

C Medicare B CONNECTION

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A Newsletter for MAC Jurisdiction N Providers

March 2016



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Provider enrollment revalidation – cycle 2

Provider types affected

This *Medicare Learning Network (MLN) Matters*® special edition article is intended for all providers and suppliers who are enrolled in Medicare and required to revalidate through their Medicare administrative contractors (MACs), including home health & hospice MACs (HH&H MACs), Medicare carriers, fiscal intermediaries, and the national supplier clearinghouse (NSC). These contractors are collectively referred to as MACs in this article.

Provider action needed

Stop – impact to you

Section 6401 (a) of the Affordable Care Act established a requirement for all enrolled providers/suppliers to revalidate their Medicare enrollment information under new enrollment screening criteria. The Centers for Medicare & Medicaid Services (CMS) has completed its initial round of revalidations and will be resuming regular revalidation cycles in accordance with 42 CFR §424.515. In an effort to streamline the revalidation process and reduce provider/supplier burden, CMS has implemented several

revalidation processing improvements that are captured within this article.

Caution – what you need to know

Special note: The Medicare provider enrollment revalidation effort does not change other aspects of the enrollment process. Providers/suppliers should continue to submit changes (for example, changes of ownership, change in practice location or reassignments, final adverse action, changes in authorized or delegated officials or, any other changes) as they always have. If you also receive a request for revalidation from the MAC, respond separately to that request.

Go – what you need to do

1. Check <http://go.cms.gov/MedicareRevalidation> for the provider/suppliers due for revalidation;
2. If the provider/supplier has a due date listed, CMS encourages you to submit your revalidation within six months of your due date or when you receive notification from your MAC to revalidate. When either of these occur:

See **REVALIDATION**, page 34



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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.

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About the 'Medicare B Connection'

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

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

Who receives the *Connection*

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

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

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

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

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

Publication format

The *Connection* is arranged into distinct sections.

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



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

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

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

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

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).

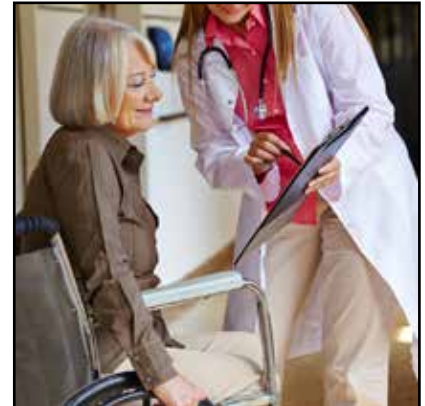
If the provider believes that the service or item may not be covered as medically reasonable and necessary, the patient must be given an acceptable advance notice of Medicare's possible denial of payment if the provider does not want to accept financial responsibility for the service or item. Advance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

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

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

Ambulatory Surgical Center

April 2016 update of the ambulatory surgical center payment system

Provider types affected

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

Provider action needed

Change request (CR) 9557 informs MACs about changes to billing instructions for various payment policies implemented in the April 2016 ASC payment system update. As appropriate, CR 9557 also includes updates to the Healthcare Common Procedure Coding System (HCPCS). Make sure that your billing staffs are aware of these changes that are effective on April 1, 2016.



Background

This article notifies MACs about updates to the ASC payment system, payment rates for separately payable drugs and biologicals, including descriptors for newly created Level II HCPCS codes for drugs and biologicals (ASC DRUG files), and the 2016 ASC payment rates for covered surgical and ancillary services (ASCFS file).

Many ASC payment rates under the ASC payment system are established using payment rate information in the Medicare physician fee schedule (MPFS). The payment files associated with CR 9557 reflect the most recent changes to 2016 MPFS payment.

The changes effective with CR 9557 are as follows:

1. HCPCS code C1822 and C1820

As described in the January 2016 update of the ASC payment system (See article [MM9484](#)), HCPCS code C1822 (Generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system) was added to the ASC list as a new pass-through device effective January 1, 2016.

- HCPCS code C1822 is based on a clinical trial that demonstrated that a high frequency spinal cord stimulator operated at 10,000 Hz and paresthesia-free provides a substantial clinical improvement in pain management versus a low-frequency spinal cord stimulator.
- No changes are being introduced to C1822, but this information is being announced as the descriptor is closely related to C1820.

In the January 2016 ASC update (See article [MM9484](#)), the Centers for Medicare & Medicaid Services (CMS) added the words “non-high-frequency” to the descriptor of C1820. CMS is revising the descriptor for C1820 back

to its original language and deleting “non-high-frequency” from the descriptor such that the descriptor again states the following: *Generator, neurostimulator (implantable), with rechargeable battery and charging system.*

- Neurostimulator generators that are not high frequency are to be reported with C1820.
- Note also that C1820, in the ASC payment system, is a packaged code.
- ASCs do not report packaged codes, but with the change in the descriptor for HCPCS code C1820, it is important to announce the differentiation between HCPCS code C1822 and C1820.

The latest short and long descriptor for HCPCS code C1820 are available at <https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update.html>.

2. Drugs, biologicals, and radiopharmaceuticals

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

For 2016, payment for non-pass-through drugs, biologicals and therapeutic radiopharmaceuticals is made at a single rate of ASP + 6 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In 2016, a single payment of ASP + 6 percent for pass-through drugs, biologicals and radiopharmaceuticals is made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items. Payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. Updated payment rates effective April 1, 2016, are available in the April 2016 ASC Addendum BB at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html.

b. New separately payable 2016 HCPCS codes and dosage descriptors for certain drugs, biologicals, and radiopharmaceuticals, effective April 1, 2016

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For April 2016, nine new HCPCS codes have been created for reporting drugs and biologicals in the ASC setting. Additionally, one existing code, J7503, is now separately payable. These new codes, their descriptors, and payment indicators (PI) are listed in the following table.

New 2016 HCPCS codes and dosage descriptors for certain drugs, biologicals, and radiopharmaceuticals, effective April 1, 2016

HCPCS code	Short descriptor	Long descriptor	ASC PI
C9137	Adynovate Factor VIII recom	Injection, Factor VIII (antihemophilic factor, recombinant) PEGylated, 1 I.U.	K2
C9138	Nuwiq Factor VIII recomb	Injection, Factor VIII (antihemophilic factor, recombinant) (Nuwiq), 1 I.U.	K2
C9461	Choline C 11, diagnostic	Choline C 11, diagnostic, per study dose	K2
C9470		Injection, aripiprazole lauroxil, 1 mg	K2
C9471	Hymovis, 1 mg	Hyaluronan or derivative, Hymovis, for intra-articular injection, 1 mg	K2
C9472	Inj talimogene	Injection, talimogene laherparepvec, 1 million plaque forming units (PFU) K2	
C9473	Injection,	Injection, mepolizumab, 1 mg	K2
C9474	Inj, irinotecan liposome	Injection, irinotecan liposome, 1 mg	K2
C9475	Injection,	Injection, necitumumab, 1 mg	K2
J7503	Tacrol envarsus ex rel oral	Tacrolimus, extended release, envarsus xr, oral, 0.25 mg	K2

c. Revised status indicator for HCPCS codes

Effective April 1, 2016, the PI for HCPCS code J0130 (Injection abciximab, 10 mg) will change from ASC PI=K2 (Drugs and biologicals paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate.) to ASC PI=N1 (Packaged service/item; no separate payment made.).

Effective April 1, 2016, the PI for HCPCS code J0583 (Injection, bivalirudin, 1 mg) will change from ASC PI=K2 (Drugs and biologicals paid separately when provided

integral to a surgical procedure on ASC list; payment based on OPPS rate.) to ASC PI=N1 (Packaged service/item; no separate payment made.).

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

Some drugs and biologicals based on ASP methodology may have payment rates that are corrected retroactively. These retroactive corrections typically occur on a quarterly basis. The list of drugs and biologicals with corrected payments rates will be accessible on the first date of the quarter at <http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/index.html>.

Suppliers who think they may have received an incorrect payment for drugs and biologicals impacted by these corrections may ask their MAC to adjust such previously processed claims.

3. Coverage determinations

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

Additional information

The official instruction, CR 9557, issued to your MAC regarding this change, is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3478CP.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: MM9557

Related Change Request (CR) #: CR 9557

Related CR Release Date: March 11, 2016

Effective Date: April 1, 2016

Related CR Transmittal #: R3478CP

Implementation Date: April 4, 2016

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Chiropractic Services

Documentation requirements for chiropractic services

Provider types affected

This *MLN Matters*® special edition article is intended for chiropractors and other practitioners who submit claims to Medicare administrative contractors (MACs) for chiropractic services provided to Medicare beneficiaries.

This article is part of a series of special edition (SE) articles prepared for chiropractors by CMS in response to the request for educational materials at the September 24, 2015, special open door forum titled: "Improving Documentation of Chiropractic Services". Other articles in the series are SE1602, which details the use of the AT modifier on chiropractic claims and SE1603, which identifies other useful resources to help chiropractors bill Medicare correctly for covered services.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) is providing this special edition article to help clarify the CMS policy regarding Medicare coverage of chiropractic services for Medicare beneficiaries and documentation requirements for the beneficiary's initial visit and subsequent visits to the chiropractor.

Be aware of these policies along with any local coverage determinations (LCDs) for these services in your area that might limit circumstances under which Medicare pays for active/corrective chiropractic services.

Background

In 2014, the comprehensive error testing program (CERT) that measures improper payments in the Medicare fee-for-service (FFS) program reported a 54 percent error rate on claims for chiropractic services. The majority of those errors were due to insufficient documentation or other documentation errors.

Medicare coverage of chiropractic services is specifically limited to treatment by means of manual manipulation (that is, by use of the hands) of the spine to correct a subluxation. The patient must require treatment by means of manual manipulation of the spine to correct a subluxation, and the manipulative services rendered must have a direct therapeutic relationship to the patient's condition and provide reasonable expectation of recovery or improvement of function. Additionally, manual devices (that is, those that are hand-held with the thrust of the force of the device being controlled manually) may be used by chiropractors in performing manual manipulation of the spine. However, no additional payment is available for use of the device, nor does Medicare recognize an extra charge for the device itself.

Chiropractors are limited to billing three *Current Procedural Terminology (CPT)*® codes under Medicare: 98940 (chiropractic manipulative treatment; spinal, one to two regions), 98941 (three to four regions), and 98942 (five regions). When submitting manipulation claims,

chiropractors must use an acute treatment (AT) modifier to identify services that are active/corrective treatment of an acute or chronic subluxation. The AT modifier, when applied appropriately, should indicate expectation of functional improvement, regardless of the chronic nature or redundancy of the problem.



Documentation requirements

The Social Security Act states that "no payment shall be made to any provider of services or other person under this part unless there has been furnished such information as may be necessary in order to determine the amounts due such provider or other person under this part for the period with respect to which the amounts are being paid or for any prior period." See the Social Security Act ([Section 1833\(e\)](#)).

In addition, the *Medicare Benefit Policy Manual* requires that the initial visit and all subsequent visits meet specific documentation requirements. See Chapter 15 ([Section 240.1.2](#)) on the CMS website.

Documentation requirements for the initial visit

The following documentation requirements apply for initial visits whether the subluxation is demonstrated by x-ray or by physical examination:

1. **History:** The history recorded in the patient record should include the following:
 - Chief complaint including the symptoms causing patient to seek treatment;
 - Family history if relevant; and
 - Past medical history (general health, prior illness, injuries, or hospitalizations; medications; surgical history).
2. **Present illness:** Description of the present illness including:
 - Mechanism of trauma;
 - Quality and character of symptoms/problem;
 - Onset, duration, intensity, frequency, location, and radiation of symptoms;
 - Aggravating or relieving factors;
 - Prior interventions, treatments, medications, secondary complaints; and
 - Symptoms causing patient to seek treatment.

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Note: Symptoms must be related to the level of the subluxation that is cited. A statement on a claim that there is “pain” is insufficient. The location of the pain must be described and whether the particular vertebra listed is capable of producing pain in that area.

3. **Physical exam:** Evaluation of musculoskeletal/nervous system through physical examination. To demonstrate a subluxation based on physical examination, two of the following four criteria (one of which must be asymmetry/misalignment or range of motion abnormality) are required and should be documented:
 - **P - pain/tenderness:** The perception of pain and tenderness is evaluated in terms of location, quality, and intensity. Most primary neuromusculoskeletal disorders manifest primarily by a painful response. Pain and tenderness findings may be identified through one or more of the following: observation, percussion, palpation, provocation, etc. Furthermore, pain intensity may be assessed using one or more of the following; visual analog scales, algometers, pain questionnaires, and so forth.
 - **A - asymmetry/misalignment:** Asymmetry/misalignment may be identified on a sectional or segmental level through one or more of the following: observation (such as, posture and heat analysis), static palpation for misalignment of vertebral segments, diagnostic imaging.
 - **R - range of motion abnormality:** Changes in active, passive, and accessory joint movements may result in an increase or a decrease of sectional or segmental mobility. Range of motion abnormalities may be identified through one or more of the following: motion palpation, observation, stress diagnostic imaging, range of motion, measurement(s).
 - **T - tissue tone, texture, and temperature abnormality:** Changes in the characteristics of contiguous and associated soft tissue including skin, fascia, muscle, and ligament may be identified through one or more of the following procedures: observation, palpation, use of instrumentation, test of length and strength.

Note: The P.A.R.T. (pain/tenderness; asymmetry/misalignment; range of motion abnormality; and tissue tone, texture, and temperature abnormality) evaluation process is recommended as the examination alternative to the previously mandated demonstration of subluxation by X-ray/MRI/CT for services beginning January 1, 2000. The acronym P.A.R.T. identifies diagnostic criteria for spinal dysfunction (subluxation).

4. **Diagnosis:** The primary diagnosis must be subluxation, including the level of subluxation,

either so stated or identified by a term descriptive of subluxation. Such terms may refer either to the condition of the spinal joint involved or to the direction of position assumed by the particular bone named. The precise level of the subluxation must be specified by the chiropractor to substantiate a claim for manipulation of the spine. This designation is made in relation to the part of the spine in which the subluxation is identified as shown in the following table:

Area of spine	Names of vertebrae	Number of vertebrae	Short form or other name	Subluxation ICD-10 code
Neck	Occiput Cervical Atlas Axis	7	Occ, CO C1-C7 C1 C2	M99.00 M99.01
Back	Dorsal or Thoracic Costovertebral	12	D1- D12 T1-T12 R1- R12 R1- R12	M99.02
Low back	Lumbar	5	L1-L5	M99.03
Pelvis	Ilii, R and L (I, Si)		I, Si	M99.05
Sacral	Sacrum, coccyx		S, SC	M99.04

In addition to the vertebrae and pelvic bones listed, the Ilii (R and L) are included with the sacrum as an area where a condition may occur which would be appropriate for chiropractic manipulative treatment.

There are two ways in which the level of the subluxation may be specified in patient’s record.

- The exact bones may be listed, for example: C 5, 6;
- The area may suffice if it implies only certain bones such as: occipito-atlantal (occiput and C1 (atlas)), lumbo-sacral (L5 and Sacrum) sacro-iliac sacrum and ilium).

