Medicare B CONNECTION

medicare.fcso.com

FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction N Providers

April 2016

In this issue

Remittance advice remark and claims adjustment reason code and Medicare Remit Easy Print and PC Print update

Provider types affected

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

Provider action needed

CR 9466 updates the claim adjustment reason code (CARC) and remittance advice remark code (RARC) lists. It also instructs Medicare system maintainers to update Medicare Remit Easy Print (MREP) and PC Print. Make sure that your billing staffs are aware of these changes and obtain the updated MREP or PC Print software if they use that software.

Background

The Health Insurance Portability and Accountability Act (HIPAA) of 1996, instructs health plans to be able to conduct standard electronic transactions adopted under HIPAA using valid standard codes. Medicare policy states that CARCs and RARCs, as appropriate, that provide either supplemental explanation for a monetary adjustment or policy information that generally applies to the monetary adjustment of a claim or service, are required in the remittance advice and coordination of benefits transactions.

The Centers for Medicare & Medicaid Services (CMS) instructs MACs and shared systems, if appropriate, to conduct updates based on the code update schedule that results in publication of updated code lists three times a year (around March 1, July 1, and November 1).

Medicare's shared system maintainers (SSMs) are responsible for implementing appropriate code deactivation, making sure that any deactivated code is not used in original business messages, but the deactivated code in derivative messages is allowed. SSMs must make sure that Medicare does not report any deactivated code

See **REMIT**, page 13

Contents

Find out first: Subscribe to First Coast *eNews*

Subscribe to First Coast Service Options *eNews*, to learn the latest Medicare news and critical program changes affecting the provider community. Join as many lists as you wish, in English or Spanish, and customize your subscription to fit your specific needs, line of business, specialty, or topics of interest. So, *subscribe to eNews, and stay informed.*

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

Publication staff:
Terri Drury
Sofia Lennie
Mark Willett
Robert Petty

Fax comments about this publication to:

Medicare Publications
904-361-0723

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

About the 'Medicare B Connection'

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

Important notifications that require communication in between publications will be posted to the First Coast Medicare provider education website at *https://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 *When to file an appeal* 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 *https://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 *https://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html*.

ABN modifiers

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

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

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

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

GA modifier and appeals

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

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

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

July update to the correct coding initiative edits

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.

Provider action needed

Change request (CR) 9516 informs MACs about the release of the latest package of national correct coding initiative (NCCI) edits, version 22.2, which will be effective July 1, 2016. Make sure that your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) developed the NCCI edits to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment in Part B claims.

The latest package of CCI edits, version 22.2, effective July 1, 2016, will be available via the CMS Data Center (CDC). A test file will be available on or about May 2, 2016, and a final file will be available on or about May 17, 2016.

Version 22.2 will include all previous versions and updates from January 1, 1996, to the present. In the past, NCCI was organized in two tables: column 1/column 2 correct coding edits and mutually exclusive code (MEC) edits.

In order to simplify the use of NCCI edit files (two tables), on April 1, 2012, CMS consolidated these two edit files into the column one/column two correct coding edit file. Separate consolidations have occurred for the two-practitioner NCCI edit files and the two-NCCI edit files used for OCE. It will only be necessary to search the column one/column correct coding edit file for active or previously deleted edits.

CMS no longer publishes a mutually exclusive edit file on its website for either practitioner or outpatient hospital services, since all active and deleted edits will appear in the single column one/column two correct coding edit file on each website. The edits previously contained in the mutually exclusive edit file are NOT being deleted but are being moved to the column one/column two correct coding edit file.

Refer to the CMS NCCI Web page for additional information at *https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html*.

***Note**: The coding policies developed are based on coding conventions defined in the American Medical Association's Current Procedural Terminology manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practice, and review of current coding practice.*

Additional information

The official instruction, CR 9516, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3482CP.pdf*.

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

MLN Matters® Number: MM9516
Related Change Request (CR) #: CR 9516
Related CR Release Date: March 18, 2016
Effective Date: July 1, 2016
Related CR Transmittal #: R3482CP
Implementation Date: July 5, 2016

Evaluation & Management

Prepayment of evaluation and management code 99285

Florida only

Recent data analysis pertaining to emergency department visits for the evaluation and management services indicates a high claim payment error rate. High level Current Procedural Terminology (CPT®) code 99285 has been over-utilized compared to other emergency E/M service codes. In addition, First Coast staff has observed a high comprehensive error rate testing (CERT) error rate related to utilization of CPT® code 99285. Errors identified include inappropriate use of high level emergency department E/M CPT® codes that were down-coded to a lower level of care, and insufficient documentation to support CPT® code 99285, which is defined in the CPT® code 99285 manual as follows:

Emergency department visits for the evaluation and management of a patient, which requires these three key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status:

- A comprehensive history;
- A comprehensive examination; and
- 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's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.

As outlined in the Centers for Medicare & Medicaid Services (CMS) *Medicare Claims Processing Manual* Chapter 12 - Physicians/Nonphysician Practitioners, Section 30.6.11 - Emergency Department Visits (Codes 99281-99288)

Use of emergency department codes by physicians not assigned to emergency department

Any physician seeing a patient registered in the emergency department may use emergency department visit codes (for services matching the code description). It is not required that the physician be assigned to the emergency department.

Use of emergency department codes in office

Emergency department coding is not appropriate if the site of service is an office or outpatient setting or any sight of service other than an emergency department. The emergency department codes should only be used if the patient is seen in the emergency department and the services described by the HCPCS code definition are provided. The emergency department is defined as an organized hospital-based facility for the provision of unscheduled or episodic services to patients who present for immediate medical attention.

Use of emergency department codes to bill nonemergency services

Services in the emergency department may not be emergencies. However the codes (codes 99281-99288) are payable if the described services are provided.

