L7520 with dates of service from January 1, 2015, through December 31, 2015.

State	K0739	L4205	L7520
AK	\$27.98	\$31.88	\$37.50
AL	\$14.86	\$22.14	\$30.05
AR	\$14.86	\$22.14	\$30.05
AZ	\$18.37	\$22.11	\$36.97
CA	\$22.79	36.34	\$42.35
CO	\$14.86	\$22.14	\$30.05
CT	\$24.81	\$22.63	\$30.05
DC	\$14.86	\$22.11	\$30.05
NC	\$14.86	\$22.14	\$30.05
ND	\$18.51	\$31.81	\$37.50
NE	\$14.86	\$22.11	\$41.90
NH	\$15.95	\$22.11	\$30.05
NJ	\$20.04	\$22.11	\$30.05
NM	\$14.86	\$22.14	\$30.05
NV	\$23.67	\$22.11	\$40.96
NY	\$27.35	\$22.14	\$30.05
DE	\$27.35	\$22.11	\$30.05
FL	\$14.86	\$22.14	\$30.05
GA	\$14.86	\$22.14	\$30.05
HI	\$18.37	\$31.88	\$37.50
IA	\$14.86	\$22.11	\$35.97
ID	\$14.86	\$22.11	\$30.05
IL	\$14.86	\$22.11	\$30.05
IN	\$14.86	\$22.11	\$30.05
KS	\$14.86	\$22.11	\$37.50
KY	\$14.86	\$28.34	\$38.43
LA	\$14.86	\$22.14	\$30.05
MA	\$24.81	\$22.11	\$30.05
MD	\$14.86	\$22.11	\$30.05
ME	\$24.81	\$22.11	\$30.05
MI	\$14.86	\$22.11	\$30.05
MN	\$14.86	\$22.11	\$30.05
MO	\$14.86	\$22.11	\$30.05
MS	\$14.86	\$22.14	\$30.05
MT	\$14.86	\$22.11	\$37.50
OH	\$14.86	\$22.11	\$30.05
OK	\$14.86	\$22.14	\$30.05
OR	\$14.86	\$22.11	\$43.21
PA	\$15.95	\$22.77	\$30.05
PR	\$14.86	\$22.14	\$30.05
RI	\$17.70	\$22.79	\$30.05
SC	\$14.86	\$22.14	\$30.05
SD	\$16.60	\$22.11	\$40.18

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State	K0739	L4205	L7520
TN	\$14.86	\$22.14	\$30.05
TX	\$14.86	\$22.14	\$30.05
UT	\$14.90	\$22.11	\$46.79
VA	\$14.86	\$22.11	\$30.05
VI	\$14.86	\$22.14	\$30.05
VT	\$15.95	\$22.11	\$30.05
WA	\$23.67	\$32.44	\$38.53
WI	\$14.86	\$22.11	\$30.05
WV	\$14.86	\$22.11	\$30.05
WY	\$20.71	\$29.50	\$41.90
WY	\$20.71	\$29.50	\$41.90

2015 national monthly payment amounts for stationary oxygen equipment

As part of CR 8999, CMS is implementing the 2015 national monthly payment amount for stationary oxygen equipment (HCPCS codes E0424, E0439, E1390 and E1391), effective for claims with dates of service on or after January 1, 2015. Included is the updated national 2015 monthly payment amount of \$180.92 for stationary oxygen equipment codes in the DMEPOS fee schedule. As required by statute, the payment amount must be adjusted on an annual basis, as necessary, to ensure budget neutrality of the new payment class for oxygen generating portable equipment (OGPE). Also, the updated 2015 monthly payment amount of \$180.92 includes the 1.5 percent update factor for the 2015 DMEPOS fee schedule. Thus, the 2014 rate changed from \$178.24 to the 2015 rate of \$180.92.

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

2015 maintenance and servicing payment amount for certain oxygen equipment

Also updated for 2015 is the payment amount for maintenance and servicing for certain oxygen equipment. Payment instructions for claims for maintenance and servicing of oxygen equipment are in Transmittal 635, CR 6792, dated February 5, 2010, (see the article at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-NetworkMLN/MLNMattersArticles/downloads/MM6792.pdf>) and Transmittal 717, CR 6990, dated June 8, 2010, (see the related article at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-NetworkMLN/MLNMattersArticles/downloads/MM6990.pdf>).

To summarize, payment for maintenance and servicing

of certain oxygen equipment can occur every six months beginning six months after the end of the 36th month of continuous use or end of the supplier's or manufacturer's warranty, whichever is later for either HCPCS code E1390, E1391, E0433, or K0738, billed with the MS modifier. Payment cannot occur more than once per beneficiary, regardless of the combination of oxygen concentrator equipment and/or transfilling equipment used by the beneficiary, for any six-month period.

Per 42 CFR Section 414.210(5)(iii), the 2010 maintenance and servicing fee for certain oxygen equipment was based on 10 percent of the average price of an oxygen concentrator. For 2011 and subsequent years, the maintenance and servicing fee is adjusted by the covered item update for DME as set forth in Section 1834(a)(14) of the Act. Thus, the 2014 maintenance and servicing fee is adjusted by the 1.5 percent MFP-adjusted covered item update factor to yield a 2015 maintenance and servicing fee of \$69.76 for oxygen concentrators and transfilling equipment.

Update to change request (CR) 8566

Effective April 1, 2014, payment on a purchase basis was established for capped rental wheelchair accessory codes furnished for use with complex rehabilitative power wheelchairs. Such accessories are considered as part of the complex rehabilitative power wheelchair and associated lump sum purchase option set forth at 42 CFR Section 414.229(a)(5). These changes were implemented in Transmittal 1332, CR 8566, dated January 2, 2014. Code E2378 is added to the list of codes eligible for payment on a purchase basis when furnished for use with a complex rehabilitative power wheelchair.

Additional information

The official instruction for CR 8999 issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3190CP.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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Medicare Physician Fee Schedule

April Medicare physician fee schedule database update

Provider types affected

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

Provider action needed

Change request (CR) 9104 informs MACs about the release of payment files based upon the 2015 Medicare physician fee schedule (MPFS) final rule. Make sure that your billing staffs are aware of these changes.

Background

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

Section 1848(c)(4) of the Social Security Act authorizes the Secretary to establish ancillary policies necessary to implement relative values for physicians' services.

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

In the final rule, Centers for Medicare & Medicaid Services (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 provider fee schedule rates before they went into effect. CMS supports legislation to permanently change the sustainable growth rate to provide more stability for Medicare beneficiaries and providers while promoting efficient, high quality care.

Changes for certain CPT[®]/HCPCS codes included in the April update to the 2015 MPFSDB are as follows:

- J1826 Procedure status = E
- J9010 Procedure status = N
- 77063 Type of service = 1
- 93355 Multiple surgery indicator = 2 and type of service = 4
- 93644 type of service = 2

Code G0279 has a new short descriptor of "Tomosynthesis, mammo".

In addition, the following codes have a procedure status of "I": 80300, 80301, 80302, 80303, 80304, 80320, 80321,

80322, 80323, 80324, 80325, 80326, 80327, 80328, 80329, 80330, 80331, 80332, 80333, 80334, 80335, 80336, 80337, 80338, 80339, 80340, 80341, 80342, 80343, 80344, 80345, 80346, 80347, 80348, 80349, 80350, 80351, 80352, 80353, 80354, 80355, 80356, 80357, 80358, 80359, 80360, 80361, 80362, 80363, 80364, 80365, 80366, 80367, 80368, 80369, 80370, 80371, 80372, 80373, 80374, 80375, 80376, and 80377.

Effective for services on or after April 1, 2015, the following codes will have a procedure status of "X": 81500, 81503, 81506, 81508, 81509, 81510, 81511, 81512, and 81599.

Also, effective for services on or after April 1, 2015, new code Q9975 is added with a short descriptor of "Factor VIII FC Fusion Recomb" and a long descriptor of "Injection, Factor VIII, FC Fusion Protein (Recombinant), per iu". The procedure status code for Q9975 is "E" and it has a global surgery modifier of "XXX".

Finally, S8032 was transposed as S0832 in the January 2015 MPFS; S0832 has been replaced with S8032 in the April 2015 MPFS.

Note: MACs will not search their files to either retract payment for claims already paid or to retroactively pay claims which were impacted by the above changes. MACs will adjust claims that you bring to their attention.

Additional information

The official instruction, CR 9104, issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3205CP.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: MM9104
 Related Change Request (CR) #: CR 9104
 Related CR Release Date: February 27, 2015
 Effective Date: April 1, 2015
 Related CR Transmittal #: R3205CP
 Implementation Date: April 6, 2015

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Preventive Services

Screening for hepatitis C virus in adults

Note: This article was revised March 13, 2015, to reflect the revised change request (CR) 8871 issued March 11. The article was revised to (1) replace “January 1, 2015, MPFSDB” with “January 1, 2016, CLFS” under “Background,” (2) remove 50 (FQHC) and 72 (RHC) from the list of place of service codes under “Professional billing requirements,” (3) clarify payment method for type of bill 13x, (4) add clarifying language for FQHC and RHC, and remove incorrect language regarding claim processing for federally qualified health centers (FQHCs) and rural health clinic (RHC), (5) clarify Medicare administrative contractor (MAC) claim processing prior to January 1, 2016, instead of January 1, 2015, also in the “Background” section. All other information remains the same. This information was previously published in the [December 2014 Medicare B Connection, Pages 15-17](#).



Provider types affected

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

What you need to know

Change request (CR) 8871 states, effective June 2, 2014, the Centers for Medicare & Medicaid Services (CMS) will cover screening for HCV consistent with the grade B recommendations by the United States Preventive Services Task Force (USPSTF) for the prevention or early detection of an illness or disability and is appropriate for individuals entitled to benefits under Medicare Part A or enrolled under Part B. Make sure your billing staffs are aware of these changes.

Background

Hepatitis C virus (HCV) is an infection that attacks the liver and is a major cause of chronic liver disease. Inflammation over long periods of time (usually decades) can cause scarring, called cirrhosis. A cirrhotic liver fails to perform the normal functions of the liver which leads to liver failure. Cirrhotic livers are more prone to become cancerous and liver failure leads to serious complications, even death. HCV is reported to be the leading cause of chronic hepatitis, cirrhosis, and liver cancer, and a primary indication for liver transplant in the western world.

Prior to June 2, 2014, CMS did not cover screening for HCV in adults. Pursuant to §1861(ddd) of the Social Security Act, CMS may add coverage of “additional preventive services” through the national coverage

determination (NCD) process.