Following are some common examples of acceptable descriptive terms for the nature of the abnormalities:

- Off-centered;
- Misalignment;
- Malpositioning;
- Spacing - abnormal, altered, decreased, increased;
- Incomplete dislocation;
- Rotation;
- Listhesis - antero, postero, retro, lateral, spondylo; and

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- Motion - limited, lost, restricted, flexion, extension, hypermobility, hypomotility, aberrant.

Other terms may be used. If they are understood clearly to refer to bone or joint space or position (or motion) changes of vertebral elements, they are acceptable.

X-rays

As of January 1, 2000, an X-ray is not required by Medicare to demonstrate the subluxation. However, an x-ray may be used for this purpose if you so choose.

The x-ray must have been taken reasonably close to (within 12 months prior or three months following) the beginning of treatment. In certain cases of chronic subluxation (for example, scoliosis), an older X-ray may be accepted if the beneficiary's health record indicates the condition has existed longer than 12 months and there is a reasonable basis for concluding that the condition is permanent.

A previous CT scan and/or MRI are acceptable evidence if a subluxation of the spine is demonstrated.

5. Treatment plan: The treatment plan should always include the following:

- Recommended level of care (duration and frequency of visits);
- Specific treatment goals; and
- Objective measures to evaluate treatment effectiveness.

Date of the initial treatment

The patient's medical record.

- Validate all of the information on the face of the claim, including the patient's reported diagnosis(s), physician work (CPT® code), and modifiers.
- Verify that all Medicare benefit and medical necessity requirements were met.

Documentation requirements for subsequent visits

The following documentation requirements apply whether the subluxation is demonstrated by X-ray or by physical examination:

1. History

- Review of chief complaint;
- Changes since last visit; and
- Systems review if relevant.

2. Physical examination

- Examination of area of spine involved in diagnosis;
- Assessment of change in patient condition since last visit;
- Evaluation of treatment effectiveness.

3. Documentation of treatment given on day of visit.

Necessity for treatment of acute and chronic subluxation

The patient must have a significant health problem in the form of a neuromusculoskeletal condition necessitating treatment, and the manipulative services rendered must have a direct therapeutic relationship to the patient's condition and provide reasonable expectation of recovery or improvement of function.

The patient must have a subluxation of the spine as demonstrated by X-ray or physical examination, as described below.

Most spinal joint problems fall into the following categories:

- **Acute subluxation** – a patient's condition is considered acute when the patient is being treated for a new injury, identified by X-ray or physical examination as specified above. The result of chiropractic manipulation is expected to be an improvement in, or arrest of progression, of the patient's condition.
- **Chronic subluxation** – a patient's condition is considered chronic when it is not expected to significantly improve or be resolved with further treatment as is the case with an acute condition); however, the continued therapy can be expected to result in some functional improvement. Once the clinical status has remained stable for a given condition, without expectation of additional objective clinical improvements, further manipulative treatment is considered maintenance therapy and is not covered.

You must place the HCPCS (healthcare common procedure coding system) modifier AT on a claim when providing active/corrective treatment to treat acute or chronic subluxation.

However, the presence of the HCPCS modifier AT may not in all instances indicate that the service is reasonable and necessary.

ICD-10 codes that support medical necessity for chiropractor services

The chiropractic local coverage determinations (LCDs) for MACs include ICD-10 coding Information for ICD-10 codes that support the medical necessity for chiropractor services. There may be additional documentation information in your LCD. There are links to the chiropractic LCDs in the *Additional information* section of this article.

The **group 1 (primary) codes** are the only covered ICD-10-CM codes that support medical necessity for chiropractor services.

- Primary: ICD-10-CM codes (names of vertebrae)
- The precise level of subluxation must be listed as the primary diagnosis.

The groups 2, 3, and 4 ICD-10-CM codes support the medical necessity for diagnoses and involve short, moderate, and long term treatment:

- **Group 2 codes:** Category I - ICD-10-CM diagnosis

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(diagnoses that generally require **short-term treatment**)

- **Group 3 codes:** Category II - ICD-10-CM diagnosis (diagnoses that generally require **moderate-term treatment**)
- **Group 4 codes:** Category III - ICD-10-CM diagnosis (diagnoses that may require **long-term treatment**)

ICD-10 codes that **do not** support medical necessity are **all** ICD-10-CM codes **not** listed in LCDs under ICD-10-CM codes that support medical necessity.

Additional information

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

To review [MM3449](#), Revised Requirements for Chiropractic

Billing of Active/Corrective Treatment and Maintenance Therapy, Full Replacement of CR 3063 go to: [MM3449](#).

Other articles in this series on chiropractic services are [SE1602](#), which discusses the use of the AT modifier and [SE1603](#), which lists a wide array of other materials to assist chiropractors in delivering covered services to Medicare beneficiaries and correctly billing for those services.

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Use of the AT modifier for chiropractic billing

Provider types affected

This special edition (SE) *MLN Matters*® article is intended for chiropractors and other practitioners who submit claims to Medicare administrative contractors (MACs) for chiropractic services provided to Medicare beneficiaries.

This article is part of a series of special edition (SE) articles prepared for chiropractors by the Centers for Medicare & Medicaid Services (CMS) in response to the request for educational materials at the September 24, 2015, special open door forum titled: Improving Documentation of Chiropractic Services.

Provider action needed

The active treatment (AT) modifier was developed to clearly define the difference between active treatment and maintenance treatment. Medicare pays only for active/corrective treatment to correct acute or chronic subluxation. Medicare does not pay for maintenance therapy. Claims should include a primary diagnosis of subluxation and a secondary diagnosis that reflects the patient's neuro musculoskeletal condition. The patient's medical record should support the services submitted. Related *MLN Matters*® [SE1601](#) discusses those medical record documentation requirements.

Be aware of these policies along with any local coverage determinations (LCDs) for these services in your area that might limit circumstances under which active/corrective chiropractic services are paid.

Background

In 2014, the comprehensive error testing program (CERT)

that measures improper payments in the Medicare fee-for-service program reported a 54 percent error rate for chiropractic services. The majority of those errors were due to insufficient documentation/documentation errors. Year after year these error rates appear. CMS is providing an explanation of the AT modifier to assist providers with correctly documenting claims for chiropractic services provided to Medicare beneficiaries.

The active treatment (AT) modifier defines the difference between active treatment and maintenance treatment. Effective October 1, 2004, the AT modifier is required under Medicare billing to receive reimbursement for CPT® codes 98940-98942. For Medicare purposes, the AT modifier is used only when chiropractors bill for active/corrective treatment (acute and chronic care). The policy requires the following:

1. Every chiropractic claim for CPT® 98940/98941/98942, with a date of service on or after October 1, 2004, should include the AT modifier if active/corrective treatment is being performed; and
2. The AT modifier should not be used if maintenance therapy is being performed. MACs deny chiropractic claims for CPT® 98940/98941/98942, with a date of service on or after October 1, 2004, that does not contain the AT modifier.

The following categories help determine coverage of treatment. (See the [Necessity for Treatment](#), Chapter 15, Section 240.1.3, of the *Medicare Benefit Policy Manual* (pages 226-227)).

1. **Acute subluxation:** A patient's condition is considered acute when the patient is being treated for a new injury (identified by X-ray or physical examination).

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(See SE1601 for details of the X-ray and examination requirements.) The result of chiropractic manipulation is expected to be **an improvement in, or arrest of progression of**, the patient's condition.

- 2. Chronic subluxation:** A patient's condition is considered chronic when it is not expected to significantly improve or be resolved with further treatment (as is the case with an acute condition); however, the continued therapy can be expected to result in some **functional improvement**. Once the clinical status has remained stable for a given condition, without expectation of additional objective clinical improvements, further manipulative treatment is considered maintenance therapy and is not covered.

Both of the above scenarios are covered by CMS as long as there is active treatment which is well documented and improvement is expected.

Maintenance: Maintenance therapy includes services that seek to prevent disease, promote health and prolong and enhance the quality of life, or maintain or prevent deterioration of a chronic condition. When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy. The AT modifier must **not** be placed on the claim when maintenance therapy has been provided.

Chiropractors should consider obtaining an advance beneficiary notice (ABN) from beneficiaries in the event of a denial of a claim. Information about the ABN, including downloadable forms is available at <https://www.cms.gov/MEDICARE/medicare-general-information/bni/abn.html>. Also, see the *Medicare Claims Processing Manual, Chapter 23 Section 20.9.1.1*, pages 49 and 50, for important information about the use of an appropriate modifier on your claims with regard to the ABN.

Be aware that once the provider cannot determine there is any improvement, treatment becomes maintenance and is no longer covered by Medicare.

Key points

For Medicare purposes, a chiropractor must place an AT modifier on a claim when providing active/corrective treatment to treat acute or chronic subluxation. However, the presence of the AT modifier may not in all instances indicate that the service is reasonable and necessary. As always, MACs may deny if appropriate after medical review determines that the medical record does not support active/corrective treatment.

Additional information

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

To review MM3449, Revised Requirements for Chiropractic Billing of Active/Corrective Treatment and Maintenance Therapy, Full Replacement of CR 3063 go to: [MM3449](#).

Other articles in this series on chiropractic services are [SE1601](#), which discusses Medicare's medical record documentation requirements for chiropractic services and [SE1603](#), which lists a wide array of other materials to assist chiropractors in delivering covered services to Medicare beneficiaries and correctly billing for those services.

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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.

Educational resources to assist chiropractors with Medicare billing

Provider types affected

This special edition (SE) *MLN Matters*[®] article is intended for chiropractors submitting claims to Medicare administrative contractors (MACs) for chiropractic services provided to Medicare beneficiaries.

This article is part of a series of SE articles prepared for chiropractors by CMS in response to the request for educational materials at the September 24, 2015, special open door forum titled: *Improving Documentation of Chiropractic Services*.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) is providing this article in order to provide education for chiropractic billers on accessing the correct resources for proper billing. This article is intended to be a comprehensive resource for chiropractic documentation and billing.

Be aware of these policies along with any local coverage determinations (LCDs) for these services in your area that might limit circumstances under which active/corrective chiropractic services are paid.

Background

In 2014, the comprehensive error testing program (CERT) that measures improper payments in the Medicare fee-for-service program reported a 54 percent error rate for chiropractic services. The majority of those errors were due to insufficient documentation/documentation errors. This article provides a detailed list of informational/educational resources that can help chiropractors avoid these errors. Those resources are as follows:

Enrollment information

The *Medicare General Information, Eligibility, and Entitlement Manual*, Chapter 5, includes [Section 70.6](#), "Chiropractors." This section outlines the definition of a chiropractor, licensure and authorization to practice, and minimum standards.

The *Medicare Benefit Policy Manual*, Chapter 15, "Covered Medical and Other Health Services," includes [Section 40.4](#), "Definition of Physician/Practitioner." This section explains that the opt-out law does not define physician to include a chiropractor; therefore, a chiropractor may not opt-out of Medicare and provide services under a private contract.

The *Medicare Program Integrity Manual*, Chapter 15 "Medicare Enrollment," includes [Section 15.4.4.11](#), "Physicians." This section explains that a physician must be legally authorized to practice medicine by the state in which he/she performs such services in order to enroll in the Medicare program and to retain Medicare billing privileges. A chiropractor who meets Medicare qualifications may enroll in the Medicare program.

Coverage, documentation, and billing

The other articles in this series of articles on chiropractic services are [SE1601](#), which discusses Medicare's medical record documentation requirements for chiropractic services, and [SE1602](#), which discusses the importance of using the AT modifier on claims for chiropractic services.

MLN Matters[®] article [MM3449](#), titled "Revised Requirements for Chiropractic Billing of Active/Corrective Treatment and Maintenance Therapy, Full Replacement of CR 3063".

The *Medicare Benefit Policy Manual*, [Chapter 15](#), "Covered Medical and Other Health Services," includes the following sections explaining coverage for a chiropractor's services:

- 30.5: Chiropractor's Services
- 220.1.3: Certification and Recertification of Need for Treatment and Therapy Plans of Care
- 240: Chiropractic Services – General; This section establishes that payment for chiropractic services is based on the Medicare Physician Fee Schedule (MPFS) and that payment is made to the beneficiary or, on assignment, to the chiropractor
- 240.1.1: Manual Manipulation
- 240.1.2: Subluxation May Be Demonstrated by X-Ray or Physician's Exam
- 240.1.3: Necessity for Treatment
- 240.1.4: Location of Subluxation
- 240.1.5: Treatment Parameters

The chiropractic local coverage determinations (LCDs) for MACs include ICD-10 coding information for ICD-10 codes that support the medical necessity for chiropractor services. Each contractor has an LCD for chiropractors. There may be additional documentation information in your LCD. There are links to the chiropractic LCDs in the additional information section of this article. Some of those LCDs are as follows:

- National Government Services ([LCD L33613](#))
- First Coast Options, Inc ([LCD L33840](#))
- CGS Administrators, LLC ([LCD L33982](#))
- Noridian Healthcare Solutions, LLC (Jurisdiction F) ([LCD L34009](#))
- Noridian Healthcare Solutions, LLC (Jurisdiction E) ([LCD 34242](#))
- Wisconsin Physicians Service Insurance Corporation ([LCD L34585](#))
- Novitas Solutions, Inc ([LCD L35424](#))

The fact sheet [Misinformation on Chiropractic Services](#) is designed to provide education on Medicare regulations

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and policies on chiropractic services to Medicare providers. It includes information on the documentation needed to support a claim submitted to Medicare for medical services.

The *MLN Matters*® article – SE1101 Revised [Overview of Medicare Policy Regarding Chiropractic Services](#) highlights Medicare policy regarding coverage of chiropractic services for Medicare beneficiaries.

The *MLN Matters*® article – SE1305 Revised [Full Implementation of Edits on the Ordering/Referring Providers in Medicare Part B, DME, and Part A Home Health Agency \(HHA\) Claims \(Change Requests 6417, 6421, 6696, and 6856\)](#) explains that chiropractors are not eligible to order or refer supplies or services.

The *Medicare Claims Processing Manual*, [Chapter 1](#) “General Billing Requirements” includes the following sections which apply to billing for a chiropractor’s services:

- 30.3.12: Carrier Annual Participation Program;
- 30.3.12.1: Annual Open Participation Enrollment Process;
- 30.3.12.1.2: Annual Medicare Physician Fee Schedule File Information; and
- 80.3.2.1.3: A/B MAC (B) Specific Requirements for Certain Specialties/Services.

The *Medicare Claims Processing Manual*, Chapter 12 “Physicians/Nonphysician Practitioners,” includes [Section 220](#), “Chiropractic Services.” This section explains the documentation requirements when billing for a chiropractor’s services. Also the claim processing edits related to payment for a chiropractor’s services are explained.

The *Medicare Claims Processing Manual*, Chapter 26 “Completing and Processing Form CMS-1500 Data Set,” includes [Section 10.4](#), “Items 14-33 – Provider of Service or Supplier Information.” This section includes specific instructions for chiropractic services for items 14, 17, and 19.