However, if the physician asks the patient to meet him or her in the emergency department as an alternative to the physician's office and the patient is not registered as a patient in the emergency department, the physician should bill the appropriate office/outpatient visit codes. Normally a lower level emergency department code would be reported for a nonemergency condition.

Emergency department or office/outpatient visits on same day as nursing facility admission

Emergency department visit provided on the same day as a comprehensive nursing facility assessment are not paid. Payments for evaluation and management services on the same date provided in sites other than the nursing facility are included in the payment for initial nursing facility care when performed on the same date as the nursing facility admission.

Physician billing for emergency department services provided to patient by both patient's personal physician and emergency department physician

If a physician advises his/her own patient to go to an emergency department (ED) of a hospital for care and the physician subsequently is asked by the ED physician to come to the hospital to evaluate the patient and to advise the ED physician as to whether the patient should be admitted to the hospital or be sent home, the physicians should bill as follows:

See **PREPAY**, next page

PREPAY

previous page

- If the patient is admitted to the hospital by the patient's personal physician, then the patient's regular physician should bill only the appropriate level of the initial hospital care (codes 99221-99223) because all evaluation and management services provided by that physician in conjunction with that admission are considered part of the initial hospital care when performed on the same date as the admission. The ED physician who saw the patient in the emergency department should bill the appropriate level of the ED codes.
- If the ED physician, based on the advice of the patient's personal physician who came to the emergency department to see the patient, sends the patient home, then the ED physician should bill the appropriate level of emergency department service. The patient's personal physician should also bill the level of emergency department code that describes the service he or she provided in the emergency department. If the patient's personal physician does not come to the hospital to see the patient, but only advises the emergency department physician by telephone, then the patient's personal physician may not bill.

Emergency department physician requests another physician to see the patient in emergency department or office/outpatient setting

If the emergency department physician requests that another physician evaluate a given patient, the other physician should bill an emergency department visit code. If the patient is admitted to the hospital by the second physician performing the evaluation, he or she should bill an initial hospital care code and not an emergency department visit code.

First Coast and the 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, access to E/M interactive worksheet, FAQs, online learning, and additional resources.
- CMS *Internet-only manual (IOM) guidelines* addressing multiple types and settings pertaining to E/M services.

First Coast response

In response to continued CERT errors and risk of improper payments First Coast will implement a prepayment threshold audit for CPT® code 99285 claims submitted **on or after June 13, 2016**, that will apply to all providers within First Coast's **Florida jurisdiction**.

Widespread probe review for daptomycin - Florida only

First Coast Service Options Inc. (First Coast) completed a complex widespread service specific probe (WSP) review related to the use of The Healthcare Common Procedure Coding System (HCPCS) J0878 (Injection, daptomycin, 1 mg). The overall widespread probe error rate was 6.03 percent. Services were denied because documentation did not indicate the exact time, date, and quantity of the amount of drug wasted.

Providers are encouraged to review the guidelines for discarded drugs and biologics found at the Centers for Medicare & Medicaid Services (CMS) Internet-only manual (IOM) Publication 100-04, Chapter 17.

Quarterly provider update

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

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

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

Laboratory/Pathology

New waived tests subject to CLIA edits

Provider types affected

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

Provider action needed

Change request (CR) 9563 informs MACs of new Clinical Laboratory Amendments of 1988 (CLIA) waived tests approved by the Food and Drug Administration (FDA). Since these tests are marketed immediately after approval, the Center for Medicare & Medicaid Services (CMS) must notify its MACs of the new tests so that MACs can accurately process claims. Make sure your billing staffs are aware of these changes.

Background

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

Listed in the following table are the latest tests approved by the FDA as waived tests under CLIA. The Current Procedural Terminology (CPT®) codes for the following new tests must have the modifier QW (CLIA waived test). However, the CPT® codes 81002, 81025, 82270, 82272, 82962, 83026, 84830, 85013, and 85651 do not require a QW modifier to be recognized as a waived test.

CPT® code	Effective date	Description
81007QW	September 25, 2015	Jant Pharmacal Corporation Accutest Uriscreen (Bacteriuria)
G0434QW	From November 3, 2015, to December 31, 2015, and G0477QW on and after January 1, 2016	Nantong Egens Biotechnology Co., Ltd., EGENS Urine Test Marijuana (THC) Cassette
G0434QW	From November 3, 2015, to December 31, 2015, and G0477QW on and after January 1, 2016	Nantong Egens Biotechnology Co., Ltd., EGENS Urine Test Marijuana (THC) Cup
G0434QW	From November 3, 2015, to December 31, 2015, and G0477QW on and after January 1, 2016	Nantong Egens Biotechnology Co., Ltd., EGENS Urine Test Marijuana (THC) DipCard
G0434QW	From November 3, 2015, to December 31, 2015, and G0477QW on and after January 1, 2016	Nantong Egens Biotechnology Co., Ltd., EGENS Urine Test MDMA Cup
G0434QW	From November 3, 2015, to December 31, 2015, and G0477QW on and after January 1, 2016	Nantong Egens Biotechnology Co., Ltd., EGENS Urine Test MDMA DipCard
87631QW	December 3, 2015	Cepheid Gene Xpert Xpress System (Xpert Flu+RSV Xpress)
G0434QW	From December 17, 2015, to December 31, 2015, and G0477QW on and after January 1, 2016	Premier BIOTECH Premier Bio-cup & Bio-Dip
G0477QW	January 13, 2016	Medical Distribution Group Inc., Identify Diagnostics Drug Test Cards
G0477QW	January 13, 2016	Medical Distribution Group Inc., Identify Diagnostics Drug Test Cups
G0477QW	January 21, 2016	American Screening Corporation, Inc. Discover Plus Drug Test Cards

See **CLIA**, next page

CLIA

From previous page

CPT® code	Effective date	Description
G0477QW	January 21, 2016	American Screening Corporation, Inc. Discover Plus Multi-Panel Drug Test Cups

The Healthcare Common Procedure Coding System (HCPCS) code G6040QW [Alcohol (ethanol); any specimen except breath] was discontinued on December 31, 2015. The new HCPCS code G0477 [Drug tests(s), presumptive, any number of drug classes; any number of devices or procedures, (eg immunoassay) capable of being read by direct optical observation only (eg, dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service] was effective January 1, 2016.

