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

In this issue

Screening for cervical cancer with human papillomavirus testing — NCD 210.2.1

Provider types affected

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

Provider action needed

Change request (CR) 9434 announces that the Centers for Medicare & Medicaid Services (CMS) has determined that, effective for dates of service on or after July 9, 2015, evidence is sufficient to add human papillomavirus (HPV) testing under specified conditions. Make sure that your billing staffs are aware of this change.

Background

Medicare covers a screening pelvic examination and Pap test for all female beneficiaries at 12- or 24-month intervals, based on specific risk factors; however, current Medicare coverage does not include the HPV testing.

Section 1861(ddd) of the Social Security Act (the Act) (see *http://www.ssa.gov/OP_Home/ssact/title18/1861.htm*) states that CMS may add coverage of "additional preventive services" through the national coverage determination (NCD) process. The preventive services must meet all of the following criteria:

1. Reasonable and necessary for the prevention or early detection of illness or disability;
2. Recommended with a grade of A or B by the United States Preventive Services Task Force (USPSTF); and,
3. Appropriate for individuals entitled to benefits under Part A or enrolled under Part B.

CMS has reviewed the USPSTF recommendations and supporting evidence for screening for cervical cancer with HPV co-testing, and has determined that the criteria were met. Therefore, effective for claims with dates of service on or after July 9, 2015, CMS will cover screening for cervical cancer with HPV co-testing under the following conditions:

CMS has determined that the evidence is sufficient to add HPV testing once every five years as an additional

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

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

About the 'Medicare B Connection'

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

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

Who receives the *Connection*

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

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

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

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

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

Publication format

The *Connection* is arranged into distinct sections.

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

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

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

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

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

Never miss an appeals deadline again

When it comes to submitting a claims appeal request, *timing is everything*. Don't worry – you won't need a desk calendar to count the days to your submission deadline. Try our new "time limit" calculators on our Appeals of claim decisions page. Each calculator will *automatically calculate* when you must submit your request based upon the date of either the initial claim determination or the preceding appeal level.

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.

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preventive service benefit under the Medicare program, for asymptomatic beneficiaries aged 30 to 65 years in conjunction with the Pap smear test. CMS will cover screening for cervical cancer with the appropriate U.S. Food and Drug Administration (FDA)-approved/cleared laboratory tests, used consistent with FDA-approved labeling, and in compliance with the Clinical Laboratory Improvement Act (CLIA) regulations.

A new Healthcare Common Procedure Coding System (HCPCS) code, G0476 (HPV combo assay, CA screen), Type of Service (TOS) 5 (diagnostic lab), has been created for this benefit. This code will:

- Be effective retroactive back to the effective date of July 9, 2015;
- Be included in the January 2016, integrated outpatient code editor, outpatient prospective payment system, and Medicare physician fee schedule database;
- Be MAC-priced from July 9, 2015, through December 31, 2016, and during this period code G0476 is paid only when it is billed by a laboratory entity; and,
- Beginning January 1, 2017, this will be priced and paid according to the clinical laboratory fee schedule (CLFS).

In addition, you should be aware of the following:

1. Your MACs will not apply beneficiary coinsurance and deductibles to claim lines containing HCPCS G0476, HPV screening;
2. Part B MACs shall only accept claims with a place of service code equal to '81', independent lab or '11', office; and
3. Effective for claims with dates of service on or after July 9, 2015, your MACs will deny line-items on claims containing HCPCS G4076, HPV screening, when reported more than once in a five-year period [at least four years and 11 months (59 months total) must elapse from the date of the last screening]. The next eligible dates for this service are shown on all common working file (CWF) provider query screens (HUQA, HIQA, HIQH, ELGA, ELGH, and PRVN).

When denying a line-item on a claim for this requirement they will use the following messages:

- Claim adjustment reason code (CARC) 119 – "Benefit maximum for this time period or occurrence has been reached;"
- Remittance advice remark code (RARC) N386 – "This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. 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;"
- Group code "CO" if the claim contains a GZ modifier to denote a signed advance beneficiary notice (ABN) is not on file or with group code "PR" (patient responsibility) if the claim has a GA modifier to show a signed ABN is on file.

4. HCPCS code G0476 will be paid only for institutional claims submitted on type of bill codes (TOB) 12x, 13x, 14x, 22x, 23x, and 85x. Institutional claims on other TOBs will be returned to the provider.
5. Effective for claims with dates of service on or after July 9, 2015, your MACs will deny line-items on claims containing HCPCS G4076, HPV screening, when the beneficiary is less than 30 years of age or older than 65 years of age.

When denying a line-item on claims for this requirement, they will use 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 vode "CO" if the claim contains a GZ modifier to denote a signed advance beneficiary notice (ABN) is not on file or with group code "PR" (patient responsibility) if the claim has a GA modifier to show a signed ABN is on file.

6. Effective for claims with dates of service on or after July 9, 2015, you must report the following diagnosis codes when submitting claims for HCPCS G0476:
   - ICD-9 (for dates of service prior to October 1, 2015): V73.81, special screening exam, HPV (as primary), and V72.31, routine gynecological exam (as secondary)
   - ICD-10: Z11.51, encounter for screening for HPV, and Z01.411, encounter for gynecological exam (general)(routine) with abnormal findings, OR Z01.419, encounter for gynecological exam (general)(routine) without abnormal findings.

Effective on this date, your MACs will deny line-items on claims containing HCPCS code G0476, HPV screening, when the claim does not contain these codes.

When denying a line-item on claim for this requirement, they will use 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*. If you do not have web access, you may contact the contractor to request a copy of the NCD;" and
- Group code CO.

7. This NCD does not change current policy as it relates

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Ambulance

Extension of provider enrollment moratoria for home health agencies and Part B ambulance suppliers

***Note**: This article was revised February 2, 2016, to reflect an extension of the temporary moratoria for an additional six months, as noted in the article. All other information remains the same. This information was previously published in the August 2015 Medicare B Connection, page 24.*

Provider types affected

This *MLN Matters*® article is intended for home health agencies, home health agency sub-units, and Part B ground ambulance suppliers in certain geographic areas of Florida, Illinois, Michigan, Texas, Pennsylvania, and New Jersey that provide services to Medicare, Medicaid, and CHIP beneficiaries.

Provider action needed

Stop – impact to you

Effective January 29, 2016, the temporary moratoria on new home health agencies, home health agency sub-units, and Part B ground ambulance suppliers are being extended for an additional six months in certain geographic locations.

Caution – what you need to know

During the six-month temporary moratoria, initial provider enrollment applications and change of information applications to add additional practice locations, received from home health agencies, home health agency sub-units, and Part B ground ambulance suppliers in the moratoria counties will be denied. Application fees that are paid for applications that are denied due to the temporary moratoria will be refunded.

Go – what you need to do

Effective January 29, 2016, home health agencies, home health agency sub-units, and Part B ground ambulance suppliers should not submit initial enrollment applications or change of information applications to add additional practice locations until the six-month moratoria has expired. CMS will announce in the *Federal Register* when the moratorium has been lifted, extended, or changed.

Background

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

On January 29, 2016, CMS announced, in a *Federal Register* notice (*http://federalregister.gov/a/2016-01835*), the extension of temporary moratoria on the enrollment of new home health agencies, home health agency sub-units and part B ambulance suppliers in designated geographic locations.

The moratoria initially became effective on July 30, 2013, and the implementation was announced in the *Federal Register* which may be accessed at: *https://federalregister.gov/a/2013-18394*. The moratoria were expanded January 30, 2014, and the expansion was announced in

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> to screening for pap smears and pelvic exams as described in the *Medicare NCD Manual*, section 210.2, or in the *Medicare Claims Processing Manual*, Chapter 18, Section 30, which you can find at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part4.pdf*.

Additional information

The official instruction, CR 9434, was issued to your MAC via two transmittals. The first updates the *NCD Manual* and is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R189NCD.pdf* and the second transmittal updates the *Medicare Claims Processing Manual* and it is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3460CP.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: MM9434
Related Change Request (CR) #: CR 9434
Related CR Release Date: February 5, 2016
Effective Date: July 9, 2015
Related CR Transmittal #: R189NCD and R3460CP
Implementation Date: July 5, 2016 (CWF analysis and design), October 3, 2016 (CWF coding, testing, and implementation, MCS and FISS implementation; January 3, 2017 (requirement 9434-04.8.2), March 7, 2016 (non-shared MAC edits)

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the *Federal Register* which may be accessed at: *https://federalregister.gov/a/2014-02166*.

Moratoria extension

Effective January 29, 2016, the temporary moratorium on new home health agencies and home health agency sub-units is being extended for an additional six months in the areas stated in Table 1.

Table 1: Home health agencies and home health agency sub-units under temporary moratorium

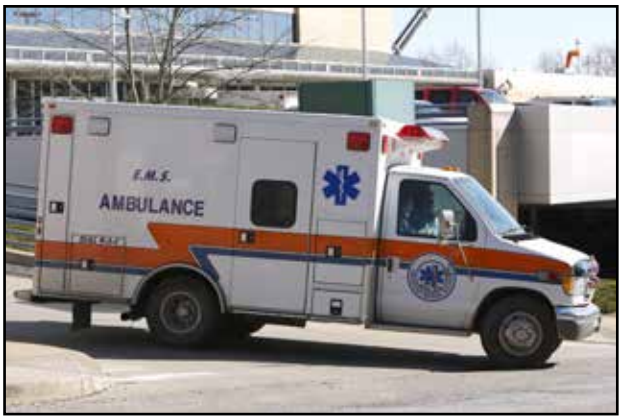
City and state	Counties
Fort Laud, FL	Broward
Miami, FL	Miami-Dade, Monroe
Detroit, MI	Macomb, Monroe, Oakland, Washtenaw, Wayne
Dallas, TX	Collin, Dallas, Denton, Ellis, Kaufman, Rockwall, Tarrant
Houston, TX	Brazoria, Chambers, Fort Bend, Galveston, Harris, Liberty, Montgomery, Waller
Chicago, IL	Cook,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

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

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

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

Initial provider enrollment applications and change of information applications to add additional practice locations



received from home health agencies, home health agency sub-units, and Part B ground ambulance suppliers in the above listed counties will be denied in accordance with 42 CFR §424.570(c). Application fees that are paid for applications that are denied due to the temporary moratoria will be refunded.