Effective June 2, 2014, CMS will cover screening for HCV with the appropriate U.S. Food and Drug Administration (FDA) approved/cleared laboratory tests (used consistently with FDA-approved labeling and in compliance with the Clinical Laboratory Improvement Act (CLIA) regulations) and point-of-care tests (such as rapid anti-body tests that are performed in outpatient clinics and physician offices) when ordered by the beneficiary’s primary care physician or practitioner within the context of a primary care setting, and performed by an eligible Medicare provider for these services, for beneficiaries who meet either of the following conditions:

1. Adults at high risk for HCV infection. “High risk” is defined as persons with a current or past history of illicit injection drug use, and persons who have a history of receiving a blood transfusion prior to 1992. Repeat screening for high risk persons is covered annually only for persons who have had continued illicit injection drug use since the prior negative screening test.
2. Adults who do not meet the high risk definition as defined above, but who were born from 1945 through 1965. A single, once-in-a-lifetime screening test is covered for these individuals.

The determination of “high risk for HCV” is identified by the primary care physician or practitioner who assesses the patient’s history, which is part of any complete medical history, typically part of an annual wellness visit and considered in the development of a comprehensive prevention plan. The medical record should be a reflection of the service provided.

General claim processing requirements for claims with dates of service on and after June 2, 2014

1. New HCPCS G0472, short descriptor – Hep C screen high risk/other and long descriptor- Hepatitis C antibody screening for individual at high risk and other covered indication(s), will be used. HCPCS G0472 will appear in the January 2016 recurring updates of the clinical laboratory fee schedule (CLFS) and the integrated outpatient code editor (IOCE) with a June 2, 2014, effective date. MACs shall apply contractor pricing to claims with dates of service June 2, 2014, through December 31, 2015 that contain HCPCS G0472. MACs will not automatically adjust claims that may be processed in error, but will adjust such claims that you bring to their attention.
2. Beneficiary coinsurance and deductibles do not apply

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to HCPCS G0472.

3. For services provided to beneficiaries born between the years 1945 and 1965 who are not considered high risk, HCV screening is limited to once per lifetime, claims shall be submitted with:
 - HCPCS G0472
4. For those determined to be high-risk initially, claims must be submitted with:
 - HCPCS G0472; and
 - ICD-9 diagnosis code V69.8, other problems related to lifestyle/ICD-10 diagnosis code Z72.89, other problems related to lifestyle (once ICD-10 is implemented).
5. Screening may occur on an annual basis if appropriate, as defined in the policy. Claims for adults at high risk who have had continued illicit injection drug use since the prior negative screening shall be submitted with:
 - HCPCS G0472;
 - ICD diagnosis code V69.8/Z72.89; and
 - ICD diagnosis code 304.91, unspecified drug dependence, continuous/F19.20, other psychoactive substance abuse, uncomplicated (once ICD-10 is implemented).

Note: Annual is defined as 11 full months must pass following the month of the last negative HCV screening.

Institutional billing requirements

Effective for claims with dates of service on and after June 2, 2014, institutional providers may use types of bill (TOB) 13x, 71x, 77x, and 85x when submitting claims for HCV screening, HCPCS G0472. Medicare will deny G0472 service line-items on other TOBs using the following messages:

- **Claim adjustment reason code (CARC) 170** – Payment denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- **Remittance advice remarks code (RARC) N95** – This provider type/provider specialty may not bill this service.
- **Group code CO** (contractual obligation) – If claim received without a GZ modifier.

The service is paid on the following basis:

- **Outpatient hospitals** – TOB 13x – based on the outpatient prospective payment system.
- **Rural health clinics (RHCs)** – TOB – and federally qualified health centers (FQHCs) - 77x - for RHCs and FQHCs that are authorized to bill under the all-inclusive rate (AIR) system, payment for the professional component is included in the AIR. For FQHCs authorized to bill under the FQHC prospective payment

system (PPS), payment for the professional component is included in the FQHC PPS rate. HCV screening is not a stand-alone payable visit for RHCs and FQHCs.

- **Critical access hospitals (CAHs)** – TOB 85x – based on reasonable cost; and
- **CAH Method II** – TOB 85x – based on 115 percent of the lesser of the MPFS amount or actual charge as applicable with revenue codes 096x, 097x, or 098x.

Note: Separate guidance shall be issued for FQHCs that are authorized to bill under the prospective payment system.

Professional billing requirements

For professional claims with dates of service on or after June 2, 2014, CMS will allow coverage for HCPCS G0472, only when services are submitted by the following provider specialties found on the provider's enrollment record:

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

Medicare will deny claims submitted for these services by providers other than the specialty types noted above. When denying such claims, Medicare will use the following messages:

- **CARC 184** – The prescribing/ordering provider is not eligible to prescribe/order the service. NOTE: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- **RARC N574** – Our records indicate the ordering/referring provider is of a type/specialty that cannot order/refer. Please verify that the claim ordering/referring information is accurate or contact the ordering/referring provider.
- **Group code CO** if claim received without GZ modifier.

For professional claims with dates of service on or after June 2, 2014, CMS will allow coverage for HCV screening, HCPCS G0472, only when submitted with one of the following place of service (POS) codes:

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

Medicare will deny claims submitted without one of the

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POS codes noted above with the following messages:

- **CARC 171** – Payment denied when performed by this type of provider in this type of facility. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- **RARC N428** – Not covered when performed in this place of service.
- **Group code CO** if claim received without GZ modifier.

Other billing information for both professional and institutional claims

On both institutional and professional claims, Medicare will deny claims line-items for HCPCS G0472 with dates of service on or after June 2, 2014, where it is reported more than once-in-a-lifetime for beneficiaries born from 1945 through 1965 and who are not high risk. Medicare will also line-item deny when more than one HCV screening is billed for the same high-risk beneficiary prior to their annual eligibility criteria being met. In denying these claims, Medicare will use:

- **CARC 119** – Benefit maximum for this time period or occurrence has been reached.
- **RARC N386** – This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp on the CMS website. If you do not have web access, you may contact the contractor to request a copy of the NCD.
- **Group code CO** if claim received without GZ modifier.

When applying the annual frequency limitation, MACs will allow both a claim for a professional service and a claim for a facility fee.

In addition, remember that the initial HCV screening for beneficiaries at high risk must also contain ICD-9 diagnosis code V69.8 (ICD-10 code Z72.89 once ICD-10 is implemented).

Then, for the subsequent annual screenings for high risk beneficiaries, you must include ICD-9 code V69.8 and 304.91 (ICD-10 of Z72.89 and F19.20 once ICD-10 is implemented). Failure to include the diagnosis code(s) for high risk beneficiaries will result in denial of the line item. In denying these payments, Medicare will use the following:

- **CARC 119** – Benefit maximum for this time period or occurrence has been reached. (for initial high risk screening), or,
- **CARC 167** – This (these) diagnosis(es) is (are) not covered. **Note:** Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. (for subsequent annual high risk screening)
- **RARC N386** – This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp on the CMS website. If you do not have web access, you may contact the contractor to request a copy of the NCD.
- **Group code CO** if claim received without GZ modifier.

Additional information

The official instruction, CR 8871, was issued to your MAC regarding this change via two transmittals. The first transmittal updates the *Medicare Claims Processing Manual* and it is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3215CP.pdf>. The second transmittal updates the *NCD Manual* and it is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R177NCD.pdf>.

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

MLN Matters® Number: MM8871 *Revised*
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 Effective Date: June 2, 2014

Implementation Date: January 5, 2015, for non-shared MAC
 Related CR Transmittal #: R3215CP and edits and CWF analysis; April 6, 2015, for remaining shared R177NCD system edits

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General Coverage

Removal of multiple national coverage determinations using an expedited process

Provider types affected

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

Provider action needed

Effective December 18, 2014, change request (CR) 9095 removes Sections 50.6 – Tinnitus masking, 160.4 – Stereotactic Cingulotomy as a Means of Psychosurgery, 160.6 – Carotid Sinus Nerve Stimulator, 160.9 – Electroencephalographic (EEG) Monitoring During Open – Heart Surgery, 190.4 – Electron Microscope, 220.7 – Xenon Scan, and 220.8 – Nuclear Radiology Procedure from the Medicare *National Coverage Determinations Manual* or the *NCD Manual*. Providers and their staffs should be aware that removing an NCD results in coverage determinations being at the discretion of local MACs within their respective jurisdictions.

Background

CR 9095 removes seven NCDs from Publication 100-03, *NCD Manual*, pursuant to the expedited process that was established in an August 7, 2013, *Federal Register* (FR) notice (78 FR 48164). The FR notice is available at <http://www.cms.gov/Medicare/Coverage/DeterminationProcess/Downloads/FR08072013.pdf>.

A CMS decision memorandum dated December 18, 2014, contains a summary of the expedited removal process and explicitly removes seven NCDs from the NCD Manual sections as follows:

- 50.6 – Tinnitus masking;
- 160.4 – Stereotactic Cingulotomy as a Means of Psychosurgery;
- 160.6 – Carotid Sinus Nerve Stimulator;
- 160.9 – Electroencephalographic (EEG) Monitoring During Open-Heart Surgery;
- 190.4 – Electron Microscope;

- 220.7 – Xenon Scan; and
- 220.8 – Nuclear Radiology Procedure.

You can review the CMS decision memorandum at <http://www.cms.gov/medicare-coverage-database/details/medicare-coverage-document-details.aspx?MCDId=29&mcctype=National+Coverage+Determinations+Proposed+for+Removal&MCDIndexType=7&bc=AgAEAAAAAAAAAAA%3d%3d&>.

In the absence of an NCD, MACs should revert to historical standing policy and consider whether any Medicare claims for these services are reasonable and necessary under the Social Security Act (Section 1862(a)(1)(A); see http://www.ssa.gov/OP_Home/ssact/title18/1862.htm) consistent with the existing guidance for making such decisions when there is no NCD.

Additional information

The official instruction, CR 9095, issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R180NCD.pdf>.

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

MLN Matters[®] Number: MM9095
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Mass adjustment of claims containing codes G0473 and 77063

Due to a systems error, coinsurance and deductible are not being waived on claims containing codes G0473 (intensive behavioral therapy for obesity) and 77063 (screening digital breast tomosynthesis, bilateral).

The problem will be corrected April 6, 2015.

For claims with dates of service of January 1, 2015, through March 31, 2015, Medicare administrative contractors will be mass adjusting these claims and issuing corrected payments for all impacted claims.

Providers must reimburse beneficiaries for any overpayment caused by this error.

Medicare fee-for-service claim processing guidance for implementing ICD-10

Note: This article was revised February 20, 2015, to add a question and answer in the “Key points of SE1408” section regarding dual processing of ICD-9 and ICD-10 codes. All other information remains the same. This information was previously published in the [August 2014 Medicare B Connection](#), Pages 25-28.