HCPCS code G0477QW describes the waived testing previously assigned code G6040QW. All tests in the attachment to CR 9563 that previously had HCPCS G6040QW are now assigned G0477QW.

The new waived complexity code 87631QW [Infectious agent detection by nucleic acid (DNA or RNA); respiratory virus (eg, adenovirus, influenza virus, coronavirus, metapneumovirus, parainfluenza virus, respiratory syncytial virus, rhinovirus) includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, multiple types or subtypes, 3-5 targets] was assigned for the detection of influenza A, influenza B and respiratory syncytial virus viral RNA by reverse transcriptase polymerase chain reaction assay performed using the Cepheid Gene Xpert Xpress System (Xpert Flu+RSV Xpress).

Note that MACs will not search their files to either retract payment or retroactively pay claims processed before implementation of CR 9563. However, MACs will adjust such claims that you bring to their attention.

Additional information

The official instruction, CR 9563, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3479CP.pdf*.

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

MLN Matters® Number: MM9563
Related Change Request (CR) #: CR 9563
Related CR Release Date: March 18, 2016
Effective Date: July 1, 2016
Related CR Transmittal #: R3479CP
Implementation Date: July 5, 2016

July 2016 changes to the laboratory NCD edit software

Provider types affected

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

What you need to know

Change request (CR) 9584 informs MACs about changes that will be included in the July 2016 quarterly release of the edit module for clinical diagnostic laboratory services. Make sure that your billing staffs are aware of these changes.

For the July 2016 update, effective for services furnished on or after July 1, 2016, International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes E61.1, M79.641, M79.642, M79.644, and M79.645 are added to the list of ICD-10-CM codes that are covered by Medicare for the serum iron studies (190.18) NCD.

Additional information

The official instruction, CR 9584, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3485CP.pdf*.

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

MLN Matters® Number: MM9584
Related Change Request (CR) #: CR 9584
Related CR Release Date: March 25, 2016
Effective Date: July 1, 2016
Related CR Transmittal #: R3485CP
Implementation Date: July 5, 2016

General Coverage

Updates to Medicare's organ acquisition and donation payment policy

Provider types affected

This *MLN Matters*® special edition article is intended for all providers and suppliers who submit claims or Medicare cost reports (MCRs) to Medicare administrative contractors (MACs) for organ procurement, transplant, and histocompatibility laboratory services provided to Medicare beneficiaries.

What you need to know

This article is intended to assist providers and suppliers by offering information and resources to clarify Medicare's organ acquisition and donation payment policy for organ procurement, transplant, and histocompatibility laboratory services provided to Medicare beneficiaries. The information does not convey any new or changed policy, but conveys clarification language in the *Provider Reimbursement Manual (PRM)*, CMS Pub. 15-1, Chapter 31. This clarification is provided to ensure appropriate reporting of organ acquisition costs, including those in a living kidney paired donation (KPD) exchange, to achieve proper Medicare reimbursement.

Background

CMS issued Chapter 31 of the PRM to clarify Medicare's payment policy regarding organ acquisition costs, formerly found in Chapter 27, Sections 2770 through 2775.4. In response to questions raised by the transplant community, chapter 31 clarifies the accounting and reporting of KPD exchange costs in the MCR. The chapter also clarifies the appropriate methodology for counting organs.

- Section 3106 clarifies the accounting for costs of services in a living KPD exchange, provides a detailed example of an exchange, and summarizes the example in a chart.
- Section 3115 clarifies the methodology for counting organs, including those procured and transplanted en bloc.

Highlights from Section 3106, kidney paired donations

- KPDs are similar to directed living donations; however, when the living donor and recipient do not match, they can consent to participate in a KPD matching program that matches living donor/recipient pairs with other living donor/recipient pairs. KPD exchanges can occur when two or more living donor/recipient pairs match each other; often, the living donor and matched recipient are at different certified transplant centers (CTCs).
- The costs of all hospital and physician services for pre-transplant living donor and recipient evaluations become acquisition costs and are included in the MCR of the recipient's CTC.

Similarly, when a recipient and donor do not match and elect to participate in a KPD matching program, the costs of the initial living donor evaluations are incurred by the original intended recipient's CTC, regardless of whether the living donor actually donates to their original intended recipient, a KPD matched recipient, or does not donate at all.

- In a KPD exchange, once the donor is matched with a recipient, any additional tests requested by the recipient's CTC, but performed by the donor's CTC are billed as charges reduced to cost to the recipient's CTC and included as acquisition costs on the MCR of the recipient CTC. This is true regardless of whether an actual donation occurs.
- When a donor's CTC procures and sends a kidney to a recipient's CTC, the donor's CTC bills the recipient's CTC the donor CTC's charges reduced to cost for the reasonable costs associated with procuring, packaging, and transporting the kidney. The donor's CTC records these costs on its MCR as kidney acquisition costs and offsets any payments received from the recipient's CTC against its kidney acquisition costs. The recipient's CTC records as part of its kidney acquisition costs, the amounts billed by the donor's CTC for the reasonable costs associated with procuring, packaging, and transporting the organ as well as any additional testing performed and billed by the donor's CTC. These costs must be reasonable and necessary.
- When a donor's CTC does not procure a kidney, but the donor travels to the recipient's CTC for the procurement, the reasonable costs associated with the procurement are included on the MCR of the recipient's CTC. Travel expenses of the living donor are not allowable Medicare costs.