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

Additional information

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

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

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

Cardiac Services

NCD for single chamber and dual chamber permanent cardiac pacemakers

Note: *This article was revised January 27, 2016, to note that the NCD for cardiac pacemakers, "Single Chamber and Dual Chamber Permanent Cardiac Pacemakers" (NCD20.8.3) was effective August 13, 2013, and remains in effect. In order to address claims processing issues, the Centers for Medicare & Medicaid Services has instructed Medicare administrative contractors (MACs) to implement this NCD at the local level until CMS is able to revise the formal claim processing instructions. All aspects of the NCD policy in the NCD Manual, Section 20.8.3, remain in effect. Additionally, CMS is temporarily removing the corresponding Medicare Claims Processing Manual, Chapter 32, Section 320, and all but two business requirements, to avoid confusion and better clarify that the MACs will use their discretionary authority to process these claims. This information was previously published in the November 2015 Medicare B Connection, Page 7.*

Provider types affected

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

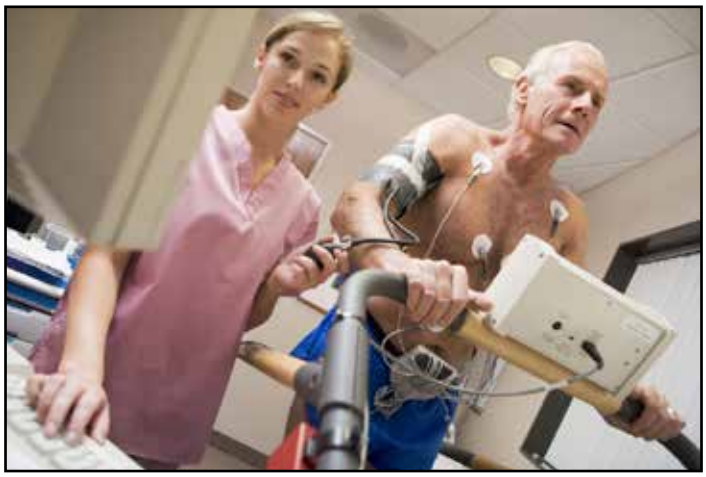
Additional information

The official instruction, CR 9078, was issued to your MAC via two transmittals. The first transmittal updates the *Medicare Claims Processing Manual* and it is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3421CP.pdf*. The second updates the Medicare *National Coverage Determination Manual* and it is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R187NCD.pdf*.

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

Document history

Date	Description
January 27, 2016	This article was revised to reflect the revised CR 9078 issued December 10, 2015. The CR was revised to further clarify that the MACs are to implement the NCD at the local level until Medicare system instructions are revised and Medicare system changes are implemented. The CR also included a specific implementation date of January 13, 2016 for local implementation.



Date	Description
November 13, 2015	All references to the old claim processing instructions were removed from the article.
October 28, 2015	This article was revised to reflect the revised CR 9078 issued October 26. The CR was revised to direct the MACs to implement the NCD at the local level until Medicare system instructions are revised and Medicare system changes are implemented.
May 26, 2015	This article was revised to add a reference to *MLN Matters® article MM8525* which allows payment for nationally covered implanted permanent cardiac pacemakers, single chamber or dual chamber, for the indications outlined in the *Medicare National Coverage Determinations Manual*.

MLN Matters® Number: MM9078 *Revised*
Related Change Request (CR) #: CR 9078
Related CR Release Date: December 10, 2015
Effective Date: August 13, 2013
Related CR Transmittal #: R3421CP and R187NCD
Implementation Date: July 6, 2015

Drugs and Biologicals

April 2016 quarterly ASP Medicare Part B drug pricing files

Provider types affected

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

Provider action needed

Medicare will use the April 2016 quarterly average sales price (ASP) and not otherwise classified (NOC) pricing files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after April 4, 2016, with dates of services from April 1, 2016, through June 30, 2016.

Change request (CR) 9536 instructs MACs to implement the April 2016 ASP Medicare Part B drug pricing file for Medicare Part B drugs, and if they are released by the Centers for Medicare & Medicaid Services (CMS), to also implement the revised January 2016, October 2015, July 2015, and April 2015 files. Make sure your billing personnel are aware of these changes.

Background

The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply contractors with the ASP and NOC drug pricing files for Medicare Part B drugs on a quarterly basis.

Payment allowance limits under the outpatient prospective payment system (OPPS) are incorporated into the outpatient code editor (OCE) through separate instructions that are in the *Medicare Claims Processing Manual*, Chapter 4, Section 50.

The following table shows how the files will be applied.

Files	Effective date for dates of service
April 2016 ASP and ASP NOC	April 1, 2016, through June 30, 2016
January 2016 ASP and ASP NOC	January 1, 2016, through March 31, 2016
October 2015 ASP and ASP NOC	October 1, 2015, through December 31, 2015
July 2015 ASP and ASP NOC	July 1, 2015, through September 30, 2015

Files	Effective date for dates of service
April 2015 ASP and ASP NOC	April 1, 2015, through June 30, 2015

Additional information

The official instruction, CR 9536 issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3450CP.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: MM9536
Related Change Request (CR) #: CR 9536
Related CR Release Date: February 4, 2016
Effective Date: April 1, 2016
Related CR Transmittal #: R3450CP
Implementation Date: April 4, 2016

Laboratory/Pathology

HCPCS codes subject to and excluded from CLIA edits

Provider types affected

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

Provider action needed

Change request (CR) 9502 informs MACs about the Healthcare Common Procedure Coding System (HCPCS) codes for 2016 that are both subject to, and excluded from, CLIA edits; and also includes the HCPCS codes discontinued as of December 31, 2015. Make sure that your billing staffs are aware of these CLIA-related changes for 2016.

Background

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

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

Discontinued HCPCS codes

The HCPCS codes listed in table 1 were discontinued on December 31, 2015

Table 1: HCPCS codes discontinued December 31, 2015

HCPCS code	Descriptor
G0431	Drug screen, qualitative; multiple drug classes by high complexity test method (e.g., immunoassay, enzyme assay), per patient encounter
G0434	Drug screen, other than chromatographic; any number of drug classes, by clia waived test or moderate complexity test, per patient encounter
G6030	Amitriptyline
G6031	Benzodiazepines
G6032	Desipramine
G6034	Doxepin
G6035	Gold
G6036	Assay of imipramine
G6037	Nortriptyline
G6038	Salicylate
G6039	Acetaminophen
G6040	Alcohol (ethanol); any specimen except breath
G6041	Alkaloids, urine, quantitative
G6042	Amphetamine or methamphetamine
G6043	Barbiturates, not elsewhere specified
G6044	Cocaine or metabolite
G6045	Dihydrocodeinone
G6046	Dihydromorphinone
G6047	Dihydrotestosterone
G6048	Dimethadione
G6049	Epiandrosterone
G6050	Ethchlorvynol
G6051	Flurazepam
G6052	Meprobamate
G6053	Methadone
G6054	Methsuximide
G6055	Nicotine
G6056	Opiate(s), drug and metabolites, each procedure
G6057	Phenothiazine
G6058	Drug confirmation, each procedure
82486	Chemical analysis
82487	Chemical analysis
82488	Chemical analysis
82489	Chemical analysis
82491	Chemical analysis
82492	Chemical analysis
82541	Chemical analysis using chromatography technique
82543	Chemical analysis using chromatography technique
82544	Chemical analysis using chromatography technique
83788	Mass spectrometry (laboratory testing method
88347	Antibody evaluation
0103T	Measurement of vitamin B-12 deficiency marker

New HCPCS codes for 2016

The HCPCS codes listed in Table 2 are new for 2016 and are subject to CLIA edits. The list does not include new HCPCS codes for waived tests or provider-performed procedures. The HCPCS codes listed below require a facility to have either a:

1. CLIA certificate of registration (certificate type code 9);

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

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

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

Table 2: New HCPCS codes subject to CLIA edits for 2016

HCPCS code	Descriptor
G0477	Drug tests(s), presumptive, any number of drug classes; any number of devices or procedures, (eg immunoassay) capable of being read by direct optical observation only (eg, dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service
G0478	Drug tests(s), presumptive, any number of drug classes; any number of devices or procedures, (eg immunoassay) read by instrument-assisted direct optical observation (eg, dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service
G0479	Drug tests(s), presumptive, any number of drug classes; any number of devices or procedures by instrumented chemistry analyzers utilizing immunoassay, enzyme assay, TOF, MALDI, LDTD, DESI, DART, GHPC, GC mass spectrometry), includes sample validation when performed, per date of service
G0480	Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (eg, IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (eg, alcohol dehydrogenase)); qualitative or quantitative, all sources(s), includes specimen validity testing, per day, 1-7 drug class(es), including metabolite(s) if performed
G0481	Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (eg, IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (eg, alcohol dehydrogenase)); qualitative or quantitative, all sources(s), includes specimen validity testing, per day, 8-14 drug class(es), including metabolite(s) if performed
G0482	Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (eg, IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (eg, alcohol dehydrogenase)); qualitative or quantitative, all sources(s), includes specimen validity testing, per day, 15-21 drug class(es), including metabolite(s) if performed
G0483	Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (eg, IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (eg, alcohol dehydrogenase)); qualitative or quantitative, all sources(s), includes specimen validity testing, per day, 22 or more drug class(es), including metabolite(s) if performed
80081	Blood test panel for obstetrics (cbc, differential wbc count, hepatitis b, hiv, rubella, syphilis, antibody screening, rbc, blood typing)
81162	Gene analysis (breast cancer 1 and 2) full sequence and duplication or deletion variants
81170	Gene analysis (ABL proto-oncogene 1, non-receptor tyrosine kinase)
81218	Gene analysis (ccaat/enhancer binding protein [c/ebp], alpha) full gene sequence
81219	Gene analysis (calreticulin), common variants
81272	Gene analysis (v-kit Hardy-Zuckerman 4 feline sarcoma viral oncogene homolog), targeted sequence