Provider types affected

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

Provider action needed

For dates of service on and after October 1, 2015, entities covered under the Health Insurance Portability and Accountability Act (HIPAA) are required to use the ICD-10 code sets in standard transactions adopted under HIPAA. The HIPAA standard health care claim transactions are among those for which ICD-10 codes must be used for dates of service on and after October 1, 2015. As a result of change request (CR) 7492 (and related *MLN Matters*[®] article MM7492), guidance was provided on processing certain claims for dates of service near the original October 1, 2013, implementation date for ICD-10. This article updates MM7492 to reflect the October 1, 2015, implementation date. Make sure your billing and coding staffs are aware of these changes.

Key points of SE1408

General reporting of ICD-10

As with ICD-9 codes today, providers and suppliers are still required to report all characters of a valid ICD-10 code on claims. ICD-10 diagnosis codes have different rules regarding specificity and providers/suppliers are required to submit the most specific diagnosis codes based upon the information that is available at the time. Please refer to <http://www.cms.gov/Medicare/Coding/ICD10/index.html> for more information on the format of ICD-10 codes. In addition, ICD-10 procedure codes (PCs) will only be utilized by inpatient hospital claims as is currently the case with ICD-9 procedure codes.

General claims submissions information

ICD-9 codes will no longer be accepted on claims (including electronic and paper) with FROM dates of service (on professional and supplier claims) or dates of discharge/through dates (on institutional claims) on or after October 1, 2015. Institutional claims containing ICD-9 codes for services on or after October 1, 2015, will be returned to provider (RTP) as unprocessable. Likewise, professional and supplier claims containing ICD-9 codes for dates of services on or after October 1, 2015, will also

be returned as unprocessable. You will be required to re-submit these claims with the appropriate ICD-10 code. A claim cannot contain both ICD-9 codes and ICD-10 codes. Medicare will RTP all claims that are billed with both ICD-9 and ICD-10 diagnosis codes on the same claim. For dates of service prior to October 1, 2015, submit claims with the appropriate ICD-9 diagnosis code. For dates of service on or after October 1, 2015, submit with the appropriate ICD-10 diagnosis code. Likewise, Medicare will also RTP all claims that are billed with both ICD-9 and ICD-10 procedure codes on the same claim. For claims with dates of service prior to October 1, 2015, submit with the appropriate ICD-9 procedure code. For claims with dates of service on or after October 1, 2015, submit with the appropriate ICD-10 procedure code. Remember that ICD-10 codes may only be used for services provided on or after October 1, 2015. Institutional claims containing ICD-10 codes for services prior to October 1, 2015, will be RTP. Likewise, professional and supplier claims containing ICD-10 codes for services prior to October 1, 2015, will be returned as unprocessable. Please submit these claims with the appropriate ICD-9 code.

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

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

Claims that span the ICD-10 implementation date

CMS has identified potential claims processing issues for institutional, professional, and supplier claims that span the implementation date; that is, where ICD-9 codes are effective for the portion of the services that were rendered on September 30, 2015, and earlier and where ICD-10 codes are effective for the portion of the services that were rendered October 1, 2015, and later. In some cases, depending upon the policies associated with those services, there cannot be a break in service or time (i.e., anesthesia) although the new ICD-10 code set must be used effective October 1, 2015. The following tables provide further guidance to providers for claims that span the periods where ICD-9 and ICD-10 codes may both be applicable.

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Table A – Institutional Providers

Bill type(s)	Facility type/ services	Claim processing requirement	Use FROM or THROUGH date
11x	Inpatient hospitals (incl. TERFHA hospitals, prospective payment system (PPS) hospitals, long term care hospitals (LTCHs), critical access hospitals (CAHs))	If the hospital claim has a discharge and/ or through date on or after 10/1/15, then the entire claim is billed using ICD-10.	THROUGH
12x	Inpatient Part B hospital services	Split claims – require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM
13x	Outpatient hospital	Split claims – require providers split the claim so all ICD-9 codes remain on one claim with DOS through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM

Bill type(s)	Facility type/ services	Claim processing requirement	Use FROM or THROUGH date
14x	Non-patient laboratory services	Split claims – require providers split the claim so all ICD-9 codes remain on one claim with DOS through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM
18x	Swing beds	If the [swing bed or SNF] claim has a discharge and/or through date on or after 10/1/2015, then the entire claim is billed using ICD-10.	THROUGH
21x	Skilled nursing (inpatient Part A)	If the [swing bed or SNF] claim has a discharge and/or through date on or after 10/1/2015, then the entire claim is billed using ICD-10.	THROUGH
22x	Skilled nursing facilities (inpatient Part B)	Split claims – require providers split the claim so all ICD-9 codes remain on one claim with DOS through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM

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Bill type(s)	Facility type/ services	Claim processing requirement	Use FROM or THROUGH date
23x	Skilled nursing facilities (outpatient)	Split claims - require providers split the claim so all ICD-9 codes remain on one claim with DOS through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM
32x	Home health (inpatient Part B)	Allow HHAs to use the payment group code derived from ICD-9 codes on claims which span 10/1/2015, but require those claims to be submitted using ICD-10 codes.	THROUGH
3x2	Home health – request for anticipated payment (RAPs)*	* Note – RAPs can report either an ICD-9 code or an ICD-10 code based on the one (1) date reported. Since these dates will be equal to each other, there is no requirement needed. The corresponding final claim, however, will need to use an ICD-10 code if the HH episode spans beyond 10/1/2015.	*See Note

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

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Bill type(s)	Facility type/ services	Claim processing requirement	Use FROM or THROUGH date
74x	Outpatient therapy	Split claims – require providers split the claim so all ICD-9 codes remain on one claim with DOS through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM
75x		Split claims – require providers split the claim so all ICD-9 codes remain on one claim with DOS through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM
76x	Community mental health clinics	Split claims – require providers split the claim so all ICD-9 codes remain on one claim with DOS through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM



Bill type(s)	Facility type/ services	Claim processing requirement	Use FROM or THROUGH date
77x	Federally qualified health clinics (effective 4/4/10)	Split claims – require providers split the claim so all ICD-9 codes remain on one claim with DOS through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM
81x	Hospice-hospital	Split claims – require providers split the claim so all ICD-9 codes remain on one claim with DOS through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM

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

Table B - Special outpatient claim processing circumstances

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

Table C – Professional claims

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

Table D – Supplier claims

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

Additional information

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

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

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

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MODIFIER

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modifier program is being gradually phased in as follows:

- In 2015, the payment adjustments will apply to physicians in groups of 100 or more EPs, based on a 2013 performance period.
- In 2016, the payment adjustments will apply to physicians in groups of 10 or more EPs based on 2014 performance;
- In 2017, the payment adjustments will apply to physician solo practitioners and physicians in groups of 2 or more EPs based on 2015 performance; and
- Beginning 2018, the payment adjustments will also apply to non-physician EPs who are solo practitioners or are in groups of two or more EPs. Please note that the performance period for the value modifier that will be applied in 2018 will be proposed and finalized in the 2016 Medicare physician fee schedule proposed and final rules, respectively.

For more information on future years of the value modifier, please visit <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html>.

Go – what you need to do

Participate in the physician quality reporting system (PQRS) every year to avoid an automatic downward payment adjustment under the value modifier during the associated payment year. The data reported to PQRS for a given calendar year are used to calculate the value modifier for the calendar year that follows it by two years. For example, PQRS quality data for calendar year 2013 were used to calculate the value modifier affecting payments in 2015.

PQRS quality data are reported during the first quarter of the year following a given performance year. Physician groups should register to participate in the PQRS group practice reporting option (GPRO) in the fall of each year, to report data for that year.

Beginning with the 2016 value modifier, based on 2014 performance, EPs in a group have the option to participate in PQRS as individuals providing at least 50 percent of the group report. Use the information provided in your group's quality and resource use report (QRUR), as described below, to improve your performance on the quality and cost measures that are used to calculate the value modifier. Also, make sure that your billing staff is aware of these new payment adjustments.

Download your QRUR to understand how you performed on the cost and quality measures used to calculate the value modifier. Information on how to access these reports, which contain valuable information on the quality and cost of care provided to the Medicare beneficiaries you or your group serve is available at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/index.html>.

Background

The Social Security Act requires that CMS establish a value modifier that provides for differential payment under the Medicare physician fee schedule (MPFS) based upon the quality of care furnished compared to cost during a performance period. By law, the value modifier is to be applied to:

- Specific physicians and groups of physicians that CMS determines appropriate starting January 1, 2015; and
- All physicians and groups of physicians by January 1, 2017.

Accordingly, CMS established the physician feedback/value-based payment modifier program to provide comparative performance information to individual physicians and groups, as part of Medicare's efforts to improve the quality and efficiency of medical care.

The program (which is specific to fee-for-service Medicare – not Medicare Advantage) contains two primary components:

- The physician quality and resource use reports (QRURs), and
- The value-based incentive payment modifier (value modifier).

What is a quality and resource use report?

CMS has already provided annual QRURs to groups with at least one physician and physicians who are solo practitioners, to provide feedback on the quality of care furnished to Medicare beneficiaries and the cost of that care. Beginning in 2015, CMS will provide QRURs based on 2014 performance to all groups and solo practitioners, including non-physician groups and solo practitioners. Groups and solo practitioners can use the information provided in the QRURs to improve the care they provide to Medicare beneficiaries and to improve performance on quality and cost measures used to calculate the value modifier. The QRURs include information about a TINs' performance on PQRS quality measures, three claims-based outcome measures, and claims-based cost measures. The reports contain detailed information on care provided both inside a group and outside the group to help improve care coordination and efficiency.

For more information about QRURs, see <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Background.html>.

What is the value-based payment modifier (value modifier)?

The value modifier can be upward, downward, or neutral (meaning no adjustment), and it applies to the Medicare paid amount of physician payments under the Medicare physician fee schedule (MPFS).

Beginning on January 1, 2015, CMS is applying the value modifier to MPFS payments made to physicians in group practices with 100 or more EPs billing under a single TIN. In 2015, groups of 100 or more EPs that met the

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minimum PQRS reporting requirement had the option to elect whether they wished to have their value modifier calculated based on quality performance. For those groups who elected this “quality-tiering approach,” CMS determined each group’s value modifier adjustment for 2015 based on their performance on PQRS measures and claims-based outcome and cost measures in 2013.

The value modifier payment adjustment for 2015 ranges from a downward adjustment of negative 1 percent (for low quality/high cost care) to an upward adjustment of positive 2.X (for low cost/high quality care). The “X” in the upward adjustment represents an adjustment factor that is used to redistribute payment reductions (taken from groups that do not successfully report and those that perform poorly on quality and cost measures) to those groups that perform well.

In future years, the quality tiering approach will be mandatory, but in 2016 and 2017, group sizes that are new to the value modifier will only be eligible for upward or neutral adjustments under quality tiering. Policies for the 2018 value modifier will be made in the 2018 physician fee schedule rule. As the value modifier’s application to smaller group sizes and groups of non-physician EPs is gradually phased in, the maximum available incentives and maximum downward adjustments are gradually increased.