Highlights from Section 3115, counting organs

- Organ procurement organizations (OPOs) and CTCs

See **ORGAN**, next page

ORGAN

From previous page

are responsible for accurately counting both Medicare and non-Medicare organs to ensure that costs are properly allocated on the MCR. The OPO and CTC must count organs procured and transplanted en bloc (two organs transplanted as one unit) as one organ. This can include, but is not limited to, en bloc kidneys and en bloc lungs.

- Medicare usable organs include organs transplanted into Medicare beneficiaries (excluding Medicare Advantage beneficiaries), organs that had partial payments by a primary insurance payer in addition to Medicare, organs sent to other CTCs, organs sent to OPOs and kidneys sent to military renal transplant centers (MRTCs) that have a reciprocal sharing agreement with the OPO in effect prior to March 3, 1988, and approved by the contractor. Medicare usable organs do not include organs used for research, organs sent to veterans' hospitals, organs sent outside the United States, organs transplanted into non-Medicare beneficiaries, organs that were totally paid by primary insurance other than Medicare, organs that were paid by a Medicare advantage plan, organs procured from a non-certified OPO and kidneys sent to MRTCs that do not have a reciprocal sharing agreement with the OPO in effect prior to March 3, 1988, and approved by the contractor.
- Kidneys counted as Medicare kidneys include those sent to CTCs, certified OPOs, or MRTCs (with a reciprocal sharing agreement with the OPO in effect prior to March 3, 1988, and approved by the contractor). It does not include kidneys sent to foreign countries, VA hospitals, or MRTCs (without a reciprocal sharing agreement with the OPO in effect prior to March 3, 1988, and approved by the contractor), or those used for research.

Information and resources

The following resources are available to find additional information regarding Medicare's organ acquisition and donation payment policy:

- PRM Transmittal 471 containing – CMS Pub. 15-1, Chapter 31;
- PRM – CMS Pub. 15-2, Chapters 33 and 40;
- *Medicare Claims Processing Manual* – CMS Pub. 100-04; and
- *Medicare Benefit Policy Manual* – CMS Pub. 100-02.

Additional information

If you have any questions, please contact your MAC at their toll-free number. To find MAC toll-free numbers, please refer to the Review Contractor Interactive Map located at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html*.

MLN Matters® Number: SE1608
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: April 1, 2016
Related CR Transmittal #: N/A
Implementation Date: N/A

ICD-10-CM diagnosis codes for bone mass measurement

***Note**: This article was revised April 12, 2016, to clarify the removal of a code (originally stated as M85.8) from the list of codes that providers may report. The code that was removed is M85.80 (Other specified disorders of bone density and structure, unspecified site). All other information is the same. This information was previously published in the November 2015 Medicare B Connection, page 21.*

Provider types affected

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

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) will implement change request (CR) 9252 on January 4, 2016, effective October 1, 2015. (See related *MLN Matters*® article *MM9252.*) This CR establishes the list of covered conditions and corresponding ICD-10-CM diagnosis codes approved for bone mass measurement studies according to the requirements set forth in national coverage determination (NCD) 150.3. CR 9252 and accompanying spreadsheet inadvertently omitted the condition of osteopenia and the ICD-10-CM codes that describe it which are classified to subcategory 'M85.8- Other specified disorders of bone density and structure'. The codes and conditions identified within this subcategory are considered covered indications for bone mass measurement under NCD 150.3 and providers should report these appropriately according to medical documentation. Additional guidance and education as to the updated complete list of covered indications will be forthcoming as CMS continues to review this issue and the systems updates required.

Background

Under ICD-9-CM, the term "Osteopenia" was indexed to ICD-9-CM diagnosis code 733.90 (Disorder of bone and cartilage). This code was listed as a covered condition under the business requirement 5521.1.1 for CR 5521/

See **BILLING**, next page

BILLING

From previous page

NCD 150.3, dated May 11, 2007, when reported with CPT® code 77080. (See related *MLN Matters*® article *MM5521*.) The accompanying *Benefit Policy Manual*, Publication 100-02, Chapter 15, Section 80.5.6, Beneficiaries Who May Be Covered, includes: "2. An individual with vertebral abnormalities as demonstrated by an X-ray to be indicative of osteoporosis, osteopenia, or vertebral fracture".

Under ICD-10-CM, the term "Osteopenia" is indexed to ICD-10-CM subcategory M85.8- Other specified disorders of bone density and structure, within the ICD-10-CM Alphabetic Index. The codes within this subcategory were inadvertently omitted from the CMS spreadsheet that accompanied CR 9252 containing the list of covered conditions and corresponding diagnosis codes. These are considered covered for NCD 150.3 indications.

Below is the list of ICD-10-CM diagnosis codes within subcategory M85.8- that providers may report as covered indications in addition to the current list provided in CR 9252 and its accompanying CMS spreadsheet.

- M85.811 Other specified disorders of bone density and structure, right shoulder
- M85.812 Other specified disorders of bone density and structure, left shoulder
- M85.821 Other specified disorders of bone density and structure, right upper arm
- M85.822 Other specified disorders of bone density and structure, left upper arm
- M85.831 Other specified disorders of bone density and structure, right forearm
- M85.832 Other specified disorders of bone density and structure, left forearm
- M85.841 Other specified disorders of bone density and structure, right hand
- M85.842 Other specified disorders of bone density and structure, left hand
- M85.851 Other specified disorders of bone density and structure, right thigh
- M85.852 Other specified disorders of bone density and structure, left thigh
- M85.861 Other specified disorders of bone density and structure, right lower leg
- M85.862 Other specified disorders of bone density and structure, left lower leg
- M85.871 Other specified disorders of bone density and structure, right ankle and foot
- M85.872 Other specified disorders of bone density and structure, left ankle and foot
- M85.88 Other specified disorders of bone density and structure, other site
- M85.89 Other specified disorders of bone density and structure, multiple sites

Additional information

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

Document history

Date of change	Description
April 12, 2016	The article was revised to clarify the removal of a code (originally stated as M85.8) from the list of codes that providers may report. The code that was removed is M85.80 (Other specified disorders of bone density and structure, unspecified site).
April 6, 2016	The article was revised to remove the code M85.8 from the list of codes that may be reported by providers.
October 28, 2015	Initial issuance of article

MLN Matters® Number: SE1525 *Revised*
Related Change Request (CR) #: CR 9252
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

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.