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HCPCS code	Descriptor
81273	Gene analysis (v-kit Hardy-Zuckerman 4 feline sarcoma viral oncogene homolog), D816 variants
81276	Gene analysis (Kirsten rat sarcoma viral oncogene homolog), additional variants;
81311	Gene analysis for cancer (neuroblastoma)
81314	Gene analysis ((platelet-derived growth factor receptor, alpha polypeptide) targeted sequence
81412	Test for detecting genes for disorders related to Ashkenazi Jews
81432	Gene analysis (breast and related cancers), genomic sequence
81433	Gene analysis (breast and related cancers), duplication or deletion variants
81434	Gene analysis (retinal disorders), genomic sequence
81437	Gene analysis (neuroendocrine tumors), genomic sequence
81438	Gene analysis (neuroendocrine tumors), duplication and deletion variants
81442	Gene analysis (noonan syndrome) genomic sequence analysis
81490	Test for detecting genes associated with rheumatoid arthritis using immunoassay technique
81493	Test for detecting genes associated with heart vessels diseases
81525	Gene analysis (colon related cancer)
81528	Gene analysis (colorectal cancer)
81535	Culture of live tumor cells and chemotherapy drug response by staining
81536	Culture of live tumor cells and chemotherapy drug response by staining
81538	Testing of lung tumor cells for prediction of survival
81540	Gene analysis (cancer)
81545	Gene analysis (thyroid cancer)
81595	Test for detecting genes associated with heart diseases
88350	Antibody evaluation
0009M	Fetal aneuploidy (trisomy 21, and 18) dna sequence analysis of selected regions using maternal plasma, algorithm reported as a risk score for each trisomy
0010M	Oncology (high-grade prostate cancer), biochemical assay of four proteins (total psa, free psa, intact psa and human kallidrein 2 (hk2)) plus patient age, digital rectal examination status, and no history of positive prostate biopsy, utilizing plasma, prognostic algorithm reported as a probability score

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

Additional information

The official instruction, CR 9502, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3439CP.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: MM9502
Related Change Request (CR) #: CR 9502
Related CR Release Date: January 15, 2016
Effective Date: January 1, 2016
Related CR Transmittal #: R3439CP
Implementation Date: April 4, 2016

Take action to combat the flu

Now is the perfect time for providers to vaccinate Medicare beneficiaries, as it can take two weeks after vaccination to develop antibodies that protect against seasonal influenza. As a health care provider, you play an important role in setting an example by getting yourself vaccinated and recommending and promoting influenza vaccination.

New waived tests subject to CLIA edits

Provider types affected

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

Provider action needed

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

The *Current Procedural Terminology*® (*CPT*®) codes that the Centers for Medicare & Medicaid Services (CMS) consider to be laboratory tests under CLIA (and thus requiring certification) change each year. Change request (CR) 9515 informs the MACs about the latest new *CPT*® codes that are subject to CLIA edits. Make sure your billing staffs are aware of the latest CLIA-related changes.

Background

Listed below are the latest tests approved by the Food and Drug Administration (FDA) as waived tests under CLIA. The *CPT*® codes for the following new tests must have the modifier QW to be recognized as a waived test. However, the tests with *CPT*® codes *81002, 81025, 82270, 82272*, *82962, 83026, 84830, 85013*, and *85651* do not require a QW modifier to be recognized as a waived test. The *CPT*® code, effective date and description for the latest tests approved by the FDA as waived tests under CLIA are the following:

- *83036*QW, August 10, 2015, PTS Diagnostics A1C + professional use;
- *82274*QW, G0328QW, September 14, 2015, Tanner Scientific iFOB one step rapid test;
- *87502*QW, September 18, 2015, Roche Molecular, cobas Liat System (cobas Liat influenza A/B assay;
- G0434QW [from October 27, 2015 to December 31, 2015] and G0477QW [on and after January 1, 2016], Clarity Diagnostics LLC, clarity multi-drug urine test cup;
- G0434QW [from October 27, 2015 to December 31, 2015] and G0477QW [on and after January 1, 2016], Clarity Diagnostics LLC, clarity multi-drug urine test dipcard;
- G0434QW [from November 10, 2015 to December 31, 2015] and G0477QW [on and after January 1, 2016], W.H.P.M., Inc. First Sign® drug of abuse butalbital cup test;
- G0434QW [from November 10, 2015 to December 31, 2015] and G0477QW [on and after January 1, 2016], W.H.P.M., Inc. First Sign® drug of abuse butalbital dip card test;
- G0434QW [from November 10, 2015 to December 31, 2015] and G0477QW [on and after January 1, 2016], W.H.P.M., Inc. First Sign® drug of abuse morphine dip card test;
- G0434QW [from November 13, 2015 to December 31, 2015] and G0477QW [on and after January 1, 2016], UCP Biosciences, Inc. u-cup drug test cards;
- G0434QW [from November 13, 2015 to December 31, 2015] and G0477QW [on and after January 1, 2016], UCP Biosciences, Inc. u-card drug test cups; and
- G0434QW [from December 14, 2015 to December 31, 2015] and G0477QW [on and after January 1, 2016], Tanner Scientific, Platinum Line® multi-panel drug test cup.

The HCPCS code G0434 [Drug screen, other than chromatographic; any number of drug classes, by CLIA waived test or moderate complexity test, per patient encounter] was discontinued December 31, 2015. The new HCPCS code G0477 [Drug tests(s), presumptive, any number of drug classes; any number of devices or procedures, (eg immunoassay) capable of being read by direct optical observation only (eg, dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service] was effective January 1, 2016. HCPCS code G0477QW describes the waived testing previously assigned code G0434QW. All tests in the attachment to CR 9515 that previously had HCPCS G0434QW are now assigned G0477QW.

You should be aware that your MAC will not search their files, to either retract payment or retroactively pay claims; however, they should adjust such claims that you bring to their attention.

Additional information

The official instruction, CR 9515, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3440CP.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: MM9515
Related Change Request (CR) #: CR 9515
Related CR Release Date: January 15, 2016
Effective Date: April 1, 2016
Related CR Transmittal #: R3440CP
Implementation Date: April 4, 2016

Preventive Services

Screening for the human immunodeficiency virus infection

Provider types affected

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

What you need to know

Change request (CR) 9403 informs MACs that the Centers for Medicare & Medicaid Services (CMS) has determined that the evidence is adequate to conclude that screening of HIV infection for all individuals between the ages of 15-65 years is reasonable and necessary for early detection of HIV, and it is appropriate for individuals entitled to benefits under Part A or enrolled in Part B.

Background

On January 1, 2009, CMS was authorized to add coverage of "additional preventive services" through the national coverage determination (NCD) process if certain statutory requirements are met. One of those requirements is that the service(s) be categorized as a grade A (strongly recommends) or grade B (recommends) rating by the United States Preventive Services Task Force (USPSTF) and meets certain other requirements. Previously, the USPSTF strongly recommended screening for all adolescents and adults at increased risk for HIV infection, as well as all pregnant women. The USPSTF made no recommendation for or against routine HIV screening in adolescents and adults not at increased risk for HIV infection. Effective December 8, 2009, CMS issued a final decision supporting the USPSTF recommendations.

Change request (CR) 6786, Transmittal 1935, Screening for Human Immunodeficiency Virus (HIV) Infection, dated March 23, 2010, provides earlier implementation instructions related to NCD210.7. You may review the *MLN Matters*® article related to Transmittal 1935 at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6786.pdf*.

In April 2013, the USPSTF updated these recommendations and recommends that clinicians screen for HIV infection in adolescents and adults aged 15 to 65 years. Younger adolescents and older adults who are at increased risk should also be screened (Grade A recommendation). The USPSTF also recommends that clinicians screen all pregnant women for HIV, including those who present in labor who are untested and whose HIV status is unknown (Grade A recommendation).

CR 9403 instructs that effective for claims with dates of service on and after April 13, 2015, CMS will cover screening for HIV with the appropriate U.S. Food and Drug Administration (FDA)-approved laboratory tests and point-of-care tests, used consistent with FDA-approved labeling and in compliance with the Clinical Laboratory Improvement Act (CLIA) regulations, when ordered by the beneficiary's physician or practitioner within the context of a healthcare setting and performed by an eligible Medicare provider for these services, for beneficiaries who meet one of the following conditions below:

1. Except for pregnant Medicare beneficiaries addressed below, a maximum of one, annual, voluntary screening for all adolescents and adults between the ages of 15 and 65, without regard to perceived risk.
2. Except for pregnant Medicare beneficiaries addressed below, a maximum of one, annual, voluntary screening for adolescents younger than 15 and adults older than 65 who are at increased risk for HIV infection. Increased risk for HIV infection is defined as follows:
   - Men who have sex with men;
   - Men and women having unprotected vaginal or anal intercourse;
   - Past or present injection drug users;
   - Men and women who exchange sex for money or drugs, or have sex partners who do;
   - Individuals whose past or present sex partners were HIV-infected, bisexual, or injection drug users;
   - Persons who have acquired or request testing for other sexually transmitted infectious diseases;
   - Persons with a history of blood transfusions between 1978 and 1985;
   - Persons who request an HIV test despite reporting no individual risk factors;
   - Persons with new sexual partners; or
   - Persons who, based on individualized physician interview and examination, are deemed to be at increased risk for HIV infection. The determination of "increased risk" for HIV infection is identified by the health care practitioner who assesses the patient's history, which is part of any complete medical history, typically part of an annual wellness visit and considered in the development of a comprehensive prevention plan. The medical recommendation should be a reflection of the service provided.
3. A maximum of three voluntary HIV screenings of pregnant Medicare beneficiaries:
   - When the diagnosis of pregnancy is known;
   - During the third trimester; and

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- At labor, if ordered by the woman's clinician.

Note: There is no co-insurance or deductible for tests paid under the clinical laboratory fee schedule (CLFS).

Billing requirements

Effective for claims with dates of service on or after April 13, 2015, MACs will recognize new HCPCS code G0475 (HIV antigen/antibody, combination assay, screening) as a new covered service for HIV screening.

Note: HCPCS G0475 will appear in the January 1, 2017, CLFS; in the January 1, 2016, integrated outpatient code editor (IOCE); in the January 2016 outpatient prospective payment system (OPPS); and in the January 1, 2016, Medicare physician fee xchedule (MPFS). HCPCS code G0475 will be effective retroactive to April 13, 2015, in the IOCE and OPPS.