The *NCCI Policy Manual for Medicare Services* under the “Downloads” section. Chapter XI, “Medicine, Evaluation and Management Services (CPT® codes 90000-99999),” includes information on chiropractic manipulative treatment.

More resources: A chiropractor is eligible to receive incentive payments under the physician quality reporting system (PQRS), electronic prescribing (eRx) incentive program, and electronic health record (EHR) incentive

program. Information on reporting these measures is available in the physician and other enrolled health care professionals pathway.

The *Medicare Claims Processing Manual*, Chapter 23 “Fee Schedule Administration and Coding Requirements,” includes [Section 30](#), “Services Paid Under the Medicare Physician’s Fee Schedule.” This section explains that a chiropractor is paid under the MPFS. The booklet [MLN Guided Pathways - Provider Specific Medicare Resources, pages 25-28](#), contains many resources useful for chiropractic billing.

Advance beneficiary notice (ABN) information

The *Medicare Benefit Policy Manual*, Chapter 15 “Covered Medical and Other Health Services,” includes reference to Advance Beneficiary Notices (ABNs) in [Section 240.1.3](#), “Necessity for Treatment.”

The *Medicare Claims Processing Manual*, Chapter 23 “Fee Schedule Administration and Coding Requirements,” includes [Section 20.9.1.1](#), “Instructions for Codes With Modifiers (Carriers Only).” This section outlines the modifiers that may be used when a chiropractor notifies a beneficiary the item or service may not be covered.

The *Medicare Claims Processing Manual*, [Chapter 30](#), “Financial Liability Protections,” includes detailed instructions on completing the ABN and use of the GA modifier.

Information about the ABN, including downloadable forms is available at <https://www.cms.gov/MEDICARE/medicare-general-information/bni/abn.html>.

Additional information

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

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Dental Services

Billing non-covered hospital outpatient dental services

The Medicare program's coverage of dental services is limited. Medicare will pay for dental services if they are an integral part of a covered service or for extractions done in preparation for radiation treatment for neoplastic diseases involving the jaw. Otherwise, items and services in connection with the care, treatment, filling, removal or replacement of teeth or structures supporting the teeth are not covered.

First Coast understands that providers may need to bill Medicare for the non-covered dental services to receive a denial in order to then bill a secondary insurance for the patient. Please make sure you are properly billing for these non-covered dental services to ensure the claims are processed correctly and inaccurate payments are not made.

Billing Part A and B

When billing for services that are statutorily excluded or do

not meet the definition of any Medicare benefit, you may use the GY modifier. The GY modifier is appended to each line item on the claim that meets the definition.

Specifically for Part A only, these services should be listed on the claim itself as non-covered. The condition code 21 may also be used on the claim to obtain a denial from Medicare for submission to a subsequent insurer. These claims are referred to as no-payment claims.

If you have any additional questions about the coverage or non-coverage of dental services, please review the resources listed below.

Sources: The Centers for Medicare & Medicaid Services' (CMS') [Medicare Dental Coverage Web page](#); Internet-only Manuals (IOMs) Pub. 100-02, [Chapter 1](#), [Chapter 15](#), & [Chapter 16](#); Pub. 100-04, [Chapter 1](#)

Durable Medical Equipment

April update for 2016 DMEPOS fee schedule

Provider types affected

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

What you need to know

Change request (CR) 9554 provides the April quarterly update for the Medicare DMEPOS fee schedule. The instructions include information, when necessary, to implement fee schedule amounts for new codes and correct any fee schedule amounts for existing codes. Because there are no updates from the previous quarter (January through March 2016), an April update to the 2016 DMEPOS and parenteral and enteral nutrition (PEN) fee schedule files is not scheduled for release. However, an April 2016 DMEPOS rural ZIP code file containing quarter two, 2016 rural ZIP code changes is being provided to the MACs.

The [April 2016 DMEPOS rural ZIP code public use file \(PUF\)](#), containing the rural ZIP codes effective for Quarter 2, 2016, will be available for state Medicaid agencies, managed care organizations, and other interested parties

shortly after the release of the above file.

Background

The Centers for Medicare & Medicaid Services (CMS) updates the DMEPOS fee schedule on an annual basis in accordance with statute and regulations. The update process for the DMEPOS fee schedule is located in the *Medicare Claims Processing Manual*, [Chapter 23](#), Section 60.

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

Additionally, Section 1834(a)(1)(F)(ii) of the Act mandates adjustments to the fee schedule amounts for certain items furnished on or after January 1, 2016, in areas that are not competitive bid areas,

based on information from competitive bidding programs (CBPs) for DME. Section 1842(s)(3)(B) provides authority for making adjustments to the fee schedule amount for enteral nutrients, equipment and supplies (enteral nutrition) based on information from CBPs. CMS issued a final rule



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November 6, 2014 (79 FR 66223), on the methodologies for adjusting DMEPOS fee schedule amounts using information from CBPs.

CMS issued a final rule November 6, 2014 (79 FR 66223), on the methodologies for adjusting DMEPOS fee schedule amounts using information from CBPs. The CBP product categories, HCPCS codes and single payment amounts (SPAs) included in each round of the CBP are available on the [competitive bidding implementation contractor \(CBIC\) website](#).

The DMEPOS and PEN fee schedule files contain HCPCS codes that are subject to the adjusted payment amount methodologies discussed above as well as codes that are not subject to the fee schedule CBP adjustments. To apply the adjusted rural payment rule for areas within the contiguous United States, the DMEPOS and PEN fee schedule files have been updated, effective January 1, 2016, to include rural payment amounts for certain HCPCS codes.

Beginning January 1, 2016, the ZIP code associated with the address used for pricing a DMEPOS claim determines the rural fee schedule payment applicability for codes with rural and non-rural adjusted fee schedule amounts based on information from the competitive bidding program. ZIP codes for non-continental metropolitan statistical areas (MSA) are not included in the DMEPOS rural ZIP code file. The DMEPOS rural ZIP code file is updated on a quarterly

basis as necessary. Program instructions on these changes are available in *MLN Matters*® 9431 ([MM9431](#)) titled “Calendar Year (CY) 2016 Update for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule” based on Transmittal 3416, change request (CR) 9431, dated November 23, 2015.

Additional information

The official instruction, CR 9554, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3472CP.pdf>. If you have any questions, please contact your MAC at their toll-free number. That number is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html> under - How Does It Work.

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End-Stage Renal Disease

Monthly capitation payment for physician services furnished to beneficiaries

First Coast Service Options Inc. (First Coast) recently identified the billing of both the monthly capitation payment (MCP) and the daily per diem payment physician service. Providers are reminded that the below guidelines are to be applied when billing monthly and daily physician services.

Physicians and practitioners managing center based patients on dialysis are paid a monthly rate for most outpatient dialysis-related physician services furnished to a Medicare end-stage renal disease (ESRD) beneficiary. The payment amount varies based on the number of visits provided within each month and the age of the ESRD beneficiary. Under this methodology, separate codes are billed for providing one visit per month, two to three visits per month and four or more visits per month. The lowest payment amount applies when a physician provides one visit per month; a higher payment is provided for two to three visits per month. To receive the highest payment amount, a physician or practitioner would have to provide at least four ESRD-related visits per month. The MCP is reported once per month for services performed in an outpatient setting that are related to the patients' ESRD.

The physician or practitioner who provides the complete assessment, establishes the patient's plan of care, and provides the ongoing management is the physician or practitioner who submits the bill for the monthly service. Visits must be furnished face-to-face by a physician, clinical nurse specialist, nurse practitioner, or physician's assistant.

The MCP physician or practitioner may use other physicians or qualified non-physician practitioners to provide some of the visits during the month. The MCP physician or practitioner does not have to be present when these other physicians or practitioners provide visits. In this instance, the rules are consistent with the requirements for hospital split/shared evaluation and management visits. The non-MCP physician or practitioner must be a partner, an employee of the same group practice, or an employee of the MCP physician or practitioner. For example, the physician or practitioner furnishing visits under the MCP may be either a W-2 employee or 1099 independent contractor. When another physician is used to furnish some of the visits during the month, the physician

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who provides the complete assessment, establishes the patient's plan of care, and provides the ongoing management should bill for the MCP service. If the non-physician practitioner is the practitioner who performs the complete assessment and establishes the plan of care, then the MCP service should be billed under the PIN of the clinical nurse specialist, nurse practitioner, or physician assistant.

Physicians and practitioners may receive payment for managing patients on dialysis for less than a full month of care in specific circumstances. Per diem ESRD services should be coded using the ESRD related services (less than full month), per day health care procedure system (HCPCS) codes for ESRD-related services in the situations described below:

- Home dialysis patients (less than full month);

- Transient patients – patients traveling away from home (less than full month);
- Partial month where there are one or more face-to-face visits without a complete assessment of the patient and the patient was either hospitalized before a complete assessment was furnished, dialysis stopped due to death, or the patient had a transplant.
- Patients who have a permanent change in their MCP physician during the month.

The ESRD-related services (less than full month), per day HCPCS codes should only be used for the circumstances described above. The per diem codes may not be used for a full month when a complete monthly assessment is not furnished.

Complete guidelines for billing of ESRD physician service can be found at Internet-only manual (IOM) guidelines 100-04 [Chapter 8](#).

Evaluation & Management

Prepayment review for CPT® codes 99232 and 99233

The top services for First Coast Service Options Inc. (First Coast) with payment errors identified by Part B comprehensive error rate testing (CERT) continue to be evaluation and management services. First Coast conducted a data analysis for *Current Procedural Terminology*® (CPT®) codes 99232 and 99233 (subsequent hospital care). The data indicates specialties internal medicine and cardiology are the primary contributors to the CERT error rate for subsequent hospital care services.

Documentation requirements

The *American Medical Association (AMA) CPT®* manual defines code 99232 as follows:

Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:

- An expanded problem focused interval history ;
- An expanded problem focused examination;
- Medical decision making of moderate complexity

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family needs.

Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 25 minutes are spent at the bedside and on the patient's hospital floor or unit.

The AMA CPT® manual defines code 99233 as follows:

Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components:

- A detailed interval history ;

- A detailed examination;
- Medical decision making of high complexity

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family needs.

Usually, the patient is unstable or has developed a significant new problem. Typically, 35 minutes are spent at the bedside and on the patient's hospital floor or unit.

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

- First Coast's [Evaluation and Management \(E/M\) services page](#), offering links to tools, FAQs, online learning, and additional resources.
- CMS [Internet-only manual \(IOM\) guidelines](#) addressing multiple types and settings pertaining to E/M services.

First Coast actions

In response to the high percentage of error rates and the continual risks of improper payments associated with subsequent hospital care billed by internal medicine and cardiology specialists, First Coast will be implementing a prepayment medical review audit for CPT® codes 99232 and 99233 billed by cardiology; and CPT® codes 99232 billed by internal medicine specialty. The new audit will be based on a threshold of claims submitted for payment by cardiology and internal medicine specialties in an effort to reduce the error rates for these hospital services. The audit will be implemented for claims processed on or after **March 15, 2016**.

Prepayment review for CPT® codes 99222 and 99223

The top services for First Coast Service Options Inc. (First Coast) with payment errors identified by Part B comprehensive error rate testing (CERT) continue to be evaluation and management services. First Coast conducted a data analysis for *Current Procedural Terminology*® (CPT®) codes 99222 and 99223 (initial hospital care). The data indicates specialties internal medicine and cardiology are the primary contributors to the CERT error rate for subsequent hospital care services.

Documentation requirements

The American Medical Association (AMA) CPT® manual defines code 99222 as follows:

Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components:

- A comprehensive history ;
- A comprehensive examination;
- Medical decision making of moderate complexity

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family needs.

Usually, the problem(s) requiring admission are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit.

The AMA CPT® manual defines code 99223 as follows:

Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components:

- A comprehensive history ;
- A comprehensive examination;
- Medical decision making of high complexity

Counseling and/or coordination of care with other



physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family needs.

Usually, the problem(s) requiring admission are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit.

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

First Coast's [Evaluation and Management \(E/M\) services page](#), offering links to tools, FAQs, online learning, and additional resources.

CMS [Internet-only manual \(IOM\) guidelines](#) addressing multiple types and settings pertaining to E/M services.

First Coast actions

In response to the high percentage of error rates and the continual risks of improper payments associated with initial hospital care billed, First Coast will be implementing a prepayment medical review audit for CPT® codes 99222 by all specialties; and CPT® code 99223 billed cardiology specialty. The new audit will be based on a threshold of claims submitted for payment by the specialties in an effort to reduce the error rates for these hospital services. The audit will be implemented for claims processed on or after April 7, 2016.

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.

Prepayment of evaluation and management code 99291

Recent data analysis pertaining to critical care services has identified that First Coast Service Options (First Coast) is at a high risk for claim payment error. First Coast continues to have a high comprehensive error rate testing (CERT) error rate related to utilization of CPT® code 99291. Errors include incorrect coding and/or insufficient documentation to support code 99291, which is defined in the *Current Procedural Terminology (CPT®)* code 99291 manual as follows:

- Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes.

As outlined in the Centers for Medicare & Medicaid Services (CMS) *Medicare Claims Processing Manual*, Publication 100-04, Chapter 12, and Section 30.6.12:

- Critical care involves high complexity decision making to assess, manipulate, and support vital system function(s) to treat single or multiple vital organ system failure and/or to prevent further life threatening deterioration of the patient's condition.
- Examples of vital organ system failure include, but are not limited to: central nervous system failure, circulatory failure, shock, renal, hepatic, metabolic, and/or respiratory failure. Although critical care typically requires interpretation of multiple physiologic parameters and/or application of advanced technology(s), critical care may be provided in life threatening situations when these elements are not present.

Providing medical care to a critically ill, injured, or post-operative patient qualifies as a critical care service only if both the illness or injury and the treatment being provided meet the above requirements.

Critical care services must be medically necessary and reasonable. Services provided that do not meet the requirements for critical care services or services provided for a patient who is not critically ill or injured in accordance with the above definitions and criteria but who happens to be in a critical care, intensive care, or other specialized care unit should be reported using another appropriate E/M code (e.g., subsequent hospital care, CPT® codes 99231-99233).

Critical care is usually, but not always, given in a critical care area such as a coronary care unit, intensive care unit, respiratory care unit, or the emergency department. However, payment may be made for critical care services



provided in any location as long as the care provided meets the definition of critical care.

Critical care is a time-based service, and for each date and encounter entry, the physician's progress note(s) shall document the total time that critical care services were provided. The duration of critical care services to be reported is the time the physician spent evaluating, providing care and managing the critically ill or injured patient's care. That time must be spent at the immediate bedside or elsewhere on the floor or unit so long as the physician is immediately available to the patient. For any given period of time spent providing critical care services, the physician must devote his or her full attention to the patient and, therefore, cannot provide services to any other patient during the same period of time.

The CPT® critical care codes 99291 and 99292 are used to report the total duration of time spent by a physician providing critical care services to a critically ill or critically injured patient, even if the time spent by the physician on that date is not continuous. Non-continuous time for medically necessary critical care services may be aggregated. Reporting CPT® code 99291 is a prerequisite to reporting CPT® code 99292. Physicians of the same specialty within the same group practice bill and are paid as though they were a single physician.