Manual updates to correct remittance advice messages

Provider types affected

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

What you need to know

Change request (CR) 9562 informs MACs about revisions to Chapters 3, 6, 7, and 15 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 the manual. CR 9562 does not reflect any change in Medicare policy.

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 Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE).

Medicare and all other payers must comply with the CAQH CORE-developed code combinations. CR 8424 established a standard format for presenting these code combinations in the *Medicare Claims Processing Manual*. CR 9562 updates Chapters 3, 6, 7, and 15 of the manual to reflect the standard format and to correct any non-compliant code combinations. CR 9562 does not reflect any change in Medicare policy.

Additional information

The official instruction, CR 9562, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3481CP.pdf*. The revised manual chapters are included in CR 9562.

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

MLN Matters® Number: MM9562
Related Change Request (CR) #: CR 9562
Related CR Release Date: March 18, 2016
Effective Date: June 20, 2016
Related CR Transmittal #: R3481CP
Implementation Date: June 20, 2016

REMIT

From front page

on or before the effective date for deactivation as posted on the Washington Publishing Company (WPC) website. If any new or modified code has an effective date past the implementation date specified in CR 9466, MACs will implement on the date specified on the WPC website. The WPC website is available at *http://www.wpc-edi.com/Reference*.

In case of any discrepancy in the code text as posted on WPC website and as reported in any CR, the WPC version should be implemented.

CR 9466 advises the SSMs and MACs to perform the updates posted on the WPC based on the March 1, 2016, CARC and RARC code change lists.

Additional information

The official instruction, CR 9466, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3489CP.pdf*.

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

MLN Matters® Number: MM9466
Related Change Request (CR) #: CR 9466
Related CR Release Date: April 1, 2016
Effective Date: July 1, 2016
Related CR Transmittal #: R3489CP
Implementation Date: July 5, 2016

Processing Issues

Radiologic examination hip/femur services billed by portable X-ray suppliers – claims that may have been denied in error

Issue

Claims submitted for radiologic examination, hip (CPT® procedure codes 73501, 73502, 73503, 73521, 73522, and 73523) or radiologic examination, femur (procedure codes 73551 and 73552) between January 1 and February 11, 2016, may have been denied in error when billed by portable X-ray suppliers.

Resolution

Closed. This error was corrected February 11, 2016.

Status/date resolved

Claims processed on or after February 12, 2016, were adjudicated correctly.

Provider action

None. First Coast Service Options Inc. will perform adjustments to correct the error on all the affected claims.

Current processing issues

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

Screening mammography related to referring physician – claims that may have been denied in error

Issue

Claims submitted for screening mammography (CPT® code 77063) between January 1, 2015, and February 24, 2016, may have been denied in error by requiring a referring physician.

Resolution

Closed. This error was corrected February 24, 2016.

Status/date resolved

Claims processed on or after February 25, 2016 were adjudicated correctly.

Provider action

None. Providers whose claims were incorrectly denied due to this error do not need to take any action. First Coast Service Options Inc. will perform adjustments to correct the error on all the affected claims.

Current processing issues

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

General Information

Provider enrollment requirements for writing prescriptions for Medicare Part D drugs

***Note**: This article was revised April 18, 2016, to show additional date changes related to the delayed enforcement of the Part D prescriber enrollment requirement until February 1, 2017. All other information remains the same. This information was previously published in the October 2015 Medicare B Connection, pages 26-29.*

Provider types affected

This *MLN Matters*® special edition article is intended for physicians, dentists, and other eligible professionals who write prescriptions for Medicare beneficiaries for Medicare Part D drugs. The article is also directed to Medicare Part D plan sponsors.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) finalized CMS-4159-F, *Medicare Program; Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs* May 23, 2014.

CMS later published CMS-6107-IFC, "Medicare Program; Changes to the Requirements for Part D Prescribers," an interim final rule with comment ("IFC"), that made changes to the final rule (CMS-4159-F), May 6, 2015. Together, these rules require virtually all physicians and other eligible professionals, including dentists, who write prescriptions for Part D drugs to be enrolled in an approved status or to have a valid opt-out affidavit on file for their prescriptions to be coverable under Part D, except in very limited circumstances.

To allow sufficient time for the prescribers to enroll in Medicare and the Part D sponsors and the pharmacy

See **PART D**, next page

PART D

From previous page

benefit managers (PBMs) to make the complex system enhancements needed to comply with the prescriber enrollment requirements, CMS announced a delay in enforcement of this rule until February 1, 2017. Nevertheless, prescribers of Part D drugs should submit their Medicare enrollment applications or opt-out affidavits to their Part B Medicare administrative contractors (MACs) by August 1, 2016, or earlier, to ensure that MACs have sufficient time to process the applications and opt-out affidavits and avoid their patients' prescription drug claims from being denied by their Part D plans, beginning February 1, 2017 (Enrollment functions for physicians and other prescribers are handled by MACs).

The purpose of these rules is to ensure that Part D drugs are prescribed only by physicians and eligible professionals who are qualified to do so under state law and under the requirements of the Medicare program and who do not pose a risk to patient safety. By implementing these rules, CMS is improving the integrity of the Part D prescription drug program by using additional tools to reduce fraud, waste, and abuse in the Medicare program. Prescribers who are determined to have a pattern or practice of prescribing Part D drugs that are abusive and represents a threat to the health and safety of Medicare enrollees or fails to meet Medicare requirements will have their billing privileges revoked under 42 USC 424.535 (a)(14).