For services from April 13 - September 30, 2015, inclusive, the diagnosis codes are:

ICD-9 code	Descriptor
V22.0	Supervision of normal first pregnancy
V22.1	Supervision of other normal pregnancy
V23.9	Supervision of unspecified high-risk pregnancy
V69.8	Other problems related to lifestyle
V73.89	Special screening examination for other specified viral diseases
V69.2	High risk sexual behavior

For dates of service on or after October 1, 2015, the diagnosis codes are:

ICD-10-CM	Long description
Z34.00	Encounter for supervision of normal first pregnancy, unspecified trimester
Z34.01	Encounter for supervision of normal first pregnancy, first trimester
Z34.02	Encounter for supervision of normal first pregnancy, second trimester
Z34.03	Encounter for supervision of normal first pregnancy, third trimester
Z34.80	Encounter for supervision of other normal pregnancy, unspecified trimester
Z34.81	Encounter for supervision of other normal pregnancy, first trimester
Z34.82	Encounter for supervision of other normal pregnancy, second trimester
Z34.83	Encounter for supervision of other normal pregnancy, third trimester
Z34.90	Encounter for supervision of normal pregnancy, unspecified, unspecified trimester
Z34.91	Encounter for supervision of normal pregnancy, unspecified, first trimester
Z34.92	Encounter for supervision of normal pregnancy, second trimester
Z34.93	Encounter for supervision of normal pregnancy, third trimester
O09.90	Supervision of high risk pregnancy, unspecified, unspecified trimester
O09.91	Supervision of high risk pregnancy, unspecified, first trimester
O09.92	Supervision of high risk pregnancy, unspecified, second trimester
O09.93	Supervision of high risk pregnancy, unspecified, third trimester
Z72.89	Other problems related to lifestyle
Z11.4	Encounter for screening for human immunodeficiency virus [HIV]
Z72.51	High risk heterosexual behavior
Z72. 52	High risk homosexual behavior
Z72.53	High risk bisexual behavior

On professional claims, the place of service must be either 81 (independent laboratory) or 11 (office).

If claims are received for screenings that exceed the maximum number allowed per year, the claim line item will be denied with the following remittance codes:

- **Claim adjustment reason code (CARC) 119**: "Benefit maximum for this time period or occurrence has been reached."
- **Remittance advice remark code (RARC) N386**: "This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. 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." and
- **Group code**: CO (contractual obligation).

Note that the next eligible date for the service will be provided on all common working file (CWF) provider query screens (HUQA, HIQA, HIQH, ELGA, ELGH, and PRVN).

Claims with HCPCS Code G0475 for beneficiaries between the ages of 15 and 65 without regard to risk must also be submitted with a primary diagnosis code of either V73.89 (ICD-9) or Z11.4 (ICD-10). If that primary code is not present, the line item will be denied using 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."

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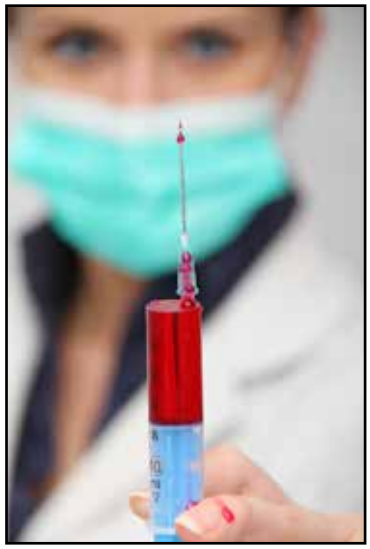
- **RARC N386**: "This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *www.cms.gov/mcd/search.asp* on the CMS website. If you do not have web access, you may contact the contractor to request a copy of the NCD."
- **Group code**: CO (contractual obligation).



Claims with HCPCS Code G0475 for beneficiaries less than age 15 or greater than age 65 with increased risk must also be submitted with a primary diagnosis code of either V73.89 (ICD-9) or Z11.4 (ICD-10) and a secondary diagnosis code that denotes the high risk. The ICD-9 secondary codes are V69.2 or V69.8. The ICD-10 secondary diagnosis codes are Z72.51, Z72.89, Z72.52, or Z72.53. If that secondary code is not present, the line item will be denied using 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 (contractual obligation).

Effective for claims with dates of service on or after April 13, 2015, MACs will deny line-items on claims for pregnant beneficiaries denoted by a secondary diagnosis code above denoting pregnancy, if HCPCS Code G0475, HIV screening, or *CPT*® code *80081*, obstetric panel, and primary diagnosis code V73.89/ Z11.4, as appropriate, are not present on the claim. Such line item denials will result in the following remittance messages:

- **CARC 11**: "The diagnosis is inconsistent with the procedure. **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 (contractual obligation).

Institutional claims for G0475 submitted on types of bill (TOB) 12x, 13x, 14x, 22x, and 23x will be paid based on the CLFS with dates of service on or after January 1, 2017. MACs will apply their pricing to claims with dates of service of April 13, 2015, through December 31, 2016. Such claims submitted on TOB 85x will be paid based on reasonable cost for dates of service beginning with April 13, 2015.

Additional information

The official instruction, CR 9403, was issued to your MAC via two transmittals. The first updates the *NCD Manual* and it is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R190NCD.pdf*. The second transmittal updates the *Medicare Claims Processing Manual* and it is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3461CP.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: MM9403
Related Change Request (CR) #: CR 9403
Related CR Release Date: February 5, 2016
Effective Date: April 13, 2015
Related CR Transmittal #: R190NCD and R3461CP
Implementation Date: March 7, 2016 (non-shared A/B MAC edits); July 5, 2016 (CWF analysis and design); October 3, 2016 (CWF coding, testing, implementation, MCS, FISS implementation; January 3, 2017 – Requirement 9403-04.9 July 5, 2016 - for CWF and January 1, 2017, for full implementation

General Coverage

Guidelines for ordering PAP devices for sleep disorders

Medicare can make payment for positive airway pressure (PAP) equipment and supplies when the patient's medical record shows the patient has obstructive sleep apnea (OSA) and meets medical documentation, test results, and health conditions as specified in the *National Coverage Determination (NCD) for Continuous Positive Airway Pressure (CPAP) Therapy for Obstructive Sleep Apnea (OSA) (240.4)* and *CMS Internet-Only Manual (IOM) Publication 100-03, Section 240.4*.

Medical record documentation determines whether your patient can receive the PAP equipment and supplies you have prescribed and the amount of the patient's out of pocket expenses.

Medical record documentation must show an in-person or face-to-face interaction with your patient within six months prior to prescribing the item, specifically to document the patient was evaluated and/or treated for a condition that supports the need for the item(s) of durable medical equipment (DME) ordered. For the initial evaluation, the report would commonly document pertinent information such as – signs and symptoms of sleep disordered breathing including snoring, daytime sleepiness, observed apneas, choking or gasping during sleep, morning headaches; the duration of those symptoms and a validated sleep hygiene inventory, but may include other details as well. Also a pertinent physical examination assessing – e.g., body mass index, neck circumference, upper airway exam and cardiopulmonary exam. It is not necessary for all of the above to be present; however, it is critical that there be detailed information that identifies symptoms commonly associated with OSA. Multiple treating practitioners may be involved in patient care. The practitioner conducting the face-to-face visit may be different than the ordering practitioner; however, the ordering practitioner must have access to evaluate the medical record.

Your patient must have a facility-based polysomnogram or a Type II, III, or IV home sleep study after your in-person evaluation, demonstrating an apnea-hypopnea index (AHI) or respiratory disturbance index (RDI) greater than or equal to 15 events per hour with a minimum of 30 events per hour or an AHI or RDI greater than or equal to five and less than or equal to 14 events per hour with a minimum of 10 events and documentation of excessive daytime sleepiness, impaired cognition, mood disorders, insomnia or hypertension, ischemic heart disease or history of stroke. This sleep study must take place on the same date or after the in-person or face-to-face interaction documenting signs and symptoms of OSA.

The prescription must include a detailed description of the item(s) being ordered. The order must also include the order date, patient name, your name, national provider identifier (NPI), signature and signature date. You must supply this signed order and the medical record documentation of your face-to-face evaluation to the supplier before they can deliver the PAP device to your patient. Please note that while PAP accessories may be provided from a dispensing order, this must be followed up with an order containing a detailed description for each item provided to your patient.

Your medical record documentation must also show a face-to-face re-evaluation with your patient between the 31st and 91st day after initiating therapy with a notation that the patient's symptoms of OSA are improving. Your medical record documentation must also demonstrate the patient is adhering to the therapy and that you have reviewed this adherence. Adherence to therapy is defined as use of the PAP greater than or equal to four hours per night on 70 percent of nights during a consecutive 30-day period anytime during the first three months of initial usage.

Following this guidance will help your patients and the Medicare program by verifying that there is medical documentation to support the provision of a PAP device and allow your patient to receive the therapy needed to treat their condition. Your assistance will allow Medicare to pay claims appropriately and ensure that your patient receives the device and accessories you have prescribed.

Additional changes to the 2016 Medicare physician fee schedule database

Revised 2016 Medicare physician fee schedule database (MPFSDB) files were made available to the Medicare administrative contractors (MACs) January 6, 2016.

Since then, the Centers for Medicare & Medicaid Services (CMS) has identified additional updates to the *Current Procedural Terminology* (*CPT*®) codes:

41530: the non-facility PE (practice expense) RVU (relative value units) is changed to 24.63

76948 and *76948*-26: the work RVU is changed to 0.67

These changes result in revised allowances for these codes. The revised fees, effective retroactive to January 1, may be found using our *fee lookup tool*.

Accredited Standards Committee healthcare claims acknowledgement flat file update

Provider types affected

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

What you need to know

Change request (CR) 9454 updates the Accredited Standards Committee (ASC) X12 Healthcare Claims Acknowledgement (277CA) flat file to allow for larger monetary amounts to meet Medicare's needs. The 277CA amount fields are currently the same size as the size used for the input files.

Additional information

The official instruction, CR 9454, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2016-Transmittals-Items/R1609OTN.*

MLN Matters® Number: MM9454
Related Change Request (CR) #: CR 9454
Related CR Release Date: February 4, 2016
Effective Date: July 1, 2016
Related CR Transmittal #: R1609OTN
Implementation Date: July 5, 2016

Authorized officials signatures on EDI enrollment and DDE request for access forms

First Coast Service Options Inc. (First Coast) would like to remind providers that only an authorized official or a delegated official, as listed on the CMS 855, can sign the electronic data interchange (EDI) enrollment form, direct data entry (DDE) access request form and other EDI forms.

The CMS defines an authorized official as "*an appointed official, such as a chief executive officer, chief financial officer, general partner, chairman of the board, or direct owner, to whom the organization has granted the legal authority to enroll it in the Medicare program, to make changes or updates to the organization's status in the Medicare program, and commit the organization to fully abide by the statutes, regulations, and instructions of the Medicare program.*"

The EDI forms certification statement states that "by signing the form the signee certifies that he or she have been appointed an authorized individual to whom the provider has granted the legal authority to enroll it in the Medicare program, to make changes and/or updates to the provider's status in the Medicare program (e.g., new practice locations, change of address, etc.), and to commit the provider to abide by the laws, regulations, and the program instructions of Medicare."

