Medicare B CONNECTION
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FIRST COAST SERVICE OPTIONS, INC.
A Newsletter for MAC Jurisdiction N Providers
January 2016

In this issue

Emergency update to the 2016 Medicare physician fee schedule database

Provider types affected

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

What you need to know

Change request (CR) 9495 amends payment files that were issued to contractors based on the 2016 Medicare physician fee schedule (MPFS) final rule. The Centers for Medicare & Medicaid Services (CMS) amended these payment files in order to correct technical errors to the MPFS update files, and to include corrections described in the 2016 MPFS final rule correction notice. Your MAC will disclose the revised MPFS fees on their website as soon as possible, if they have not done so already.

Background

Some relative value units published in the 2016 MPFS final rule have been revised to align their values with the 2016 MPFS final rule policies. These changes are discussed in the 2016 MPFS final rule correction notice. In addition, there were corrections made to invalid or missing payment indicators for several procedure codes. The amended 2016 MPFS payment files reflect all these changes for services furnished on or after January 1, 2016.

Additional information

The official instruction, CR 9495, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3438CP.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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Contents

The *Medicare B Connection* is published monthly by First Coast Service Options Inc.'s Provider Outreach & Education division to provide timely and useful information to Medicare Part B providers.

Publication staff:
Terri Drury
Sofia Lennie
Kathleen Storey
Mark Willett
Robert Petty

Fax comments about this publication to:

Medicare Publications
904-361-0723

Articles included in the *Medicare B Connection* represent formal notice of coverage policies. Policies have or will take effect on the date given. Providers are expected to read, understand, and abide by the policies outlined within to ensure compliance with Medicare coverage and payment guidelines.

About the 'Medicare B Connection'

The *Medicare B Connection* is a comprehensive publication developed by First Coast Service Options Inc. (First Coast) for Part B providers in Florida, Puerto Rico, and the U.S. Virgin Islands and is distributed on a monthly basis.

Important notifications that require communication in between publications will be posted to the First Coast Medicare provider education website at *http://medicare.fcso.com*. In some cases, additional unscheduled special issues may be posted.

Who receives the *Connection*

Anyone may view, print, or download the *Connection* from our provider education website(s). Providers who cannot obtain the *Connection* from the Internet are required to register with us to receive a complimentary hardcopy.

Distribution of the *Connection* in hardcopy is limited to providers who have billed at least one Part B claim to First Coast Medicare during the twelve months prior to the release of each issue. Providers meeting these criteria are eligible to receive a complimentary copy of that issue, if a technical barrier exists that prevents them from obtaining it from the Internet and they have returned a completed registration form to us.

Registration forms must be submitted annually or when you experience a change in circumstances that impacts your electronic access.

For additional copies, providers may purchase a separate annual subscription (see order form in the back of this issue). All issues published since 1997 may be downloaded from the Internet, free of charge.

We use the same mailing address for all correspondence, and cannot designate that the *Connection* be sent to a specific person/department within a provider's office. To ensure continued receipt of all Medicare correspondence, providers must keep their addresses current with the Medicare provider enrollment department. Please remember that address changes must be done using the appropriate CMS-855.

Publication format

The *Connection* is arranged into distinct sections.

- The **Claims** section provides claim submission requirements and tips.
- The **Coverage/Reimbursement** section discusses specific *CPT*® and HCPCS procedure codes. It is arranged by categories (not specialties). For example,

"Mental Health" would present coverage information of interest to psychiatrists, clinical psychologists and clinical social workers, rather than listing articles separately under individual provider specialties. Also presented in this section are changes to the Medicare physician fee schedule, and other pricing issues.

- The section pertaining to **Electronic Data Interchange** (EDI) submission also includes information pertaining to the Health Insurance Portability and Accountability Act (HIPAA).
- The **Local Coverage Determination** section features summaries of new and revised local coverage determinations (LCDs) developed as a result of either local medical review or comprehensive data analysis initiatives.
- The **General Information** section includes fraud and abuse, and national provider identifier topics, plus additional topics not included elsewhere.
- In addition to the above, other sections include:
- **Educational Resources**, and
- **Contact information** for Florida, Puerto Rico, and the U.S. Virgin Islands.

The *Medicare B Connection* represents formal notice of coverage policies

Articles included in each edition represent formal notice that specific coverage policies either have or will take effect on the date given. Providers are expected to read, understand, and abide by the policies outlined in this document to ensure compliance with Medicare coverage and payment guidelines.

Medicare Part B advance beneficiary notices

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

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

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

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

Patient liability notice

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

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

ABN modifiers

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

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

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

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

GA modifier and appeals

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

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

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

Ambulatory Surgical Center

January 2016 update of the ambulatory surgical center payment system

Provider types affected

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

Provider action needed

Change request (CR) 9484 informs MACs about changes to and billing instructions for various payment policies implemented in the January 2016 ASC payment system update. As appropriate, this notification also includes updates to the Healthcare Common Procedure Coding System (HCPCS). Make sure that your billing staff are aware of these changes.

Background

Included in CR 9484 are 2016 payment rates for separately payable drugs and biologicals, including descriptors for newly created Level II HCPCS codes for drugs and biologicals (ASC DRUG files), and the 2016 ASC payment rates for covered surgical and ancillary services (ASCFS file). There is also an update to Chapter 14 of the *Medicare Claims Processing Manual*.

Many ASC payment rates under the ASC payment system are established using payment rate information in the Medicare physician fee schedule (MPFS). The payment files associated with this transmittal reflect the most recent changes to 2016 MPFS payment. Key updates are:

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

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

The Centers for Medicare & Medicaid Services (CMS) is establishing one new HCPCS device pass-through category as of January 1, 2016, for the OPPS and the ASC payment systems. Table 1 provides a listing of new coding and payment information concerning the new device category for transitional pass-through payment. HCPCS code C1822 (Gen, neuro, HF, rechg bat) is assigned ASC PI=J7 (OPPS pass-through device paid separately when provided integral to a surgical procedure on ASC list; payment contractor-priced). Table 1 below shows more details.

Table 1 − New device pass-through code

HCPCS code	Effective date	Short descriptor	Long descriptor	ASC PI
C1822	01-01-2015	Gen, neuro, HF, rechg bat	Generator,	J7

2. Device offset from payment for new device category

Section 1833(t)(6)(D)(ii) of the Act requires that CMS deduct from pass-through payments for devices an amount that reflects the portion of the ambulatory payment classification (APC) payment amount in the outpatient prospective payment system (OPPS). This policy is also in effect in the ASC payment system. Basically, CMS has determined that a portion of the APC payment amount associated with the cost of HCPCS code C1822 is reflected in APC 5464. The HCPCS code C1822 device should always be billed with *CPT*® code *63685* (Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling) which is assigned to APC 5464 for 2016. The device portion included in the ASC procedure payment for 63685 is 84 percent, and is deducted from the procedure payment when performed with C1822.

3. Revised short and long descriptors for packaged code HCPCS code C1820

ASCs do not report packaged codes but with the establishment of HCPCS code C1822, CMS is modifying the short and long descriptors for existing HCPCS code C1820 to appropriately differentiate between HCPCS code C1822 and C1820.

The revised descriptors for C1820 are (short descriptor: Gen, neuro, non-HF rechg bat; long descriptor: Generator, neurostimulator (implantable), non high-frequency with rechargeable battery and charging system).

CMS notes that HCPCS code C1820 describes an implantable non high-frequency neurostimulator generator device with rechargeable battery and charging system, while HCPCS code C1822 describes an implantable high-frequency neurostimulator generator device with rechargeable battery and charging system. While ASCs do not report packaged codes, it is important to announce this distinction.

4. Removal of device portion from procedures that are assigned to a device-intensive APC and that are discontinued prior to the administration of anesthesia

In accordance with the regulations at 42 CFR 416.172(f) and Section 40.4 of Chapter 14 of the *Medicare Claims Processing Manual*, when a surgical procedure, for which anesthesia is planned, is terminated after the patient is prepared and taken to the room where the procedure

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is to be performed, but prior to the administration of anesthesia, ASCs are instructed to append modifier "73" to the procedure line item on the claim. Medicare processes these line items by removing one-half of the full program allowance.

In the 2016 OPPS/ASC (outpatient prospective payment system/ambulatory surgical center) final rule, that was published in the *Federal Register* on November 13, 2015, CMS revised its payment policy for surgical procedures, for which anesthesia is planned and that are discontinued prior to the administration of anesthesia, appended with modifier 73. Specifically, effective January 1, 2016, for such procedures that are assigned to device-intensive procedures, CMS will remove the full device portion of the device-intensive procedure payment prior to applying the additional payment adjustments that apply when the procedure is discontinued. This policy does not apply to procedures and services that are discontinued after the administration of anesthesia and include the 74 modifier. Additional information on this policy is included in CR 9297, dated November 6, 2015. An *MLN Matters*® article related to CR 9297 is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9297.pdf*.

5. New brachytherapy source HCPCS

Section 1833(t)(2)(H) of the Act mandates the creation of additional groups of covered outpatient department (OPD) services that classify devices of brachytherapy consisting of a seed or seeds (or radioactive source) ("brachytherapy sources") separately from other services or groups of services. The additional groups must reflect the number, isotope, and radioactive intensity of the brachytherapy sources furnished. CivaSheet is a new brachytherapy source.

This new brachytherapy source is payable in the ASC payment system. The HCPCS code assigned to this source and the payment rate under OPPS are listed in Table 2.

Table 2 – New brachytherapy source HCPCS

HCPCS code	Effective date	Short descriptor	Long descriptor	ASC PI
C2645	1/1/16	Brachytx planar, p-103	Brachytherapy planar source, palladium-103, per square millimeter	H2

6. Billing instructions for corneal tissue

As finalized in the 2016 OPPS/ASC final rule with comment period (80 FR 70472), procurement/acquisition of corneal tissue will be paid separately only when it is used in corneal transplant procedures. Specifically, corneal tissue will be separately paid when used in procedures performed in the OPD only when the corneal tissue is used in a corneal transplant procedure described by one of the following *CPT*® codes:

- *65710* (Keratoplasty (corneal transplant); anterior lamellar);
- *65730* (Keratoplasty (corneal transplant); penetrating (except in aphakia or pseudophakia));
- *65750* (Keratoplasty (corneal transplant); penetrating (in aphakia));
- *65755* (Keratoplasty (corneal transplant); penetrating (in pseudophakia));
- *65756* (Keratoplasty (corneal transplant); endothelial and any successor code or new code describing a new type of corneal transplant procedure that uses eye banked corneal tissue.

HCPCS code V2785 (Processing, preserving, and transporting corneal tissue) should only be reported when corneal tissue is used in a corneal transplant procedure; V2785 should not be reported in any other circumstances.

7. Drugs, biologicals, and radiopharmaceuticals

New 2016 HCPCS codes and dosage descriptors for certain drugs, biologicals, and radiopharmaceuticals

For 2016, several new HCPCS codes were created for reporting drugs and biologicals in the ASC setting. These new codes, their descriptors, and payment indicator (PI) are listed in Table 3.

Table 3 – New 2016 HCPCS codes effective for certain drugs, biologicals, and radiopharmaceuticals

2016 code	Effective date	Short descriptor	Long descriptor	ASC PI
C9458	1/1/2016	Florbetaben f18	Florbetaben F18, diagnostic, per study dose, up to 8.1 millicuries	K2
C9459	1/1/2016	Flutemetamol f18		K2
C9460	1/1/2016	Injection, cangrelor	Injection, cangrelor, 1 mg	K2
J0714	1/1/2016		'Injection, ceftazidime and avibactam, 0.5g/0.125g	K2
J1575	1/1/2016	Hyqvia 100mg	Injection, immune globulin/	K2

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2016 code	Effective date	Short descriptor	Long descriptor	ASC PI
J7188	1/1/2016	Factor viii recomb obizur	Injection, factor viii	K2
J7340	1/1/2016		Carbidopa 5 mg/ levodopa 20 mg enteral suspension	K2

a. Other changes to 2016 HCPCS and CPT® codes for certain drugs, biologicals, and radiopharmaceuticals

Many HCPCS and *CPT*® codes for drugs, biologicals, and radiopharmaceuticals have undergone changes in their HCPCS and *CPT*® code descriptors that will be effective in 2016. In addition, several temporary HCPCS C-codes have been deleted effective December 31, 2015, and replaced with permanent HCPCS codes in 2016. ASCs should pay close attention to accurate billing for units of service consistent with the dosages contained in the long descriptors of the 2016 HCPCS and *CPT*® codes. Table 4 notes those drugs, biologicals, and radiopharmaceuticals that have undergone changes in their HCPCS/*CPT*® code, their long descriptor, and/or short descriptor. Each product's 2015 HCPCS/*CPT*® code and long descriptor are noted in the two left hand columns and the 2016 HCPCS/ *CPT*® code and long descriptor are noted in the adjacent right hand columns. 2016 HCPCS short descriptors that are unchanged from their crosswalked 2015 short descriptor are annotated with an asterisk (*). 2016 short descriptors are provided if changed from the 2015 crosswalked short descriptor.