Background

If you write prescriptions for covered Part D drugs and you are not already enrolled in Medicare in an approved status or have a valid record of opting out, you should submit an enrollment application or an opt-out affidavit to your MAC by August 1, 2016, or earlier, so that the prescriptions you write for Part D beneficiaries are coverable on and after February 1, 2017.

To enroll in Medicare for the limited purpose of prescribing:

You may submit your enrollment application electronically using the Internet-based Provider Enrollment, Chain, and Ownership System (PECOS) located at *https://www.cms.gov/medicare/provider-enrollment-and-certification/medicareprovidersupenroll/internetbasedpecos.html* or by completing the paper CMS-855O application, which is available at *https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms855o.pdf*, which must be submitted to the MAC that services your geographic area. Note that there is no application fee required for your application submission. For step-by-step instructions, refer to the PECOS how-to guide, available at *https://go.cms.gov/orderreferhowtoguide* or watch an instructional video at *https://go.cms.gov/videotutorial*.

The CMS-855O is a shorter, abbreviated form and takes minimal time to complete. While the CMS-855O form states it is for physicians and non-physician practitioners who want to order and certify, it is also appropriate for use by prescribers, who want to enroll to also prescribe Part D drugs. (CMS is in the process of updating the CMS-855O form). If you do not see your specialty listed on the application, please select the undefined physician/non-physician type option and identify your specialty in the space provided.

Note: Dentists are recognized by Medicare as physicians and should select the "Part B Physician Specialties" option and specify general dentist in the free form text box.

The average processing time for CMS-855O applications submitted online is 45 days versus paper submissions which is 60 days. However, your application could be processed sooner depending on the MAC's current workload.

To enroll to bill for services (and prescribe Part D drugs):

To enroll in Medicare to bill for your services, you may complete the CMS-855I application. The CMS-855R should also be completed if you wish to reassign your right to bill the Medicare program and receive Medicare payments for some or all of the services you render to Medicare beneficiaries. All actions can be completed via PECOS or the paper enrollment application. For more information on enrolling in Medicare to bill for services refer to *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedEnroll_PECOS_PhysNonPhys_FactSheet_ICN903764.pdf*. If you are a physician or non-physician practitioner who wants to opt-out of Medicare, you must submit an opt-out affidavit to the MAC that services your geographic area. Physicians and non-physician practitioners should be aware that if they choose to opt-out of Medicare, they are **not** permitted to participate in a Medicare advantage plan. In addition, once a physician or non-physician practitioner has opted out they are not permitted to terminate their opt-out affidavit early. Section 1802(b)(3)(B)(ii) of the Act establishes the term of the opt-out affidavit. The Act does not provide for early termination of the opt-out term. Under CMS regulations, physicians and practitioners who have not previously submitted an opt-out affidavit under Section 1802(b)(3) of the Act, may choose to terminate their opt-out status within 90 days after the effective date of the opt-out affidavit, if the physician or practitioner satisfies the requirements of 42 CFR § 405.445(b). No other method of terminating opt-out status before the end of the two year opt-out term is available.

Prior to enactment of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), physician/practitioner opt-out affidavits were only effective for two years. As a result of changes made by MACRA, valid opt-out affidavits signed on or after June 16, 2015, will

See **PART D**, next page

PART D

From previous page

automatically renew every two years. If physicians and practitioners that file affidavits effective on or after June 16, 2015, do not want their opt-out to automatically renew at the end of a two year opt-out period, they may cancel the renewal by notifying all Medicare administrative contractors (MACs) with which they filed an affidavit in writing at least 30 days prior to the start of the next opt-out period. Valid opt-out affidavits signed before June 16, 2015, will expire two years after the effective date of the opt out. If physicians and practitioners that filed affidavits effective before June 16, 2015, want to extend their opt out, they must submit a renewal affidavit within 30 days after the current opt-out period expires to all MACs with which they would have filed claims absent the opt-out. For more information on the opt-out process, refer to *MLN Matters*® article SE1311, titled "Opting out of Medicare and/or Electing to Order and Certify Items and Services to Medicare Beneficiaries," which is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1311.pdf* and *https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2015-06-25-eNews.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending&imagelink=y#_Toc422891549*.

CMS would like to highlight the following limitations that apply to billing and non-billing providers:

- A resident is defined in 42 CFR § 413.75 as an intern, resident, or fellow who participates in an approved medical residency program, including programs in osteopathy, dentistry, and podiatry, as required in order to become certified by the appropriate specialty board. Interns, residents, and fellows may enroll in Medicare to prescribe if the state licenses them. Licensure can include a provisional license or similarly-regulated credential. Un-licensed interns, residents, and fellows must specify the teaching physician who is enrolled in Medicare as the authorized prescriber on a prescription for a Part D drug (assuming this is consistent with state law). Licensed residents have the option to either enroll themselves or use the teaching physician's name on prescriptions for Part D drugs, unless state law specifies which name is to be used. CMS strongly encourages teaching physicians and facilities to ensure that the NPI of the lawful prescriber under state law is included on prescriptions to assist pharmacies in identifying the correct prescriber and avoid follow up from the pharmacies, which experience rejected claims from Medicare Part D plans due to missing or wrong prescriber NPIs on the claims.
- The prescriber enrollment requirements also apply to physicians and non-physician practitioners who write prescriptions for Part D drugs and are employed by a Part A institutional provider (e.g., hospital, federally qualified health center (FQHC), rural health center (RHC)). Since Part A institutional providers may bill for services provided by an employed physician or non-physician practitioner, the physician or non-physician practitioner may not have separately enrolled, unless he or she is also billing for Part B services. Therefore, if the physician or non-physician practitioner prescribes Part D drugs as an employee of the institutional provider, he or she must be enrolled in an approved status for their prescriptions to be coverable under Part D beginning June 1, 2016.
- "Other authorized prescribers" are exempt from the Medicare Part D prescriber enrollment requirement. In other words, prescriptions written by "other authorized prescribers are still coverable under Part D, even if the prescriber is not enrolled in or opted out of Medicare. For purposes of the Part D prescriber enrollment requirement only, "other authorized prescribers" are defined as individuals other than physicians and eligible professionals who are authorized under state or other applicable law to write prescriptions but are not in a provider category that is permitted to enroll in or opt-out of Medicare under the applicable statutory language. CMS believes "other authorized prescribers" are largely pharmacists who are permitted to prescribe certain drugs in certain states, but based on the applicable statute, pharmacists are not able to enroll in or opt-out of Medicare.