The new EDI forms are designed to be completed online, and can be signed electronically. There are three methods for submitting your EDI forms:

- **By mail to**: First Coast Medicare EDI, P.O. Box 44071, Jacksonville, FL 32231-4071
- **By fax to**: (904) 361-0470
- **By email to**: *EDIenrollmentteamfaxes@fcso.com*

Starting on March 15, 2016, any DDE request for access form or any other EDI forms submitted on an outdated form or not signed by an authorized or delegated official will be returned for corrections. A new form will be required.

For questions contact First Coast Medicare EDI support team at (888) 670-0940.

Source: *IOM 100-04, Chapter 24, Section 30.2.C* and *IOM 100-08, Chapter 15, Section 15.1.1*

Where do I find...

Looking for something specific and don't know where to find it? Find out how to perform routine tasks or locate information that visitors frequently visit our site to accomplish or find. Check out the "Where do I find" page.

Guidance on the PQRS 2014 reporting year and 2016 payment adjustment for RHCs, FQHCs, and CAHs

Provider types affected

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

What you need to know

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

Frequently asked questions - RHCs and FQHCs

Question:

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

Answer:

If you bill professional services paid under or based on the Part B Medicare physician fees schedule (PFS) submitted via CMS-1500 or CMS-1450 claim form or the electronic equivalents 837P and 837I, you are considered a PQRS eligible professional (EP) and you are subject to PQRS analysis. Technical services, which are covered under Part B Medicare PFS, are not eligible for PQRS.

Additionally, services rendered under billing methodologies other than Part B Medicare PFS will not be included in PQRS analysis (that is, an EP who bills under an organization that is registered as a FQHC, yet he or she renders services that are not covered by the FQHC methodology).

The *2015 Physician Quality Reporting System List of Eligible Professionals* is available on the CMS website.

Question:

I'm an EP and I furnish professional Medicare Part B services at an RHC/FQHC and also furnish services at a non-RHC/FQHC setting. Are the non-RHC/FQHC services eligible for the 2016 PQRS negative payment adjustment?

Answer:

If an eligible PQRS EP renders services under the Medicare PFS in addition to services under other billing schedules or methodologies, he or she must meet the PQRS reporting requirements for those services that fall under the Medicare PFS to avoid future payment adjustments regardless of the organization's participation in other fee schedules or methodologies.

Question:

Under what circumstances are professional Part B Medicare PFS services furnished by an EP at a setting outside an RHC/FQHC subject to the 2016 PQRS 2.0 percent negative payment adjustment?

Answer:

An EP is subject to the 2016 PQRS 2.0 percent negative payment adjustment if he or she has not satisfactorily reported 2014 PQRS quality measures as required by the EP's selected reporting mechanism (that is, as an individual EP or as an EP who is a part of a PQRS group practice).

For more information about the 2016 PQRS 2.0 percent negative payment adjustment, visit *Physician Quality Reporting System Payment Adjustment Information* on the CMS website.

To find timeline information, refer to the *2015 – 2017 Physician Quality Reporting System (PQRS) Timeline*.

To find general PQRS information, including information about payment adjustments, visit *Physician Quality Reporting System*.

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

Frequently asked questions - CAHs

Question:

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

Answer:

Yes, beginning in 2014, EPs at CAHs who bill Medicare Part B using Method II can participate in PQRS (and the Electronic Health Record [EHR] Incentive program) if they add their individual national provider identifier (NPI) on the CMS-1450 institutional claim form (not the CMS-1500 form). For the 5010 version of the 837 I, fiscal intermediary shared system (FISS) shall accept rendering physician/practitioner information at the line level (loop 2420A) or at the claim level if the rendering physician/practitioner is different from the attending physician/practitioner (loop 2310D).

For the 2014 PQRS program year, EPs who bill using CAH Method II will not be able to report via the claims-based reporting mechanism as the claims system needed to be updated to pull PQRS quality-data codes (QDCs) off the 1450 claim form and only pulled off of the CMS 1500 claim form in 2014. However, EPs who bill using CAH Method II will be able to report PQRS via registry, EHR, qualified clinical data registry (QCDR), and group practice reporting option (GPRO).

If you need assistance determining whether or not your provided services are included in PQRS measures, please contact the QualityNet help desk at 1-866-288-8912 (TTY 1-877-715-6222) or via *qnetsupport@hcqis.org*. The

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QualityNet help desk is available from 7:00 a.m. to 7:00 p.m., Monday through Friday.

Question:

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

Answer:

Yes, a CAH provider paid under Method II is required to report the rendering NPI at the line level if it is different from the rendering NPI at the claim level. For more information about this billing standard requirement, refer to *Fiscal Intermediary Shared System (FISS) and Common Working File (CWF) System Enhancement for Storing Line Level Rendering Physicians/Practitioners National Provider Identifier (NPI) Information*.

Additional information

For additional information about PQRS, visit *Physician Quality Reporting System*.

For more information about EPs under CAH II participating in PQRS, refer to the "CAH-II Reporting for PQRS" toolkit at *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/EducationalResources.html*.

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

MLN Matters® Number: SE1606
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

New non-physician specialty code for dentists

Provider types affected

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

Provider action needed

Change request (CR) 9355 announces that the Centers for Medicare & Medicaid Services (CMS) has created a new non-physician specialty code (C5) for dentist.

Background

Physicians self-designate their Medicare physician specialty on the Medicare enrollment application ((CMS-855B, CMS-855I or CMS-855O) or Internet-based Provider Enrollment, Chain and Ownership System (PECOS) when they enroll in the Medicare program. Non-physician practitioners are assigned a Medicare specialty code when they enroll.

The specialty code becomes associated with the claims that the physician or non-physician practitioner submits, and describes the specific/unique types of medicine that they (and certain other suppliers) practice. CMS uses specialty codes for programmatic and claim processing purposes.

Additional information

The official instruction, CR 9355, issued to your MAC regarding this change consists of two transmittals. The first revises the *Medicare Claims Processing Manual* and it is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3447CP.pdf*. The second transmittal updates the *Medicare Financial Management Manual* and it is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R262FM.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: MM9355
Related Change Request (CR) #: CR 9355
Related CR Release Date: January 29, 2016
Effective Date: July 1, 2016
Related CR Transmittal #: R3447CP and R262FM
Implementation Date: July 5, 2016

Update to 'Medicare Program Integrity Manual,' Chapter 15

Provider types affected

This *MLN Matters*® article is intended for providers, including home health agencies (HHAs), submitting claims to Medicare administrative contractors (MACs) for services to Medicare beneficiaries.

Provider action needed

Change request (CR) 9390, from which this article was developed, makes several minor revisions to Chapter 15 of the *Medicare Program Integrity Manual*. These changes include, but are not limited to:

1. Clarifying the process for verifying correspondence telephone numbers
2. Clarifying the process for validating the credentials of technicians of Independent diagnostic testing facilities (IDTF); and
3. Identifying the timeframe by which approval letters must be sent and to whom they must be sent.

Make sure that your billing staffs are aware of these revisions.

Background

Chapter 15 of the *Medicare Program Integrity Manual* contains instructions regarding the processing of Form CMS-855 applications. CR 9390 makes the following key changes:

1. If online verification of an IDTF technician's credentials is not available or cannot be made, the MAC will request a copy of the technician's certification card.
2. The MAC will not request a social security card to verify an individual's identity or social security number.
3. Absent a CMS instruction or directive to the contrary, the MAC will send enrollment approval letters within 5 business days of approving the enrollment application.
4. For all applications other than the Form CMS-855S, the MAC will send development/approval letters/ revocation letters, etc., to the contact person if one is listed; otherwise, the contractor may send the letter to the provider or supplier at the provider's/supplier's correspondence address or special payments address.

Note: CR 9390 does not involve any legislative or regulatory policies and is restricted to changes in operational procedures.

Many of the other Chapter 15 revisions are small, such as inserting single words or short sentences, etc. Others are more significant and those revisions are in the revised Chapter 15, which is attached to CR 9390.

Additional information

The official instruction, CR 9390, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R636PI.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: MM9390
Related Change Request (CR) #: CR 9390
Related CR Release Date: February 4, 2016
Effective Date: March 4, 2016
Related CR Transmittal #: R636PI
Implementation Date: March 4, 2016

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Implementation of fingerprint-based background checks

Provider types affected

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

Provider action needed

Stop – impact to you

This special edition article is being provided by the Centers for Medicare & Medicaid Services (CMS) to announce the implementation of fingerprint-based background checks as part of enhanced enrollment screening provisions contained in Section 6401 of the Affordable Care Act.

Caution – what you need to know

Fingerprint-based background checks are generally completed on individuals with a 5 percent or greater ownership interest in a provider or supplier that falls under the high risk category. **A 5 percent or greater owner includes any individual that has any partnership (general or limited) in a high risk provider or supplier**. Note that the high level of risk category applies to providers and suppliers who are newly enrolling durable Medicare equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers or home health agencies (HHA). It also applies to providers and suppliers who have been elevated to the high risk category. CMS may adjust a particular provider or supplier's screening level from "limited" to "high" or "moderate" to "high" if any of the following occur:

- CMS has imposed a payment suspension within the last 10 years;
- Has been excluded from Medicare by the OIG;
- Has had billing privileges revoked by CMS within the previous 10 years;
- Has been excluded from any federal health care program;
- Has been subject to any final adverse action, in the previous 10 years;
- Has been terminated or is otherwise precluded from billing Medicaid; or
- CMS lifts a temporary moratorium for a particular provider or supplier type and a provider or supplier that was prevented from enrolling based on the moratorium, applies for enrollment as a Medicare provider or supplier at any time within six months from the date the moratorium was lifted.

Go – what you need to do

See the *Background* and *Additional information* sections of this article for further details.

Background

As part of the enhanced enrollment screening provisions contained in the Affordable Care Act (see *http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf*), the CMS implemented fingerprint-based background checks. The fingerprint-based background checks will be used to detect bad actors who are attempting to enroll in the Medicare program and to remove those currently enrolled. Once fully implemented, the fingerprint-based background check will be completed on all individuals with a 5 percent or greater ownership interest in a provider or supplier that falls under the high risk category. A 5 percent or greater owner includes any individual that has any partnership (general or limited) in a provider or supplier. Fingerprint-based background checks are also required for any provider or supplier who has been elevated to the high risk category for any of the following reasons:

- CMS has imposed a payment suspension within the last 10 years;
- Has had billing privileges revoked by CMS within the previous 10 years;
- Has been excluded from any federal health care program;
- Has been subject to any final adverse action, in the previous 10 years;
- Has been terminated or is otherwise precluded from billing Medicaid; or
- CMS lifts a temporary moratorium for a particular provider or supplier type and a provider or supplier that was prevented from enrolling based on the moratorium, applies for enrollment as a Medicare provider or supplier at any time within six months from the date the moratorium was lifted.