More information on the value modifier is available at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html>.

What payments are affected by the value modifier?

In 2015 CMS applies the value modifier adjustment at the TIN level to the items and services billed by physicians in the group, not to other eligible professionals that also may bill under the TIN. A “physician” is defined for the value modifier program as: a doctor of medicine; doctor of osteopathy; doctor of podiatric medicine; doctor of optometry; doctor of dental surgery; doctor of dental medicine; or doctor of chiropractic.

Beginning with 2018 payments, the value modifier will apply to non-physician EP’s payments as well. These include non-physician practitioners (e.g., nurse practitioners, physician assistants, and clinical nurse specialists), occupational therapists, physical therapists, speech-language pathologists, and audiologists. The value modifier is applied to the Medicare paid amounts for the items and services billed under the MPFS so that beneficiary cost-sharing is not affected.

Application of the value modifier at the TIN level means that if a physician changes groups from TIN A in the performance period (2013) to TIN B in the payment adjustment period (2015), then CMS would apply TIN B’s value modifier to the physician’s payments for items and services provided during 2015 and billed under TIN B.

What if I think there is an error in my value modifier?

If a physician group believes that CMS has made an

error in the calculation of the group’s value modifier, then the group may request a correction through our informal review process. For the 2016 value modifier and beyond, informal review must be requested no later than 60 days after receipt of the QRUR. If, upon review, CMS determines that we have made an error in the calculation of the quality composite and we are unable to recalculate it, then we will classify the TIN as “average quality.” For the 2016 value modifier and beyond, if we are able to receive and utilize corrected quality data, then we will recalculate the quality composite. If we determine we made an error in the calculation of the cost composite then we will recompute the cost composite to correct the error.

Who can I contact for further information?

Physician value help desk (for value modifier questions)
Monday-Friday: 8:00 am-8:00 pm EST
Phone: 888-734-6433, press option 3
QualityNet help desk (for PQRS questions: 866-288-8912 (TTY 877-715-6222)
7:00 a.m.–7:00 p.m. CST M-F or qnetssupport@hcqis.org

You will be asked to provide basic information such as name, practice, address, phone, and e-mail address.

Additional Information

More information about the full implementation of the CMS physician feedback/value-based payment modifier program is available at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html>.

A summary of the 2015 physician value-based payment modifier policies can be found at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/CY2015ValueModifierPolicies.pdf>.

You can review the timeline (2012-2017) for the physician feedback/value-based payment modifier program at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Background.html>.

More information about the value modifier program is available at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/index.html>.

You can find out more about the PQRS program at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html>.

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Guidance on the PQRS for rural health clinics, federally qualified health centers, and critical access hospitals

Provider types affected

This article is intended for rural health clinics (RHCs), federally qualified health centers (FQHCs), and critical access hospitals (CAHs) who submit claims to Medicare administrative contractors (MACs) for services furnished to Medicare beneficiaries.

What you need to know

In this informational article the Centers for Medicare & Medicaid Services (CMS) provides answers to some frequently asked questions raised by staff at RHCs, FQHCs, and CAHs.

Frequently asked questions - RHCs and FQHCs

Question: If I furnish professional Medicare Part B services only at an RHC or an FQHC, are the services eligible for PQRS?

Answer: No, if you furnish Medicare Part B professional services **only** at an RHC or an FQHC, such services are not eligible for either the PQRS incentive payment or for the PQRS negative payment adjustment.

Question: I'm an eligible professional (EP) and I furnish professional Medicare Part B services at an RHC/FQHC and also furnish services at a non-RHC/FQHC setting. Are the non-RHC/FQHC services eligible for the 2015 PQRS incentive payment or for the PQRS negative payment adjustment?

Answer: Yes, for an EP who furnishes professional Medicare Part B services at an RHC/FQHC and also furnishes services at a non-RHC/FQHC setting, the non-RHC/FQHC services may be eligible for the PQRS incentive payment or the negative payment adjustment. The PQRS program applies a negative payment adjustment to practices with EPs, identified on claims by their individual national provider identifier (NPI) and tax identification number (TIN), or group practices participating via the group practice reporting option (GPRO) (referred to as PQRS group practices) who do **not** satisfactorily report data on quality measures for covered Medicare physician fee schedule services furnished to Medicare Part B fee-for-service beneficiaries. A negative payment adjustment may be triggered in future year(s) if an EP furnishes services, but does not report them.

Question: Under what circumstances are professional Medicare Part B services furnished by an EP at a setting outside an RHC/FQHC subject to the 2015 PQRS 1.5 percent negative payment adjustment if he or she has not satisfactorily reported 2013 PQRS quality measures?

Answer: There are two circumstances under which professional Medicare Part B services furnished by an EP at a setting outside an RHC/FQHC may be subject to the



2015 PQRS negative payment adjustment if he or she has not satisfactorily reported 2013 PQRS quality measures:

1. The non-RHC/FQHC services furnished by the EP are billed under his or her own TIN/NPI combination as reported via Provider Enrollment, Chain, and Ownership System (PECOS). The 2015 PQRS payment adjustment applies to the EP as an individual, **not** to the clinic or the facility; and
2. The non-RHC/FQHC services an EP furnished are billed under a group practice's TIN, which may be registered to participate in the 2013 PQRS under the GPRO registration or self-nomination. The 2015 PQRS payment adjustment applies to the EP under the group practice's TIN, which applies to the entire group practice.

For more information about how the 2015 PQRS 1.5 percent negative payment adjustment applies to RHC/FQHC providers, refer to "Listserv 2015 PQRS Payment Adjustment and Providers who Rendered Services at RHCs/FQHCs," located at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/CMS_listserv_2015_PQRS_PA_RHC_FQHC_final.pdf and "FAQ on 2015 PQRS Payment Adjustment and Providers who Render Services at RHCs/FQHCs," located at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/CMS_FAQ_2015_PQRS_PA_RHC_FQHC_final.pdf.

To find timeline information, refer to "2015 – 2017 Physician Quality Reporting System (PQRS) Timeline" located at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2015-17_CMS_PQRS_Timeline.pdf. To find general PQRS information, including information about payment adjustments, visit <http://cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html>.

For additional questions, contact the QualityNet Help Desk at 1-866-288-8912 (TTY 1-877-715-6222) or via qnetsupport@hcqis.org. The Help Desk is available from 7:00 a.m. to 7:00 p.m. central time Monday through Friday.

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Frequently asked questions – CAHs

Question: I'm an EP who furnishes professional Medicare Part B services at a CAH and the CAH is paid under the Optional Payment Method (Method II). Are my services eligible for PQRS?

Answer: Not in 2013. An EP who furnishes Medicare Part B services at a CAH and the CAH is paid under Method II is not eligible for the 2013 PQRS incentive payment or for the 2015 PQRS negative payment adjustment if he or she has not satisfactorily reported 2013 PQRS quality measures. Please note that this applies only to Tax ID and the rendering NPI used for Medicare billings on UB-04 claims.

An EP who furnishes Medicare Part B services at a CAH and the CAH is paid under Method II may be eligible for PQRS beginning in 2014 for the 2014 PQRS incentive payment and will be subject to the 2016 PQRS negative adjustment payment if he or she does not report by the deadline specified for each reporting method. Any physician-reported NPI, at either the claim level or the line level of a UB-04 claim, is considered eligible to participate in PQRS.

Question: I'm a CAH provider paid under Method II. Am I required to report line item rendering NPI information?

Answer: Yes, a CAH provider paid under Method II is required to report the rendering NPI at the line level if it is different than the rendering NPI at the claim level. For more information about this billing standard requirement, refer to *MLN Matters* article[®] MM7578 titled "Fiscal Intermediary Shared System (FISS) and Common Working File (CWF) System Enhancement for Storing Line Level Rendering Physicians/Practitioners National Provider



Identifier (NPI) Information," located at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7578.pdf>.

Additional information

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

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Learn the secrets to billing Medicare correctly

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

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

Incorporation of revalidation policies into the 'Program Integrity Manual'

Provider types affected

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

What you need to know

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 9011 to incorporate various existing Medicare enrollment revalidation policies into Chapter 15 of the *Program Integrity Manual* (PIM).

Background

CR 9011 incorporates various existing revalidation policies into the PIM. As these policies were previously established via business requirements, those business requirements are not being repeated in this article. The new policies announced in CR 9011 are as follows:

- When processing a voluntary termination of a reassignment, the MAC will contact the group to confirm that the group member's provider transaction access number (PTAN) is being terminated from all locations and, if multiple group member PTANs exist for multiple group locations, each PTAN is terminated.
- Many enrolled providers may actually be subparts of other enrolled providers, and some of those subparts entered their "doing business as name" as their LBN when applying for their NPIs. Once a contractor determines for certain that this situation exists, the contractor shall ask the provider to correct its NPPES information. The provider can (1) change its LBN in NPPES to read in accordance with the IRS CP-575, and (2) report its "doing business as" name in NPPES as an "other name" and indicate the type of other name as a "doing business as" name.



Additional information

The official instruction for CR 9011 issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R578PI.pdf>.

If you have questions please contact your MAC at their toll-free number, which 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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PQRS: Program year 2014 submission errors with incorrect program name

Submission of quality reporting data for program year 2014 of the Physician Quality Reporting System (PQRS) began January 1, 2015. A number of organizations have submitted program year 2014 Quality Reporting Document Architecture (QRDA) III files with the incorrect CMS program name extension within the "informationRecipient" data element. The "informationRecipient" represents the CMS eligible professional program to which the report is being submitted. You must select the program name that

correctly applies to your submission to ensure that CMS properly analyzes your quality reporting data. Valid CMS program names can be found in the [2014 QRDA III Implementation Guides for Eligible Professionals Clinical Quality Measures](#), Volume 2, Section 1.1.4.

For more information, visit the eQIM Library. You may also contact the QualityNet Help Desk at 866-288-8912 (TTY 1-877-715-6222) or Qnetsupport@hcqis.org from 7am to 7pm CT Monday through Friday.

CMS updates 'Provider Integrity Manual' to incorporate new revocation and denial rules for Medicare providers

Provider types affected

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

Provider action needed

Change request (CR) 9065, on which this article is based, incorporates provisions in final rule CMS-6045-F into the *Medicare Program Integrity Manual* (PIM). CR 9065 also addresses several minor provider enrollment policy issues that have arisen recently. Make sure that your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) final rule (CMS-6045-F titled "Medicare Program; Requirements for the Medicare Incentive Reward Program and Provider Enrollment") was published in the *Federal Register*, Vol. 79, No. 234 December 5, 2014. See <http://www.gpo.gov/fdsys/pkg/FR-2014-12-05/html/2014-28505.htm>. As mentioned, CR 9065 incorporates provisions in CMS-6045-F into the PIM in Chapter 15 (Medicare Enrollment), which is included as an attachment to CR 9065. One such change outlined in CR 9065 is that if a supplier submits a corrective action plan (CAP) for a revocation based in part on 42 CFR § 424.535(a)(1), the MAC shall (A) only consider the portion of the CAP pertaining to (a)(1); and (B) notify the supplier in its decision letter (or, if the MAC

wishes, via letter or e-mail prior to issuing the decision letter) that under 42 CFR § 405.809, the CAP was/will be reviewed only with respect to the (a)(1) revocation reason. See the full manual revision attached to CR 9065 for details on other updates.