First Coast response

In response to continued CERT errors and risk of improper payments First Coast will implement a prepayment threshold edit for CPT® code 99291 claims submitted on or after **March 15, 2016**, that will apply to all providers within First Coast's Florida jurisdiction.

Widespread probe notification for CPT® code 99214

First Coast Service Options Inc. (First Coast) will conduct a widespread probe (WSP) in response to an aberrant billing pattern identified for *Current Procedural Terminology (CPT®)* code 99214 (Office/outpatient visit established). Provider types affected include internal medicine, family practice and cardiologist. Comprehensive error rate

testing (CERT) reviews indicated the errors were based on insufficient documentation, medically unnecessary services, and services incorrectly coded.

First Coast will complete a WSP for dates of service August 1, 2015, to January 31, 2016, to validate the documentation supports the medical necessity and the level of care billed.

Prepayment of evaluation and management codes 99204 and 99205

Data analysis was conducted recently due to the high comprehensive error rate testing (CERT) error rate for evaluation and management service pertaining to *Current Procedural Terminology (CPT®)* codes 99204 (Office/outpatient visit new) and 99205 (Office/outpatient visit new). CERT reviews indicated the errors were based on insufficient documentation and services coded incorrectly.

Documentation requirements

The American Medical Association (AMA) *CPT®* manual defines code 99204 as follows:

Office or other outpatient visit for the evaluation and management (E/M) of a new patient, which requires these three key components:

- A comprehensive history
- A comprehensive examination
- Medical decision making of moderate complexity.

Usually the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.

The American Medical Association (AMA) *CPT®* manual defines code 99205 as follows:

Office or other outpatient visit for the evaluation and management (E/M) of a new patient, which requires three key components:

- A comprehensive history

Prepayment of evaluation and management code 99215

First Coast Service Options Inc. (First Coast) recently conducted data analysis due to the high comprehensive error rate testing (CERT) error rate for evaluation and management service pertaining *Current Procedural Terminology (CPT®)* code 99215 (Office/outpatient visit established). CERT reviews indicated the errors were based on insufficient documentation, medically unnecessary services and services incorrectly coded.

Documentation requirements

The American Medical Association (AMA) *CPT®* manual defines code 99215 as follows:

Office or other outpatient visit for the evaluation and management (E/M) of an established patient, which requires at least two of these three key components:

- A comprehensive history
- A comprehensive examination
- Medical decision making of high complexity.

Usually the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.

- A comprehensive examination
- Medical decision making of high complexity.

Usually the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.

Furthermore, claims submitted with E/M code 99204 and 99205 must be supported by documentation indicating the medical necessity for this level of service.

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

- First Coast's [Evaluation and Management \(E/M\) services page](#), offering links to tools, frequently asked questions (FAQs), online learning, and additional resources.
- CMS [Internet-only manual \(IOM\) guidelines](#) addressing multiple types and settings pertaining to E/M services.

In addition, in recent years First Coast has offered multiple webcasts addressing E/M issues, which have been recorded and can be accessed at [First Coast University](#). E/M will continue to be a point of focus in upcoming months -- please check our events calendar to be aware of E/M education being offered.

First Coast will implement a prepay threshold for prepayment review of CPT® codes 99204 and 99205, which will be applied to claims processed on or after April 7, 2016.

Furthermore, claims submitted with E/M code 99215 must be supported by documentation indicating the medical necessity for this level of service.

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

- First Coast's [Evaluation and Management \(E/M\) services page](#), offering links to tools, frequently asked questions (FAQs), online learning, and additional resources.
- CMS [Internet-only manual \(IOM\) guidelines](#) file addressing multiple types and settings pertaining to E/M services.

In addition, in recent years First Coast has offered multiple webcasts addressing E/M issues, which have been recorded and can be accessed at [First Coast University](#). E/M will continue to be a point of focus in upcoming months – please check our events calendar to be aware of E/M education being offered.

First Coast will implement additional prepay threshold for prepayment review of CPT® code 99215 will be applied to claims processed on or after **March 15, 2016**.

Medicare Physician Fee Schedule

April update to the 2016 Medicare physician fee schedule database

Provider types affected

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

Provider action needed

Change request (CR) 9531 amends payment files that were issued to your MAC based upon the 2016 Medicare physician fee schedule (MPFS) final rule published in the *Federal Register* November 16, 2015. These payment files are to be effective for services furnished between January 1, 2016, and December 31, 2016. Please make sure your billing staff is aware of these changes.

Background

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

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

The key changes for the April update that are effective as of January 1, 2016 are as follows:

- CPT[®]/HCPCS code G0464 is assigned a procedure status of I;
- Code 10030 is assigned global period days of 000;
- Code 77014 is assigned a PC/TC Indicator of 1; and
- Code 80055 is assigned a procedure status of X.

Other changes that are effective for services performed on or after April 1, 2016, are as follows:

- Code G9678 is assigned a procedure status of X;
- G9481 (Remote E/M new pt 10mins) has a PE RVU = 0, all other MPFS indicators/values = code 99201;
- G9482 (Remote E/M new pt 20mins) has a PE RVU = 0, all other MPFS indicators/values = 99202;
- G9483 (Remote E/M new pt 30mins) has a PE RVU = 0, all other MPFS indicators/values = 99203;
- G9484 (Remote E/M new pt 45mins) has a PE RVU = 0, all other MPFS indicators/values = 99204;
- G9485 (Remote E/M new pt 60mins) has a PE RVU = 0, all other MPFS indicators/values = 99205;
- G9486 (Remote E/M est. pt 10mins) has a PE RVU = 0, all other MPFS indicators/values = 99212;



- G9487 (Remote E/M est. pt 15mins) has a PE RVU = 0, all other MPFS indicators/values = 99213;
- G9488 (Remote E/M est. pt 25mins) has a PE RVU = 0, all other MPFS indicators/values = 99214;
- G9489 (Remote E/M est. pt 40mins) has a PE RVU = 0, all other MPFS indicators/values = 99215; and
- G9490 (Joint replac mod home visit) with all MPFS indicators & RVUs = those of G9187.

Codes G9481-G9490 are new and are assigned type of service of 1. See the *MLN Matters*[®] article MM9533 at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9533.pdf> for further details of these new codes.

Additional information

The official instruction, CR 9531 issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3469CP.pdf>.

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

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Mandatory payment reduction of 2 percent continues until further notice for the Medicare FFS program – ‘Sequestration’

Medicare fee-for-service (FFS) claims with dates-of-service or dates-of-discharge on or after April 1, 2013, will continue to incur a 2 percent reduction in Medicare payment until further notice.

Claims for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), including claims under the DMEPOS Competitive Bidding Program, will continue to be reduced by 2 percent based upon whether the date-of-service, or the start date for rental equipment or multi-day supplies, is on or after April 1, 2013.

The claims payment adjustment will continue to be applied to all claims after determining coinsurance, any

applicable deductible, and any applicable Medicare secondary payment adjustments. Though beneficiary payments for deductibles and coinsurance are not subject to the 2 percent payment reduction, Medicare’s payment to beneficiaries for unassigned claims is subject to the 2 percent reduction.

The Centers for Medicare & Medicaid Services (CMS) encourages Medicare physicians, practitioners, and suppliers who bill claims on an unassigned basis to continue discussions with beneficiaries on the impact of sequestration on Medicare’s reimbursement. Questions about reimbursement should be directed to your Medicare administrative contractor (<http://go.usa.gov/cymuF>).

Surgery

Comprehensive care for joint replacement model provider education

Provider types affected

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

What You Need to Know

Change request (CR) 9533 supplies information to providers about the CJR model. The intent of the comprehensive care for joint replacement (CJR) model is to promote quality and financial accountability for episodes of care surrounding a lower-extremity joint replacement (LEJR) or reattachment of a lower extremity procedure. CJR will test whether bundled payments to certain acute care hospitals for LEJR episodes of care will reduce Medicare expenditures while preserving or enhancing the quality of care for Medicare beneficiaries. Make sure that your billing staffs are aware of these changes.

Background

Section 1115A of the Social Security Act (the Act) authorizes the Centers for Medicare & Medicaid Services (CMS) to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care furnished to Medicare, Medicaid, and Children’s Health Insurance Program beneficiaries. Under this authority, CMS published a rule to implement a new five year payment model called the comprehensive care for joint replacement (CJR) model April 1, 2016.

Under the CJR model, acute care hospitals in certain selected geographic areas will take on quality and payment accountability for retrospectively calculated

bundled payments for LEJR episodes. Episodes will begin with admission to an acute care hospital for an LEJR procedure that is paid under the inpatient prospective payment system (IPPS) through medical severity diagnosis-related group (MS-DRG) 469 (Major joint replacement or reattachment of lower extremity with MCC) or 470 (Major joint replacement or reattachment of lower extremity without MCC) and end 90 days after the date of discharge from the hospital.

Key points of CR 9533

CJR episodes of care

LEJR procedures are currently paid under the IPPS through: MS-DRG 469 or MS-DRG 470. The episode will include the LEJR procedure, inpatient stay, and all related care covered under Medicare Parts A and B within the 90 days after discharge. The day of discharge is counted as the first day of the 90-day bundle.

CJR participant hospitals

The model requires all hospitals paid under the IPPS in selected geographic areas to participate in the CJR model, with limited exceptions. A list of the selected geographic areas and participant hospitals is available at <https://innovation.cms.gov/initiatives/cjr>. Participant hospitals initiate episodes when an LEJR procedure is performed within the hospital and will be at financial risk for the cost of the services included in the bundle. Eligible beneficiaries who elect to receive care at these hospitals will automatically be included in the model.

CJR model beneficiary inclusion criteria

Medicare beneficiaries whose care will be included in the CJR model must meet the following criteria upon

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basis of the end-stage renal disease benefit;

- The beneficiary is not enrolled in any managed care plan;
- The beneficiary is not covered under a United Mine Workers of America health plan; and
- Medicare is the primary payer.

If at any time during the episode the beneficiary no longer meets all of these criteria, the episode is canceled.

CJR performance years

CMS will implement the CJR model for FIVE performance years, as detailed in the table below. Performance years for the model correlate to calendar years with the exception of performance year one, which is April 1, 2016, through December 31, 2016.

CJR model: Five performance years

Performance year	Date for episodes
Performance year 1 (2016)	Episodes that start on or after April 1, 2016, and end on or before December 31, 2016
Performance year 2 (2017)	Episodes that end between January 1, 2017, and December 31, 2017, inclusive
Performance year 3 (2018)	Episodes that end between January 1, 2018, and December 31, 2018, inclusive
Performance year 4 (2019)	Episodes that end between January 1, 2019, and December 31, 2019, inclusive
Performance year 5 (2020)	Episodes that end between January 1, 2020, and December 31, 2020, inclusive

CJR episode reconciliation activities

CMS will continue paying hospitals and other providers and suppliers according to the usual Medicare fee-for-service payment systems during all performance years. After completion of a performance year, Medicare will compare or “reconcile” actual claims paid for a beneficiary during the 90 day episode to an established target price. The target price is an expected amount for the total cost of care of the episode. Hospitals will receive separate target prices to reflect expected spending for episodes assigned to MS-DRGs 469 and 470, as well as hip fracture status. If the actual spending is lower than the target price, the difference will be paid to the hospital, subject to certain adjustments, such as for quality. This payment will be called a reconciliation payment. If actual spending is higher than the target price, hospitals will be responsible for repayment of the difference to Medicare, subject to certain adjustments, such as for quality.

Identifying CJR claims

To validate the retroactive identification of CJR episodes,

CMS is associating the demonstration code 75 with the CJR initiative. This code will also be utilized in future CRs to operationalize a waiver of the three-day stay requirement for covered skilled nursing facility (SNF) services, effective for CJR episodes beginning on or after January 1, 2017.

Medicare will automatically apply the CJR demonstration code to claims meeting the criteria for inclusion in the demonstration. **Participant hospitals need not include demonstration code 75 on their claims.** Instructions for submission of claims for SNF services rendered to beneficiaries in a CJR episode of care will be communicated once the waiver of the three-day stay requirement is operationalized.

Waivers and amendments of Medicare program rules

The CJR model waives certain existing payment system requirements to provide additional flexibilities to hospitals participating in CJR, as well as other providers that furnish services to beneficiaries in CJR episodes. The purpose of such flexibilities would be to increase LEJR episode quality and decrease episode spending or provider and supplier internal costs, or both, and to provide better, more coordinated care for beneficiaries and improved financial efficiencies for Medicare, providers, and beneficiaries.

Post-discharge home visits

In order for Medicare to pay for home health services, a beneficiary must be determined to be “home bound.” A beneficiary is considered to be confined to the home if the beneficiary has a condition, due to an illness or injury, that restricts his or her ability to leave home except with the assistance of another individual or the aid of a supportive device (that is, crutches, a cane, a wheelchair or a walker) or if the beneficiary has a condition such that leaving his or her home is medically contraindicated. Additional information regarding the homebound requirement is available in the *Medicare Benefit Policy Manual*; [Chapter 7](#), Home Health Services, Section 30.1.1, Patient Confined to the Home.

Medicare policy allows physicians and non-physician practitioners (NPPs) to furnish and bill for visits to any beneficiary’s home or place of residence under the Medicare physician fee schedule (MPFS). Medicare policy also allows such physicians and practitioners to bill Medicare for services furnished incident to their services by licensed clinical staff. Additional information regarding the “incident to” requirements is available in [42 CFR 410.26](#).

For those CJR beneficiaries who could benefit from home visits by licensed clinical staff for purposes of assessment and monitoring of their clinical condition, care coordination, and improving adherence with treatment, CMS will waive the “incident to” direct physician supervision requirement to allow a beneficiary who does not qualify for Medicare home health services to receive post-discharge visits in his or her home or place of residence any time during the episode, subject to the following conditions:

- Licensed clinical staff will provide the service under

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the general supervision of a physician or NPP. These staff can come from a private physician office or may be either an employee or a contractor of the participant hospital.

- Services will be billed under the MPFS by the supervising physician or NPP or by the hospital or other party to which the supervising physician has reassigned his or her billing rights.
- Up to 9 post discharge home visits can be billed and paid per beneficiary during each CJR episode, defined as the 90-day period following the anchor hospitalization.
- The service cannot be furnished to a CJR beneficiary who has qualified, or would qualify, for home health services when the visit was furnished.
- All other Medicare rules for coverage and payment of services incident to a physician's service continue to apply.

As described in the *Medicare Claims Processing Manual, Chapter 12*, Sections 40-40.4, Medicare policy generally does not allow for separate billing and payment for a postoperative visit furnished during the global period of a surgery when it is related to recovery from the surgery. However, for CJR, CMS will allow the surgeon or other practitioners to bill and be paid separately for a post-discharge home visit that was furnished in accordance with these conditions. All other Medicare rules for global surgery billing during the 90-day post-operative period continue to apply.

CMS expects that the post-discharge home visits by licensed clinical staff could include patient assessment, monitoring, assessment of functional status and fall risk, review of medications, assessment of adherence with treatment recommendations, patient education, communication and coordination with other treating clinicians, and care management to improve beneficiary connections to community and other services.