Please refer to 42 CFR 424.518(c)(3) at *http://www.ecfr.gov/cgi-bin/text-idx?SID=a39ae0804106965d82b5ae6413ba550e&node=42:3.0.1.1.11.12.5.11&rgn=div8* and the *Medicare Program Integrity Manual* (Chapter 15 (Medicare Enrollment), Section 15.19.2.1C (Screening Categories-Background-High)) at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c15.pdf*.

Note: The fingerprint-based background checks will be applied to providers and suppliers in the high level of risk category, which includes newly enrolling DMEPOS suppliers, home health agencies (HHA), and providers and suppliers who have been elevated to the high risk category in accordance with enrollment screening regulations.

The fingerprint-based background check implementation has been phased in beginning in 2014.

Affected providers and suppliers will receive notification of the fingerprint requirements from their MAC. The MAC will send a notification letter to the affected providers or suppliers listing all 5 percent or greater owners who are required to be fingerprinted. The notification letter will be mailed to the provider or supplier's correspondence address and the special payments address on file with Medicare. Generally, an individual will be required to be fingerprinted only once, but CMS reserves the right to request additional fingerprints if needed.

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The relevant individuals will have 30 days from the date of the notification letter to be fingerprinted. If the provider or supplier finds a discrepancy in the ownership listing, the provider or supplier should contact their MAC immediately to communicate the discrepancy and take the appropriate action to update the enrollment record to correctly reflect the ownership information.

The notification letter will identify contact information for the fingerprint-based background check contractor (FBBC). The relevant individual(s) are required to contact the FBBC prior to being fingerprinted to ensure the fingerprints are accurately submitted to the Federal Bureau of Investigation (FBI) and results are properly returned to CMS. Providers/suppliers may contact the FBBC by telephone or by accessing the FBBC's website. Contact information for the FBBC will be provided in the notification letter received from the MAC. Once contacted, the FBBC will provide at least three fingerprint locations convenient to the relevant individual's location. One of these locations will be a local, state, or federal law enforcement facility.

The relevant individuals who are required to undergo the fingerprint-based background check will incur the cost of having their fingerprints taken, and the cost may vary depending on location. **Once an individual has submitted his/her fingerprints, if that individual is subsequently required to undergo a fingerprint-based background check in accordance with 42 CFR 424.518(c), CMS will, to the extent possible, rerun the fingerprint-based background check rather than requiring resubmission of fingerprints.** You can review 42 CFR 424.518(c) at *http://www.ecfr.gov/cgi-bin/text-idx?SID=f14b263d1175a355d736e9f38f3a6baf&node=42:3.0.1.1.11.12.5.11&rgn=div8*.

Fingerprinting can be completed on the FD-258 form or electronically at certain locations. CMS strongly encourages all required applicants to provide electronic fingerprints, but CMS will accept the FD-258 card instead. If the FD-258 form is submitted, the FBBC will convert the paper form to electronic submission to the FBI. You can review the FD-258 form at *https://www.fbi.gov/about-us/cjis/identity-history-summary-checks/fd-258-1*.

Once the fingerprint process is complete, the fingerprints will be forwarded to the FBI for processing. Within 24 hours of receipt, the FBI will compile the background history based on the fingerprints and will share the results with the FBBC. CMS, through the FBBC, will assess the law enforcement data provided for the fingerprinted individuals. The FBBC will review each record and provide a fitness recommendation to CMS. CMS will assess the recommendation and make a final determination.

- All fingerprint data will be stored according to:
  - Federal requirements;
  - FBI Security and Management Control Outsourcing Standards for Channelers and Non-Channelers; and
  - The FBI Criminal Justice Information Services (CJIS) security policy.

The FBBC will maintain Federal Information Systems Management Act (FISMA) certification and comply with the FBI (CJIS) Security Policy. All data will be secured in accordance with the Privacy Act of 1974 and the FBI CJIS security policy.

CMS will rely on existing authority to deny enrollment applications and revoke existing Medicare billing privileges per 42 CFR §424.530(a) and §424.535(a) (*http://www.ecfr.gov/cgi-bin/text-idx?SID=f14b263d1175a355d736e9f38f3a6baf&node=42:3.0.1.1.11.12.5.15&rgn=div8*) if an individual who maintains a 5 percent or greater direct or indirect ownership interest in a provider or supplier has submitted an enrollment application that contains false or misleading information. Providers or suppliers will be notified by CMS if the assessment of the fingerprint based background check results in the denial of its enrollment application or revocation of its existing Medicare billing privileges.

Additional information

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

Document history

Date of change	Description
January 27, 2016	The article was revised to update language in the article and to emphasize affected providers and suppliers in the Caution section.

MLN Matters® Number: SE1417 *Revised*
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

When not to show patient paid amounts on claims

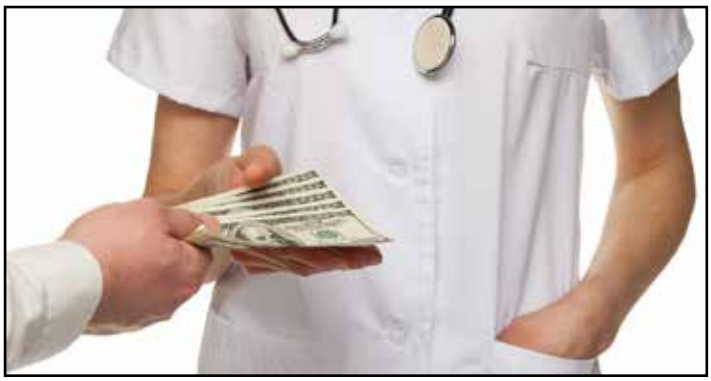
First Coast Service Options was recently contacted by our Centers for Medicare & Medicaid Services (CMS) regional field office regarding beneficiary complaints of being charged up front in the office for services rendered and the money was collected **prior** to a claim being submitted to Medicare.

Although it's not a violation for participating providers to accept payment prior to rendering services, there are specific guidelines to follow, especially when reporting these payments.

Additionally, some providers who accept assignment have a concern that Medicare issues partial checks to beneficiaries. Such checks are generally issued because of a patient paid amount in item 29 of the CMS-1500 (02/12) claim form.

Here are a few notes concerning this situation:

- When assignment is accepted, Medicare Part B recommends:
  - Since it is difficult to predict when deductible/ coinsurance amounts will be applicable (and over-collection is considered program abuse), it is recommended that providers do not collect these amounts until Medicare Part B payment is received.
  - If you believe you can accurately predict the coinsurance amount and wish to collect it before Medicare Part B payment is received, note the amount collected for coinsurance on your claim form. It is recommended that providers do not collect the deductible prior to receiving payment from Medicare Part B because, as noted above, over-collection is considered program abuse. In addition, this practice can cause a portion of the provider's check to be issued to beneficiaries on assigned claims.
  - Do not show any amounts collected from patients if the service is never covered by Medicare Part B or you believe, in a particular case, the service will be denied payment. Where patient paid amounts are shown for services that are denied payment, a portion of the provider's check may go to the beneficiary.
- There is no need to show a patient paid amount in item 29 of form CMS-1500 (or electronic equivalent) when assignment is not accepted.



Source: The Centers for Medicare & Medicaid Services (CMS) Internet-only manual (IOM) *Pub. 100-04 Chapter 1, Sections 30.3.1.1 and 30.3.3.B*; *Chapter 26, Section 10.4*

Prohibition on balance billing dually eligible individuals enrolled in the QMB program

***Note**: This article was revised February 1 and February 4, 2016, to include updated information for 2016 and a correction to the second sentence in paragraph 2 under "Important Clarifications Concerning Qualified Medicare Beneficiary (QMB) Balance Billing Law." All other information is the same. This information was previously published in the* *September 2012 Medicare B Connection, page 47*.

Provider types affected

This article pertains to all Medicare physicians, providers and suppliers, including those serving beneficiaries enrolled in original Medicare or a Medicare Advantage plan.

What you need to know

Stop – impact to you

This special edition *MLN Matters*® article from the Centers for Medicare & Medicaid Services (CMS) reminds **all Medicare providers that they may not bill beneficiaries enrolled in the QMB program for Medicare cost-sharing** (such charges are known as "balance billing").

QMB is a Medicare savings program that exempts Medicare beneficiaries from Medicare cost-sharing liability.

Caution – what you need to know

The QMB program is a state Medicaid benefit that covers Medicare deductibles, coinsurance, and copayments, subject to state payment limits. (States may limit their liability to providers for Medicare deductibles, coinsurance and copayments under certain circumstances.) Medicare providers may not balance bill QMB individuals for Medicare cost-sharing, regardless of whether the state reimburses providers for the full Medicare cost-sharing amounts. Further, all original Medicare and MA providers – not only those that accept Medicaid – must refrain from charging QMB individuals for Medicare cost-sharing. Providers who inappropriately balance bill QMB individuals are subject to sanctions.

Go – what you need to do

Refer to the *Background* and *Additional information* sections of this article for further details and resources

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about this guidance. Please ensure that you and your staffs are aware of the federal balance billing law and policies regarding QMB individuals. Contact the Medicaid agency in the states in which you practice to learn about ways to identify QMB patients in your State and procedures applicable to Medicaid reimbursement for their Medicare cost-sharing. If you are a Medicare Advantage provider, you may also contact the MA plan for more information. Finally, all Medicare providers should ensure that their billing software and administrative staff exempt QMB individuals from Medicare cost-sharing billing and related collection efforts.

Background

This article provides CMS guidance to Medicare providers to help them avoid inappropriately billing QMBs for Medicare cost-sharing, including deductibles, coinsurance, and copayments. This practice is known as "balance billing."

Balance billing of QMBs is prohibited by federal law

Federal law bars Medicare providers from balance billing a QMB beneficiary under any circumstances. See **Section 1902(n)(3)(B) of the Social Security Act, as modified by Section 4714 of the Balanced Budget Act of 1997**. (Please note, this section of the Act is available at *http://www.ssa.gov/OP_Home/ssact/title19/1902.htm*.)