Table 4 – Other 2016 HCPCS and *CPT*® code changes for certain drugs, biologicals, and radiopharmaceuticals

2015 code	2015 long descriptor	2016 code	2016 long descriptor	2016 short descriptors
C9025	Injection, ramucirumab, 5 mg	J9308	Injection, ramucirumab, 5 mg	*
C9026	Injection, vedolizumab, 1 mg	J3380	Injection, vedolizumab, 1 mg	*
C9027	Injection, pembrolizumab, 1 mg	J9271	Injection, pembrolizumab, 1 mg	*
Q9975	Injection, Factor VIII, FC Fusion Protein	J7205	Injection, factor viii fc fusion	*
C9442	Injection, belinostat, 10 mg	J9032	Injection, belinostat, 10 mg	
C9443	Injection, dalbavancin, 10 mg	J0875	Injection,	*
C9444	Injection, oritavancin, 10 mg	J2407	Injection, oritavancin, 10 mg	*
C9445	Injection, c-1 esterase inhibitor	J0596	Injection, c1 esterase inhibitor	*
C9446	Injection, tedizolid phosphate, 1 mg	J3090	Injection, tedizolid phosphate, 1 mg	*
Q9978	Netupitant 300 mg and Palonosetron 0.5 mg, oral	J8655	Netupitant 300 mg and	*
C9449	Injection,	J9039	Injection,	*
C9450	Injection, fluocinolone acetonide intravitreal implant, 0.01 mg	J7313	Injection,	
C9451	Injection, peramivir, 1 mg	J2547	Injection, peramivir, 1 mg	*
C9452	Injection, ceftolozane 50 mg and tazobactam 25 mg	J0695	Injection, ceftolozane 50 mg and tazobactam 25 mg	*
C9453	Injection, nivolumab, 1 mg	J9299	Injection, nivolumab, 1 mg	*
C9454	Injection, pasireotide long acting, 1 mg	J2502	Injection, pasireotide long acting, 1 mg	*
C9455	Injection, siltuximab, 10 mg	J2860	Injection, siltuximab, 10 mg	*

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2015 code	2015 long descriptor	2016 code	2016 long descriptor	2016 short descriptors
C9456	Injection,	J1833	Injection,	*
C9457	Injection, sulfur hexafluoride lipid microsphere, per ml	Q9950	Injection, sulfur	Inj sulf hexa lipid
J1446	Injection, tbo-filgrastim, 5 micrograms	J1447	Injection, tbo-filgrastim, 1 microgram	Inj tbo
J7302		J7297		*
J7302		J7298		*
J7506	Prednisone, oral, per 5mg	J7512		*
J7508	Tacrolimus, extended release, oral, 0.1 mg	J7508	Tacrolimus, extended release, (astagraf xl), oral, 0.1 mg	*
Q9979	Injection,	J0202	Injection,	*
Q4153	Dermavest, per square centimeter	Q4153	Dermavest and plurivest, per square centimeter	*
Q9976	Injection, ferric	J1443	Injection, ferric	*
Q9977	Compounded Drug, Not Otherwise Classified	J7999		*
S5011	5 % dextrose in lactated ringers, 1000 ml	J7121	5 % dextrose in lactated ringers infusion, up to 1000 cc	*

***2016 HCPCS short descriptors that are unchanged from their crosswalked 2015 short descriptor.**

b. Drugs and biologicals with payments based on average sales price (ASP) effective January 1, 2016

For 2016, payment for nonpass-through drugs, biologicals, and therapeutic radiopharmaceuticals is made at a single rate of ASP + six percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological, or therapeutic radiopharmaceutical. In 2016, a single payment of ASP + six 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 January 1, 2016, are available in the January 2016 ASC Addendum BB at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html*.

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

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

d. Biosimilar payment policy

Effective January 1, 2016, the payment rate for biosimilars approved for payment in the ASC payment system will be the same as the payment rate in the OPPS and physician office setting, calculated as the ASP of the biosimilar(s) described by the HCPCS code + 6 percent of the ASP of the reference product. Payment will be made at the single ASP + 6 percent rate.

e. Updated guidance: Billing and payment for new drugs, biologicals, or radiopharmaceuticals approved by the FDA but before assignment of a product-specific HCPCS code

As in the OPPS, ASCs are allowed to bill for new drugs, biologicals, and therapeutic radiopharmaceuticals that are approved by the FDA on or after January 1, 2004, for which OPPS pass-through status has not been approved and a C-code and APC payment have not been assigned using the “unclassified” drug/biological HCPCS code C9399 (Unclassified drugs or biological). Drugs, biologicals, and therapeutic radiopharmaceuticals that are assigned to HCPCS code C9399 are MAC priced.

Diagnostic radiopharmaceuticals and contrast agents are policy packaged under both the OPPS and ASC payment system unless they have been granted pass-through status. Therefore, new diagnostic radiopharmaceuticals and contrast agents are an exception to the above policy and should not be billed with C9399 prior to the approval of pass-through status. Instead, they are packaged in the ASC setting with payment already included in the surgical procedure performed, and are not billed.

f. Skin substitute procedure edits

The payment for skin substitute products that do not qualify for OPPS pass-through status are packaged into

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the OPPS payment for the associated skin substitute application procedure. This policy is also implemented in the ASC payment system. The skin substitute products are divided into two groups: 1) high cost skin substitute products and 2) low cost skin substitute products for packaging purposes. Table 5 lists the skin substitute products and their assignment as either a high cost or a low cost skin substitute product, when applicable. ASCs should not separately bill for packaged skin substitutes (ASC PI=N1).

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

Table 5 – Skin substitute product assignment to high cost/low cost status for 2016

2016 HCPCS code	2016 short descriptor	ASC PI	Low/high cost skin substitute
C9349	PuraPly, PuraPly antimic	K2	High
C9363	Integra Meshed Bil Wound Mat	N1	High
Q4101	Apligraf	N1	High
Q4102	Oasis Wound Matrix	N1	Low
Q4103	Oasis Burn Matrix	N1	High
Q4104	Integra BMWD	N1	High
Q4105	Integra DRT	N1	High
Q4106	Dermagraft	N1	High
Q4107	GraftJacket	N1	High
Q4108	Integra Matrix	N1	High
Q4110	Primatrix	N1	High
Q4111	Gammagraft	N1	Low
Q4115	Alloskin	N1	Low
Q4116	Alloderm	N1	High
Q4117	Hyalomatrix	N1	Low
Q4119	Matristem Wound Matrix	N1	Low
Q4120	Matristem Burn Matrix	N1	High
Q4121	Theraskin	K2	High
Q4122	Dermacell	N1	High
Q4123	Alloskin	N1	High
Q4124	Oasis Tri-layer Wound Matrix	N1	Low
Q4126	Memoderm/derma/ tranz/integup	N1	High
Q4127	Talymed	N1	High
Q4128	Flexhd/Allopatchhd/ Matrixhd	N1	High
Q4129	Unite Biomatrix	N1	Low
Q4131	Epifix	N1	High
Q4132	Grafix Core	N1	High
Q4133	Grafix Prime	N1	High
Q4134	hMatrix	N1	Low
Q4135	Mediskin	N1	Low
Q4136	Ezderm	N1	Low
Q4137	Amnioexcel or Biodexcel, 1cm	N1	High
Q4138	Biodfence DryFlex, 1cm	N1	High
Q4140	Biodfence 1cm	N1	High
Q4141	Alloskin ac, 1cm	N1	High
Q4143	Repriza, 1cm	N1	Low
Q4146	Tensix, 1CM	N1	Low
Q4147	Architect ecm, 1cm	N1	High
Q4148	Neox 1k, 1cm	N1	High
Q4150	Allowrap DS or Dry 1 sq cm	N1	High
Q4151*	AmnioBand, Guardian 1 sq cm	N1	High
Q4152*	Dermapure 1 square cm	N1	High
Q4153	Dermavest 1 square cm	N1	High
Q4154*	Biovance 1 square cm	N1	High
Q4156*	Neox 100 1 square cm	N1	High
Q4157	Revitalon 1 square cm	N1	Low
Q4158	MariGen 1 square cm	N1	Low
Q4159	Affinity 1 square cm	N1	High
Q4160	NuShield 1 square cm	N1	High
Q4161	Bio-Connekt per square cm	N1	Low
Q4162	Amnio bio and woundex flow	N1	Low
Q4163	Amnion bio and woundex sq cm	N1	Low
Q4164	Helicoll, per square cm	N1	Low

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2016 HCPCS code	2016 short descriptor	ASC PI	Low/high cost skin substitute
Q4165	Keramatrix, per square cm	N1	Low

*HCPCS codes Q4151, Q4152, Q4154, and Q4156 were assigned to the low cost group in the 2016 OPPS/ASC final rule with comment period. Upon submission of updated pricing information, Q4151, Q4152, Q4154, and Q4156 are assigned to the high-cost group for 2016.

8. 2016 ASC wage index

In the 2016 OPPS/ASC final rule, CMS-1633-FC, and CMS-1607-F2 (80 FR 70298), CMS reminded readers that in the 2015 OPPS/ASC final rule with comment period (79 FR 66937), CMS finalized one-year transition or "blended" policy that it applied in 2015 for all ASCs that experienced any decrease in their actual wage index exclusively due to the implementation of the new OMB delineations. When the 2015 wage index blended value did not correspond to an existing core based statistical area (CBSA) number, CMS implemented this transition by creating alternate or pseudo CBSA numbers (50000 series) to accommodate those wage index values. This transition became operational via CR 9021, dated January 9, 2015. This transition does not apply in 2016. For 2016, the final 2016 ASC wage indexes fully reflect the new OMB labor market area delineations and the pseudo-CBSAs are being end dated.

The complete set of pseudo-CBSAs and their crosswalk to their final 2016 ASC wage indices are included in Attachment B of CR 9484. Attachment B is an Excel® spreadsheet that is sorted in this manner: columns A-C show state/county and state/county code, columns D-E are provided as a historical reference, and columns F-H show the 2015 pseudo-CBSA related data that will be crosswalked to the final 2016 CBSA information contained in columns I-K.

9. Continued use of C1841 in ASCs

Effective October 1, 2013, and expiring December 31, 2015, one device (C1841 - Retinal prosthesis, includes all internal and external components) was eligible for pass-through payment in the OPPS and ASC payment systems. After pass-through status expires for a medical device, the payment for the device is packaged into the payment for the associated procedure. Effective January 1, 2016, in the OPPS and ASC payment systems, C1841 is now packaged into *CPT*® code *0100T*, which is assigned to new technology APC 1599 with a final payment of $95,000 for 2016.

Due to current ASC systems limitations, CMS cannot implement the identical policy in ASCs. As an administrative workaround until CMS can correct this system limitation, both C1841 and *0100T* must be reported when a retinal prosthesis is implanted in the ASC.

10. Coverage determinations

The fact that a drug, device, procedure, or service is assigned a HCPCS 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. MACs determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, MACs determine that it is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment.

Additional information

The official instruction, CR 9484, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3430CP.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/MLN MattersArticles/index.html* under - How Does It Work?