The service will be billed under the MPFS with a HCPCS G-code (G9490) specific to the CJR post-discharge home visit, as listed in Attachment A. The post-discharge home visit HCPCS code will be payable for CJR model beneficiaries beginning April 1, 2016, the start date of the first CJR model performance year. Claims submitted for post-discharge home visits for the CJR model will be accepted only when the claim contains the CJR specific HCPCS G-code. Although CMS is associating the demonstration code 75 with the CJR initiative, no demonstration code is needed or required on Part B claims submitted with the post-discharge home visit HCPCS G-Code.

Additional information on billing and payment for the post-discharge home visit HCPCS G-code will be available in the April 2016 release of the MPFS recurring update. Future updates to the relative value units (RVUs) and payment for this HCPCS code will be included in the

MPFS final rules and recurring updates each year.

Billing and payment for telehealth services

Medicare policy covers and pays for telehealth services when beneficiaries are located in specific geographic areas. Within those geographic areas, beneficiaries must be located in one of the health care settings that are specified in the statute as eligible originating sites. The service must be on the list of approved Medicare telehealth services. Medicare pays a facility fee to the originating site and provides separate payment to the distant site practitioner for the service. Additional information regarding Medicare telehealth services is available in the *Medicare Benefit Policy Manual, Chapter 15*, Section 270 and the *Medicare Claims Processing Manual, Chapter 12*, Section 190.

Under CJR, CMS will allow a beneficiary in a CJR episode in any geographic area to receive services via telehealth. CMS also will allow a home or place of residence to be an originating site for beneficiaries in a CJR episode. This will allow payment of claims for telehealth services delivered to beneficiaries at eligible originating sites or at their residence, regardless of the geographic location of the beneficiary. CMS will waive these telehealth requirements, subject to the following conditions:

- Telehealth services cannot substitute for in-person home health visits for patients under a home health episode of care.
- Telehealth services performed by social workers for patients under a home health episode of care will not be covered under the CJR model.
- The telehealth geographic area waiver and the allowance of home as an originating site under the CJR model does not apply for instances where a physician or allowed NPP is performing a face-to-face encounter for the purposes of certifying patient eligibility for the Medicare home health benefit.
- The principal diagnosis code reported on the telehealth claim cannot be one that is specifically excluded from the CJR episode definition.
- If the beneficiary is at home, the physician cannot furnish any telehealth service with a descriptor that precludes delivering the service in the home (for example, a hospital visit code).
- If the physician is furnishing an evaluation and management visit via telehealth to a beneficiary at home, the visit must be billed by one of nine unique HCPCS G-codes developed for the CJR model that reflect the home setting.
- For CJR telehealth home visits billed with HCPCS codes G9484, G9485, G9488, and G9489, the physician must document in the medical record that auxiliary licensed clinical staff were available on site in the patient's home during the visit or document the reason that such a high-level visit would not require such personnel.
- Physicians billing distant site telehealth services under

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these waivers must include the GT modifier on the claim, which attests that the service was furnished in accordance with all relevant coverage and payment requirements.

- The facility fee paid by Medicare to an originating site for a telehealth service will be waived if the service was originated in the beneficiary’s home.

The telehealth home visits will be billed under the MPFS with one of nine HCPCS G-code specific to the CJR telehealth home visits. Those codes are G9481, G9482, G9483, G9484, G9485, G9586, G9487, G9488, and G9499. **Attachment A of CR 9533 provides the long descriptors of these codes.** The telehealth home visit HCPCS codes will be payable for CJR model beneficiaries beginning April 1, 2016, the start date of the first CJR model performance year. Claims submitted for telehealth home visits for the CJR model will be accepted only when the claim contains one of nine of the CJR specific HCPCS G-Code. **Although CMS is associating the demonstration code 75 with the CJR initiative, no demonstration code is needed or required on Part B claims submitted with the post-discharge home visit HCPCS G-code.** Additional information on billing and payment for the telehealth home visit HCPCS G-codes will be available in the April 2016 release of the MPFS

Qualifying geographic areas and post-discharge visits – attachment to CR 9533

Qualifying geographic areas

The comprehensive care for joint replacement (CJR) model requires all hospitals paid under the inpatient prospective payment system in selected geographic areas (metropolitan statistical areas (MSAs)) to participate in the CJR model, with limited exceptions. A list of the selected geographic areas and participant hospitals can be found in the following table:

MSA	MSA title
10420	Akron, OH
10740	Albuquerque, NM
11700	Asheville, NC
12020	Athens-Clarke County, GA
12420	Austin-Round Rock, TX
13140	Beaumont-Port Arthur, TX
13900	Bismarck, ND
14500	Boulder, CO
15380	Buffalo-Cheektowaga-Niagara Falls, NY
16020	Cape Girardeau, MO-IL

recurring update. Future updates to the RVUs and payment for these HCPCS codes will be included in the MPFS final rules and recurring updates each year.

Additional information

The official instruction, CR 9533, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R140DEMO.pdf>.

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

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MSA	MSA title
16180	Carson City, NV
16740	Charlotte-Concord-Gastonia, NC-SC
17140	Cincinnati, OH-KY-IN
17860	Columbia, MO
18580	Corpus Christi, TX
19500	Decatur, IL
19740	Denver-Aurora-Lakewood, CO
20020	Dothan, AL
20500	Durham-Chapel Hill, NC
22420	Flint, MI
22500	Florence, SC
23540	Gainesville, FL
23580	Gainesville, GA
24780	Greenville, NC
25420	Harrisburg-Carlisle, PA
26300	Hot Springs, AR
26900	Indianapolis-Carmel-Anderson, IN
28140	Kansas City, MO-KS

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MSA	MSA title
28660	Killeen-Temple, TX
30700	Lincoln, NE
31080	Los Angeles-Long Beach-Anaheim, CA
31180	Lubbock, TX
31540	Madison, WI
32820	Memphis, TN-MS-AR
33100	Miami-Fort Lauderdale-West Palm Beach, FL
33340	Milwaukee-Waukesha-West Allis, WI
33700	Modesto, CA
33740	Monroe, LA
33860	Montgomery, AL
34940	Naples-Immokalee-Marco Island, FL
34980	Nashville-Davidson--Murfreesboro--Franklin, TN
35300	New Haven-Milford, CT
35380	New Orleans-Metairie, LA
35620	New York-Newark-Jersey City, NY-NJ-PA
35980	Norwich-New London, CT
36260	Ogden-Clearfield, UT
36420	Oklahoma City, OK
36740	Orlando-Kissimmee-Sanford, FL
37860	Pensacola-Ferry Pass-Brent, FL
38300	Pittsburgh, PA
38940	Port St. Lucie, FL
38900	Portland-Vancouver-Hillsboro, OR-WA
39340	Provo-Orem, UT
39740	Reading, PA
40980	Saginaw, MI
41860	San Francisco-Oakland-Hayward, CA
42660	Seattle-Tacoma-Bellevue, WA
42680	Sebastian-Vero Beach, FL
43780	South Bend-Mishawaka, IN-MI
41180	St. Louis, MO-IL
44420	Staunton-Waynesboro, VA
45300	Tampa-St. Petersburg-Clearwater, FL
45780	Toledo, OH
45820	Topeka, KS
46220	Tuscaloosa, AL
46340	Tyler, TX
48620	Wichita, KS



claims to Medicare:

Code	Short	Long descriptor	Eff date
G9490	Joint replac mod home visit	<i>Comprehensive Care for Joint Replacement model, home visit for patient assessment performed by clinical staff for an individual not considered homebound, including, but not necessarily limited to patient assessment of clinical status, safety/fall prevention, functional status/ambulation, medication reconciliation/management, compliance with orders/plan of care, performance of activities of daily living, and ensuring beneficiary connections to community and other services. (for use only in the Medicare-approved Comprehensive Care for Joint Replacement model); may not be billed for a 30 day period covered by a transitional care management code</i>	4/1/16

G-codes for beneficiaries in CJR episodes

Physicians and nonphysician practitioners billing for post-discharge home visits and telehealth home visits furnished to beneficiaries in CJR episodes must comply with the conditions of payments described in CR 9533, which includes the use of the following codes when submitting

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Code	Short	Long descriptor	Eff date
G9481	Remote E/M new pt 10 mins	<p><i>Remote in-home visit for the evaluation and management of a new patient for use only in the Medicare-approved Comprehensive Care for Joint Replacement model, which requires these 3 key components:</i></p> <ul style="list-style-type: none"> ▪ <i>A problem focused history;</i> ▪ <i>A problem focused examination; and</i> ▪ <i>Straightforward medical decision making,</i> <p><i>furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent with the patient or family or both via real time, audio, and video intercommunications technology.</i></p>	4/1/16

Code	Short	Long descriptor	Eff date
G9482	Remote E/M new pt 20 mins	<p><i>Remote in-home visit for the evaluation and management of a new patient for use only in the Medicare-approved Comprehensive Care for Joint Replacement model, which requires these 3 key components:</i></p> <ul style="list-style-type: none"> ▪ <i>An expanded problem focused history;</i> ▪ <i>An expanded problem focused examination;</i> ▪ <i>Straightforward medical decision making,</i> <p><i>furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology.</i></p>	4/1/16

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Code	Short	Long descriptor	Eff date
G9483	Remote E/M new pt 30 mins	<p><i>Remote in-home visit for the evaluation and management of a new patient for use only in the Medicare-approved Comprehensive Care for Joint Replacement model, which requires these 3 key components:</i></p> <ul style="list-style-type: none"> ▪ <i>A detailed history;</i> ▪ <i>A detailed examination;</i> ▪ <i>Medical decision making of low complexity,</i> <p><i>furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology.</i></p>	4/1/16

Code	Short	Long descriptor	Eff date
G9484	Remote E/M new pt 45 mins	<p><i>Remote in-home visit for the evaluation and management of a new patient for use only in the Medicare-approved Comprehensive Care for Joint Replacement model, which requires these 3 key components:</i></p> <ul style="list-style-type: none"> ▪ <i>A comprehensive history;</i> ▪ <i>A comprehensive examination;</i> ▪ <i>Medical decision making of moderate complexity,</i> <p><i>furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology.</i></p>	4/1/16

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Code	Short	Long descriptor	Eff date
G9485	Remote E/M new pt 60 mins	<p><i>Remote in-home visit for the evaluation and management of a new patient for use only in the Medicare-approved Comprehensive Care for Joint Replacement model, which requires these 3 key components:</i></p> <ul style="list-style-type: none"> ▪ <i>A comprehensive history;</i> ▪ <i>A comprehensive examination;</i> ▪ <i>Medical decision making of high complexity,</i> <p><i>furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology.</i></p>	4/1/16

Code	Short	Long descriptor	Eff date
G9486	Remote E/M est. pt 10mins	<p><i>Remote in-home visit for the evaluation and management of an established patient for use only in the Medicare-approved Comprehensive Care for Joint Replacement model, which requires at least 2 of the following 3 key components:</i></p> <ul style="list-style-type: none"> ▪ <i>A problem focused history;</i> ▪ <i>A problem focused examination;</i> ▪ <i>Straightforward medical decision making,</i> <p><i>furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology.</i></p>	4/1/16

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Code	Short	Long descriptor	Eff date
G9487	Remote E/M est. pt 15 mins	<p><i>Remote in-home visit for the evaluation and management of an established patient for use only in the Medicare-approved Comprehensive Care for Joint Replacement model, which requires at least 2 of the following 3 key components:</i></p> <ul style="list-style-type: none"> ▪ <i>An expanded problem focused history;</i> ▪ <i>An expanded problem focused examination;</i> ▪ <i>Medical decision making of low complexity,</i> <p><i>furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology.</i></p>	4/1/16

Code	Short	Long descriptor	Eff date
G9488	Remote E/M est. pt 25 mins	<p><i>Remote in-home visit for the evaluation and management of an established patient for use only in the Medicare-approved Comprehensive Care for Joint Replacement model, which requires at least 2 of the following 3 key components:</i></p> <ul style="list-style-type: none"> ▪ <i>A detailed history;</i> ▪ <i>A detailed examination;</i> ▪ <i>Medical decision making of moderate complexity,</i> <p><i>furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology.</i></p>	4/1/16

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Code	Short	Long descriptor	Eff date
G9489	Remote E/M est. pt 40 mins	<p><i>Remote in-home visit for the evaluation and management of an established patient for use only in the Medicare-approved Comprehensive Care for Joint Replacement model, which requires at least 2 of the following 3 key components:</i></p> <ul style="list-style-type: none"> ▪ <i>A comprehensive history;</i> ▪ <i>A comprehensive examination;</i> ▪ <i>Medical decision making of high complexity,</i> 	4/1/16

Code	Short	Long descriptor	Eff date
(cont') G9489	Remote E/M est. pt 40 mins	<p><i>furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology.</i></p>	

General Coverage

Update to Medicare telehealth services

Provider types affected

This *MLN Matters*® article is intended for providers submitting claims to Medicare administrative contractors for telehealth services provided to Medicare beneficiaries.

What you need to know

Change request (CR) 9428:

- Informs MACs that the list of telehealth services that were once available through the manual updates will now be displayed at <http://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/>.
- Adds certified registered nurse anesthetists (CRNAs) to the list of Medicare practitioners who may bill for covered telehealth services.
- Removes the telehealth language from *Chapter 15, Section 270 of the Medicare Benefit Policy Manual* and puts a reference in the text to see *Chapter 12, Section 190 of the Medicare Claims Processing Manual* for further information regarding telehealth service.

The text added to Chapter 12 of the *Medicare Claims Processing Manual* addresses the following topics:

- Payment for ESRD-related services as a telehealth service;

- Payment for subsequent hospital care services and subsequent nursing facility care services as telehealth services;
- Payment for diabetes self-management training (DSMT) as a telehealth service;
- Originating site facility fee payment methodology; and
- Payment methodology for physician/practitioner at the distant site.



Several conditions must be met for Medicare to make payments for telehealth services under the Medicare physician fee schedule (MPFS). The service must be on the list of Medicare telehealth services and meet **all** of the following additional requirements:

- The service must be furnished via an interactive telecommunications system;

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Timely response to additional documentation request

First Coast Service Options (First Coast), frequently requires a clinical review of records to determine the medical necessity of services. When documentation is required an additional documentation request (ADR) letter is mailed. Before records are returned, they should be reviewed to ensure billing accuracy. This includes verification of any conflicting patient information as well as claim form billing information. Your office should also verify that the appropriate signatures are included. When reviewing medical records, First Coast must be able to clearly identify who performed the services, especially in those situations where there are two signatures. If the record is unclear an attestation statement should be included to identify who rendered the services.



The Centers for Medicare & Medicaid Services (CMS) allows a provider 45 days to submit the records. The 45 day clock starts with the date of the ADR letter. The claims processing system is set to automatically deny on day 46 if the records have not been received and matched to the claim. Therefore, in order to prevent claims from denying, it is extremely important to allow ample time for records

to be received and matched with the claim. First Coast has seen a tremendous increase in the number of claims denied for timeliness. Serious consideration should be given to the method of submission. When responding after day thirty, please take into consideration other means of submission such as SPOT, fax, esMD, etc. A minimum of five days should be allowed for mail time.