QMB is a Medicaid program for Medicare beneficiaries that exempt them from liability for Medicare cost-sharing. State Medicaid programs may pay providers for Medicare deductibles, coinsurance and copayments.

However, as permitted by federal law, states can limit provider reimbursement for Medicare cost-sharing under certain circumstances. See the chart at the end of this article for more information about the QMB benefit.

Medicare providers must accept the Medicare payment and Medicaid payment (if any) as payment in full for services rendered to a QMB beneficiary. Medicare providers who violate these billing prohibitions are violating their Medicare provider agreement and may be subject to sanctions. (See Sections 1902(n)(3)(C); 1905(p)(3); 1866(a)(1)(A); 1848(g)(3)(A) of the Social Security Act.)

Inappropriate balance billing persists

Despite federal law, erroneous balance billing of QMB individuals persists. Many beneficiaries are unaware of the billing restrictions (or concerned about undermining provider relationships) and simply pay the cost-sharing amounts. Others may experience undue distress when unpaid bills are referred to collection agencies. See *Access to Care Issues Among qualified Medicare beneficiaries (QMB)*, Centers for Medicare & Medicaid Services July 2015 at *https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/*

Downloads/Access_to_Care_Issues_Among_Qualified_Medicare_Beneficiaries.pdf.

Important clarifications concerning QMB balance billing law

Be aware of the following policy clarifications to ensure compliance with QMB balance billing requirements. First, know that all original Medicare and MA providers – not only those that accept Medicaid – must abide by the balance billing prohibitions.

In addition, QMB individuals retain their protection from balance billing when they cross state lines to receive care. Providers cannot charge QMB individuals even if the patient's QMB benefit is provided by a different state than the state in which care is rendered.

Finally, note that QMBs cannot choose to "waive" their QMB status and pay Medicare cost-sharing. The federal statute referenced above supersedes Section 3490.14 of the *State Medicaid Manual*, which is no longer in effect.

Ways to improve processes related to QMBs

Proactive steps to identify QMB individuals you serve and to communicate with state Medicaid agencies (and Medicare advantage plans if applicable), can promote compliance with QMB balance billing prohibitions.

1. Determine effective means to identify QMB individuals among your patients. Find out what cards are issued to QMB individuals so you can in turn ask all your patients if they have them. Learn if you can query state systems to verify QMB enrollment among your patients. If you are a Medicare advantage provider contact the plan to determine how to identify the plan's QMB enrollees.
2. Discern what billing processes apply to seek reimbursement for Medicare cost-sharing from the states in which you operate. Different processes may apply to original Medicare and MA services provided to QMB beneficiaries. For original Medicare claims, nearly all states have electronic crossover processes through the Medicare Benefits Coordination & Recovery Center (BCRC) to automatically receive Medicare-adjudicated claims.

- If a claim is automatically crossed over to another

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payer, such as Medicaid, it is customarily noted on the Medicare remittance advice.

- Understand the processes you need to follow to request reimbursement for Medicare cost-sharing amounts if they are owed by your state. You may need to complete a state provider registration process and be entered into the state payment system to bill the state.

3. Make sure that your billing software and administrative staff exempt QMB individuals from Medicare cost-sharing billing and related collection efforts.

QMB eligibility and benefits

Dual eligibility	Eligibility criteria	Benefits
Qualified Medicare Beneficiary (QMB only)	▪ Resources cannot exceed $7,280 for a single individual or $10,930 in 2015 for an individual living with a spouse and no other dependents. ▪ Income cannot exceed 100% of the federal poverty level (FPL) +$20 ($1,001/month – Individual $1,348/month – couple in 2015). **Note**: **These guidelines are a federal floor. Under Section 1902 (r)(2) of the Social Security Act, states can effectively raise these limits above these baseline federal standards**.	Medicaid pays Medicare Part A and B premiums, deductibles, co-insurance and co-pays to the extent required by the state Medicaid plan. ▪ Exempts beneficiaries from Medicare cost-sharing charges ▪ The state may choose to pay the Medicare advantage (Part C) premium.
QMB Plus	▪ Meets all of the standards for QMB eligibility as described above, but also meets the financial criteria for full Medicaid coverage	Provides all benefits available to QMBs, as well as all benefits available under the state Plan to a fully eligible Medicaid recipient

Additional information

For more information about dual eligible categories and benefits, please visit *http://www.medicare.gov/Publications/Pubs/pdf/10126.pdf*.

Also, for more information about QMBs and other individuals who are dually eligible to receive Medicare and Medicaid benefits, please refer to the *Medicare Learning Network*® publication titled *Medicaid Coverage of Medicare Beneficiaries (Dual Eligibles)*.

For general Medicaid information, please visit the Medicaid Web page at *http://www.medicaid.gov/index.html*.

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Implementation Date: N/A

Processing Issues

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

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.

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.

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

Revisions to LCDs

Bisphosphonates (intravenous [IV]) and monoclonal antibodies in the treatment of osteoporosis and their other indications – revision to the LCD

LCD ID number: L33270 (Florida/Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for bisphosphonates (intravenous [IV]) and monoclonal antibodies in the treatment of osteoporosis and their other indications was revised to add ICD-10-CM diagnosis codes M80.00XA – M80.88XS to the "ICD-10 Codes that Support Medical Necessity" section of the LCD.

The updated LCD will be available on the Medicare coverage database (MCD) on or after February 11, 2016.

Effective date

This LCD revision is effective for claims processed **on or after February 8, 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*.

Carboplatin (Paraplatin®, Paraplatin-AQ®) – revision to the LCD

LCD ID number: L33275 (Florida/Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for carboplatin (paraplatin, paraplatin-AQ) was revised to add ICD-10-CM diagnosis code C45 to the "ICD-10 Codes that Support Medical Necessity" section of the LCD.

The updated LCD will be available on the Medicare coverage database (MCD) on or after February 11, 2016.

Effective date

This LCD revision is effective for claims processed **on or after February 8, 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*.

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.

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 include R07.9 in the "ICD-10 Codes that Support Medical Necessity" section of the LCD for *Current Procedural Terminology®* (*CPT®*) codes *75571, 75572, 75573*, and *75574*.

Effective date

This LCD revision is effective for claims processed **on or after February 8, 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*.

Destruction of malignant skin lesions – revision to the LCD

LCD ID number: L33813 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for destruction of malignant skin lesions was revised to add ICD-10-CM diagnosis code range code range C4A.0-C4A.9 to the "ICD-10 Codes that Support Medical Necessity" section of the LCD.

Effective date

This LCD revision is effective for claims processed **on or after February 12, 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*.

Diagnostic and therapeutic esophagogastroduodenoscopy – revision to the Part AB LCD

LCD ID number: L33583 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for diagnostic and therapeutic esophagogastroduodenoscopy was revised to add ICD-10-CM diagnosis codes F45.8, F98.21, K44.9 and Z87.11 and ICD-10-CM diagnosis ranges T56.4X1A-T56.4X1S and T65.5X1A-T65.5X1S to the "ICD-10 Codes that Support Medical Necessity" section of the LCD.

Effective date

This LCD revision is effective for claims processed **on or after February 3, 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*.

Excision of Malignant Skin Lesions – revision to the LCD

LCD ID number: L33818 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for excision of malignant skin lesions was revised to add ICD-10-CM diagnosis code range C4A.52-C4A.72 for procedure codes *11600-11606*, ICD-10 -CM diagnosis codes C4A.4 and C4A.51 and diagnosis range C4A.60-C4A.72 for procedure codes *11620-11626*, and ICD-10-CM diagnosis ranges C4A.0-C4A.39 and C4A.8-C4A.9 for procedure codes *11640-11646* in the "ICD-10 Codes that Support Medical Necessity" section of the LCD.

Effective date

This LCD revision is effective for claims processed **on or after February 8, 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*.

Flow cytometry – revision to the Part AB LCD

LCD ID number: L33661 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for flow cytometry was revised to add ICD-10-CM diagnosis codes to the "ICD-10 Codes that Support Medical Necessity" section of the LCD. ICD-10-CM code C20 was added for procedure code 88182 and ICD-10-CM diagnosis codes A18.01, C78.2, D46.4, D46.9, and M08.1 and ICD-10-CM diagnosis ranges C56.1-C56.9, K51.00-K51.019, T86.00-T86.819, T86.830-T86.839 and T86.850-T86.99 were added for procedure codes *88184, 88185, 88187, 88188*, and *88189*.

Effective date

This LCD revision is effective for claims processed **on or after February 4, 2016**, for services rendered **on or after October 1, 2015**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Multiple Part A/B local coverage determinations revised

LCD ID number: L33693, L33695, L33696, L33667 (Florida/Puerto Rico/U.S. Virgin Islands)

The following local coverage determinations (LCDs) are being revised. Review of the LCDs identified an invalid *Current Procedural Terminology®* (*CPT®*) code (*93381*) in the body of the LCDs. Therefore, the LCDs are being revised to replace *CPT®* code *93881* with *93882* in the "Limitations" and "Documentation Requirements" sections of the LCDs.

- Non-Invasive Evaluation of Extremity Veins
- Non-Invasive Extracranial Arterial Studies
- Non-Invasive Physiologic Studies of Upper or Lower Extremity Arteries
- Duplex Scan of Lower Extremity Arteries

Effective date

This LCD revision is effective for claims processed **on or after November 12, 2015**, for services rendered **on or after October 1, 2015**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Check the status of claim redeterminations online

Don't wait up learn the status of your appeal. You may check on its status at your convenience -- online, which enables providers to check the status on active redeterminations to confirm if the appeal has been received by First Coast Service Options.

Scanning computerized ophthalmic diagnostic imaging – revision to the LCD

LCD ID number: L33751 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for scanning computerized ophthalmic diagnostic imaging (SCODI) was revised to add ICD-10-CM diagnosis codes H40.032 and H40.033 to the "ICD-10 Codes that Support Medical Necessity" section of the LCD for *Current Procedural Terminology*® (*CPT*®) code *92132*. In addition, the LCD was revised to add language to the "Indications of Coverage for Posterior Segment SCODI" section of the LCD to clarify retinal disease coverage.

Effective date

The LCD revision related to the addition of ICD-10-CM diagnosis codes H40.032 and H40.033 is effective for claims processed **on or after February 18, 2016**, for services rendered **on or after October 1, 2015**. The LCD revision related the addition of language to clarify retinal disease coverage is effective for claims processed **on or after February 18, 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*.

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 Healthcare Common Procedure Coding System (HCPCS) code G0279:

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, please *click here*.