MLN Matters® Number: MM9484
Related Change Request (CR) #: CR 9484
Related CR Release Date: December 29, 2015
Effective Date: January 1, 2016
Related CR Transmittal #: R3430CP
Implementation Date: January 4, 2016

Durable Medical Equipment

2016 DMEPOS HCPCS jurisdiction list

Provider types affected

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

Provider action needed

Change Request (CR) 9481 notifies suppliers that the spreadsheet containing an updated jurisdiction list of Healthcare Common Procedure Coding System (HCPCS) codes is updated annually to reflect codes that have been added or discontinued (deleted) each year. Changes in Chapter 23, Section 20.3 of the *Medicare Claims Processing Manual* are reflected in the recurring update notification.

The spreadsheet for the 2016 DMEPOS jurisdiction list is an Excel® spreadsheet and is available under the Coding Category at *http://www.cms.gov/Center/Provider-Type/Durable-Medical-Equipment-DME-Center.html* and is also attached to CR 9481.

Additional information

The official instruction, CR 9481, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3432CP.pdf*.

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

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2016 DMEPOS jurisdiction listing

This article is informational and is based on change request (CR) 9481 that notifies providers that the spreadsheet containing an updated list of the healthcare common procedure coding system (HCPCS) codes for durable medical equipment Medicare administrative contractor (DME MAC) and Part B local carrier or A/B MAC jurisdictions is updated annually to reflect codes that have been added or discontinued (deleted) each year.

The spreadsheet is helpful to billing staff by showing the appropriate Medicare contractor to be billed for HCPCS appearing on the spreadsheet. The spreadsheet for the 2016 jurisdiction list is attached to CR 9481 at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3432CP.pdf*. Note that deleted codes are valid for dates of service on or before the date of deletion and updated codes are in bold. The jurisdiction list includes codes that are not payable by Medicare. Please consult the Medicare contractor in whose jurisdiction a claim would be filed in order to determine coverage under Medicare.

Note: Deleted codes are valid for dates of service on or before the date of deletion.

Note: Updated codes are in **bold**.

Note: The jurisdiction list includes codes that are not payable by Medicare. Please consult the Medicare contractor in whose jurisdiction a claim would be filed in order to determine coverage under Medicare.

HCPCS	Description	Jurisdiction
A0021-A0999	Ambulance services	Local carrier
A4206-A4209	Medical, surgical, and self- administered injection supplies	Local carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A4210	Needle free injection device	DME MAC
A4211	Medical, surgical, and self- administered injection supplies	Local carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A4212	Non coring needle or stylet with or without catheter	Local carrier

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HCPCS	Description	Jurisdiction
A4213-A4215	Medical , surgical, and self-administered injection supplies	Local carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A4216-A4218	Saline	Local carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A4220	Refill kit for implantable pump	Local carrier
A4221-A4250	Medical, surgical, and self- administered injection supplies	Local carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A4252-A4259	Diabetic supplies	DME MAC
A4261	Cervical cap for contraceptive use	Local carrier
A4262-A4263	Lacrimal duct implants	Local carrier
A4264	Contraceptive implant	Local carrier
A4265	Paraffin	Local carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A4266-A4269	Contraceptives	Local carrier
A4270	Endoscope sheath	Local carrier
A4280	Accessory for breast prosthesis	DME MAC
A4281-A4286	Accessory for breast pump	DME MAC
A4290	Sacral nerve stimulation test lead	Local carrier
A4300-A4301	Implantable catheter	Local carrier
A4305-A4306	Disposable drug delivery system	Local carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A4310-A4358	Incontinence supplies/urinary supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the local carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME MAC.
A4360-A4435	Urinary supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the local carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME MAC.
A4450-A4456	Tape; adhesive remover	Local carrier if incident to a physician's service (not separately payable), or if supply for implanted prosthetic device. If other, DME MAC.

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HCPCS	Description	Jurisdiction
A4458-A4459	Enema bag/ system	DME MAC
A4461-A4463	Surgical dressing holders	Local carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A4465-A4466	Non-elastic binder and elastic garment	DME MAC
A4470	Gravlee jet washer	Local carrier
A4480	Vabra aspirator	Local carrier
A4481	Tracheostomy supply	Local carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A4483	Moisture exchanger	DME MAC
A4490-A4510	Surgical stockings	DME MAC
A4520	Diapers	DME MAC
A4550	Surgical trays	Local carrier
A4554	Disposable underpads	DME MAC
A4555-A4558	Electrodes; lead wires; conductive paste	Local carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A4559	Coupling gel	Local carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A4561-A4562	Pessary	Local carrier
A4565	Sling	Local carrier
A4570	Splint	Local carrier
A4575	Topical hyperbaric oxygen chamber, disposable	DME MAC
A4580-A4590	Casting supplies & material	Local carrier
A4595	TENS supplies	Local carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A4600	Sleeve for intermittent limb compression device	DME MAC
A4601-A4602	Lithium replacement batteries	DME MAC
A4604	Tubing for positive airway pressure device	DME MAC
A4605	Tracheal suction catheter	DME MAC
A4606	Oxygen probe for oximeter	DME MAC
A4608	Transtracheal oxygen catheter	DME MAC
A4611-A4613	Oxygen equipment batteries and supplies	DME MAC
A4614	Peak flow rate meter	Local carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A4615-A4629	Oxygen & tracheostomy supplies	Local carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A4630-A4640	DME supplies	DME MAC
A4641-A4642	Imaging agent; contrast material	Local carrier
A4648	Tissue marker, implanted	Local carrier

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HCPCS	Description	Jurisdiction
A4649	Miscellaneous surgical supplies	Local carrier if incident to a physician's service (not separately payable), or if supply for implanted prosthetic device or implanted DME. If other, DME MAC.
A4650	Implantable radiation dosimeter	Local carrier
A4651-A4932	Supplies for ESRD	DME MAC (not separately payable)
A5051-A5093	Additional ostomy supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the local carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME MAC.
A5102-A5200	Additional incontinence and ostomy supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the local carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME MAC.
A5500-A5513	Therapeutic shoes	DME MAC
A6000	Non-contact wound warming cover	DME MAC
A6010-A6024	Surgical dressing	Local carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other, DME MAC.
A6025	Silicone gel sheet	Local carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other, DME MAC.
A6154-A6411	Surgical dressing	Local carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other, DME MAC.
A6412	Eye patch	Local carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other, DME MAC.

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HCPCS	Description	Jurisdiction
A6413	Adhesive bandage	Local carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other, DME MAC.
A6441-A6512	Surgical dressings	Local carrier if incident to a physician's service (not separately payable), or if supply for implanted prosthetic device or implanted DME. If other, DME MAC.
A6513	Compression burn mask	DME MAC
A6530-A6549	Compression gradient stockings	DME MAC
A6550	Supplies for negative pressure wound therapy electrical pump	DME MAC
A7000-A7002	Accessories for suction pumps	DME MAC
A7003-A7039	Accessories for nebulizers, aspirators and ventilators	DME MAC
A7040-A7041	Chest drainage supplies	Local carrier
A7044-A7047	Respiratory accessories	DME MAC
A7048	Vacuum drainage supply	Local carrier
A7501-A7527	Tracheostomy supplies	DME MAC
A8000-A8004	Protective helmets	DME MAC
A9150	Non-prescription drugs	Local carrier
A9152-A9153	Vitamins	Local carrier
A9155	Artificial saliva	Local carrier
A9180	Lice infestation treatment	Local carrier
A9270	Noncovered items or services	DME MAC
A9272	Disposable wound suction pump	DME MAC
A9273	Hot water bottles, ice caps or collars, and heat and/or cold wraps	DME MAC
A9274-A9278	Glucose monitoring	DME MAC
A9279	Monitoring feature/ device	DME MAC
A9280	Alarm device	DME MAC
A9281	Reaching/grabbing device	DME MAC
A9282	Wig	DME MAC
A9283	Foot off-loading device	DME MAC
A9284	Non-electric spirometer	DME MAC
A9300	Exercise equipment	DME MAC
A9500-A9700	Supplies for radiology procedures	Local carrier
A9900	Miscellaneous DME supply or accessory	Local carrier if used with implanted DME. If other, DME MAC.
A9901	Delivery	DME MAC
A9999	Miscellaneous DME supply or accessory	Local carrier if used with implanted DME. If other, DME MAC.
B4034-B9999	Enteral and parenteral therapy	DME MAC
D0120-D9999	Dental procedures	Local carrier
E0100-E0105	Canes	DME MAC
E0110-E0118	Crutches	DME MAC
E0130-E0159	Walkers	DME MAC
E0160-E0175	Commodes	DME MAC
E0181-E0199	Decubitus care equipment	DME MAC
E0200-E0239	Heat/cold applications	DME MAC

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HCPCS	Description	Jurisdiction
E0240-E0248	Bath and toilet aids	DME MAC
E0249	Pad for heating unit	DME MAC
E0250-E0304	Hospital beds	DME MAC
E0305-E0326	Hospital bed accessories	DME MAC
E0328-E0329	Pediatric hospital beds	DME MAC
E0350-E0352	Electronic bowel irrigation system	DME MAC
E0370	Heel pad	DME MAC
E0371-E0373	Decubitus care equipment	DME MAC
E0424-E0484	Oxygen and related respiratory equipment	DME MAC
E0485-E0486	Oral device to reduce airway collapsibility	DME MAC
E0487	Electric spirometer	DME MAC
E0500	IPPB machine	DME MAC
E0550-E0585	Compressors/ nebulizers	DME MAC
E0600	Suction pump	DME MAC
E0601	CPAP device	DME MAC
E0602-E0604	Breast pump	DME MAC
E0605	Vaporizer	DME MAC
E0606	Drainage board	DME MAC
E0607	Home blood glucose monitor	DME MAC
E0610-E0615	Pacemaker monitor	DME MAC
E0616	Implantable cardiac event Recorder	Local carrier
E0617	External defibrillator	DME MAC
E0618-E0619	Apnea monitor	DME MAC
E0620	Skin piercing device	DME MAC
E0621-E0636	Patient lifts	DME MAC
E0637-E0642	Standing devices/ lifts	DME MAC
E0650-E0676	Pneumatic compressor and appliances	DME MAC
E0691-E0694	Ultraviolet light therapy systems	DME MAC
E0700	Safety equipment	DME MAC
E0705	Transfer board	DME MAC
E0710	Restraints	DME MAC
E0720-E0745	Electrical nerve stimulators	DME MAC
E0746	EMG device	Local carrier
E0747-E0748	Osteogenic stimulators	DME MAC
E0749	Implantable osteogenic stimulators	Local carrier
E0755- E0770	Stimulation devices	DME MAC
E0776	IV pole	DME MAC
E0779-E0780	External infusion pumps	DME MAC
E0781	Ambulatory infusion pump	Billable to both the Local carrier and the DME MAC. This item may be billed to the DME MAC whenever the infusion is initiated in the physician's office but the patient does not return during the same business day.
E0782-E0783	Infusion pumps, implantable	Local carrier
E0784	Infusion pumps, insulin	DME MAC
E0785-E0786	Implantable infusion pump catheter	Local carrier
E0791	Parenteral infusion pump	DME MAC
E0830	Ambulatory traction device	DME MAC
E0840-E0900	Traction equipment	DME MAC
E0910-E0930	Trapeze/fracture frame	DME MAC
E0935-E0936	Passive motion exercise device	DME MAC