Providers must keep their addresses and phone numbers current through notification to provider enrollment to ensure that these letters are received timely. Delays resulting from having to deliver letters to a forwarding address

will significantly decrease the timeframe for submitting the records.

For claims processed where the records have been submitted timely, CMS requires the contractor to make a determination within 30 days. Claims denied for timeliness cost the contractor additional resources to process and are allowed 60 days for processing.

It is the goal of First Coast to ensure that providers are properly reimbursed for medically reasonable and necessary services.

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- The service must be furnished by a physician or authorized practitioner;
- The service must be furnished to an eligible telehealth individual; and
- The individual receiving the service must be located in a telehealth originating site.

Additional information

The official instruction, CR 9248, was issued to your MAC via two transmittals. The first updates the *Medicare Benefit Policy Manual* and it is at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R221BP.pdf>. The second transmittal updates *Medicare Claims Processing Manual* and it is at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3476CP.pdf>. The actual manual updates are attached to each transmittal.

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: MM9428
 Related Change Request (CR) #: CR 9428
 Related CR Release Date: March 11, 2016
 Effective Date: January 1, 2015
 Related CR Transmittal #: R221BP and R3476CP
 Implementation Date: April 11, 2016

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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

DDE request for access forms 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*

Manual updates to correct remittance advice messages

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) 9424 revises Chapters 4 and 5 of the *Medicare Claims Processing Manual* to ensure that all remittance advice coding is consistent with nationally standard operating rules. It also provides a format for consistently showing remittance advice coding throughout this manual.

CR 9424 directs MACs to use remittance coding that is compliant with nationally standard Council for Affordable Quality Healthcare Committee on Operating Rules for Information Exchange (CAQH CORE) operating rules.

Background

Section 1171 of the Social Security Act requires a standard set of operating rules to regulate the health insurance industry’s use of electronic data interchange (EDI) transactions. Operating Rule 360: Uniform Use of CARCs and RARCs regulates the way in which group codes, claims adjustment reason codes (CARCs) and remittance advice remark codes (RARCs) may be used. The rule requires specific codes, which are to be used in combination with one another if one of the named business scenarios applies. This rule is authored by the CAQH CORE.

Medicare and all other payers must comply with the CAQH CORE-developed code combinations. The business scenario for each payment adjustment must be defined, if applicable, and a valid code combination selected for all remittance advice messages.

With CR 9424, the Centers for Medicare & Medicaid Services (CMS) makes the following adjustments to CARC/RARC usage:

- MACs will use CARC 54 without an associated RARC when denying assistant at surgery services.
- MACs will use CARC 54 without an associated RARC when denying co-surgery services.
- MACs will use CARC 16 with RARCs MA66 and N56 when returning as unprocessable claims for outpatient intravenous insulin therapy (OIVIT) billed with code 99199.
- MACs will use CARC 16 with RARCs MA66 and N56 when returning as unprocessable claims for OIVIT billed with the incorrect diagnosis code.
- MACs will also apply reformatted, but not changed, remittance advice coding as described in the revised Chapters 4 and 5 of the *Medicare Claims Processing Manual*.

Additional information

The official instruction, CR 9424, issued to your MAC regarding this change, is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3475CP.pdf>.

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Healthcare provider taxonomy code set update

Provider types affected

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

What you need to know

Change request (CR) 9461 instructs MACs to obtain the most recent healthcare provider taxonomy code (HPTC) set and to update their internal HPTC tables and/or reference files.

Background

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

The National Uniform Claim Committee (NUCC) maintains the HPTC set for standardized classification of health care providers, and updates it twice a year with changes effective

April 1 and October 1. These changes include the addition of a new code and addition of definitions to existing codes.

You should note that:

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

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

CR 9461 implements the NUCC HPTC code set that is effective on April 1, 2016, and instructs MACs to obtain the most recent HPTC set and use it to update their internal HPTC tables and/or reference files. The HPTC set is available for view or for download from the Washington Publishing Company (WPC) at <http://www.wpc-edi.com/codes>.

When reviewing the HPTC set online, you can identify revisions made since the last release by the color code:

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

Additional information

The official instruction, CR 9461, issued to your MAC regarding this change, is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3467CP.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: MM9461

Related Change Request (CR) #: CR 9461

Related CR Release Date: February 19, 2016

Effective Date: April 1, 2016

Related CR Transmittal #: R3467CP

Implementation Date: As soon as April 1, 2016, but no later than July 5, 2016

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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: MM9424

Related Change Request (CR) #: CR 9424

Related CR Release Date: March 4, 2016

Effective Date: June 6, 2016

Related CR Transmittal #: R3475CP

Implementation Date: June 6, 2016

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REVALIDATION

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- Submit a revalidation application through Internet-based PECOS located at <https://pecos.cms.hhs.gov/pecos/login.do>, the fastest and most efficient way to submit your revalidation information. Electronically sign the revalidation application and upload your supporting documentation or sign the paper certification statement and mail it along with your supporting documentation to your MAC; or
- Complete the appropriate CMS-855 application available at <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html>;
- If applicable, pay your fee by going to <https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do>; and
- Respond to all development requests from your MAC timely to avoid a hold on your Medicare payments and possible deactivation of your Medicare billing privileges.

Background

Section 6401 (a) of the Affordable Care Act established a requirement for all enrolled providers/suppliers to revalidate their Medicare enrollment information under new enrollment screening criteria. CMS has completed its initial round of revalidations and will be resuming regular revalidation cycles in accordance with 42 CFR §424.515. This cycle of revalidation applies to those providers/suppliers that are currently and actively enrolled.

What's ahead for your next Medicare enrollment revalidation?

Established due dates for revalidation

CMS has established due dates by which the provider/supplier's revalidation application must reach the MAC in order for them to remain in compliance with Medicare's provider enrollment requirements. The due dates will generally be on the **last day of a month** (for example, June 30, July 31, or August 31). Submit your revalidation application to your MAC within six months of your due date to avoid a hold on your Medicare payments and possible deactivation of your Medicare billing privileges. Generally, this due date will remain with the provider/supplier throughout subsequent revalidation cycles.

- The list will be available at <http://go.cms.gov/MedicareRevalidation> and will include **all** enrolled providers/suppliers. Those due for revalidation will display a revalidation due date, all other providers/suppliers not up for revalidation will display a "TBD" (to be determined) in the due date field. In addition, a crosswalk to the organizations that the individual provider reassigns benefits will also be available at <http://go.cms.gov/MedicareRevalidation>.

Important: *The list identifies billing providers/suppliers only that are required to revalidate. If you are enrolled*



solely to order, certify, and/or prescribe via the CMS-855O application or have opted out of Medicare, you will not be asked to revalidate and will not be reflected on the list.

- Due dates are established based on your last successful revalidation or initial enrollment (approximately three years for DME suppliers and five years for all other providers/suppliers).
- In addition, the MAC will send a revalidation notice within 2-3 months prior to your revalidation due date either by email (to email addresses reported on your prior applications) or regular mail (at least two of your reported addresses: correspondence, special payments and/or your primary practice address) indicating the provider/supplier's due date.

Revalidation notices sent via email will indicate **"URGENT: Medicare Provider Enrollment Revalidation Request"** in the subject line to differentiate from other emails. If all of the emails addresses on file are returned as undeliverable, your MAC will send a paper revalidation notice to at least two of your reported addresses: correspondence, special payments and/or primary practice address.

Note: Providers/suppliers who are within two months of their listed due dates on <http://go.cms.gov/MedicareRevalidation> but have not received a notice from their MAC to revalidate, are encouraged to submit their revalidation application.

- To assist with submitting complete revalidation applications, revalidation notices for individual group members, will list the identifying information of the organizations that the individual reassigns benefits.

Large group coordination

Large groups (200+ members) accepting reassigned benefits from providers/suppliers identified on the CMS list will receive a letter from their MACs listing the providers linked to their group that are required to revalidate for the upcoming six month period. A spreadsheet detailing the applicable provider's name, national provider identifier (NPI) and specialty will also be provided. CMS encourages the groups to work with their practicing practitioners to ensure that the revalidation application is submitted prior

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to the due date. We encourage all groups to work together as only one application from each provider/supplier is required, but the provider must list all groups they are reassigning to on the revalidation application submitted for processing. MACs will have dedicated provider enrollment staff to assist in the large group revalidations.

Groups with less than 200 reassignments will not receive a letter or spreadsheet from their MAC, but can utilize PECOS or the CMS list available on <http://go.cms.gov/MedicareRevalidation> to determine their provider/supplier's revalidation due dates.

Unsolicited revalidation submissions

All unsolicited revalidation applications submitted more than six months in advance of the provider/supplier's due date will be **returned**.

- What is an unsolicited revalidation?
 - If you are not due for revalidation in the current 6 month period, your due date will be listed as "TBD" (to be determined). This means that you do not yet have a due date for revalidation. Please do not submit a revalidation application if there is NOT a listed due date.
 - Any off-cycle or ad hoc revalidations specifically requested by CMS or the MAC are not considered unsolicited revalidations.
- If your intention is to submit a change to your provider enrollment record, you must submit a 'change of information' application using the appropriate CMS-855 form.

Submitting your revalidation application

Important: Each provider/supplier is required to revalidate their entire **Medicare enrollment record**.

A provider/supplier's enrollment record includes information such as the provider's individual practice locations and every group that benefits are reassigned (that is, the group submits claims and receives payments directly for services provided). This means the provider/supplier is recertifying and revalidating all of the information in the enrollment record, including all assigned NPIs and provider transaction access numbers (PTANs).

If you are an individual who reassigns benefits to more than one group or entity, you must include all organizations to which you reassign your benefits on one revalidation application. If you have someone else completing your revalidation application for you, encourage coordination with all entities to which you reassign benefits to ensure your reassignments remain intact.

The fastest and most efficient way to submit your revalidation information is by using the Internet-based PECOS.

To revalidate via the Internet-based PECOS, go to <https://pecos.cms.hhs.gov/pecos/login.do>. PECOS allows you to review information currently on file and update and submit your revalidation via the Internet. Once completed, YOU MUST electronically sign the revalidation application and upload any supporting documents or print, sign, date, and mail the paper certification statement along with all required supporting documentation to your appropriate MAC IMMEDIATELY.

PECOS ensures accurate and timelier processing of all types of enrollment applications, including revalidation applications. It provides a far superior alternative to the antiquated paper application process.

To locate the paper enrollment applications, refer to <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html>.

Getting access to PECOS:

To use PECOS, you must get approved to access the system with the proper credentials which are obtained through the identity and access management system, commonly referred to as "I&A". The I&A system ensures you are properly set up to submit PECOS applications. Once you have established an I&A account you can then

use PECOS to submit your revalidation application as well as other enrollment application submissions.

To learn more about establishing an I&A account or to verify your ability to submit applications using PECOS, please refer to https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedEnroll_PECOS_PhysNonPhys_FactSheet_ICN903764.pdf.

If you have questions regarding filling out your application via PECOS, please contact the MAC that sent you the revalidation notice. You may also find a list of MAC's at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/contact_list.pdf.

For questions about accessing PECOS (such as login, forgot username/password) or I&A, contact the External User Services (EUS) help desk at 1-866-484-8049 or at EUSupport@cgi.com.

Deactivations due to non-response to revalidation or development requests

It is important that you submit a complete revalidation application by your requested due date and you respond to all development requests from your MACs timely. **Failure to submit a complete revalidation application or**



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respond timely to development requests will result in possible deactivation of your Medicare enrollment.

If your application is received substantially after the due date, or if you provide additional requested information substantially after the due date (including an allotted time period for US or other mail receipt) your provider enrollment record may be deactivated. Providers/suppliers deactivated will be required to submit a new full and complete application in order to reestablish their provider enrollment record and related Medicare billing privileges. The provider/supplier will maintain their original PTAN; however, an interruption in billing will occur during the period of deactivation resulting in a gap in coverage.

Note: The reactivation date after a period of deactivation will be based on the receipt date of the new full and complete application. Retroactive billing privileges back to the period of deactivation will not be granted. Services provided to Medicare patients during the period between deactivation and reactivation are the provider’s liability.

Revalidation timeline and example

Providers/suppliers may use the following table /chart as a guide for the sequence of events through the revalidation progression.

Action	Timeframe	Example
Revalidation list posted	Approximately six months prior to due date	March 30, 2016
Issue large group notifications	Approximately six months prior to due date	March 30, 2016
MAC sends email/letter notification	75-90 days prior to due date	July 2-17, 2016
MAC sends letter for undeliverable emails	75-90 days prior to due date	July 2-17, 2016
Revalidation due date		September 30, 2016
Apply payment hold/issue reminder letter (group members)	Within 25 days after due date	October 25, 2016
Deactivate	60-75 days after due date	November 29-December 14, 2016

Application fees

Institutional providers of medical or other items or services and suppliers are required to submit an application fee for revalidations. The application fee is \$554.00 for 2016. CMS has defined “institutional provider” to mean any provider or supplier that submits an application via PECOS or a paper Medicare enrollment application using the CMS-



855A, CMS-855B (except physician and non-physician practitioner organizations), or CMS-855S forms.

Summary

- CMS will post the revalidation due dates for the upcoming revalidation cycle on <http://go.cms.gov/MedicareRevalidation> for all providers/suppliers. This list will be refreshed periodically. Check this list regularly for updates.
- MACs will continue to send revalidation notices (either by email or mail) within 2-3 months prior to your revalidation due date. When responding to revalidation requests, be sure to revalidate your entire **Medicare enrollment record, including all reassignment and practice locations**. If you have multiple reassignments/billing structures, you must coordinate the revalidation application submission with all parties.
- If a revalidation application is received but incomplete, the MACs will develop for the missing information. If the missing information is not received within 30 days of the request, the MACs will deactivate the provider/supplier’s billing privileges.
- If a revalidation application is not received by the due date, the MAC may place a hold on your Medicare payments and deactivate your Medicare billing privileges.
- If billing privileges are deactivated, a reactivation will result in the same PTAN but an interruption in billing during the period of deactivation. This will result in a gap in coverage.
- If the revalidation application is approved, the provider/supplier will be revalidated and no further action is needed.

Additional information

To find out whether a provider/supplier has been mailed a revalidation notice go to <http://go.cms.gov/MedicareRevalidation>. A sample revalidation letter is available at <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/SampleRevalidationLetter.pdf>. A revalidation checklist is available at <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Revalidations.html>.

For more information about the enrollment process and required fees, refer to *MLN Matters*® article MM7350, which is available at <http://www.cms.gov/Outreach->

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[and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7350.pdf](#).

For more information about the application fee payment process, refer to *MLN Matters*® article SE1130, which is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1130.pdf>.

The *MLN*® fact sheet titled *The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Provider and Supplier Organizations* is designed to provide education to provider and supplier organizations on how to use Internet-based PECOS to enroll in the Medicare program and is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_PECOS_ProviderSup_FactSheet_ICN903767.pdf.