Transthoracic echocardiography – revision to the LCD

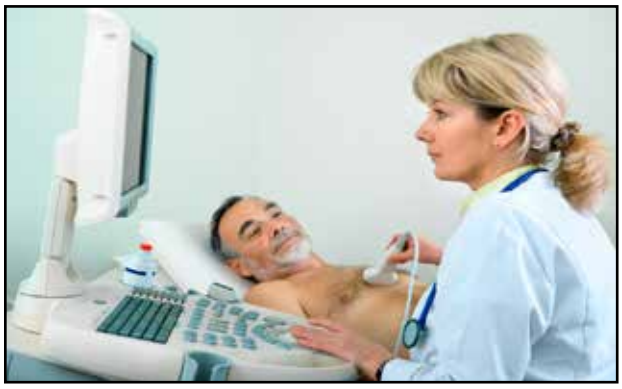
LCD ID number: L33768 (Florida/Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for transthoracic echocardiography (TTE) was revised to add ICD-10-CM diagnosis code Z08 to the "ICD-10 Codes that Support Medical Necessity" section of the LCD.

The updated LCD will be available on the Medicare coverage database (MCD) **on or after February 11, 2016**.

Effective date

This LCD revision is effective for claims processed **on or after January 27, 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*.

Additional information

Computed tomography – multiple coding guidelines (new and existing)

LCD ID number: L33284, L33285, L33721, L33282, L33283 (Florida/Puerto Rico/U.S. Virgin Islands)

Based on change request (CR) 9250, three coding guidelines were developed related to services that do not meet the National Electrical Manufacturers Association (NEMA) Standard. In addition, two coding guidelines were revised to add language related to services that do not meet the NEMA Standard. New coding guidelines were developed for the following local coverage determinations (LCDs): computed tomography of the abdomen and pelvis (L33284), computed tomography of the thorax (L33285), and computed tomography scans of the head or brain (L33721). Two existing coding guidelines were revised for the following LCDs: computed tomographic angiography of the chest, heart and coronary arteries (L33282) and computed tomographic colonography (L33283).

Effective date

This LCD revision is effective for services rendered **on or after January 1, 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, *click here*.

Open public meeting notification draft list amended – one draft deleted

Local coverage determination (LCD) draft, NSCLC, Comprehensive Genomic Profile Testing, will not be posted for comment at this time. The draft may be presented in a later policy cycle. The LCD drafts that will be available for a 45-day comment period beginning February 12, 2016 are listed below.

1. Chiropractic services (new LCD)
2. Left atrial appendage closure or occlusion (new LCD)
3. Noncovered services (revised LCD)

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.

CMS MLN Connects® Provider eNews

The Centers for Medicare & Medicaid Services (CMS) *MLN Connects*® Provider eNews is an official *Medicare Learning Network*® (*MLN*) – branded product that contains a week's worth of news for Medicare fee-for-service (FFS) providers. CMS sends these messages weekly to national health industry provider associations, who then disseminates the e-News to their membership as appropriate.

MLN Connects® Provider eNews for January 28, 2016

MLN Connects® Provider eNews for January 28, 2016
View this edition as a PDF

In this edition:

MLN Connects® Events

- IMPACT Act: Connecting Post-Acute Care across the Care Continuum Call — Last Chance to Register

Other CMS Events

- Special Open Door Forum: Understanding the IMPACT Act
- LTCH Quality Reporting Program Webinar
- Physician Compare Public Reporting Information Sessions

Medicare Learning Network® Publications and Multimedia

- CMS Provider Minute: Duplicate Professional Claims Video — New
- Medicare Advance Beneficiary Notices Booklet — Revised
- Skilled Nursing Facility Billing Reference Fact Sheet — Revised
- Suite of Products & Resources for Billers & Coders Educational Tool — Revised
- Suite of Products & Resources for Compliance Officers Educational Tool — Revised
- Suite of Products & Resources for Educators & Students Educational Tool — Revised
- Suite of Products & Resources for Inpatient Hospitals Educational Tool — Revised
- Updated MLN Matters® Search Indices
- New Educational Web Guides Fast Fact

Announcements

- CMS Releases Guide to Preventing Readmissions among Racially and Ethnically Diverse Medicare Beneficiaries
- PQRS: Submission Timeframes for 2015 Data
- Comment Period for IMPACT Act Measures Extended to January 29
- PQRS: Self-Nomination for 2016 Qualified Registries and QCDRs Open through January 31
- CMS to Release a Comparative Billing Report on Modifier 25: Internal Medicine in February
- CMS Seeks Public Comments on Draft Quality Measure Development Plan by March 1
- Prior Authorization for Certain DMEPOS Items: FAQs on the Final Rule
- PEPPERs Available for SNFs, HHAs, Hospices, CAHs, LTCHs, IPFs, IRFs and PHPs
- Payment for Group 3 Power Wheelchair Cushions and Accessories
- Changes to the Medicare EHR Incentive Program Hardship Exception Process
- Testing QRDA I Release 2 and QRDA III Release 1 Files

Claims, Pricers, and Codes

- New Drug Testing Laboratory Codes Editing Incorrectly

Learn the secrets to billing Medicare correctly

Who has the power to improve your billing accuracy and efficiency? You do – visit the *Tools to improve your billing* section where you'll discover the tools you need to learn how to consistently bill Medicare correctly – the first time. You'll find First Coast's most popular self-audit resources, including the E/M interactive worksheet, provider data summary (PDS) report, and the comparative billing report (CBR).

MLN Connects® Provider eNews for February 4, 2016

MLN Connects® Provider eNews for February 4, 2016
View this edition as a PDF

In this edition:

MLN Connects® Events

- New Audio Recordings and Transcripts Available

Other CMS Events

- Medicare Quality Reporting Programs Webinar: What Eligible Providers Need to Know in 2016

Medicare Learning Network® Publications and Multimedia

- Prohibition on Balance Billing Dually Eligible Individuals Enrolled in the QMB Program *MLN Matters®* Article — Revised
- Implementation of Fingerprint-Based Background Checks *MLN Matters®* Article — Revised
- The Medicare Home Health Benefit Web-Based Training Course — Revised
- Remittance Advice Information: An Overview Fact Sheet — Revised
- Medicare Advance Beneficiary Notices Booklet — Revised
- How to Use the Searchable Medicare Physician Fee Schedule Booklet — Revised

Announcements

- CMS Announces Proposed Improvements to Medicare Shared Savings Program
- CMS Releases Home Health Patient Experience of Care Star Ratings
- New Proposal to Give Providers and Employers Access to Information to Drive Quality and Patient Care Improvement
- Comment Period for IMPACT Act Measures Extended to February 5
- Comment Period for RFI on Reporting of Quality Measures Extended to February 16
- Hospice, IRF, LTCH, SNF, HHA: QIES System Downtime from March 16 through 21
- Register in Open Payments System to Review and Dispute 2015 Data
- 2015 PQRS Data: Submission Deadlines
- Applying for an EHR Hardship Exception: FAQs
- Temporary Moratoria Extended on Enrollment of New Home Health Agencies and Part B Ambulance Suppliers
- Stop Hepatitis C Virus Transmission in Patients Undergoing Hemodialysis
- Flu Season Begins: Severe Influenza Illness Reported
- February is American Heart Month

What is Medicare Fraud?

Fraud is defined as making false statements or representations of material facts to obtain some benefit or payment for which no entitlement would otherwise exist. Learn more at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Fraud_and_Abuse.pdf*.

MLN Connects® Provider eNews for February 11, 2016

MLN Connects® Provider eNews for February 11, 2016
View this edition as a PDF

In this edition:

MLN Connects® Events

- Provider Enrollment Revalidation Call — Registration Now Open

Other CMS Events

- Physician Compare Public Reporting Information Sessions

Medicare Learning Network® Publications and Multimedia

- Telehealth Services Fact Sheet — Revised
- Ambulance Fee Schedule Fact Sheet — Revised
- Reading a Professional Remittance Advice Booklet — Reminder

Announcements

- 39 Million Medicare Beneficiaries Utilized Free Preventive Services in 2015
- Nursing Facility Initiative Annual Report
- EHR Incentive Programs: Clinical Decision Support Interventions
- EHR Incentive Programs: New Tipsheet on Eligibility for Broadband Access Exclusions
- Implementation of Section 2 of the Patient Access and Medicare Protection Act
- Influenza Activity Continues

Claims, Pricers, and Codes

- Qualifiers for ICD-10 Diagnosis Codes on Electronic Claims

MLN Connects® Provider eNews for February 18, 2016

MLN Connects® Provider eNews for February 18, 2016
View this edition as a PDF

In this edition:

MLN Connects® Events

- Provider Enrollment Revalidation Call — Register Now
- New Audio Recording and Transcript Available

Other CMS Events

- Comparative Billing Report on Electrodiagnostic Testing Webinar

Medicare Learning Network® Publications and Multimedia

- Medicare Basics Commonly Used Acronyms Educational Tool — Revised
- PECOS Technical Assistance Contact Information Fact Sheet – Reminder
- Medicare Enrollment for Physicians and Other Part B Suppliers Fact Sheet – Reminder

Announcements

- Medicare Reporting and Returning of Self-Identified Overpayments
- IMPACT Act Technical Expert Panel Call for Nominations through February 26
- Submitting Comments on MACRA Episode Groups: Deadline Extended to March 1
- 2015 PQRS EHR Submission Deadline Extended to March 11
- EHR Incentive Programs Attestation Deadline Extended to March 11
- Hospice, IRF, LTCH, SNF, HHA: QIES System Downtime from March 16 through 21
- EHR Incentive Programs: Updated FAQs Available

Medicare Learning Network®

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

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

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

Education event registration hotline
904-791-8103 (NOT toll-free)

Electronic data interchange (EDI)
888-670-0940

Electronic funds transfers (EFT) (CMS-588)
866-454-9007
877-660-1759 (TTY)

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

Interactive voice response (IVR) system
877-847-4992

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

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

Addresses

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Websites

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

http://medicare.fcso.com

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

Centers for Medicare & Medicaid Services

http://www.cms.gov

First Coast University

http://www.fcsouniversity.com/

Beneficiaries
Centers for Medicare & Medicaid Services

http://www.medicare.gov

Phone numbers

Customer service

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

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

Websites

Provider

First Coast Service Options Inc. (First Coast), your CMS-contracted Medicare administrative contractor
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http://www.cms.gov

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

Beneficiaries

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

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