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HCPCS	Description	Jurisdiction
E0940	Trapeze equipment	DME MAC
E0941	Traction equipment	DME MAC
E0942-E0945	Orthopedic devices	DME MAC
E0946-E0948	Fracture frame	DME MAC
E0950-E1298	Wheelchairs	DME MAC
E1300-E1310	Whirlpool equipment	DME MAC
E1352-E1392	Additional oxygen related equipment	DME MAC
E1399	Miscellaneous DME	Local carrier if implanted DME. If other, DME MAC.
E1405-E1406	Additional oxygen equipment	DME MAC
E1500-E1699	Artificial kidney machines and accessories	DME MAC (not separately payable)
E1700-E1702	TMJ device and supplies	DME MAC
E1800-E1841	Dynamic flexion devices	DME MAC
E1902	Communication board	DME MAC
E2000	Gastric suction pump	DME MAC
E2100-E2101	Blood glucose monitors with special features	DME MAC
E2120	Pulse generator for tympanic treatment of inner ear	DME MAC
E2201-E2397	Wheelchair accessories	DME MAC
E2402	Negative pressure wound therapy pump	DME MAC
E2500-E2599	Speech generating device	DME MAC
E2601-E2633	Wheelchair cushions and accessories	DME MAC
E8000-E8002	Gait trainers	DME MAC
G0008-G0329	Misc. professional services	Local carrier
G0333	Dispensing fee	DME MAC
G0337-G0365	Misc. professional services	Local carrier
G0372	Misc. professional services	Local carrier
G0378-**G9677**	Misc. professional services	Local carrier
J0120-J3570	Injection	Local carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.
J3590	Unclassified biologicals	Local carrier
J7030-J7131	Miscellaneous drugs and solutions	Local carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.
J7178	Fibrinogen	Local carrier
J7180-J7195	Antihemophilic factor	Local carrier
J7196-J7197	Antithrombin III	Local carrier
J7198	Anti-inhibitor; per I.U.	Local carrier
J7199-**J7205**	Other hemophilia clotting factors	Local carrier
J7297-J7307	Contraceptives	Local carrier
J7308-J7309	Aminolevulinic acid HCL	Local carrier
J7310	Ganciclovir, Long-Acting Implant	Local carrier
J7311-J7316	Ophthalmic Drugs	Local carrier
J7321-**J7328**	Hyaluronan	Local carrier
J7330	Autologous cultured chondrocytes, implant	Local carrier
J7336	Capsaicin	Local carrier

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HCPCS	Description	Jurisdiction
J7340	**Carbidopa/ levodopa**	**Local carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.**
J7500-J7599		Local carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.
J7604-J7699	Inhalation solutions	Local carrier if incident to a physician's service. If other, DME MAC.
J7799 -**J7999**	NOC **drugs**, other than inhalation drugs	Local carrier if incident to a physician's service **or used in an implanted infusion pump**. If other, DME MAC.
J8498	Anti-emetic drug	DME MAC
J8499	Prescription drug, oral, non chemotherapeutic	Local carrier if incident to a physician's service. If other, DME MAC.
J8501-J8999	Oral anti-cancer drugs	DME MAC
J9000-J9999	Chemotherapy drugs	Local carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.
K0001-K0108	Wheelchairs	DME MAC
K0195	Elevating leg rests	DME MAC
K0455	Infusion pump used for uninterrupted administration of epoprostenal	DME MAC
K0462	Loaner equipment	DME MAC
K0552	External infusion pump supplies	DME MAC
K0601-K0605	External infusion pump batteries	DME MAC
K0606-K0609	Defibrillator accessories	DME MAC
K0669	Wheelchair cushion	DME MAC
K0672	Soft interface for orthosis	DME MAC
K0730	Inhalation drug delivery system	DME MAC
K0733	Power wheelchair accessory	DME MAC
K0738	Oxygen equipment	DME MAC
K0739	Repair or nonroutine service for DME	Local carrier if implanted DME. If other, DME MAC
K0740	Repair or nonroutine service for oxygen equipment	DME MAC
K0743-K0746	Suction pump and dressings	DME MAC
K0800-K0899	Power mobility devices	DME MAC
K0900	Custom DME, other than wheelchair	DME MAC
K0901-K0902	Knee orthoses	DME MAC
L0112-L4631	Orthotics	DME MAC
L5000-L5999	Lower limb prosthetics	DME MAC
L6000-L7499	Upper limb prosthetics	DME MAC
L7510-L7520	Repair of prosthetic device	Local carrier if repair of implanted prosthetic device. If other, DME MAC.
L7600	Prosthetic donning sleeve	DME MAC
L7900-L7902	Vacuum erection system	DME MAC
L8000-L8485	Prosthetics	DME MAC
L8499	Unlisted procedure for miscellaneous prosthetic services	Local carrier if implanted prosthetic device. If other, DME MAC.

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HCPCS	Description	Jurisdiction
L8500-L8501	Artificial larynx; tracheostomy speaking valve	DME MAC
L8505	Artificial larynx accessory	DME MAC
L8507	Voice prosthesis, patient inserted	DME MAC
L8509	Voice prosthesis, inserted by a licensed health care provider	Local carrier for dates of service on or after 10/01/2010. DME MAC for dates of service prior to 10/01/2010
L8510	Voice prosthesis	DME MAC
L8511-L8515	Voice prosthesis	Local carrier if used with
L8600-L8699	Prosthetic implants	Local carrier
L9900	Miscellaneous orthotic or prosthetic component or accessory	Local carrier if used with implanted prosthetic device. If other, DME MAC.
M0075- M0301	Medical services	Local carrier
P2028-P9615	Laboratory tests	Local carrier
Q0035	Influenza vaccine; cardio-kymography	Local carrier
Q0081	Infusion therapy	Local carrier
Q0083-Q0085	Chemotherapy administration	Local carrier
Q0091	Smear preparation	Local carrier
Q0092	Portable x-ray setup	Local carrier
Q0111-Q0115	Miscellaneous lab services	Local carrier
Q0138-Q0139	Ferumoxytol injection	Local carrier
Q0144	Azithromycin dihydrate	Local carrier if incident to a physician's service. If other, DME MAC.
Q0161-Q0181	Anti-emetic	DME MAC
Q0478-Q0509	Ventricular assist devices	Local carrier
Q0510-Q0514	Drug dispensing fees	DME MAC
Q0515	Sermorelin acetate	Local carrier
Q1004-Q1005	New technology IOL	Local carrier
Q2004	Irrigation solution	Local carrier
Q2009	Fosphenytoin	Local carrier
Q2017	Teniposide	Local carrier
Q2026-Q2028	Injectable dermal fillers	Local carrier
Q2034-Q2039	Influenza vaccine	Local carrier
Q2043	Sipuleucel-T	Local carrier
Q2049-Q2050	Doxorubicin	Local carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.
Q3001	Supplies for radiology procedures	Local carrier
Q3014	Telehealth originating site facility fee	Local carrier
Q3027-Q3028	Vaccines	Local carrier
Q3031	Collagen skin test	Local carrier
Q4001-Q4051	Splints and casts	Local carrier
Q4074	Inhalation drug	Local carrier if incident to a physician's service. If other, DME MAC.
Q4081	Epoetin	Local carrier
Q4082	Drug subject to competitive acquisition program	Local carrier
Q4100-**Q4165**	Skin substitutes	Local carrier
Q5001-Q5010	Hospice services	Local carrier
Q5101	**Injection**	**Local carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.**

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HCPCS	Description	Jurisdiction
Q9950-Q9954	Imaging agents	Local carrier
Q9955-Q9957	Microspheres	Local carrier
Q9958-Q9969	Imaging agents	Local carrier
Q9980	**Hyaluronan**	**Local carrier**
R0070-R0076	Diagnostic radiology services	Local carrier
V2020-V2025	Frames	DME MAC
V2100-V2513	Lenses	DME MAC
V2520-V2523	Hydrophilic contact lenses	Local carrier if incident to a physician's service. If other, DME MAC.
V2530-V2531	Contact lenses, scleral	DME MAC
V2599	Contact lens, other type	Local carrier if incident to a physician's service. If other, DME MAC.
V2600-V2615	Low vision aids	DME MAC
V2623-V2629	Prosthetic eyes	DME MAC
V2630-V2632	Intraocular lenses	Local carrier
V2700-V2780	Miscellaneous vision service	DME MAC
V2781	Progressive lens	DME MAC
V2782-V2784	Lenses	DME MAC
V2785	Processing-corneal tissue	Local carrier
V2786	Lens	DME MAC
V2787-V2788	Intraocular lenses	Local carrier
V2790	Amniotic membrane	Local carrier
V2797	Vision supply	DME MAC
V2799	Miscellaneous vision service	DME MAC
V5008-V5299	Hearing services	Local carrier
V5336	Repair/ modification of augmentative communicative system or device	DME MAC
V5362-V5364	Speech screening	Local carrier

Source: CR 9481

Drugs and Biologicals

Update to the January 2016 average sales price (ASP) drug pricing file

The Centers for Medicare & Medicaid Services (CMS) has made revisions to the January 2016 ASP drug pricing file. Medicare administrative contractors (MACs) are making these changes to their payment files; the public files posted to the Centers for Medicare & Medicaid Services (CMS) website will be updated to reflect the changes noted below.

- Healthcare Common Procedure Coding System (HCPCS) codes J0886 (Epoetin alfa 1000 units ESRD) and J7506 (Prednisone oral) are being removed from the January file. These codes were terminated on December 31, 2015.
- HCPCS code J7512 (Prednisone, immediate release or delayed release, 1 mg) is being added to the January file.
- The dosage associated with HCPCS code J3090 (Inj tedizolid phosphat) in the ASP drug pricing file is being changed from 10 mg to 1 mg.

First Coast Service Options' (First Coast) fee lookup tool will reflect these revisions.

Where do I find...

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Evaluation and Management

Advance care planning as an optional element of an annual wellness visit

Provider types affected

This *MLN Matters*® article is intended for providers who submit claims to Medicare administrative contractors (MACs) for dvance care planning (ACP) services provided as an optional element of the annual wellness visit (AWV) to Medicare beneficiaries.

Provider action needed

Change request (CR) 9271 informs providers to waive the deductible and the coinsurance for ACP when furnished as an optional element of an AWV. Make sure your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) made the *Current Procedural Terminology* (*CPT*®) codes for ACP separately payable for Medicare. The change in policy will be implemented through the annual Medicare physician fee schedule database (MPFSDB) update.

In addition, CMS is also including voluntary ACP as an optional element of the AWV. ACP services furnished on the same day and by the same provider as an AWV are considered a preventive service. Therefore, the deductible and coinsurance are not applied to the codes used to report ACP services when performed as part of an AWV.

Voluntary ACP means the face-to-face service between a physician (or other qualified health care professional) and the patient discussing advance directives, with or without completing relevant legal forms. An advance directive is a document appointing an agent and/or recording the wishes of a patient pertaining to his/her medical treatment at a future time should he/she lack decisional capacity at that time.

Voluntary ACP, upon agreement with the patient, would be an optional element of the AWV. Effective January 1, 2016, when ACP services are provided as a part of an AWV, practitioners would report *CPT*® code *99497* (plus add-on code *99498* for each additional 30 minutes, if applicable) for the ACP services in addition to either of the AWV codes G0438 and G0439. *CPT*® codes *99497* and *99498* used to describe ACP are separately payable under the Medicare Physician Fee Schedule (MPFS). When voluntary ACP services are furnished as a part of an AWV, the coinsurance and deductible would not be applied for ACP. Under that circumstance, both the ACP and AWV must also be billed together on the same claim. In order to have the deductible and coinsurance waived for ACP when performed with an AWV, the ACP code(s) must be billed with modifier 33 (Preventive services). Since payment for an AWV is limited to only once a year, the deductible

and coinsurance for ACP billed with an AWV can only be waived once a year.

Critical access hospitals (CAHs) may also bill for these professional services provided on or after January 1, 2016, using type of bill 85x with revenue codes 96x, 97x, and 98x. The CAH Method II payment will be based on the lesser of the actual charge or the facility-specific MPFS.

However, the deductible and coinsurance does apply when ACP is not furnished as part of a covered AWV.

Additional information

The official instruction, CR 9271, was issued to your MAC regarding this change via two transmittals. The first updates the *Medicare Benefit Policy Manual* and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R216BP.pdf*. The second transmittal updates the *Medicare Claims Processing Manual* and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3428CP.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: MM9271
Related Change Request (CR) #: CR 9271
Related CR Release Date: December 22, 2015
Effective Date: January 1, 2016
Related CR Transmittal #: R216BP and R3428CP
Implementation Date: January 4, 2016

Documentation requirements for home health prospective payment

***Note**: This article was rescinded January 15, 2016, to reflect changes regarding the documentation requirements for HH face-to-face encounters, which were updated in the 2015 home health prospective payment system (HH PPS) final rule. Those changes eliminated the narrative requirement for face-to-face encounter as part of the certification of eligibility, for episodes on or after January 1, 2015. For information regarding certifying patients for the Medicare home health benefit, please review SE1436. This was previously published in the January 2014 Medicare B Connection, Pages 28-29.*

Document history

Date of change	Description
January 15, 2016	The article was rescinded due to changes regarding the documentation changes to HH face-to-face encounters, which were updated in the 2015 HH PPS final rule. Those changes eliminated the narrative requirement for face-to-face encounter as part of the certification of eligibility for episodes on or after January 1, 2015.