Additional information

The official instruction, CR 9065, issued to your MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R582PI.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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 Related CR Transmittal #: R582PI
 Implementation Date: May 28, 2015

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Requesting duplicate remittance advice

First Coast sometimes receives requests for duplicate Medicare remittance notices (MRNs), also known as Medicare summary notices (MSNs).

Trading partners who are directly submitting through the EDI Gateway using their own submitter number and receive electronic remittance advices (ERAs) may use the [Remittance reload request for X12 v5010](#).

Providers who are sending/receiving files through a clearinghouse should contact the clearinghouse for any reload requests. Providers may also download free software to retrieve ERAs.

How do I get the free software?

- For Part A providers, download [PC-Print Software](#).
- For Part B providers, download [MREP software](#).

What if I receive paper remittance notices?

Medicare contractors do not routinely provide duplicate

paper remits (standard paper remittance or SPR). Providers who receive SPR may contact customer service for duplicates if the originals were never received or were lost due to natural disaster. (**Note:** Customer service can only send the duplicates to the address printed on the SPR. In addition, Part A requests must be made within 30 days of the remit date; otherwise, there is a \$25 fee for duplicates.)

Please be sure to submit the request along with the \$25 fee to the following address:

First Coast Service Options
 Attn: Finance Control
 P.O. Box 406443
 Atlanta, GA 30384-6443

We recommend using ERA. [Click here](#) for answers to concerns you may have regarding ERA, or [click here](#) to view ERA FAQs.

ICD-10 testing – acknowledgement testing with providers

Provider types affected

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

Provider action needed

Change request (CR) 8858 instructs MACs to promote three specific acknowledgement testing weeks with providers, and provide data and statistics to the Centers for Medicare & Medicaid Services (CMS) to demonstrate readiness for the International Classification for Disease 10th Edition Clinical Modification (ICD-10) transition. Make sure that your billing staffs are aware of these ICD-10 testing opportunities.

Background

The Centers for Medicare and Medicaid Services (CMS) is in the process of implementing ICD-10. All covered entities must be fully compliant on October 1, 2015.

CR 8858 instructs all MACs and the DME MAC common electronic data interchange (CEDI) contractor to promote ICD-10 acknowledgement testing with trading partners during three separate testing weeks, and to collect data about the testing. These testing weeks are:

- November 17-21, 2014
- March 2-6, 2015
- June 1-5, 2015

The concept of trading partner testing was originally designed to validate the trading partners' ability to meet technical compliance and performance processing standards during the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 5010 implementation. While submitters may acknowledgement test ICD-10 claims at any time through implementation, the ICD-10 testing weeks have been created to generate awareness and interest, and to instill confidence in the provider community that CMS and the MACs are ready and prepared for the ICD-10 implementation.

These testing weeks will allow trading partner's access to MACs and CEDI for testing with real-time help desk support. The event will be conducted virtually and will be posted on the CMS website, the CEDI website and each MAC's website.

Key points of the testing process for CR 8858

- Test claims with ICD-10 codes must be submitted with current dates of service since testing does not support future dates of service.
- Claims will be subject to existing NPI validation edits.
- MACs and CEDI will be staffed to handle increased call volume during this week.
- Test claims will receive the 277CA or 999 acknowledgement as appropriate, to confirm that the



claim was accepted or rejected by Medicare.

- Test claims will be subject to all existing EDI front-end edits, including submitter authentication and NPI validation.
- Testing will not confirm claim payment or produce a remittance advice.
- MACs and CEDI will be appropriately staffed to handle increased call volume on their electronic data interchange (EDI) help desk numbers, especially during the hours of 9:00 a.m. to 4:00 p.m. local MAC time, during this week.
- Your MAC will announce and promote these testing weeks via their listserv messages and their website.

Additional information

The official instruction, CR 8858, issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1472OTN.pdf>.

The EDI help desk numbers for institutional claim submitters are available at <http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/downloads/EDIHelplinePartA.pdf> and the numbers for professional claims submitters are available at <http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/downloads/EDIHelplinePartB.pdf>.

MLN Matters® Number: MM8858

Related Change Request (CR) #: CR 8858

Related CR Release Date: February 24, 2015

Effective Date: 30 Days From Issuance (See test dates)

Related CR Transmittal #: R1472OTN

Implementation Date: November 17 through 21, 2014, for the November testing week; March 2 through 6, 2015 for the March testing week; June 1 through 5, 2015, for the June testing week.

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.

CMS conducts successful Medicare FFS ICD-10 end-to-end testing week

From January 26 through February 3, 2015, Medicare fee-for-service (FFS) health care providers, clearinghouses, and billing agencies participated in the first successful ICD-10 end-to-end testing week with all Medicare administrative contractors (MACs) and the durable medical equipment (DME) MAC common electronic data interchange (CEDI) contractor. CMS was able to accommodate all volunteers, which represented a broad cross-section of provider, claim, and submitter types.

Approximately 660 providers and billing companies submitted nearly 15,000 test claims. This successful week of testing continues to put us on course for successful implementation of this important initiative that better reflects modern practice of medicine by October 1, 2015.

Testing demonstrated that CMS systems are ready to accept ICD-10 claims. [View the results.](#)

Overall, participants in the January 26 to February 3 testing were able to successfully submit ICD-10 claims and have them processed through our billing systems. To the extent that some claims were rejected, most didn't meet the mark because of errors unrelated to ICD-9 or ICD-10.

Testing allows us to identify areas of improvement, and we

will work with outside entities and stakeholders to improve those very small deficiencies identified. And, we will continue to do testing, especially in those areas we identify as needing improvement.

In addition to acknowledgement testing, which may be completed at any time, two more end-to-end testing weeks will be held before the October 1, 2015, compliance date for ICD-10:

- April 27 through May 1: Volunteers have been selected
- July 20 through July 24: Volunteer forms will be available March 13 on the MAC and CEDI websites
- Testers who participated in the January testing are automatically eligible to test again in April and July

For more information

- [MLN Matters® article #MM8867](#), "ICD-10 Limited End-to-End Testing with Submitters for 2015"
- [MLN Matters® special edition article #SE1435](#), "FAQs – ICD-10 End-to-End Testing"
- [MLN Matters® special edition article #SE1409](#), "Medicare FFS ICD-10 Testing Approach"

ICD-10 conversion and coding revisions with ICD-9 updates to NCDs – second maintenance update

Provider types affected

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

Provider action needed

This article is based on change request (CR) 9087 which is the second maintenance update of ICD-10 conversions and coding updates specific to national coverage determinations (NCDs).

The majority of the NCDs included are a result of feedback received from previous ICD-10 NCD CRs, specifically CR 7818, CR 8109, CR 8197, and CR 8691. Links to related *MLN Matters®* articles MM7818, MM8109, MM8197, and MM8691 are available in the additional information section of this article. Some are the result of revisions required to other NCD-related CRs released separately that also included ICD-10.

Edits to ICD-10 coding specific to NCDs will be included in subsequent, quarterly updates. No policy-related changes are included with these updates. Any policy-related changes to NCDs continue to be implemented via the current, long-standing NCD process. Make sure that your billing staffs are aware of these spreadsheets attached to CR 9087 for the following 13 NCDs:

NCD	NCD title
20.29	Hyperbaric oxygen therapy
20.9.1	Ventricular assist devices
50.3	Cochlear implantation
80.2	Photodynamic therapy
80.2.1	Ocular photodynamic therapy (OPT)
80.3	Photosensitive drugs
80.3.1	Verteporfin
110.10	Intravenous iron therapy
150.3	Bone (mineral) density studies
160.18	Vagus nerve stimulation
180.1	Medical nutrition therapy
210.2	Screening Pap smears and pelvic examinations for early detection of cervical or vaginal cancer
250.3	Intravenous immune globulin for the treatment of autoimmune mucocutaneous blistering diseases

Background

CR 9087's purpose is to create and update NCD editing, both hard-coded shared system edits as well as local MAC edits, that contain either ICD-9 diagnosis/procedure codes or ICD-10 diagnosis/procedure codes, or both,

CONVERSION

From previous page

plus all associated coding infrastructure such as HCPCS/CPT® codes, reason/remark codes, frequency edits, POS/TOB/provider specialties, and so forth. The requirements described in CR 9087 reflect the operational changes that are necessary to implement the conversion of the Medicare shared system diagnosis codes specific to the attached Medicare NCD spreadsheets.

Please note that there are 10 spreadsheets attached to CR 9087. These spreadsheets relate to 13 NCDs, and provide pertinent policy/coding information necessary to implement ICD-10. Further, you should be aware that NCD policies may contain specific covered, non-covered and/or discretionary diagnosis coding. These spreadsheets are designated as such and are based on current NCD policies and their corresponding edits. Nationally covered and non-covered diagnosis code editing is finite and cannot be revised without subsequent discussions with CMS. Discretionary code lists are to be regarded as CMS' compilation of discretionary codes based on current analysis/interpretation. Local MACs may or may not expand discretionary lists based on their individual local authority within their respective jurisdictions. Nothing contained in CR 9087 should be construed as new policy.

Some coding details are as follows:

1. The ICD-10 diagnosis/procedure codes associated with the NCDs attached to CR 9087 are not to be implemented until October 1, 2015, or until ICD-10 is implemented.
2. Your MAC will use default Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) messages, where appropriate:
 - **Remittance advice remark code (RARC) N386** (This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered), along with Claim Adjustment Reason Code (CARC) 50 (These are noncovered services because this is not deemed a "medical necessity" by the payer), CARC 96 (Non-covered charge(s). At least one Remark Code must be provided [may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT]), and/or CARC 119 (Benefit maximum for this time period or occurrence has been reached).
3. When denying claims associated with the attached NCDs, except where otherwise indicated, your MACs will use:
 - **Group code PR** (patient responsibility) assigning financial responsibility to the beneficiary (if a claim is received with occurrence code 32 (advance beneficiary notice), or with occurrence code 32 and a GA modifier (The provider or supplier has provided an advance beneficiary notice (ABN) to the patient), indicating a signed ABN is on file).
 - **Group code CO** (contractual obligation) assigning

financial liability to the provider (if a claim is received with a GZ modifier (The provider or supplier expects a medical necessity denial; however, did not provide an advance beneficiary notice (ABN) to the patient), indicating no signed ABN is on file).