To access PECOS, your authorized official must register with the PECOS Identification and Authentication system. To register for the first time go to <https://pecos.cms.hhs.gov/pecos/PecosIAConfirm.do?transferReason=CreateLogin> and create an account.

For additional information about the enrollment process and Internet-based PECOS, please visit the *Medicare Provider-Supplier Enrollment* Web page at <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html>.

If you have questions, contact your MAC. Medicare provider enrollment contact information for each state can be found at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/contact_list.pdf.

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Effective Date: N/A
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Implementation Date: N/A

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Top educational resources to avoid billing errors

The following list of resources has been compiled to assist providers with some of the top billing errors.

Determine if a procedure is bundled

Fee schedule lookup: This tutorial demonstrates how to use this popular tool in determining if a procedure is part of a bundled service: http://medicare.fcso.com/Fee_resources/0323300.asp

Validate if QW is needed

Clinical Laboratory Improvement Amendments (CLIA) – this tutorial provides step-by-step instructions in finding out if a *CPT*® code requires the QW modifier: http://medicare.fcso.com/Clinical_lab/0321651.asp

Code denial due to NCCI

National Correct Coding Initiative (NCCI) – code pair

denials – this tutorial takes a confusing process and makes it simple by demonstrating how to use CMS's files to determine if a code pair will be denied due to NCCI: <http://medicare.fcso.com/NCCI/0326651.asp>

Find procedure to diagnosis relationship

Procedure to diagnosis lookup – this tutorial will demonstrate the diagnosis relationship lookup tool to assist in determining if a procedure to diagnosis relationship exists for the procedure performed: http://medicare.fcso.com/Claim_submission_guidelines/0326666.asp



New provider contact center hours

U.S. Virgin Islands providers

The provider contact center (PCC) hours of availability for U.S. Virgin Islands providers has been revised. The hours for calling into First Coast's PCC is 8:00 a.m. - 4:00 p.m. atlantic standard time (AST). This change coincides with the start of daylight saving time (DST) in the eastern United States.

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*

New LCD

BRCA1 and BRCA2 Genetic Testing – new Part A/B LCD

LCD ID number: L36499 (Florida, Puerto Rico/ U.S. Virgin Islands)

This local coverage determination (LCD), BRCA1 and BRCA2 genetic testing, has been adopted by MAC JN. Evidence in the published, peer-reviewed scientific literature indicates that BRCA1 and BRCA2 genetic testing is appropriate for a specific subset of adult individuals who have been identified to be at high risk for hereditary breast and ovarian cancers. BRCA1 and BRCA2 genetic testing is a covered service for a known mutation in a family for individuals with signs and/or symptoms of breast cancer, a personal history of epithelial ovarian, fallopian tube, or primary peritoneal cancer, personal history of pancreatic cancer or prostate cancer meeting certain criteria. Medicare is a defined benefit program and requires that testing is only performed on patients with signs and symptoms of disease. Therefore, testing of unaffected individuals or family

members is not a covered Medicare service.

The LCD addresses a general overview of BRCA1 and BRCA2 testing, criteria for indications of coverage, limitations of coverage, multi-gene panel testing, and test results and management.

Effective date

This new LCD is effective for services rendered **on or after April 11, 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](#).

Hyperbaric Oxygen Therapy – new Part A/B LCD

LCD ID number: L36504 (Florida, Puerto Rico/ U.S. Virgin Islands)

The Centers for Medicare & Medicaid Services (CMS) Innovation Center has taken on responsibility for implementing a number of specific demonstration projects authorized and funded by statute. The findings from these demonstrations inform possible changes in health care payment and policy, as well as the development and testing of new models, if appropriate.

Non-emergent hyperbaric oxygen therapy was one focus due to the high incidences of improper payments for these services as reported by the Department of Health and Human Services Office of Inspector General, as well as concerns about beneficiaries receiving services that are not medically necessary. The prior authorization model for non-emergent hyperbaric oxygen therapy was implemented in Illinois, Michigan, and New Jersey [J6, J8, and JL-Novitas (First Coast sister company)]. First Coast (MAC JN) did not participate in the prior authorization model.

However, First Coast’s data analysis identified an increase in utilization of hyperbaric oxygen therapy. The Medicare Part B Extraction Summary System (BESS) statistical medical data obtained for dates of service July 01, 2014, through December 31, 2014 indicated a carrier-to-nation ratio for Florida at *1.92 (between 50-100 percent above the national average) and for Puerto Rico *3.50 (between 200-250 percent above the national average) for procedure code 99183. Due to the risk of a high dollar claim payment error, First Coast took this opportunity to

adopt Novitas’ local coverage determination (LCD) given it is consistent with standards of care as identified during the demonstration project.

Hyperbaric Oxygen (HBO) Therapy LCD addresses indications and limitations of coverage and/or medical necessity, limitations, Current Procedural Terminology® (CPT®) codes, documentation guidelines, and utilization guidelines. Of note: ICD-10 codes are not included in this LCD. It is the provider’s responsibility to select codes carried out to the highest level of specificity and selected from the ICD-10-CM code book appropriate to the year in which the service is rendered for the claim(s) submitted. For the list of CMS hard-coded diagnosis codes, please refer to National Coverage Determination (NCD) 20.29 Hyperbaric Oxygen Therapy for covered diagnoses and make reference to TN 1580 (CR 9252).

Effective date

This new LCD is effective for services rendered **on or after April 11, 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](#).

Revisions to LCDs

Bisphosphonates (IV) and monoclonal antibodies (HCPCS code J3489 [Reclast®]) – 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 change ICD-10-CM diagnosis code range M88.1-M88.9 to ICD-10-CM diagnosis code range M88.0-M88.9 for HCPCS code J3489 (Reclast®) 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 March 10, 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](#).

Botulinum toxins – revision to the Part A and Part B LCD (J0585, J0588)

LCD ID number: L33274 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for botulinum toxins was revised based on reconsideration requests to include the indication, upper limb spasticity in adult patients for Xeomin, which was approved by the Food and Drug Administration (FDA) on December 22, 2015, and the indication, lower limb spasticity in adult patients for Botox, which was FDA approved January 21, 2016. The “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD was revised to add these indications.

Also, “spastic hemiplegia”, and “spasticity related to stroke” were removed from the “Off Label Indications for Botox” section of the LCD and added to the “FDA Indications for Botox” section of the LCD. In addition, ICD-10-CM diagnosis codes G80.1, I69.061-I69.065, I69.161-I69.165, I69.261-I69.265 and I69.361-I69.365 were added

under the “ICD-10 Codes that Support Medical Necessity” section of the LCD for procedure code J0585.

Effective date

The LCD revision for Xeomin is effective for claims processed **on or after March 29, 2016**, for services rendered **on or after December 22, 2015**. The LCD revision for Botox is effective for claims processed **on or after March 29, 2016**, for services rendered **on or after January 21, 2016**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>.

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

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

Botulinum Toxins – revision to the LCD

LCD ID number: L33274 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for Botulinum Toxins was revised based on a reconsideration request to include the indication upper limb spasticity in adult patients for Dysport, which was FDA approved on July 15, 2015. The “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD was revised to add this indication.

Effective date

This LCD revision is effective for claims processed **on or**

after February 24, 2016, for services rendered **on or after July 15, 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](#).

Computerized Corneal Topography – revision to the LCD

LCD ID number: L33810 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for Computerized Corneal Topography was revised to add ICD-10-CM diagnosis code T86.848 (Other complications of corneal transplant) 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 24, 2016**, for services rendered **on or after October 01, 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](#).

Erythropoiesis Stimulating Agents – revision to the LCD

LCD ID number: L36276 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for Erythropoiesis Stimulating Agents was revised to remove ICD-10-CM diagnosis code D47.0 from “J0881 List 1” in the “ICD-10 Codes that Support Medical Necessity” section of the LCD and replace it with ICD-10-CM diagnosis code D47.1. ICD-10-CM diagnosis code D47.0 was mistakenly added to “J0881 List 1” when the ICD-9-CM diagnosis codes were crosswalked to ICD-10-CM.

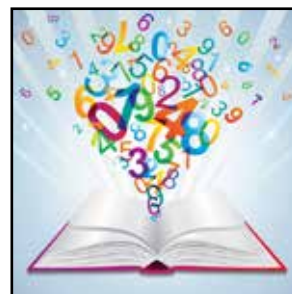
Effective date

This LCD revision is effective for claims processed **on or after March 1, 2016**, for services rendered **on or after**

October 01, 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](#).



Genetic testing for Lynch syndrome and special histochemical stains and immunohistochemical stains – revision to the LCDs

LCD ID number: L34912, L36234 (Florida, Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for genetic testing for Lynch syndrome was revised in the “Indications of Coverage” section of the LCD to update verbiage for Lynch syndrome tumor screening to align with the verbiage in the “Indications and Limitations of Coverage and/or Medical Necessity” section of the special histochemical stains and immunohistochemical stains LCD. The updated language in both LCDs reads as follows:

The special histochemical stains and immunohistochemical stains LCD was revised to change the age for Lynch syndrome testing from ≤ 50 to ≤ 70 , under the “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD.

Effective date

This LCD revision for the genetic testing for Lynch syndrome is effective for services rendered **on or after March 8, 2016**. The LCD revision for special histochemical stains and immunohistochemical stains is effective for claims processed **on or after March 8, 2016**, for services rendered **on or after December 6, 2015**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>.

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

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

Implantable Miniature Telescope – revision to the LCD

LCD ID number: L33377 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for Implantable Miniature Telescope was revised to remove language related to ambulatory surgery centers (ASCs) and HCPCS code C1840 from the “CPT®/HCPCS Codes” section of the LCD as the language is no longer applicable since the LCD is now an A/B combined LCD.

Effective date

This LCD revision is effective for claims processed on

or after **March 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](#).

Major Joint Replacement (Hip and Knee) – revision to the LCD

LCD ID number: L33618 (Florida, Puerto Rico/ U.S. Virgin Islands)

Following the October 1, 2015, implementation date of ICD-10-CM diagnosis code sets, First Coast Service Options, Inc., (First Coast) was made aware of inappropriate claims denials related to ICD-10-CM dual procedure code requirements. Since that time, the system editing has been corrected, and the local coverage determination (LCD) CPT® /HCPCS section has been revised to remove to dual procedure code requirement.

Additionally, the dual diagnosis requirement has been removed and ICD-10-CM diagnosis codes Z89.621-Z89.622 (acquired absence of right/left hip joint) were added to support medical necessity for Current Procedural Terminology (CPT®) codes 27130, 27132, 27134, 27137 and 27138. In addition, code range Z89.521-Z89.522 (acquired absence of right/left knee) was

added to support medical necessity for CPT® codes 27445, 27447, 27486, and 27487.

No action is required on the part of providers; a mass adjustment will be performed to correct any inappropriately denied claims.

Effective date

This LCD revision is effective for claims processed on or after **March 2, 2016**, for dates of service 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](#).

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 based on data analysis by the Program Safeguards Communication Group (PSCG) at First Coast Service Options related to excessive utilization of breast sonography billed on the same day as mammography in Puerto Rico and in Florida. This policy does not outline complete indications and limitations of breast ultrasound but addresses the limitations of screening mammography with breast ultrasound. The Medicare benefit for screening mammography does not include breast ultrasound. As such, routine breast cancer screening with ultrasound (including patients with dense breast tissue) is not a Medicare covered service.

If breast ultrasound is medically reasonable and necessary and done with a screening mammography, the mammography is considered to be a diagnostic test. The request (order) for the ultrasound examination must be

originated by a treating physician/NPP. (This requirement is not applicable to hospital based radiologists for inpatient or outpatient breast ultrasound.) If the testing facility has no order for breast ultrasound and cannot reach the treating physician/practitioner to obtain a new order for the addition of breast ultrasound, when needed, and documents this in the medical record, then the testing facility may furnish the additional diagnostic test under certain criteria, which are listed in the finalized LCD.

Effective date

This LCD revision is effective for services rendered on or after **April 11, 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](#).

Viscosupplementation therapy for knee – revision to the Part A and Part B LCD

LCD ID number: L33767 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for viscosupplementation therapy for knee was revised based on a reconsideration request to remove the following language, “Per the Food and Drug Administration (FDA) package insert, the effectiveness of Monovisc™ has not been established for more than one course of treatment.” from the “Limitations” section of the LCD.

Also, the language, “(the effectiveness of Monovisc™ has not been established for more than one course of treatment)” was removed from the “Utilization Guidelines” section of the LCD. In addition, “Monovisc™ was added indicating that it is administered as a single intra-articular

injection per course of treatment in the “Utilization Guidelines” section of the LCD.

Effective date

This LCD revision is effective for claims processed **on or after January 4, 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](#).

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

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

The local coverage determination (LCD) for Vitamin D; Hydroxy, includes Fraction(s), if performed was revised based on data analysis by the Program Safeguards Communication Group (PSCG) at First Coast Service Options, as well as, comprehensive error rate testing (CERT) issues related to the absence of documented medical necessity for vitamin D testing. As stated in the “Limitations” section of the LCD, vitamin D assay testing is not covered for routine screening; therefore, preventive care is not recognized as a covered indication for vitamin D serum testing. Tests that are performed in the absence of signs, symptoms, complaints, personal history of disease, or injury are not covered by Medicare except when there is a statutory provision that explicitly

covers tests for screening, as described in the Medicare manual. The following sections of the LCD were revised: “Indications and Limitations of Coverage and/or Medical Necessity,” “Documentation Requirements,” and “Utilization Guidelines.”

Effective date

This LCD revision is effective for services rendered **on or after April 11, 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](#).

Additional Information

G-CSF (Neupogen®, Granix™, Zarxio™) – clarification related to HCPCS code Q5101

LCD ID number: L34002 (Florida, Puerto Rico/ U.S. Virgin Islands)

Change request (CR) 9205 (July 2015 Update of the Hospital Outpatient Prospective Payment System [OPPS]) and CR 9152 (Quarterly Update to the Medicare Physician Fee Schedule Database [MPFSDB] – July CY 2015 Update) listed the effective date for HCPCS code Q5101 as March 6, 2015. At that time, the local coverage determination (LCD) for G-CSF (Neupogen®, Granix™, Zarxio™) was updated to include HCPCS code Q5101 with an effective date of March 6, 2015.

Since that time, based on Centers for Medicare &

Medicaid Services (CMS) direction, A/B MACs are to use July 1, 2015, as the effective date for HCPCS code Q5101. Therefore, this article serves to clarify that the effective date for the addition of HCPCS code Q5101 to the G-CSF (Neupogen®, Granix™, Zarxio™) LCD is July 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](#).

Left atrial appendage closure or occlusion – retired Part A and Part B draft LCD

LCD ID number: DL36620 (Florida, Puerto Rico/U.S. Virgin Islands)

The draft local coverage determination (LCD) for left atrial appendage closure or occlusion is being retired. The draft LCD was posted for the 45-day comment period the week of February 1, 2016, which was viewable to the public February 11, 2016.