MLN Matters® Number: SE1405 *Rescinded*
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

2016 'Medicare Part B Participating Physician and Supplier Directory'

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

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

Source: Pub 100-04, Transmittal 3397, CR 9368

Laboratory/Pathology

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

Provider types affected

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

Provider action needed

Change request (CR) 9485 revises the payment of travel allowances when billed on a per mileage basis using Healthcare Common Procedure Coding System (HCPCS) code P9603 and when billed on a flat-rate basis using HCPCS code P9604 for 2016.

Background

Medicare Part B allows payment for a specimen collection fee and travel allowance, when medically necessary, for a laboratory technician to draw a specimen from either a nursing home patient or homebound patient under Section 1833(h)(3) of the Social Security Act. Payment for these services is made based on the clinical laboratory fee schedule.

The travel codes allow for payment either on a per mileage basis (P9603) or on a flat-rate per trip basis (P9604). Payment of the travel allowance is made only if a specimen collection fee is also payable. The travel allowance is intended to cover the estimated travel costs of collecting a specimen, including the laboratory technician's salary and travel expenses.

Your MAC has the discretion to choose either a mileage basis or a flat rate, and how to set each type of allowance. Many MACs established local policy to pay based on a flat-rate basis only.

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

Per mile travel allowance (P9603): The minimum "per mile travel allowance" is $0.99, which is to be used in situations where the average trip to the patients' homes is longer than 20 miles round trip, and is to be prorated in situations where specimens are drawn from non-Medicare patients in the same trip. This allowance per mile was computed using the federal mileage rate of $0.54 per mile plus an additional $0.45 per mile to cover the technician's time and travel costs. MACs have the option of establishing a higher per mile rate in excess of the minimum $0.99 per mile if local conditions warrant it. The minimum mileage rate will be reviewed and updated throughout the year, as well as in conjunction with the clinical laboratory fee schedule (CLFS), as needed. At no time will the laboratory be allowed to bill for more miles than are reasonable, or for miles that are not actually traveled by the laboratory technician. The Internal Revenue Service (IRS) determines the standard mileage rate for businesses based on periodic studies of the fixed and variable costs of operating and automobile.

Per flat-rate trip basis travel allowance (P9604): The per flat-rate trip basis travel allowance is $9.90.

Note: MACs will not search their files to either retract payment for claims already paid or to retroactively pay claims. However, MACs will adjust claims brought to their attention.

Additional information

The official instruction, CR 9485, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3433CP.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: MM9485
Related Change Request (CR) #: CR 9485
Related CR Release Date: December 31, 2015
Effective Date: January 1, 2016
Related CR Transmittal #: R3433CP
Implementation Date: February 1, 2016

NCD for screening for colorectal cancer using Cologuard™

***Note**: This article was revised January 5, 2016, to reflect the revised change request (CR) 9115 issued December 30, 2015. The CR was revised to show that HCPCS code G0464 expired December 31, 2015, and is replaced in the 2016 clinical laboratory fee schedule with CPT® code 81528. The article is revised to reflect this change. Also, the CR release date, transmittal number, and the Web address for accessing the CR are changed. All other information remains the same. This information was previously published in the September 2015 Medicare B Connection, Pages 9-10 .*

Provider types affected

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

Provider action needed

Stop – impact to you

This article is based on CR 9115 which announces effective October 9, 2014, the Centers for Medicare & Medicaid Services (CMS) has determined that the evidence is sufficient to cover Cologuard™ - a multitarget stool DNA test – as a colorectal cancer screening test for asymptomatic, average risk beneficiaries, aged 50 to 85 years.

Caution – what you need to know

CR 9115 instructs the MACs that effective for claims with dates of service on or after October 9, 2014, Medicare will recognize new Healthcare Common Procedure Coding System (HCPCS) code G0464, (Colorectal cancer screening; stool-based DNA and fecal occult hemoglobin (for example, KRAS, NDRG4 and BMP3)) as a covered service. Only laboratories authorized by the manufacturer to perform the Cologuard™ test may bill for this service.

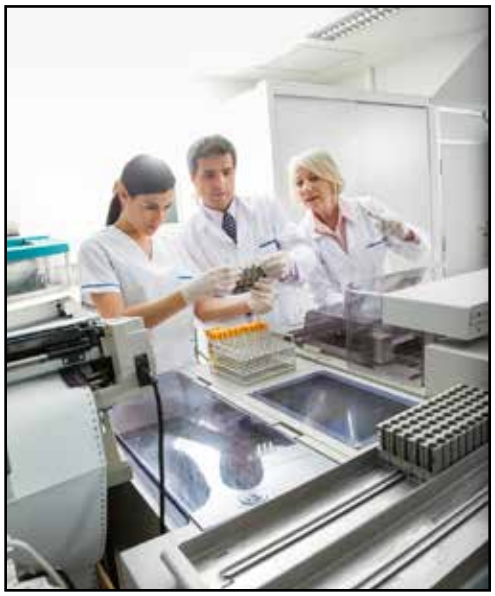
Go – what you need to do

Make sure that your billing staff are aware of these changes.

Background

The Social Security Act (the Act) (Sections 1861(s)(2)(R) and 1861(pp) - see *http://www.ssa.gov/OP_Home/ssact/title18/1861.htm*) and regulations at 42 CFR 410.37 (see *http://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol2/pdf/CFR-2011-title42-vol2-sec410-37.pdf*) authorize coverage for screening colorectal cancer (CRC) tests under Medicare Part B. The statute and regulations authorize the Secretary to add other tests and procedures (and modifications to such tests and procedures for colorectal cancer screening) as the Secretary determines appropriate in consultation with appropriate experts and organizations.

As part of the CMS – Food and Drug Administration (FDA) Parallel Review Pilot Program, CMS finalized a NCD for Screening for CRC Using Cologuard™ - A Multitarget Stool DNA Test. After considering public comments and consulting with appropriate organizations, effective October 9, 2014, CMS has determined that the evidence is sufficient to cover Cologuard™ - a multitarget stool DNA test – as a colorectal cancer screening test for asymptomatic, average risk beneficiaries, who are ages 50 to 85 years.



Effective for claims with dates of service on or after October 9, 2014, MACs will recognize the new HCPCS code G0464 as a covered service. Be aware that claims for HCPCS code G0464 must also include ICD-9 diagnosis codes V76.41 and V76.51. Once ICD-10 is implemented, the claim must reflect ICD-10 diagnosis codes Z12.12 and Z12.11.

MACs will only pay for HCPCS code G0464 when it is submitted on types of bill (TOB) 13x hospital outpatient departments), 14x (hospital non-patient laboratories), or 85x (critical access hospitals. Payments will be made on TOB 13x and 14x based on the clinical laboratory fee schedule (CLFS). Payment for TOB 85x will be based on reasonable cost.

Note: HCPCS code G0464 is in the January 1, 2015, CLFS and integrated outpatient code editor (IOCE) updates with an effective date of October 9, 2014. Therefore, MACs shall apply contractor pricing to claims containing HCPCS G0464 with dates of service October 9, 2014, through December 31, 2014. However, in the 2016 CLFS, G0464 expires effective December 31, 2015, and effective January 1, 2016, *CPT*® code *81528* replaces *G0464*.

You can refer to the revised Pub. 100-03, *Medicare NCD Manual*, Chapter 1, Section 210.3, Colorectal Cancer Screening Tests, for coverage policy. For claims processing instructions, refer to revised Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 18, Section 60, Colorectal Cancer Screening. Both of these revised manuals are included as attachments to CR 9115.

Effective for dates of service on or after October 9, 2014, Medicare Part B will cover the Cologuard™ test once every three years for Medicare beneficiaries that meet all of the following criteria:

- Age 50 to 85 years;
- Asymptomatic (no signs or symptoms of colorectal disease including but not limited to lower gastrointestinal pain, blood in stool, positive guaiac fecal occult blood test or fecal immunochemical test); and

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- At average risk of developing colorectal cancer (no personal history of adenomatous polyps, colorectal cancer, or inflammatory bowel disease, including Crohn's disease and ulcerative colitis; no family history of colorectal cancers or adenomatous polyps, familial adenomatous polyposis, or hereditary nonpolyposis colorectal cancer).

There is no coinsurance or deductible for tests paid under the CLFS. Therefore, there is no coinsurance or deductible for HCPCS code G0464.

Medicare will pay for this service for eligible beneficiaries only once every three years. Next eligible dates will be displayed on all common working file (CWF) provider query screens. Subsequent claim lines for HCPCS code G0464 received in the same three-year period will be denied using the following:

- Claim adjustment reason code (CARC) 119 - "Benefit maximum for this time period has been reached;"
- Remittance advice remarks code (RARC) N386 - "This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *www.cms.gov/mcd/search.asp*. If you do not have web access, you may contact the contractor to request a copy of the NCD;" and
- 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.

To be eligible for this service, beneficiaries must be aged 50-85 or the claim line item will be denied with the following messages:

- CARC 6 - "The procedure/revenue code is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
- RARC N129 - "Not eligible due to the patient's age."
- Group code CO assigning financial liability to the provider, if a claim is received with a Z modifier indicating no signed ABN is on file.

Failure to include the required ICD-9 or ICD-10 codes on the claim line will result in denial of the claim line with the following messages:

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

Claim line items submitted on TOBs other than 13x, 14x, or 85x will be denied with the following messages:

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

All other indications for colorectal cancer screening not otherwise specified in the Act and regulations, or otherwise specified in Section 210.3 of the *NCD Manual*, remain nationally non-covered.

Additional information

The official instruction, CR 9115, was issued to your MAC regarding this change via two transmittals. The first updates the *Medicare National Coverage Determinations Manual* and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R188NCD.pdf*. The second transmittal updates the *Medicare Claims Processing Manual* and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3319CP.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: MM9115 *Revised*
Related Change Request (CR) #: CR 9115
Related CR Release Date: December 30, 2015
Effective Date: October 9, 2014
Related CR Transmittal #: R188NCD and R3319CP
Implementation Date: September 8, 2015 for non-shared MAC edits; January 4, 2016 for shared systems changes

Medicare Physician Fee Schedule Database

Summary of policies in the 2016 MPFS final rule and telehealth originating site facility fee payment amount

Provider types affected

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

Provider action needed

This article is based on change request (CR) 9476 which provides a summary of the policies in the 2016 Medicare physician fee schedule (MPFS) final rule and announces the telehealth originating site facility fee payment amount. Make sure that your billing staff is aware of these updates for 2016.

Background

The Social Security Act (Section 1848(b)(1); see *http://www.ssa.gov/OP_Home/ssact/title18/1848.htm*) requires the Centers for Medicare & Medicaid Services (CMS) to establish by regulation a fee schedule of payment amounts for physicians' services for the subsequent year. CMS issued a final rule with comment period on October 30, 2015, (see *http://www.gpo.gov/fdsys/pkg/FR-2015-11-16/pdf/2015-28005.pdf*), that updates payment policies and Medicare payment rates for services furnished by physicians and non-physician practitioners (NPPs) that are paid under the MPFS in 2016.

The final rule also addresses public comments on Medicare payment policies proposed earlier this year. The proposed rule "Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2016" was published in the *Federal Register* on July 15, 2015 (see *http://www.gpo.gov/fdsys/pkg/FR-2015-07-15/pdf/2015-16875.pdf*).

The final rule also addresses interim final values established in the 2015 MPFS final rule with comment period. The final rule assigns interim final values for new, revised, and potentially misvalued codes for 2016 and requests comments on these values. CMS will accept comments on those items open to comment in the final rule with comment period until December 29, 2015.

CR 9476 provides a summary of the payment polices under the MPFS and makes other policy changes related to Medicare Part B payment. These changes are applicable to services furnished in 2016 and they are as follows:

Sustainable growth rate (SGR)

The Medicare Access and CHIP Reauthorization Act of 2015 (Pub. L. 114-10, enacted on April 16, 2015) (MACRA; see *http://www.gpo.gov/fdsys/pkg/BILLS-114hr2enr/pdf/BILLS-114hr2enr.pdf*) repealed the Medicare SGR update formula for payments under the MPFS.