Note: For modifier GZ, use CARC 50 and MSN 8.81 (If the provider/supplier should have known that Medicare would not pay for the denied items or services and did not tell you in writing before providing them that Medicare probably would deny payment, you may be entitled to a refund of any amounts you paid. However, if the provider/supplier requests a review of this claim within 30 days, a refund is not required until we complete our review. If you paid for this service and do not hear anything about a refund within the next 30 days, contact your provider/supplier).

Additional information

The official instruction, CR 9087, issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1478OTN.pdf>. The spreadsheet attachments to CR 9087 are available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1478OTN.zip>.

MM7818 is available for review at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7818.pdf>.

MM8109 is available for review at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8109.pdf>.

MM8197 is available for review at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8197.pdf>.

MM8691 is available for review at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8691.pdf>.

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

MLN Matters® Number: MM9087

Related Change Request (CR) #: CR 9087

Related CR Release Date: March 6, 2015

Effective Date: April 6, 2015; for designated ICD-9 updates and all local system edits (ICD-9 and ICD-10); July 1, 2015, for all ICD-9 shared system edits; October 1, 2015, for all ICD-10 shared system edits (or whenever ICD-10 is implemented)

Related CR Transmittal #: R1478OTN

Implementation Date: April 6, 2015, for designated ICD-9 updates and all local system edits; July 6, 2015, for ICD-9 and ICD-10 shared system edits

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Healthcare provider taxonomy code set update

Provider types affected

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

Provider action needed

Change request (CR) 8993 instructs MACs to obtain the most recent Healthcare provider taxonomy code (HPTC) set and use it to update their internal HPTC tables and/or reference files.

Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that covered entities use the standards adopted under this law for electronically transmitting certain health care transactions, including health care claims. The standards include implementation guides which dictate when and how data must be sent, including specifying the code sets which must be used. The institutional and professional claim electronic standard implementation guides (X12 837-I and 837-P) each require use of valid codes contained in the HPTC set when there is a need to report provider type or physician, practitioner, or supplier specialty for a claim.

The National Uniform Claim Committee (NUCC) maintains the HPTC set for standardized classification of health care providers, and updates it twice a year with changes effective April 1 and October 1. These changes include the addition of a new code and addition of definitions to existing codes.

You should note that:

1. Valid HPTCs are those that the NUCC has approved for current use;
2. Terminated codes are not approved for use after a specific date;
3. Newly approved codes are not approved for use prior to the effective date of the code set update in which each new code first appears; and

4. Specialty and/or provider type codes issued by any entity other than the NUCC are not valid.

CR 8993 implements the NUCC HPTC code set that is effective on April 1, 2015, and instructs MACs to obtain the most recent HPTC set and use it to update their internal HPTC tables and/or reference files. The HPTC set is available for view or for download from the Washington Publishing Company (WPC) at <http://www.wpc-edi.com/codes>.

When reviewing the health care provider taxonomy code set online, you can identify revisions made since the last release by the color code:

- New items are green;
- Modified items are orange; and
- Inactive items are red.

Additional information

The official instruction, CR 8993, issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3201CP.pdf>.

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

MLN Matters[®] Number: MM8993

Related Change Request (CR) #: CR 8993

Related CR Release Date: February 20, 2015

Effective Date: April 1, 2015

Related CR Transmittal #: R3201CP

Implementation Date: As soon as April 1, 2015, but no later than July 6, 2015

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.

CMS releases two new ICD-10 videos

The Centers for Medicare & Medicaid Services has released two animated short videos that explain key ICD-10 concepts. The videos are less than four minutes each and available on the [Provider Resources](#) Web page:

- [Introduction to ICD-10 Coding](#) – gives an overview of ICD-10's features and explains the benefits of the new code set to patients and to the health care community
- [ICD-10 Coding and Diabetes](#) – uses diabetes as an example to show how the code set captures important clinical details

Keep up to date on ICD-10

Visit the [ICD-10](#) website for the latest news and resources to help you prepare.

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.*

Revisions to LCDs

Collagenase clostridium histolyticum (Xiaflex®) – revision to the Part B LCD

LCD ID number: L31243 (Florida/Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for collagenase clostridium histolyticum (Xiaflex®) was revised based on a reconsideration request to include the Food and drug administration (FDA) label expansion for the treatment of Dupuytren’s contracture to allow for up to two injections affecting two joints or two cords of the same hand within the same treatment visit. The “Utilization Guidelines” and “Sources of Information and Basis of Decision” sections of the LCD were updated.

Effective date

This LCD revision is effective for claims processed **on or after February 17, 2015**, for dates of service **on or after October 20, 2014**. 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](#).

Mohs micrographic surgery (MMS) – revision to the Part B LCD

LCD ID number: L29230 (Florida) LCD ID number: L29366 (Puerto Rico/U.S. Virgin Islands)

Based on change request (CR) 9007, the “Documentation Requirements” section of the Mohs micrographic surgery (MMS) local coverage determination (LCD) was revised to indicate that if a pathology code is billed on the same day as MMS, then the documentation must support a separate excision/biopsy/repair was performed. The Coding Guidelines attachment was also revised.

Effective date

This LCD revision is effective for services rendered **on or after February 9, 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](#).

Surgical management of morbid obesity – revision to the Part B LCD

LCD ID number: L29317 (Florida) LCD ID number: L29477 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for surgical management of morbid obesity was revised to update the “Comorbid Conditions” and “Contraindications to Bariatric Surgery” under the “Indications and Limitations of Coverage and /or Medical Necessity” section of the LCD. 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 February 19, 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](#).

Syphilis test – revision to the Part B LCD

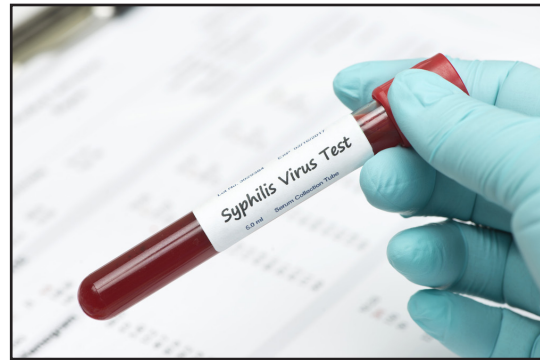
LCD ID number: L29416 (Florida)

LCD ID number: L29478 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for syphilis test was most recently revised January 1, 2010. Since that time, a revision was made under the “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD to reflect current Centers for Medicare & Medicaid Services (CMS) language based on change request (CR) 7610 [Screening for Sexually Transmitted Infections (STIs) and High Intensity Behavioral Counseling (HIBC) to Prevent STIs] and *Medicare National Coverage Determinations (NCD) Manual*, Chapter 4, §210.10, Screening for Sexually Transmitted Infections (STIs) and High Intensity Behavioral Counseling (HIBC) to Prevent STIs. In addition, the “CMS National Coverage Policy” section of the LCD was updated to include CR 7610 and NCD 210.10. This LCD limits diagnostic syphilis testing for the treatment of syphilis. Screening for syphilis will be covered when provided in accordance to the coverage limitations of NCD 210.10.

Effective date

This LCD revision is effective for claims processed on



or after **March 12, 2015**, for services rendered **on or after November 8, 2011**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>.

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

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

Additional Information

Independent diagnostic testing facility (IDTF) – revision to the coding guideline

LCD ID number: L29195 (Florida)

LCD ID number: L29330 (Puerto Rico/U.S. Virgin Islands)

Based on The Centers for Medicare & Medicaid Services (CMS) direction, the ‘coding guideline’ associated with local coverage determination (LCD) for independent diagnostic testing facility (IDTF) has been revised to remove the requirement that (CMS) Form-855R be submitted with CMS Form-855B application.

Effective date

This LCD “coding guideline” revision is effective for services rendered **on or after April 4, 2014**. 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](#).

Future ICD-10 local coverage determinations

It has come to our attention that ICD-10 LCDs currently published in the Medicare coverage database (MCD) for notice that include diagnosis code ranges may be missing diagnosis codes within the range. First Coast Service Options, Inc. (First Coast) is working with the MCD national contractor to resolve the issue. If you have an immediate need to clarify aspects of a future effective ICD-10 LCD, please contact medical.policy@fcso.com. When these issues are resolved an update will be published.

Noncovered services – revision to the draft 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 draft noncovered services local coverage determination (LCD) and are open for comment. The comment period for this revision is from February 14, 2015, to March 30, 2015. 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.

- C2624: Implantable wireless pulmonary artery pressure sensor with delivery catheter, including all system components
- C9737: Laparoscopy, surgical, esophageal sphincter augmentation with device (eg, magnetic band)
- 0378T-0379T: Visual field assessment, with concurrent real time data analysis and accessible data storage with patient initiated data transmitted to a remote surveillance center for up to 30 days
- 0380T: *Computer-aided animation and analysis of time series retinal images for the monitoring of disease progression, unilateral or bilateral, with interpretation and report*
- 0381T-0382T: External heart rate and 3-axis accelerometer data recording up to 14 days to assess changes in heart rate and to monitor motion analysis for the purposes of diagnosing nocturnal epilepsy seizure events
- 0383T-0384T: External heart rate and 3-axis accelerometer data recording from 15 to 30 days to assess changes in heart rate to monitor motion analysis for the purposes of diagnosing nocturnal epilepsy seizure events
- 0385T-0386T: External heart rate and 3-axis accelerometer data recording more than 30 days to assess changes in heart rate to monitor motion analysis for the purposes of diagnosing nocturnal epilepsy seizure events
- * 0387T: *Transcatheter insertion or replacement of permanent leadless pacemaker, ventricular*
- * 0388T: *Transcatheter removal of permanent leadless pacemaker, ventricular*



- * 0389T: *Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report, leadless pacemaker system*
- * 0390T: *Peri-procedural device evaluation (in person) and programming of device system parameters before or after a surgery, procedure or test with analysis, review and report, leadless pacemaker system*
- * 0391T: *Interrogation device evaluation (in person) with analysis, review and report, includes connection, recording and disconnection per patient encounter, leadless pacemaker system*
- 43289: *Unlisted laparoscopy procedure, esophagus (LINX)*
- * 91200: *Liver elastography, mechanically induced shear wave (eg, vibration), without imaging, with interpretation and report*
- 93799: *Unlisted cardiovascular service or procedure (CardioMEMS™)*

**Covered if beneficiary is enrolled in a MAC approved investigational device exemption (IDE) study.*

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.

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 draft is finalized, 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

See **NONCOVERED**, next page

NONCOVERED

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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 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.