If you believe you are an "other authorized prescriber" and are not a pharmacist, please contact *providerenrollment@cms.hhs.gov*. In addition, CMS strongly recommends that pharmacists in particular make sure that their primary taxonomy associated with their NPI in the National Plan & Provider Enumeration System (NPPES) reflects that they are a pharmacist. To review and update your NPPES information, please go to the National Plan & Provider Enumeration System Web page at *http://nppes.cms.hhs.gov/NPPES/Welcome.do*. Upon enforcement of the regulation, Part D plans will need to be able to determine if the prescriber is a pharmacist in order to properly adjudicate the pharmacy claim at point-of-sale.

In an effort to prepare the prescribers and Part D sponsors for the February 1, 2017, enforcement date, CMS has made available an enrollment file that identifies physician and eligible professional who are enrolled in Medicare in an approved or opt-out status. However, the file does not specify if a particular prescriber is eligible to prescribe, as prescribing authority is largely determined by state law. The enrollment file is available at *https://data.cms.gov/dataset/Medicare-Individual-Provider-List/u8u9-2upx*. The file contains production data but is considered a test file since the Part D prescriber enrollment requirement is not yet applicable. An updated enrollment file will be generated

See **PART D**, next page

PART D

From previous page

every two weeks, with a purposeful goal of providing updates twice a week by the date of enforcement.

The file displays physician and eligible professional eligibility as of and after November 1, 2014, (that is, currently enrolled, new approvals, or changes from opt-out to enrolled as of November 1, 2014). Any periods, prior to November 1, 2014, for which a physician or eligible professional was not enrolled in an approved or opt-out status will not be displayed on the enrollment file. However, any gaps in enrollment after November 1, 2014, for which a physician or eligible professional was not enrolled in an approved or opt-out status will be reflected on the file with its respective effective and end dates for that given provider. For opted out providers, the opt-out flag will display a Y/N (Yes/No) value to indicate the periods the provider was opted out of Medicare. The file will include the provider's:

- (NPI);
- First and last names;
- Effective and end dates; and
- Opt-out flag

Example 1– Dr. John Smith's effective date of enrollment is January 1, 2014. Since he was enrolled prior to the generation of the test file, his effective date will display as November 1, 2014. Dr. Smith submits an enrollment application to voluntarily withdraw from Medicare effective December 15, 2014. Dr. Smith will appear on the applicable file as:

NPI	First name	Last name	Eff date	End date	Opt out flag
123456789	John	Smith	11/1/14	12/15/14	N

Example 2 - Dr. Mary Jones submits an affidavit to opt-out of Medicare, effective December 1, 2014. Since she has opted out after the generation of the test file, her effective date will display as December 1, 2014. After the two year opt-out period expires, Dr. Jones decides she wants to enroll in Medicare to bill, order, and certify, or to write prescriptions. The enrollment application is received on January 31, 2017, and the effective date issued is January 1, 2017. Dr. Jones will display on the applicable file as:

NPI	First name	Last name	Eff date	End date	Opt out flag
987654321	Mary	Jones	12/1/14	12/1/16	Y
87654321	Mary	Jones	1/1/17		N

After the enforcement date of February 1, 2017, the applicable effective dates on the file will be adjusted to February 1, 2017, and it will no longer be considered a test file. All inactive periods prior to February 1, 2017, will be removed from the file and it will only contain active and inactive enrollment or opt-out periods as of February 1, 2017, and after. The file will continue to be generated every two weeks, with a purposeful goal of providing updates twice a week by the date of enforcement. Part D sponsors may utilize the file to determine a prescriber's Medicare enrollment or opt-out status when processing Part D pharmacy claims. The file will not validate the provider's ability to prescribe under applicable laws. Please submit questions or issues encountered in accessing the file to *providerenrollment@cms.hhs.gov*.

Additional information

For more information on the enrollment requirements, visit *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html*. If you have questions and need to speak with the Part B contractor that handles your enrollment, you may find their toll-free number at *MAC List*.

For a list of frequency asked questions (FAQs) refer to *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/CMS-4159_FAQs.pdf*.

Document History

Date of change	Description
April 18, 2016	The article was revised to amend additional dates in the article to reflect the delayed enforcement date of February 1, 2017.
April 7, 2016	The article was revised to communicate changes to and the delayed enforcement of the Part D prescriber enrollment requirement until February 1, 2017, and to provide clarifying information regarding the enrollment process.
December 5, 2014	The article was revised to add language to emphasize that form CMS-855O is appropriate for use by prescribers.
October 20, 2015	The article was revised to communicate changes to and the delayed enforcement of the Part D prescriber enrollment requirement until June 1, 2016, and to provide clarifying information regarding the enrollment process.

MLN Matters® Number: SE1434
Revised Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Reporting principal and interest amounts when refunding previously recouped money on the remittance advice

***Note**: This article was revised April 19, 2016, to reflect the revised change request (CR) 9168 issued March 24. In the article, the CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same. This information was previously published in the November 2015 Medicare B Connection, page 23.*

Provider types affected

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

Provider action needed

Change request (CR) 9168 explains to providers who received a favorable appeals decision that it will be easier and consequently more transparent to identify the claim and/or the refund of principal and interest paid by Medicare. Your MAC will make sure that the remittance advices are reporting the refunded principal and interest amounts separately, and provide individual claim information. CR 9168 applies to electronic remittance advice (ERA) only.