Access to telehealth services

CMS is adding the following services to the list of services that can be furnished to Medicare beneficiaries under the telehealth benefit: Prolonged service inpatient CPT® codes *99356* and *99357* and ESRD-related services *90963* through *90966*. The prolonged service codes can only be billed in conjunction with subsequent hospital and subsequent nursing facility codes. Limits of one subsequent hospital visit every three days, and one subsequent nursing facility visit every 30 days, would continue to apply when the services are furnished as telehealth services.

For the ESRD-related services, the required clinical examination of the catheter access site must be furnished face-to-face "hands on" (without the use of an interactive telecommunications system) by a physician, clinical nurse specialist (CNS), nurse practitioner (NP), or physician assistant (PA). For the complete list of telehealth services, visit *http://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index.html*.

Certified registered nurse anesthetists (CRNAs) initially were omitted from the list of distant site practitioners for telehealth services in the regulation because CMS did not believe these practitioners would furnish any of the service on the list of Medicare telehealth services. However, CRNAs in some states are licensed to furnish certain services on the telehealth list, including evaluation and management services. Therefore, CMS revised the regulation at *42 CFR 410.78(b)(2)* (Telehealth services) to include a CRNA, as described under *42 CFR 410.69*, to the list of distant site practitioners who can furnish Medicare telehealth services.

Telehealth origination site facility fee payment amount update

The Social Security Act (Section 1834(m)(2)(B); see *https://www.ssa.gov/OP_Home/ssact/title18/1834.htm*) establishes the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001, through December 31, 2002, at $20. For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased by the percentage increase in the Medicare economic index (MEI) as defined in the Social Security Act (Section 1842(i)(3); see *https://www.ssa.gov/OP_Home/ssact/title18/1842.htm*).

The MEI increase for 2016 is 1.1 percent. Therefore, for 2016, the payment amount for HCPCS code Q3014 (Telehealth originating site facility fee) is 80 percent of the lesser of the actual charge, or $25.10. (The beneficiary is responsible for any unmet deductible amount and Medicare coinsurance.)

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Incomplete colonoscopies

The method for calculating the payment for incomplete colonoscopies has been revised for 2016. New payment rates will apply when modifier 53 (discontinued procedure) is appended to codes *44388, 45378*, G0105, and G0121. (For more information, see the *MLN Matters*® article (MM9317) corresponding to CR 9317 at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9317.pdf*.

Advance care planning, and with an annual wellness visit

Advance care planning (ACP) services are separately payable under the MPFS in 2016 (deductible and coinsurance apply). When voluntary ACP services are furnished as part of an annual wellness visit (AWV), the deductible and coinsurance would not be applied for ACP.

Portable X-ray transportation fee

The *Medicare Claims Processing Manual*, Chapter 13, Section 90.3 was revised to remove the word "Medicare" before "patient" in Section 90.3. Also, guidance for the billing of the transportation fee of portable X-ray suppliers has been clarified. When more than one patient is X-rayed at the same location, the single transportation payment under the physician fee schedule is to be prorated among all patients (Medicare Parts A and B, and non-Medicare) receiving portable X-ray services during that trip, regardless of their insurance status. For more information, see the *MLN Matters*® article (MM9354) corresponding to CR 9354 for more information at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9354.pdf*.

"Incident to" policy

CMS finalized the changes to *42 CFR 410.26*(a)(1) without modification, and the change to the regulation at 42 CFR 410.26(b)(5) with a clarifying modification. Specifically, CMS is amending the definition of the term, "auxiliary personnel" at § 410.26(a)(1) that are permitted to provide "incident to" services to exclude individuals who have been excluded from the Medicare program or have had their Medicare enrollment revoked. Additionally, CMS is amending § 410.26(b)(5) by revising the final sentence to make clear that the physician (or other practitioner) directly supervising the auxiliary personnel need not be the same physician (or other practitioner) that is treating the patient more broadly, and adding a sentence to specify that only the physician (or other practitioner) that supervises the auxiliary personnel that provide incident to services may bill Medicare Part B for those incident to services.

Establishing values for new, revised, and misvalued codes

The list of codes with changes for 2016 included under this definition of "adjustments to relative value units (RVUs) for misvalued codes" is available under the "downloads"

section at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html*.

Target for relative value adjustments for misvalued services

The Protecting Access to Medicare Act of 2014 (PAMA; Section 220(d); see *http://www.gpo.gov/fdsys/pkg/BILLS-113hr4302enr/pdf/BILLS-113hr4302enr.pdf*) added a new subparagraph tot the Social Security Act (Section 1848(c)(2)(O)) to establish an annual target for reductions in MPFS expenditures resulting from adjustments to relative values of misvalued codes. Under the Social Security Act (Section 1848(c)(2)(O)(ii)), if the estimated net reduction in expenditures for a year as a result of adjustments to the relative values for misvalued codes is equal to or greater than the target for that year, reduced expenditures attributable to such adjustments will be redistributed in a budget-neutral manner within the MPFS in accordance with the existing budget neutrality requirement under the Social Security Act (Section 1848(c)(2)(B)(ii)(II)). The provision also specifies that the amount by which such reduced expenditures exceeds the target for a given year will be treated as a net reduction in expenditures for the succeeding year, for purposes of determining whether the target has been met for that subsequent year. Section 1848(c)(2)(O)(iv)) defines a target recapture amount as the difference between the target for the year and the estimated net reduction in expenditures under the MPFS resulting from adjustments to RVUs for misvalued codes. Section 1848(c)(2)(O)(iii)) specifies that, if the estimated net reduction in MPFS expenditures for the year is less than the target for the year, an amount equal to the target recapture amount will not be taken into account when applying the budget neutrality requirements specified in the Social Security Act (Section 1848(c)(2)(B)(ii)(II)). The PAMA (Section 220(d)) applies to 2017 through 2020 and sets the target under the Social Security Act (Section 1848(c)(2)(O)(v)) at 0.5 percent of the estimated amount of expenditures under the PFS for each of those four years.

The Achieving a Better Life Experience Act of 2014 (ABLE; Section 202) (Division B of Pub. L. 113-295, enacted December 19, 2014) amended the Social Security Act (Section 1848(c)(2)(O)) to accelerate the application of the MPFS expenditure reduction target to 2016, 2017, and 2018, and to set a 1 percent target for 2016 and 0.5 percent for 2017 and 2018. As a result of these provisions,

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if the estimated net reduction for a given year is less than the target for that year, payments under the MPFS will be reduced.

In the 2016 PFS proposed rule, CMS proposed a methodology to implement this statutory provision in a manner consistent with the broader statutory construct of the MPFS. CMS finalized the policy to calculate the net reduction using the simpler method as proposed. CMS estimates the 2016 net reduction in expenditures resulting from adjustments to relative values of misvalued codes to be 0.23 percent. Since this does not meet the 1 percent target established by the Achieving a Better Life Experience Act of 2014 (ABLE), payments under the MPFS must be reduced by the difference between the target for the year and the estimated net reduction in expenditures (the "Target Recapture Amount"). As a result, CMS estimates that the 2016 target recapture amount will produce a reduction to the CF of -0.77 percent.

Additional information

The official instruction, CR 9476, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3423CP.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: MM9476
Related Change Request (CR) #: CR 9476
Related CR Release Date: December 18, 2015
Effective Date: January 1, 2016 Related CR Transmittal #:R3423CP
Implementation Date: January 4, 2016

Preventive Services

New influenza virus vaccine code

***Note**: This article was revised December 24, 2015, to reflect the revised change request (CR) 9357 issued December 22. In the article, the CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same. This information was previously published in the December 2015 Medicare B Connection, Page 18.*

Provider types affected

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

Provider action needed

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

Background

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

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

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

- Pay for vaccine code *90630* on institutional claims as follows:
  - **Hospitals** – types of bill (TOB) 12x and 13x, skilled nursing facilities (SNFs) –TOB 22x and 23x, home health agencies (HHAs) – TOB 34x, hospital-based renal dialysis facilities (RDFs) – TOB 72x, and critical access hospitals (CAHs) – TOB 85x, based on reasonable cost;

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INFLUENZA

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- **Indian health service (IHS) hospitals** – TOB 12x, and 13x and IHS CAHs – TOB 85x, based on the lower of the actual charge or 95 percent of the average wholesale price (AWP); and
- **Comprehensive outpatient rehabilitation facility (CORF)** – TOB 75x, and independent RDFs – TOB 72x, based on the lower of actual charge or 95 percent of the AWP.

- Pay for code *90630* on professional claims using the CMS Seasonal Influenza Vaccines Pricing Web page at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html* to determine the payment rate for influenza virus vaccine code *90630*.

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

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

Additional information

The official instruction, CR 9357, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3429CP.pdf*.

MLN Matters® Number: MM9357
Related Change Request (CR) #: CR 9357
Related CR Release Date: December 22, 2015
Effective Date: August 1, 2015
Related CR Transmittal #: R3429CP
Implementation Date: April 4, 2016

Prompt payment interest rate revision

Medicare must pay interest on clean claims if payment is not made within the applicable number of calendar days (i.e., 30 days) after the date of receipt. The applicable number of days is also known as the payment ceiling. For example, a clean claim received March 1, 2015, must be paid before the end of business March 31, 2015.

The interest rate is determined by the applicable rate on the day of payment. This rate is determined by the Treasury Department on a six-month basis, effective every January and July 1. Providers may access the Treasury Department Web page *https://www.fiscal.treasury.gov/fsservices/gov/pmt/promptPayment/rates.htm* for the correct rate.

The interest period begins on the day after payment is due and ends on the day of payment.

The new rate of 2.5 percent is in effect through June 30, 2016.

Interest is not paid on:

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

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

Provider enrollment application fee amount for 2016

On December 3, CMS issued a notice: Provider Enrollment Application Fee Amount for Calendar Year 2016 [CMS–6066–N] (*http://go.usa.gov/ckj8Z*). Effective January 1, 2016, the calendar year (CY) 2016 application fee is $554 for institutional providers that are:

- Initially enrolling in the Medicare or Medicaid program or the Children's Health Insurance Program (CHIP)
- Revalidating their Medicare, Medicaid, or CHIP enrollment
- Adding a new Medicare practice location

This fee is required with any enrollment application submitted from January 1 through December 31, 2016.

Processing Issues

Additional ICD-10 diagnosis codes for J0717 (certolizumab pegol, 1 mg)

Issue

Claims for HCPCS code J0717 (certolizumab pegol, 1 mg) billed with ICD-10 codes L40.50-L40.59 for dates of service on or after October 1, 2015, were denied.

Resolution

ICD-10 codes L40.50-L40.59 (Arthropathic psoriasis) will be added as payable diagnosis codes for J0717. Both Part A and B claim processing systems has been updated and claims that were denied incorrectly have been adjusted.

Status

Closed.

Provider action

None.

Current processing issues

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

CMS resolves claims processing issue for reference laboratory and anti-markup payment limitation services

Issue

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

Resolution

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

Status/date resolved

Closed. All adjustments were completed January 5.

Provider action

None.

Reminder: For all claims received on or after October 1, 2015, billing physicians/suppliers must submit the national provider identifiers (NPIs) of performing physicians/ suppliers that furnish reference lab tests or services subject to the anti-markup payment limitation, even if the performing physician/suppliers are located outside of the biller's jurisdiction. The NPI should be included in Item 32a of the CMS-1500 claim form (or the electronic equivalent.)

Current processing issues

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

Guidelines for unsolicited/voluntary refunds

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

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

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

The Centers for Medicare & Medicaid Services reminds providers that:

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

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

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

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

Effective and notice dates

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

Electronic notification

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

More information

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

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

Looking for LCDs?

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

Advance beneficiary notice

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

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

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

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

"We are aware of the changes in medical policies via First Coast *eNews* we receive every week. We are continuously monitoring to identify changes and thus prevent claims to be denied."

Sign up for *eNews* by clicking *here*.

– Luis Rodríguez Félix,
Billing manager, Ashford Presbyterian Community Hospital

Correction

2016 HCPCS local coverage determination – correction to the changes

The 2016 HCPCS local coverage determination changes based on the 2016 Healthcare Common Procedure Coding System (HCPCS) annual update was previously published in the *December 2015 Connection*. Below are corrections to the previously published article. The corrections are listed in bold type.