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

Local coverage determinations – missing information

It has come to our attention that some LCDs listed in the current Medicare coverage database (MCD) are incomplete in that the “CPT/HCPCS”, and “ICD-9 codes that support medical necessity” sections may be missing. First Coast Service Options, Inc. (First Coast) wants to clarify that the missing information is due to a database issue and it does not represent a change in LCD coverage nor documentation or

utilization requirements. This information may be also missing from the First Coast LCD lookup tool. First Coast is working with the MCD national contractor to resolve the issue. If you have an immediate need to clarify aspects of a current LCD, please contact medical.policy@fcsso.com with the LCD name and number. When these issues are resolved an update will be published.

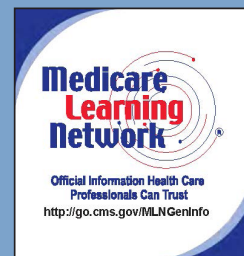
Widespread probe notification for daptomycin

First Coast Service Options Inc. (First Coast) has identified an aberrant billing pattern for The Healthcare Common Procedure Code System (HCPCS) code J0878 (Injection, daptomycin, 1mg). Based on national comparison data Florida

represents 34.92 percent of the total national allowed dollars. First Coast will conduct a widespread probe for dates of service August 1, 2014, to January 31, 2015, to validate administration of the drug meets approved indications and dosage criteria.

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>.



Upcoming provider outreach and educational events

Medicare “Ask-the-Contractor” teleconference (ACT): Chronic Care Management

When: Wednesday, April 29

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

<http://medicare.fcso.com/Events/279017.asp>

First Coast’s fee schedule lookup

When: Tuesday, May 5

Time: 11:30 a.m.-noon **Type of event:** Webcast

<http://medicare.fcso.com/Events/278626.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.



MLN Connects™ Provider eNews for February 19, 2015

MLN Connects™ Provider eNews for February 19, 2015
[View this edition as a PDF](#)

In this edition:

MLN Connects™ National Provider Calls

- ICD-10 Implementation and Medicare Testing – Last Chance to Register
- National Partnership to Improve Dementia Care in Nursing Homes and QAPI – Register Now
- Video Slideshow and Follow-up Information Available for IRF-PAI MLN Connects™ National Provider Call

CMS Events

- Participate in ICD-10 Acknowledgement Testing Week: March 2 through 6, 2015
- Webinar for Comparative Billing Report on Modifiers 24 & 25: Specialty Surgeons
- Healthy Aging Summit

Announcements

- New Affordable Care Act Initiative to Encourage Better Oncology Care
- Update for Pharmacists Prescribing Part D Drugs
- Measles: Information for Healthcare Professionals
- Hospitals Must Start Medicare EHR Participation in 2015 to Earn Incentives
- PQRS: Program Year 2014 QRDA III Submission Errors with Incorrect Program Name

Medicare Learning Network® Educational Products

- “Independent Diagnostic Testing Facility (IDTF)” Fact Sheet – Released
- “Chronic Care Management Services” Fact Sheet – Released



- “Provider Compliance Tips for Spinal Orthoses” Fact Sheet – Released
- “Provider Compliance Tips for Enteral Nutrition Pumps” Fact Sheet – Released
- “Provider Compliance Tips for Diabetic Test Strips” Fact Sheet – Released
- “Medicare Learning Network® Suite of Products & Resources for Educators and Students” Educational Tool – Reminder
- “Medicare Learning Network® Suite of Products & Resources for Billers and Coders” Educational Tool – Reminder
- “Medicare Learning Network® Suite of Products & Resources for Inpatient Hospitals” Educational Tool – Reminder
- “Medicare Learning Network® Suite of Products & Resources for Compliance Officers” Educational Tool – Reminder
- 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 26, 2015

MLN Connects™ Provider eNews for February 26, 2015
[View this edition as a PDF](#)

In this edition:

MLN Connects™ National Provider Calls

- National Partnership to Improve Dementia Care in Nursing Homes and QAPI – Register Now
- Physician Quality Reporting Programs: Reporting Once in 2015 – Registration Now Open

CMS Events

- Participate in ICD-10 Acknowledgement Testing Week: March 2 through 6, 2015

Announcements

- It's Still Flu Season
- CMS Strengthens Five Star Quality Rating System for Nursing Homes
- EHR Incentive Program: Deadline to Register Intent for a Public Health Measure is March 1
- Hospital Engagement Network Solicitation: Responses due March 30
- Medicare Geographic Reclassification under the IPPS Wage Index for FY 2016

MLN Connects™ Provider eNews for March 5, 2015

MLN Connects™ Provider eNews for March 5, 2015
[View this edition as a PDF](#)

In this edition:

MLN Connects™ National Provider Calls

- National Partnership to Improve Dementia Care in Nursing Homes and QAPI – Last Chance to Register
- Physician Quality Reporting Programs: Reporting Once in 2015 – Register Now
- New MLN Connects® National Provider Call Audio Recording and Transcript
- Providers and Suppliers – Browse the MLN Connects® Call Program Collection of Resources

CMS Events

- Special Open Door Forum: Home Health Electronic Clinical Template and Home Health Paper Clinical Template

Announcements

- Help Your Medicare Patients “Bite into a Healthy Lifestyle” During National Nutrition Month® and Beyond
- Physician Groups that Demonstrate High Quality Care Receive Increases to Their Medicare Payments
- CMS Announces Release of 2015 Impact Assessment of Quality Measures Report
- Register for the Health Care Payment Learning and

- New FAQs on CY 2015 DMEPOS Medicare Payment Final Rule
- CMS to Release Comparative Billing Report in March on Modifier 25: Nurse Practitioners
- Sterilization of Ophthalmologic Surgical Instruments
- Two New ICD-10 Videos

Medicare Learning Network® Educational Products

- “Medicare Basics Commonly Used Acronyms” Educational Tool – Released
- “Medicare Fee-For-Service (FFS) Claims Processing Guidance for Implementing International Classification of Diseases, 10th Edition (ICD-10) – A Re-Issue of MM7492” MLN Matters® Article – Revised
- “The Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program - A Better Way for Medicare to Pay for Medical Equipment” Fact Sheet – Revised
- New Medicare Learning Network® Educational Web Guides Fast Fact
- Medicare Learning Network® Products Available In Electronic Publication Format



Action Network

- New EHR Attestation Deadline for Medicare Eligible Professionals: March 20
- Submission Extension for EPs Participating in PQRS via EHR and QCDR: March 20
- Hospital VBP FY 2017 Baseline Measures Report Now Available
- HHAs: Get Started with HHCAHPS Participation
- Request for Comments on ESRD Conditions for Coverage
- Physicians and Teaching Hospitals: Register in Open Payments System
- PQRS Payment Adjustments and Providers Who Rendered Services at IDTFs
- CMS is Accepting Suggestions for Potential PQRS Measures

See **ENEWS**, next page

MLN Connects™ Provider eNews for March 12, 2015

MLN Connects™ Provider eNews for March 12, 2015
View this edition as a PDF

In this edition:

MLN Connects™ National Provider Calls

- Physician Quality Reporting Programs: Reporting Once in 2015 – Last Chance to Register
- Medicare Shared Savings Program ACO: Preparing to Apply for 2016 – Registration Now Open
- Medicare Shared Savings Program ACO: Application Process – Registration Now Open
- New MLN Connects® National Provider Call Audio Recording and Transcript

CMS Events

- ICD-10 Coordination and Maintenance Committee Meeting
- Webinar for Comparative Billing Report on Modifier 25: Nurse Practitioners

Announcements

- Affordable Care Act Initiative Builds on Success of ACOs
- Physician-owned Hospital Initial Annual Ownership/Investment Report: Extension of Filing Deadline
- New ST PEPPER Available

- Medicare EHR Incentive Program: Hardship Exceptions for Hospitals due April 1
- EHR Incentive Program: Part B Drugs and Payment Adjustments

Claims, Pricers, and Codes

- April 2015 Average Sales Price Files Now Available
- FY 2015 Inpatient PPS PC Pricer Update Available
- FY 2014 Inpatient PPS PC Pricer Update Available

Medicare Learning Network® Educational Products

- “Guidance on the Physician Quality Reporting System (PQRS) 2013 Reporting Year and 2015 Payment Adjustment for Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs), and Critical Access Hospitals (CAHs)” *MLN Matters®* Article – Released
- “Global Surgery” Fact Sheet – Revised
- “Guidelines for Teaching Physicians, Interns, and Residents” Fact Sheet – Revised
- “Mental Health Services” Booklet – Revised
- “Medicare Vision Services” Fact Sheet – Reminder
- “HIPAA Privacy and Security Basics for Providers” Fact Sheet – Reminder
- Medicare Learning Network®* Products Available In Electronic Publication Format

ENEWS

From previous page

Claims, Pricers, and Codes

- Special CBSA Codes for Home Health Claims
- FQHC Prospective Payment System File Update

Medicare Learning Network® Educational Products

- “Physician Feedback, Quality and Resource Use Reports (QRURs) and Value-Based Modifier Program – Overview & Implementation” *MLN Matters®* Article – Released

- “Diagnosis Coding: Using the ICD-10-CM” Web-Based Training Course – Released
- “Medicare Physician Fee Schedule” Fact Sheet – Revised
- “Medicare Enrollment Guidelines for Ordering/Referring Providers” Fact Sheet – Reminder
- “Medicare Fraud & Abuse: Prevention, Detection, and Reporting” Fact Sheet – Reminder
- New *Medicare Learning Network®* Provider Compliance Fast Fact
- Medicare Learning Network®* Product Available In Electronic Publication Format

MLN Connects™ Provider eNews for March 19, 2015

MLN Connects™ Provider eNews for March 19, 2015
View this edition as a PDF

In this edition:

MLN Connects™ National Provider Calls

- Medicare Shared Savings Program ACO: Preparing to Apply for 2016 – Register Now
- Open Payments (Sunshine Act) 2015: Prepare to Review Reported Data – Registration Opening Soon
- Medicare Shared Savings Program ACO: Application Process – Register Now

CMS Events

- Volunteer for ICD-10 End-to-End Testing in July – Forms Due April 17
- eHealth Webinar: eCQM 101 on Quality Reporting Programs
- Medicare Basics for New Providers Webinar – Registration Now Open

Announcements

- Prepare for a Successful Transition to ICD-10 with Medicare Testing Resources
- RAs from January 2015 ICD-10 End-to-End Testing
- Bidding for Round 2 Recompete/National Mail-Order Recompete of the DMEPOS Competitive Bidding Program Closes March 25
- March is National Colorectal Cancer Awareness

- Month—Encourage Your Patients to Get Screened
- March is Save Your Vision Month
- Flu on the Decline but Still Active
- EHR Incentive Program: Eligible Professionals Attest for 2014 Participation by March 20
- CMS Extends Letter of Intent Deadlines for the Oncology Care Model
- Obtaining Your Quality and Resource Use Report: Updated Information Available
- CMS to Release Ophthalmology Comparative Billing Report in April
- Physician-owned Hospital Initial Annual Ownership/Investment Report: Extension of Filing Deadline

Claims, Pricers, and Codes

- Mandatory Payment Adjustment Percentage of 2 percent Extended for Medicare FFS Claims (Sequestration)
- Correcting the Display Issue for OPPS Claims Where Value Code “FD” Is Present
- Mass Adjustment of Claims Containing Codes G0473 and 77063

Medicare Learning Network® Educational Products

- March 2015 Version of The *Medicare Learning Network®* Catalog – Released

Additional Resources

Updates to the ‘Medicare Internet-Only Manual’ for skilled nursing facility providers

Provider types affected

This *MLN Matters®* article is intended for physicians, providers, and suppliers submitting claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries who are in a skilled nursing facility (SNF).