The contractor became aware that the Centers for

Medicare and Medicaid Services (CMS) published a final decision memorandum for percutaneous left atrial appendage (LAA) closure therapy (CAG-00445N) February 8, 2016, addressing LAA closure for non-valvular atrial fibrillation (NVAf) through coverage with evidence development (CED) under 1862(a)(1)(E) of the Social Security Act under certain conditions. Due to CMS' final decision memorandum addressing coverage of LAA closure under CED, the contractor has retired the current draft LCD.

Claims resubmitted after a clinical review of records

As part of First Coast Service Options' (First Coast) routine data analysis process we have identified and are monitoring an increased number of providers that are cancelling and/or resubmitting claims that should be submitted via the appeals process. First Coast views this as an abuse of the process and is considering additional actions to address the problem.

The Part A claim processing system (fiscal intermediary shared system or FISS) is designed to allow providers to cancel and resubmit a claim when appropriate. The appropriate instances include those situations where a claim has been rejected due to incomplete submissions, missing information, and invalid submissions.

The Part B claims processing system (multi-carrier system or MCS) is not designed to allow a provider to cancel a claim, but does allow a claim to be resubmitted if appropriate.

A claim that has been clinically reviewed and/or denied should never be resubmitted as a claim, but submitted as a redetermination.

When a letter (additional development request) is sent to your office asking for patient records, a claim has failed one of the preprogrammed edits in our claims processing systems. This editing may include procedure codes, code combinations, modifiers, national or local coverage determination, billing patterns, utilization parameters, etc. Although there is provider-specific auditing, the majority of requests are service specific and set to look at anyone billing one of the subsets mentioned above. Record reviews are completed initially by the company's staff of clinicians or MDs in the Program Integrity department. Once a claim decision has been made to deny based on a service being "not medically reasonable and necessary," the correct process or next step is to follow the appeals process. By following the appeals process you are given an opportunity to include attestations, signature logs, missing or omitted records, add addenda, etc. Additionally, it allows for a different set of clinical reviewers to take a look at your records. Resubmitting the claim rather than requesting an appeal (redetermination) is considered an abuse of the program and adds additional scrutiny for medical review to your practice by our data analysis department.

Single chamber and dual chamber permanent cardiac pacemakers – Part A and Part B coding and billing

Article ID number: A54926 (Florida, Puerto Rico/U.S. Virgin Islands)

The Centers for Medicare & Medicaid Services (CMS) national coverage determination (NCD) 20.8.3, single chamber and dual chamber permanent cardiac pacemakers, was effective on August 13, 2013.

The CMS A/B Medicare administrative contractors (MACs) have been instructed to implement the NCD at the local level until CMS is able to revise the formal claim processing instructions. All aspects of the NCD policy in Publication 100-03, *NCD Manual*, Section 20.8.3, remain in effect. This article serves as a 45-day notice for the coding and billing instructions for the implementation of NCD 20.8.3.

Effective date

This coding and billing article is effective for services rendered **on or after May 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, please [click here](#).

Upcoming provider outreach and educational event April 2016

Medicare Internet-based PECOS training by appointment

Type of Event: Face-to-face

<http://medicare.fcso.com/Events/0324673.asp>

LCD coverage criteria for drug assays

Date: Thursday, April 28

Time: 11:30 a.m.-1:00 p.m.

Type of Event: Webcast

<http://medicare.fcso.com/Events/0331284.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 February 25, 2016

MLN Connects® Provider eNews for February 25, 2016

[View this edition as a PDF](#)

In this edition:

MLN Connects® Events

- Provider Enrollment Revalidation Call — Last Chance to Register
- Medicare Shared Savings Program Listening Session: Proposed Rule on Revised Benchmark Rebased Methodology — New

Medicare Learning Network® Publications and Multimedia

- Guidance on the PQRS 2014 Reporting Year and 2016 Payment Adjustment for RHCs, FQHCs, and CAHs
MLN Matters® Article – Released

- Ambulatory Surgical Center Fee Schedule Fact Sheet — Revised
- New Educational Web Guides Fast Fact

Announcements

- Alignment and Simplification of Quality Measures
- CMS Publishes Medicare FFS Provider and Supplier Lists
- Strengthening Provider and Supplier Enrollment Screening
- CMS Seeks Public Comments on Draft Quality Measure Development Plan by March 1
- Quality of Patient Care Star Ratings TEP: Nomination Period Open through March 18
- EHR Hardship Exception Application: New FAQ

MLN Connects® Provider eNews for March 3, 2016

MLN Connects® Provider eNews for March 3, 2016

[View this edition as a PDF](#)

In this edition:

MLN Connects® Events

- Medicare Shared Savings Program Listening Session: Proposed Rule on Revised Benchmark Rebased Methodology— Reminder

Medicare Learning Network® Publications and Multimedia

- Provider Enrollment Revalidation: Cycle 2 *MLN Matters*® Article — New
- CMS Quality Conference 2015: Industry Leaders Discuss IMPACT Act Video — New
- CMS Provider Minute: Multiple Same Day Surgeries and Modifier 51 Video — New
- Home Health Prospective Payment System Booklet — Revised
- Suite of Products & Resources for Rural Health Providers Educational Tool — Revised
- DMEPOS Quality Standards Booklet — Reminder

Announcements

- Major Commitments from Healthcare Industry to Make Electronic Health Records Work Better
- Program Integrity Enhancements to the Provider Enrollment Process
- CMS to Release a Comparative Billing Report on Non-invasive Vascular Studies in March
- EHR Incentive Program Hardship Application Deadline Extended to July 1
- EHR Incentive Programs: FAQs on Public Health Reporting Requirements
- ICD-10 Next Steps Toolkit
- Antipsychotic Drug use in Nursing Homes: Trend Update
- “Savor the Flavor of Eating Right” During National Nutrition Month® and Beyond

Claims, Pricers, and Codes

- Mandatory Payment Reduction of 2% Continues until Further Notice for the Medicare FFS Program – “Sequestration”

MLN Connects® Provider eNews for March 10, 2016

MLN Connects® Provider eNews for March 10, 2016
[View this edition as a PDF](#)

In this edition:

MLN Connects® Events

- Medicare Shared Savings Program ACO: Preparing to Apply for 2017 Call — Registration Opening Soon
- IMPACT Act: Data Element Library Call — Registration Now Open
- Medicare Shared Savings Program ACO Application Process Call — Registration Opening Soon

Medicare Learning Network® Publications and Multimedia

- Videos on Medicare Quality Reporting — New
- Swing Bed Services Fact Sheet — Revised
- Rural Health Clinic Fact Sheet — Revised
- Diagnosis Coding: Using the ICD-9 Web-Based Training — Revised

Announcements

- CMS Proposes to Test New Medicare Part B Prescription Drug Models
- HHS Reaches Goal of Tying 30 Percent of Medicare Payments to Quality Ahead of Schedule
- 2016 Value Modifier Results and Upward Payment Adjustment Factor
- Open Payments System Registration for Physicians and Teaching Hospitals
- 2015 PQRS Data Submission Deadlines
- EHR Incentive Programs: Attest to 2015 Program



Requirements by March 11

- Hospice, IRF, LTCH, SNF, HHA: QIES System Downtime from March 16 through 21
- Quality of Patient Care Star Ratings TEP Call for Nominations through March 18
- Home Health Agencies: Register for HHCAHPS before April 1
- Next Generation ACO Model Second Application Cycle: Letter of Intent due May 2
- New ST PEPPER Available
- Five Ways Patients Can Become Informed Medicare Consumers
- March is Colorectal Cancer Awareness Month

Claims, Pricers, and Codes

- April 2016 Average Sales Price Files Available



Learn the secrets to billing Medicare correctly

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

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

MLN Connects® Provider eNews for March 17, 2016

MLN Connects® Provider eNews for March 17, 2016

[View this edition as a PDF](#)

In this edition:

MLN Connects® Events

- Medicare Shared Savings Program ACO: Preparing to Apply for 2017 Call — Registration Now Open
- Open Payments 2016: Prepare to Review Reported Data Call — Registration Now Open
- IMPACT Act: Data Element Library Call — Register Now
- Medicare Shared Savings Program ACO Application Process Call — Registration Now Open
- New Audio Recording and Transcript Available

Other CMS Events

- Comparative Billing Report on Modifier 25: Internal Medicine Webinar
- Comparative Billing Report on Non-invasive Vascular Studies Webinar

Medicare Learning Network® Publications and Multimedia

- February 2016 Catalog Available

MLN Connects® Provider eNews for March 24, 2016

MLN Connects® Provider eNews for March 24, 2016

[View this edition as a PDF](#)

In this edition:

MLN Connects® Events

- Medicare Shared Savings Program ACO: Preparing to Apply for 2017 Call — Register Now
- Open Payments 2016: Prepare to Review Reported Data Call — Register Now
- IMPACT Act: Data Element Library Call — Register Now
- Medicare Shared Savings Program ACO Application Process Call — Register Now
- New Audio Recording and Transcript Available

Other CMS Events

- March ICD-10 Coordination and Maintenance Committee: Comments on Proposals due April 8

Medicare Learning Network® Publications and Multimedia

- Series of *MLN Matters*® Special Edition Articles for Chiropractors — New

- Dual Eligible Beneficiaries Fact Sheet and *MLN Matters*® Article — Revised
- Health Professional Shortage Area Physician Bonus Program Fact Sheet — Revised
- SNF Consolidated Billing Web-Based Training Course — Reminder
- HIPAA EDI Standards Web-Based Training Course — Reminder
- Medicare-Required SNF PPS Assessments Educational Tool — Reminder

Announcements

- Medicare SNF Transparency Data for CY 2013
- DMEPOS Competitive Bidding Payment Amounts and Contract Offers for Round 2 Recompete and the National Mail-Order Recompete
- Eligible Professionals and Hospitals: Submitting QRDA Files in the 2016 Reporting Period
- ICD-10: Track and Improve Your Progress
- CMS Acting Administrator Andy Slavitt's Comments at HIMSS
- HCAHPS: Measurement of the Patient Experience in Hospitals
- It Is Still Influenza Season

- Medicare Costs at a Glance: 2016 Educational Tool — Revised
- PECOS for Physicians and Non-Physician Practitioners — Reminder
- Medicare Enrollment for Institutional Providers Fact Sheet — Reminder
- New Educational Web Guides Fast Fact

Announcements

- CMS Releases Interactive Mapping Medicare Disparities Tool
- Delivery System Reform: Making Health Care Work Better
- CMS to Release a CBR on Subsequent Nursing Facility E/M Services in April
- Next Generation ACO Model Second Application Cycle: LOI due May 2
- 2016 PQRS Educational Materials Available
- DMEPOS Suppliers: List of HCPCS Codes Affected by Section 2 of PAMPA

Claims, Pricers, and Codes

- Update to the RHC Qualifying Visit List

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

Provider enrollment

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

Medical policy

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

Medicare secondary payer

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

Electronic data interchange (EDI)

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

Overpayments

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

Medicare Education and Outreach

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

Fraud and abuse

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

Freedom of Information Act requests

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

Overnight mail and/or special courier service

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

Websites

Provider

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

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

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

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

Beneficiaries

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

Phone numbers

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866-454-9007

877-660-1759 (speech and hearing impaired)

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904-791-8103 (NOT toll-free)

Electronic data interchange (EDI)

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866-454-9007

877-660-1759 (TTY)

Fax number (for general inquiries)

904-361-0696

Interactive voice response (IVR) system

877-847-4992

Provider enrollment

888-845-8614

877-660-1759 (TTY)

The SPOT help desk

855-416-4199

email: FCSOSPOTHelp@FCSO.com

Addresses

Claims

Medicare Part B Claims

P.O. Box 45098

Jacksonville, FL 32232-5098

Redeterminations

Medicare Part B Redetermination

P.O. Box 45024

Jacksonville, FL 32232-5024

Redetermination of overpayments

First Coast Service Options Inc.

P.O. Box 45091

Jacksonville, FL 32232-5091

Reconsiderations

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@fcsso.com

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

Provider enrollment

Provider Enrollment

P.O. Box 44021

Jacksonville, FL 32231-4021

Medical policy

Medical Policy and Procedure

P.O. Box 2078

Jacksonville, FL 32231-0048

Email: medical.policy@fcsso.com

Medicare secondary payer

Medicare Part B Secondary Payer Dept.

P.O. Box 44078

Jacksonville, FL 32231-4078

Electronic data interchange (EDI)

Medicare EDI, 4C

P.O. Box 44071

Jacksonville, FL 32231-4071

Overpayments

Medicare Part B Debt Recovery

P.O. Box 44141

Jacksonville, FL 32231-4141

Medicare Education and Outreach

Medicare Education and Outreach

P.O. Box 45157

Jacksonville, FL 32232-5157

Fraud and abuse

Fraud and abuse complaints

P.O. Box 45087

Jacksonville, FL 32232-5087

Freedom of Information Act requests

FOIA USVI

P.O. Box 45073

Jacksonville, FL 32231-5073

Special courier service

First Coast Service Options Inc.

532 Riverside Avenue

Jacksonville, FL 32202-4914

Websites

Provider

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

Provider enrollment

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

Medical policy

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

Medicare secondary payer

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

Electronic data interchange (EDI)

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

Overpayments

Medicare Part B Debt Recovery
P.O. Box 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.fcsso.com>

Beneficiaries

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

Order form for Medicare Part B materials

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

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

Item	Acct Number	Cost per item	Quantity	Total cost
Part B subscription – The Medicare Part B jurisdiction N publications, in both Spanish and English, are available free of charge online at http://medicare.fcso.com/Publications_B/index.asp (English) or http://medicareespanol.fcso.com/Publicaciones/ (Español). Nonprovider entities or providers who need additional copies may purchase an annual subscription. This subscription includes all issues published from October 2015 through September 2016.	40300260	\$33		
2016 fee schedule – The Medicare Part B Physician and Nonphysician Practitioner Fee Schedules, effective for services rendered January 1 through December 31, 2016, are available free of charge online at http://medicare.fcso.com/Data_files/ (English) or http://medicareespanol.fcso.com/Fichero_de_datos/ (Español). Additional copies are available for purchase. The fee schedules contain payment rates for all localities. These items do not include the payment rates for injectable drugs, clinical lab services, mammography screening, or DMEPOS items. Note: Requests for hard copy paper disclosures will be completed as soon as CMS provides the direction to do so. Revisions to fees may occur; these revisions will be published in future editions of the Medicare Part B publication.	40300270	\$12		
Language preference: English [<input type="checkbox"/>] Español [<input type="checkbox"/>]				
<i>Please write legibly</i>			Subtotal	\$
			Tax (add % for your area)	\$
			Total	\$

Mail this form with payment to:
First Coast Service Options Inc.
Medicare Publications
P.O. Box 406443
Atlanta, GA 30384-6443

Contact Name: _____
 Provider/Office Name: _____
 Phone: _____
 Mailing Address: _____
 City: _____ State: _____ ZIP: _____

(Checks made to "purchase orders" not accepted; all orders must be prepaid)



Medicare B Connection

First Coast Service Options Inc.
P.O. Box 2078 Jacksonville, FL. 32231-0048

Attention Billing Manager