LCD title	Changes
Noncovered Services	Descriptor change for *CPT*® codes *87320, 90632, 90633, 90634, 90644, 90647, 90648, 90649, 90650, 90680, 90681*, and *0358T*. Deleted *CPT*® code *0099T* (replaced with *CPT*® code *65785*), *CPT*® code *0103T* (replaced with unlisted *CPT*® code *84999*), *CPT*® code *0123T* (replaced with unlisted *CPT*® code *66999*), *CPT*® code *0223T*, *0224T*, and *0225T* (replaced with unlisted *CPT*® code *93799*), *CPT*® code *0233T* (replaced with unlisted *CPT*® code *88749*) , *CPT*® code *0243T* and *0244T* (replaced with unlisted *CPT*® code *94799*), *CPT*® code *0262T* (replaced with *CPT*® code *33477*),

LCD title	Changes
Noncovered Services (continued)	*Deleted CPT*® code *0311T* (replaced with *CPT*® code *93050*), **HCPCS codes G6027 and G6028 (replaced with *CPT*® codes *46601* and *46607*)** and unlisted *CPT*® code *20999* for Magnetic resonance guided focused ultrasound surgery (MRgFUS) (e.g., ExAblate) (replaced with *CPT*® code *0398T*) Deleted *CPT*® codes *90645, 90646, 90692*, and *90693*
*Viscosupplementation Therapy for **Knee***	Added HCPCS codes J7328 and Q9980

Revisions to LCDs

Computed tomographic angiography of the chest, heart, and coronary arteries – revision to the LCD

LCD ID number: L33282 (Florida/Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for computed tomographic angiography of the chest, heart, and coronary arteries was revised to change ICD-10-CM diagnosis code range R07.1-R07.89 to R07.1-R07.9 in the "ICD-10 Codes that Support Medical Necessity" section of the LCD for *Current Procedural Terminology* (*CPT*®) code *71275*.

The updated LCD will be available on the Medicare coverage database (MCD) on or after January 1, 2016.

Effective date

This LCD revision is effective for claims processed **on or after December 28, 2015**, for services rendered **on or after October 1, 2015**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Noncovered services and gene expression profiling panel for use in the management of breast cancer treatment – revision to the LCD

LCD ID number: L33777 and L33586 (Florida/ Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for noncovered services (L33777) was revised based on a reconsideration request to remove *CPT®* code *0008M* [*Oncology (breast), mRNA analysis of 58 genes using hybrid capture, on formalin-fixed paraffin-embedded (FFPE) tissue, prognostic algorithm reported as a risk score*] and was added to the gene expression profiling panel for use in the management of breast cancer treatment LCD (L33586) with limited indications. The "Indications and Limitations of Coverage and/or Medical Necessity," "*CPT®*/HCPCS Codes," and "Sources of Information and Basis for Decision" sections of LCD L33586 were updated.

Effective date

This LCD revision is effective for services rendered **on or after January 21, 2016**. 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*.

Pemetrexed – revision to the LCD

LCD ID number: L33978 (Florida/Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for Pemetrexed was revised based on a reconsideration request to include National Comprehensive Cancer Network (NCCN) 2A indications for the treatment of non-small cell lung cancer (NSCLC): (a) for the initial treatment as definitive concurrent chemoradiation in combination with carboplatin or cisplatin and (b) for preoperative concurrent chemoradiation in combination with cisplatin or carboplatin. The "Indications and Limitations of Coverage and/or Medical Necessity" and "Sources of Information and Basis for Decision" sections of the LCD were updated.

Effective date

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

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

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

Find fees faster: Try First Coast's fee schedule lookup

Find the fee schedule information you need fast - with First Coast's fee schedule lookup, located at *http://medicare.fcso.com/Fee_lookup/fee_schedule.asp*. This exclusive online resource features an intuitive interface that allows you to search for fee information by procedure code. Plus, you can find any associated local coverage determinations (LCDs) with just the click of a button.

Radiation therapy for T1 basal cell and squamous cell carcinomas of the skin – revision to the LCD

LCD ID number: L33538 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for radiation therapy for T1 basal cell and squamous cell carcinomas of the skin was revised to add ICD-10-CM diagnosis codes C44.41 and C44.42 to the "ICD-10 Codes that Support Medical Necessity" section of the LCD for the following HCPCS/*CPT*® codes.

Part B

Healthcare Common Procedure Coding System (HCPCS) codes G6003, G6004, G6005, and G6006 and *CPT*® codes *77401, 77767, 77768*, and *77789*

The updated LCD will be available on the Medicare coverage database (MCD) on or after January 21, 2016.

Effective date

This LCD revision is effective for claims processed **on or after January 14, 2016**, for services rendered **on or after October 1, 2015**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Screening and diagnostic mammography – revision to the LCD

LCD ID number: L36342 (Florida/Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for screening and diagnostic mammography was revised to add the following additional national ICD-10-CM diagnosis codes to the "ICD-10 Codes that Support Medical Necessity" section of the LCD for *Current Procedural Terminology* (*CPT*®) codes *77055* and *77056* and Healthcare Common Procedure Coding System (HCPCS) codes G0204 and G0206, based on national coverage determination (NCD) 220.4:

C43.52, C43.59, C44.501, C44.509, C44.511, C44.519, C44.521, C44.529, C44.591, C44.599, C45.9, C56.1-C56.9, C78.00-C78.02, C78.1, C78.2, C78.7, C79.31-C79.32, C79.40-C79.49, C79.51-C79.52, C79.60-C79.62, C80.0, C80.1, D03.52, D03.59, D04.5, D22.5, D23.5, D48.5, D49.1, D49.2, D49.6, D49.7, M70.80, M70.88, M70.89, M70.90, M70.98, M70.99, M79.5, M79.81-M79.89, M79.9, N64.81, N64.9, N65.0, N65.1, R59.0-R59.9, R92.0, R93.9, S20.00xA, S20.01xA, S20.02xA, S21.001A, S21.002A, S21.009A, S21.011A, S21.012A, S21.019A, S21.021A, S21.022A, S21.029A, S21.031A, S21.032A, S21.039A, S21.041A, S21.042A, S21.049A, S21.051A, S21.052A, S21.059A, S28.211A, S28.212A, S28.219A, S28.221A, S28.222A, S28.229A, S29.001A, S29.009A, S29.091A, S29.099A, S29.8xxA, S29.9xxA, S39.001A, S39.091A, S39.81xA, S39.91xA, T85.41xA, T85.42xA, T85.43xA, T85.44xA, T85.49xA, T85.79xA, Z03.89, Z08, Z77.123, Z77.128, Z77.9, Z85.831, Z85.89, Z91.89, Z92.89, Z98.82, and Z98.86

Effective date

This LCD revision is effective for claims processed **on or after February 1, 2016,** for services rendered **on or after October 1, 2015**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Take advantage of First Coast's exclusive PDS report

Did you know that First Coast's exclusive provider data summary (PDS) report can help you improve the accuracy and efficiency of the Medicare billing? Accessible through First Coast's PDS's portal at *http://medicare.fcso.com/PDS/index.asp*, this free online report helps J9 providers identify recurring billing issues through a detailed analysis of personal billing patterns in comparison with those of similar provider types (during a specific time period). Best of all, the PDS report allows you to respond proactively to prevent the recurrence of avoidable errors that could negatively impact your business botton line.

Visual field examination – revision to the LCD

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

The local coverage determination (LCD) for visual field examination was revised to add ICD-10-CM diagnosis code range H35.51-H35.54 to the "ICD-10 Codes that Support Medical Necessity" section of the LCD for *Current Procedural Terminology* (*CPT*®) codes *92081, 92082*, and *92083*.

The updated LCD will be available on the Medicare coverage database (MCD) on or after January, 14 2016.

Effective date

This LCD revision is effective for claims processed **on or after December 28, 2015**, for services rendered **on or after October 1, 2015**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Vitamin D; 25 hydroxy, includes fraction(s), if performed – revision to the LCD

LCD ID number: L33771 (Florida/Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for vitamin D; 25 hydroxy, includes fraction(s), if performed, was revised to add ICD-10-CM diagnosis codes M89.9 and M94.9 to the "ICD-10 Codes that Support Medical Necessity" section of the LCD for *Current Procedural Terminology* (*CPT*®) code *82306*.

The updated LCD will be available on the Medicare coverage database (MCD) on or after January 14, 2016.

Effective date

This LCD revision is effective for claims processed **on or after December 28, 2015**, for services rendered **on or after October 1, 2015**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Additional information

Clarification for coding related to Cologuard®

The Centers for Medicare & Medicaid Services (CMS) recently implemented a national coverage determination to cover Cologuard® – a multitarget stool DNA test – as a colorectal cancer screening test for asymptomatic, average risk beneficiaries, aged 50 to 85 years.

Previously, providers/suppliers used Healthcare Common Procedure Coding System (HCPCS) code G0464 to bill for the Cologuard® test.

Per the 2016 clinical lab fee schedule change request (CR) 9465, effective December 31, 2015, HCPCS code G0464 expires.

Beginning January 1, 2016, providers/suppliers should bill *CPT*® code *81528* for the Cologuard® test. Continue to use HCPCS code G0464 for claims with prior dates of service through December 31, 2015.

New requirement for CMS approved investigational device exemption (IDE) studies

Change request (CR) 8921 released by the Centers for Medicare and Medicaid Services (CMS) became effective January 1, 2015. The CR updated procedures related to items and services in FDA-approved Category B IDE exemptions. Per the CR, CMS established a centralized approval process for studies approved by the Food and Drug Administration (FDA) on or after January 1, 2015.

Recently, First Coast Service Options Inc. (First Coast) has been made aware of denied claims related to studies approved by CMS on or after the January 1 implementation date because the prior process entailed linking provider facility numbers to approved IDEs. In order to avoid inappropriately denied claims for studies approved by CMS (FDA approved on or after January 1, 2015), the following documents must be submitted to the contractor at *clinicaltrials@fcso.com* prior to claims being submitted for processing:

- Cover letter that includes the IDE G-number and clinical trial (NCT) number and the provider (facility) number
- A copy of the CMS approval letter
- A copy of the Institutional Review Board (IRB) approval letter
- A copy of the signed cost and coding information form

Prepayment review for nursing facility evaluation and management services

CPT® codes *99306, 99307, 99308, 99309* and *99310*

First Coast Service Options Inc. (First Coast) recently conducted data analysis due to the high Comprehensive Error Rate Testing (CERT) error rates for evaluation and management services pertaining to *Common Procedural Terminology*® (*CPT*®) codes *99306* (initial nursing facility visit), *99307* (subsequent nursing facility visit), *99308* (subsequent nursing facility visit), *99309* (subsequent nursing facility visit) and *99310* (subsequent nursing facility visit). Data analysis identified potential overutilization of high level and repeat nursing facility visits. These errors continue to impact Medicare administrative contractors (MAC) Jurisdiction N CERT error rates.

First Coast and the Centers for Medicare & Medicaid Service (CMS) offer multiple resources addressing the documentation guidelines for E/M service levels at:

- First Coast's *Evaluation and Management (E/M) services page*, offering links to tools, FAQs, online learning, and additional resources.
- CMS *Internet-only manual (IOM) guidelines* addressing multiple types and settings pertaining to E/M services.
- First Coast's skilled nursing facility (SNF) documentation checklist:

http://medicare.fcso.com/medical_documentation/192475.pdf

First Coast's local coverage determination (LCD) is available to assist providers in utilizing nursing facility *CPT*® codes for evaluation and management services. The LCD L36230 – Evaluation and Management Services in a Nursing Facility is effective as of November 15, 2015. Excerpts from LCD L36230 that identify proper documentation and medical necessity

- In the nursing home environment, patients are in a controlled environment in which they are under close supervision and have immediate access to care from trained medical professionals. Under these circumstances, it is customary for physicians to direct nursing home personnel to perform, in the absence of the physician, many of those services that may be necessary but of a relatively minor nature. Frequent visits by the physician under these circumstances would then be unnecessary, particularly if the patient is medically stable. However, it would not be unreasonable for the attending physician to make several visits at the time of a new episode of illness or an acute exacerbation of a chronic illness. The medical record must clearly reflect the particular circumstances requiring the increased frequency of services by documenting the following:
- Patient instability or change in condition that the physician documents is significant enough to require a timely medical or mental status evaluation and/or physical examination to establish the appropriate treatment intervention and/or change in care plan;
- Therapeutic issues that the physician documents require a timely follow-up evaluation to assess effectiveness of therapy or treatment; for example, recent surgical or invasive diagnostic procedures, pressure ulcer evaluation, psychotropic medication regimens, or (for the terminally ill) comfort measures;
- Medical conditions including delirium, dementia, or changes in mental status manifested with behavioral symptoms that require timely evaluation; and
- Nursing staff, rehabilitation staff, patient, or family requests to address a documented medical issue of concern that requires a physical (or mental status) examination.