Provider action needed

Change request (CR) 8997 updates sections of the *Medicare Benefit Policy Manual* and the *Medicare Claims Processing Manual* in regards to SNF policy and billing. If you provide services to Medicare beneficiaries in a SNF stay, information in CR 8997 could impact your payments.

Background

CR 8997 updates two chapters of the *Medicare Claims Processing Manual* and one chapter of the *Medicare Benefit Policy Manual*. The following summarizes these manual updates:

‘Medicare Benefit Policy Manual,’ Chapter 8: Section 20.2.3 (Readmission to SNF)

- If an individual who is receiving covered post-hospital extended care, leaves a SNF and is readmitted to the same or any other participating SNF for further covered care within 30 days of the last covered skilled day, the 30-day transfer requirement is considered to be met; and
- The same is true if the beneficiary remains in the SNF to receive custodial care following a covered stay, and subsequently develops a renewed need for covered care there within 30 consecutive days. Thus, the period of extended care services may be interrupted briefly and then resumed, if necessary, without hospitalization preceding the resumption of SNF coverage. *Medicare Claims Processing Manual*, Chapter 6: Section 20.1.1.2 - Hospital’s “Facility Charge” in Connection with Clinic Services of a Physician.

See **MANUAL**, next page

MANUAL

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- When a beneficiary receives clinic services from a hospital-based physician, the physician in this situation would bill his or her own professional services directly to the Part B MAC and would be reimbursed at the facility rate of the Medicare physician fee schedule – which does not include overhead expenses.
- The hospital historically has submitted a separate Part B “facility charge” for the associated overhead expenses to its Part A MAC. The hospital’s facility charge does not involve a separate service (such as a diagnostic test) furnished in addition to the physician’s professional service; rather, it represents solely the overhead expenses associated with furnishing the professional service itself.
- Accordingly, hospitals bill for “facility charges” under the physician evaluation and management (E&M) codes in the range of 99201-99245 and G0463 (for hospitals paid under the outpatient prospective payment system).
- E&M codes, representing the hospital’s “facility charge” for the overhead expenses associated with furnishing the professional service itself, are excluded from SNF consolidated billing (CB). Effective for claims with dates of service on or after January 1, 2006, Medicare’s common working file will bypass CB edits when billed with revenue code 0510 (clinic visit) with an E&M HCPCS code in the range of 99201-99245 and, effective January 1, 2014, with HCPCS code G0463.

Section 30.1: Health Insurance Prospective Payment System (HIPPS) Rate Code

- The HIPPS rate code consists of the three-character resource utilization group (RUG) code that is obtained from the “grouper” software program followed by a two digit assessment indicator (AI) that specifies the type of assessment associated with the RUG code obtained from the grouper. Providers may access the resident assessment instrument (RAI) manual located at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/index.html>.

When coding PPS bills for ancillary services associated with a Part A inpatient stay, the traditional revenue codes will continue to be shown, for example, 0250 – pharmacy, 042x – physical Therapy, in conjunction with the appropriate entries in service units and total charges.

Section 30.2: Coding PPS bills for ancillary services

- SNFs are required to report the number of units based on the procedure or service.
- For therapy services, that is revenue codes 042x, 043x, and 044x, units represent the number of calendar days of therapy provided. For example, if the beneficiary received physical therapy, occupational therapy or speech-language pathology on May 1, that would be considered one calendar day and would be billed as one unit.



- SNFs are required to report the actual charge for each line item, in total charges.

Section 30.3: Adjustment requests

Adjustment requests based on corrected assessments must be submitted within 120 days of the service “through” date. The “through” date will be used to calculate the period during which adjustment requests may be submitted based on corrected RAI assessments. The “through” date indicates the last day of the billing period for which the HIPPS code is billed. Adjustment requests based on corrected assessments must be submitted within 120 days of the “through” date on the bill. For HIPPS changes resulting from an MDS correction, providers must append a condition code D2 on their adjustment claim. An edit is in place to limit the time for submitting this type of adjustment request to 120 days from the service “through” date.

CMS expects that most HIPPS code corrections will be made during the course of the beneficiary’s Medicare Part A stay. Therefore, providers that routinely submit corrections after the beneficiary’s Part A stay has ended may be subject to focused medical review.

Adjustment requests to change a HIPPS code may not be submitted for any claim that has already been medically reviewed. This applies whether or not the medical review was performed either pre- or post-payment. All adjustment requests submitted are subject to medical review. Information regarding medical review is located in the *Medicare Program Integrity Manual*.

Section 40.3.5.2: Leave of absence:

- Leave of absence (LOA) days are shown on the bill with revenue code 018x and LOA days as units. However, charges for LOA days are shown as zero on the bill, and the SNF cannot bill the beneficiary for them except as specified in Chapter 1 of this manual at Section 30.1.1.1. Occurrence span code 74 is used to report the LOA from and through dates.
- Providers should review the RAI manual to clarify situations where an LOA is not appropriate, for example observation stays in a hospital lasting greater than 24 hours.

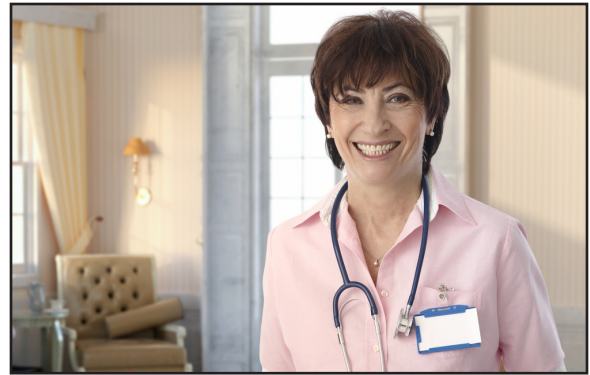
‘Medicare Claims Processing Manual’, Chapter 13, Section 90.5 (Transportation of Equipment Billed by a SNF to a MAC)

See MANUAL, next page

MANUAL

From previous page

- When a SNF resident receives a portable x-ray service during the course of a Medicare-covered stay in the SNF, only the service's professional component (representing the physician's interpretation of the test results) is a separately billable physician service under Part B (see Section 20 of Chapter 6).
- By contrast, the technical component representing the procedure itself, including any associated transportation and setup costs, would be subject to consolidated billing (CB) (the SNF "bundling" requirement for services furnished to the SNF's Part A residents), and must be included on the SNF's Part A bill for the resident's covered stay (bill type 21x) rather than being billed separately under Part B.



at their toll-free number. That number is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html> under - How Does It Work?

MLN Matters® Number: MM8997
 Related Change Request (CR) #: CR 8997
 Related CR Release Date: March 13, 2015
 Effective Date: June 15, 2015
 Related CR Transmittal #: R3216CP and R204BP
 Implementation Date: June 15, 2015

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.

Additional information

The official instruction for CR 8997 was issued to your MAC via two transmittals. The first transmittal updates the *Medicare Claims Processing Manual* and it is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3216CP.pdf>.

The second updates the *Medicare Benefit Policy Manual* and it is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R204BP.pdf>.

If you have any questions, please contact your MAC

Get ready for ICD-10

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

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

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

Online ICD-10 guide

ICD-10 basics for large medical practices



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@fcsso.com
Online form: <http://medicare.fcso.com/Feedback/161670.asp>

Provider enrollment

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

Medical policy

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

Medicare secondary payer

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

Electronic data interchange (EDI)

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

Overpayments

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

Medicare Education and Outreach

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

Fraud and abuse

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

Freedom of Information Act requests

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

Overnight mail and/or special courier service

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

Websites

Provider

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

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

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

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

Beneficiaries

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

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866-454-9007

877-660-1759 (TTY)

Fax number (for general inquiries)

904-361-0696

Interactive voice response (IVR) system

877-847-4992

Provider enrollment

888-845-8614

877-660-1759 (TTY)

The SPOT help desk

855-416-4199

email: FCSOSPOTHelp@FCSO.com

Addresses

Claims

Medicare Part B Claims

P.O. Box 45098

Jacksonville, FL 32232-5098

Redeterminations

Medicare Part B Redetermination

P.O. Box 45024

Jacksonville, FL 32232-5024

Redetermination of overpayments

First Coast Service Options Inc.

P.O. Box 45091

Jacksonville, FL 32232-5091

Reconsiderations

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@fcsso.com

Online form: <http://medicare.fcsso.com/Feedback/161670.asp>

Provider enrollment

Provider Enrollment

P.O. Box 44021

Jacksonville, FL 32231-4021

Medical policy

Medical Policy and Procedure

P.O. Box 2078

Jacksonville, FL 32231-0048

Email: medical.policy@fcsso.com

Medicare secondary payer

Medicare Part B Secondary Payer Dept.

P.O. Box 44078

Jacksonville, FL 32231-4078

Electronic data interchange (EDI)

Medicare EDI, 4C

P.O. Box 44071

Jacksonville, FL 32231-4071

Overpayments

Medicare Part B Debt Recovery

P.O. Box 44141

Jacksonville, FL 32231-4141

Medicare Education and Outreach

Medicare Education and Outreach

P.O. Box 45157

Jacksonville, FL 32232-5157

Fraud and abuse

Fraud and abuse complaints

P.O. Box 45087

Jacksonville, FL 32232-5087

Freedom of Information Act requests

FOIA USVI

P.O. Box 45073

Jacksonville, FL 32231-5073

Special courier service

First Coast Service Options Inc.

532 Riverside Avenue

Jacksonville, FL 32202-4914

Websites

Provider

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<http://medicare.fcsso.com>

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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
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Online form: <http://medicare.fcsso.com/Feedback/161670.asp>

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Jacksonville, FL 32231-0048
Email: medical.policy@fcsso.com

Medicare secondary payer

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

Electronic data interchange (EDI)

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

Overpayments

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

Medicare Education and Outreach

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

Fraud and abuse

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

Freedom of Information Act requests

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

Special courier service

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

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>

Order form for Medicare Part B materials

The following materials are available for purchase. To order these items, please complete and **submit this form along with your check/money order** payable to First Coast Service Options Inc. account # (use appropriate account number). Do not fax your order; it must be mailed.

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

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