For complete coverage and documentation guidance please refer to *http://medicare.fcso.com/coverage_find_lcds_and_ncds/lcd_search.asp*.

See **PREPAYMENT**, next page

Widespread probe results with modifier 24

First Coast Service Options Inc. (First Coast) conducted a widespread post payment probe review in response to education that was provided related to the previous widespread probe results.

Current Procedural Terminology (*CPT*®) *99233* (Subsequent hospital inpatient care), *99223* (Initial hospital care), *99291* (Critical care, first hour), *99308* (Subsequent nursing facility visit), *99309* (Subsequent nursing facility visit), *99310* (Subsequent nursing facility visit) *92012* (Eye and medical examination for diagnosis and treatment, established patient), *92014* (Eye and medical examination for diagnosis and treatment, established patient, 1 or more visits) that were billed with the modifier *24* (unrelated evaluation and management service by the same physician during a postoperative period).

The results from the previous widespread probe review were;

- *99223, 99233 and 99291* with modifier *24* - 66.95 percent
- *92012* and *92014* with modifier *24* - 33.99 percent
- *99308, 99309* and *99310* with modifier *24* - 65.54 percent

The widespread probe results that were conducted as the follow up to education:

- *99223, 99233* and *99291* with modifier *24* – 42.39 percent
- *99308, 99309* and *99310* with modifier *24* – 62.01 percent
- *92012* and *92014* with modifier *24* – 33.99 percent

The codes with the most significant errors utilizing the modifier *24*;

- *99233* with modifier *24* – 79.08 percent
- *99308* with modifier *24* – 70.38 percent
- *92012* with modifier *24* – 25 percent
- *92014* with modifier *24* – 27 percent

Services were denied because submitted medical records did not meet documentation requirements as outlined in IOM 100-4 – *Medicare Claims Processing Manual*, Chapter 12 – Physician/Non-physician practitioners; 30.6.1 – Selection of level of evaluation and management service and Section 40.2 – Billing requirements for Global Surgeries (Rev. 1875, Issued 12-14-09, Effective: 01-01-10, Implementation: 01-04-10).

Due to the high error rates, First Coast will be implementing prepayment utilization audits for *CPT*® codes *99233, 99308, 92012* and *92014* to review medical records to ensure that medical necessity and proper documentation are evident. The new audits will be implemented effective February 1, 2016.

References for additional information:

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

PREPAYMENT

From previous page

First Coast actions

In response to the high percentage of error rates and the continual risks of improper payments associated with nursing facility visits, First Coast has implemented a threshold audit for *CPT*® code *99306* and a prepayment utilization audit for *CPT*® codes *99307, 99308, 99309* and *99310*. The new edit is based on a predetermined percentage of claims in an effort to reduce the error rates for these nursing facility services. The audit was implemented effective February 1, 2016.

Quarterly provider update

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

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

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

Upcoming provider outreach and educational event

Medicare Part B changes and regulations

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

http://medicare.fcso.com/Events/0315841.asp

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

Two easy ways to register

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

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

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

Please Note:

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

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Provider Address: _____

City, State, ZIP Code: _____

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

Never miss a training opportunity

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

Take advantage of 24-hour access to free online training

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

MLN Connects® Provider eNews for January 7, 2016

MLN Connects® Provider eNews for January 7, 2016

View this edition as a PDF

In this edition:

MLN Connects® Events

- ESRD QIP: Payment Year 2019 Final Rule Call — Register Now
- Collecting Data on Global Surgery as Required by MACRA Listening Session — Register Now
- IMPACT Act: Connecting Post-Acute Care across the Care Continuum Call — Register Now
- New Audio Recordings and Transcripts Available
- Stay Informed about Medicare Program Changes

Other CMS Events

- Comparative Billing Report on Home E/M Services Webinar

Medicare Learning Network® Publications and Multimedia

- FY 2017 and After Payments to Hospice Agencies That Do Not Submit Required Quality Data MLN Matters® Article — Released
- Remittance Advice Resources and FAQs Fact Sheet — New
- Medicare Overpayments Fact Sheet — Revised
- Medicare Vision Services Fact Sheet — Revised
- Screening, Brief Intervention, and Referral to Treatment Services Fact Sheet — Revised
- Medicare Enrollment Guidelines for Ordering/Referring Providers Fact Sheet — Revised
- Certificate of Medical Necessity Web-Based Training Course — Revised
- New Educational Web Guides Fast Fact

Announcements

- Medicare FFS Utilization and Payment Data Available for HHAs
- CMS Finalizes Rule Creating Prior Authorization Process for Certain DMEPOS Items
- CMS Quality Measure Development Plan
- Improving the Submission of Quality Data to CMS Quality Reporting Programs
- Pilot Project to Test Improving Patients' Health by Addressing Their Social Needs
- EHR Incentive Programs: 2015 Program Year Attestation Begins January 4
- PQRS: Submission Timeframes for 2015 Data
- PQRS: Self-Nomination for 2016 Qualified Registries and QCDRs Open through January 31
- IRF Data Submission Deadline Extended to February 15
- LTCH Data Submission Deadline Extended to February 15
- LTCH QRP: FAQs and Provider Training Materials Available
- Hospice Item Set Timeliness Compliance Threshold Fact Sheet Available
- Improving the Documentation of Chiropractic Services Video
- Reporting the Diabetes: Hemoglobin A1c Measure for Program Year 2015
- CMS to Release a Comparative Billing Report on Domiciliary E/M Services in January
- January Quarterly Provider Update Available
- Get Your Patients Off to a Healthy Start in 2016
- Continue Seasonal Influenza Vaccination through January and Beyond

Claims, Pricers, and Codes

- Holding of 2016 Date-of-Service Claims for Services Paid Under the 2016 MPFS
- Provider Enrollment Application Fee Amount for CY 2016
- Clarification for Coding Relating to Cologuard
- January 2016 OPPS Pricer File Available
- January 2016 FQHC Pricer Files Available
- Transcatheter Mitral Valve Repair Claims Editing Incorrectly
- Pharmacogenomic Testing for Warfarin Responsiveness Claims Editing Incorrectly
- Adjustments to Correct Home Health Claim Payments

MLN Connects® Provider eNews for January 14, 2016

MLN Connects® Provider eNews for January 14, 2016
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In this edition:

MLN Connects® Events

- ESRD QIP: Payment Year 2019 Final Rule Call — Last Chance to Register
- Collecting Data on Global Surgery as Required by MACRA Listening Session — Last Chance to Register
- IMPACT Act: Connecting Post-Acute Care across the Care Continuum Call — Register Now

Medicare Learning Network® Publications and Multimedia

- Introduction to the IMPACT Act of 2014 Video — New
- Preventive Services Poster — New
- Drug Diversion: Schemes, Auditing, and Referrals Web-Based Training — New
- Medicare Parts C and D General Compliance Training Web-Based Training — New
- Combatting Medicare Parts C and D Fraud, Waste, and Abuse Web-Based Training — New
- Medicare Quarterly Provider Compliance Newsletter Educational Tool — New
- Hospice Payment System Fact Sheet — Revised
- ICD-10 Post-Implementation: Coding Basics Revisited

Video — Reminder

Announcements

- Accountable Care Organization Initiatives Announced to Improve Health System Care Delivery
- Home Health Compare: Deadline to have Data Suppressed is January 25
- CMS to Release a Comparative Billing Report on Electrodiagnostic Testing in February
- Revised Two-Midnight Rule Guidelines
- PQRS Web-Based Measure Search Tool
- January is Cervical Health Awareness Month

MLN Connects® Provider eNews for January 21, 2016

MLN Connects® Provider eNews for January 21, 2016
View this edition as a PDF

In this edition:

MLN Connects® Events

- IMPACT Act: Connecting Post-Acute Care across the Care Continuum Call — Register Now

Other CMS Events

- Comparative Billing Report on Domiciliary E/M Services Webinar

Medicare Learning Network® Publications and Multimedia

- PECOS FAQs Fact Sheet — Revised
- The Medicare Home Health Benefit Booklet — Revised

Announcements

- CMS Updates Open Payments Data and Improves Website
- Open Payments System Downtime from January 21 through 26
- LTCH Quality Reporting Program Data Submission Deadline: February 15
- IRF Quality Reporting Program Data Submission Deadline: February 15
- Hospice, IRF, LTCH, SNF, HHA: QIES System Downtime from March 16 through 21
- LTCH and IRF Dry Run Readmission Reports Available
- Update to IRF-PAI Training Manual V1.4
- Read More about What is Next for the EHR Incentive Programs
- Help Protect the Vision of Your Medicare Patients

Claims, Pricers, and Codes

- January 2016 OPPS Pricer File Update

Phone numbers

Customer service

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

Education event registration hotline

904-791-8103 (NOT toll-free)

Electronic data interchange (EDI)

888-670-0940

Electronic funds transfers (EFT) (CMS-588)

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

Fax number (for general inquiries)

904-361-0696

Interactive voice response (IVR) system

877-847-4992

Provider enrollment

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

The SPOT help desk

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

Addresses

Claims

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

Redeterminations

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

Redetermination of overpayments

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

Reconsiderations

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

General inquiries

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

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

Provider enrollment

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

Medical policy

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

Medicare secondary payer

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

Electronic data interchange (EDI)

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

Overpayments

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

Medicare Education and Outreach

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

Fraud and abuse

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

Freedom of Information Act requests

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

Overnight mail and/or special courier service

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

Websites

Provider

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

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

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

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

Beneficiaries

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

Phone numbers

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Fax number (for general inquiries)
904-361-0696

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

The SPOT help desk
855-416-4199
email: *FCSOSPOTHelp@FCSO.com*

Addresses

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

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

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

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

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

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

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

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

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

Electronic data interchange (EDI)
Medicare EDI, 4C
P.O. Box 44071
Jacksonville, FL 32231-4071

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

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

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

Freedom of Information Act requests
FOIA USVI
P.O. Box 45073
Jacksonville, FL 32231-5073

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

Websites

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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

Phone numbers

Customer service

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

Education event registration hotline

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

Electronic data interchange (EDI)

888-875-9779

Electronic funds transfers (EFT) (CMS-588)

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

General inquiries

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

Interactive voice response (IVR) system

877-847-4992

Provider enrollment

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

The SPOT help desk

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

Addresses

Claims

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

Redeterminations

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

Redetermination of overpayments

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

Reconsiderations

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

General inquiries

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

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

Provider enrollment

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

Medical policy

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

Medicare secondary payer

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

Electronic data interchange (EDI)

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

Overpayments

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

Medicare Education and Outreach

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

Fraud and abuse

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

Freedom of Information Act requests

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

Special courier service

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532 Riverside Avenue
Jacksonville, FL 32202-4914

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http://www.fcsouniversity.com/

Beneficiaries

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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.

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2015 fee schedule – The Medicare Part B Physician and Nonphysician Practitioner Fee Schedules, effective for services rendered January 1 through December 31, 2015, are available free of charge online at *http://medicare.fcso.com/Data_files/* (English) or *http://medicareespanol.fcso.com/Fichero_de_datos/* (Español). Additional copies are available for purchase. The fee schedules contain payment rates for all localities. These items do not include the payment rates for injectable drugs, clinical lab services, mammography screening, or DMEPOS items. **Note:** Requests for hard copy paper disclosures will be completed as soon as CMS provides the direction to do so. Revisions to fees may occur; these revisions will be published in future editions of the Medicare Part B publication.	40300270	$12		
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