Background

Currently reporting of refunded principal and interest amounts for all related claims on the remittance advice (RA) is shown as one lump sum amount. This practice creates problems for the provider community as this is not conducive to posting payment properly. Providers have the money but are not able to identify the claim and/or the refund of principal and interest paid by Medicare.

CR 9168 instructs MACs to report the principal and interest separately and also to provide individual claim information. Specifically, the reporting will be in the provider level balance (PLB) segment of the 835 with an example as follows:

PLB details - reporting principal refunds

PLB03-1: WW to report overpayment recovery (negative sign for the amount in PLB04) being refunded

PLB03-2 Positions 1 – 25: Account payable (AP) invoice number

PLB03-2 Positions 26 – 50: Claim adjustment account receivable (AR) number

PLB 04: Refund amount (principal refund amount)

PLB details - reporting interest refunds

PLB03-1: RU to report interest paid (negative sign for the amount in PLB04)

PLB03-2 Positions 1 – 25: AP invoice number

PLB03-2 Positions 26 – 50: Claim adjustment AR number

PLB04: Interest amount on refund

Additional information

The official instruction, CR 9168 issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1639OTN.pdf*.

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

Document history

- The article was revised April 19, 2016 to reflect the revised CR 9168 issued March 24.

MLN Matters® Number: MM9168
Revised Related Change Request (CR) #: CR 9168
Related CR Release Date: March 24, 2016
Effective Date: July 1, 2016
Related CR Transmittal #: R1639OTN
Implementation Date: July 5, 2016

Check the status of claim redeterminations online

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

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

Retired LCDs

Intensity modulated radiation therapy (IMRT) – retired Part A and Part B LCD

LCD ID number: L33378 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for intensity modulated radiation therapy (IMRT) is being retired due to the coding information within the LCD, which is secondary to the National Correct Coding Initiative (NCCI) manual standard, and is in need of updating. The future coding information will be revised and updated in the June 2016 LCD cycle.

Effective date

This LCD retirement is effective for services rendered **on or after April 7, 2016**. This LCD retirement is effective for services rendered on or after April 7, 2016. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Multiple Part A and Part B local coverage determinations (LCDs) being retired

LCD ID number: L33971, L33992, L33993, L33995, L34044 (Florida/Puerto Rico/U.S. Virgin Islands)

Based on data analysis and a review of the local coverage determinations (LCDs), it was determined that the following LCDs are no longer required and, therefore, were retired.

- levocarnitine (Carnitor®, L-carnitine®) – Part A
- epirubicin hydrochloride - Part A and B
- floxuridine (FUDR) – Part A and B
- fludarabine (Fludara®) - Part A and B
- mitoxantrone hydrochloride - Part A and B

Effective date

The retirement of these LCDs is effective for services rendered **on or after April 14, 2016**. First Coast Service Options Inc. LCDs are available, through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

Articles 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*.

Medicare signature requirements

The Medicare requirement to authenticate the medical record is to ensure the services rendered have been thoroughly documented and authenticated by the author of the medical record entry. *Click here* for information on Medicare's signature requirements and how adhering to these requirements can prevent impacts to your claims.

Revisions to LCDs

Bendamustine hydrochloride (Treanda®) – revision to the Part A and Part B LCD

LCD ID number: L33268 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for Bendamustime hydrochloride (Treanda®) was revised based on a LCD reconsideration request to include Bendeka™ which was approved by the Food and Drug Administration (FDA) on December 7, 2015.The title of the LCD and the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD were revised to add Bendeka™. Also, Healthcare Common Procedure Coding System (HCPCS) codes C9399 and J9999 were added in the "CPT®/HCPCS Codes" section of the LCD. In addition, the "Sources of Information and Basis for Decision" section of the LCD was updated.

Effective date

This LCD revision is effective for claims processed **on or after April 14, 2016**, for services rendered **on or after December 7, 2015**. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

Articles 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*.

B-Scan – revision to the Part B LCD

LCD ID number: L33904 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for b-scan was revised to add ICD-10-CM diagnosis code H25.89 (Other age-related cataract) 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 March 21, 2016**, for services rendered **on or after October 1, 2015**. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx.*

Articles 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*.

Etoposide (Etopophos®, Toposar®, Vepesid®, VP-16) – revision to the Part A and Part B LCD

LCD ID number: L33723 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for Etoposide (Etopophos®, Toposar®, Vepesid®, VP-16) was revised based on reconsideration requests to include the ICD-10-CM diagnosis codes C7A.1 and C80.1 under the "ICD-10 Codes that Support Medical Necessity" section of the LCD for procedure code J9181.

Effective date

This LCD revision is effective for claims processed **on or after April 6, 2016**, for services rendered **on or after October 1, 2015**. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quicksearch.aspx*.

Articles 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*.

Hemophilia clotting factors – revision to the Part A and Part B LCD

LCD ID number: L33684 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for Hemophilia clotting factors was revised based on the Centers for Medicare & Medicaid Services (CMS) change request (CR) 9549 (April 2016 Update of the Hospital Outpatient Prospective Payment System (OPPS) and CR 9557 (April 2016 Update of the Ambulatory Surgical Center (ASC) Payment System). Healthcare Common Procedure Coding System (HCPCS) codes C9137 (Injection, Factor VIII [antihemophilic factor, recombinant] [Adynovate], PEGylated, 1 I.U.) and C9138 (Injection, Factor VIII [antihemophilic factor, recombinant] [Nuwiq], 1 I.U.) were added to the "CPT®/HCPCS Codes" and "ICD-10 Codes that Support Medical Necessity" sections of the LCD.

In addition, HCPCS code J7199, for Adynovate and Nuwiq, was added to the "CPT®/HCPCS Codes" and "ICD-10 Codes that Support Medical Necessity" sections of the LCD.

Effective date

This LCD revision is effective for services rendered on or after April 1, 2016. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *https://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*.

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 the Centers for Medicare & Medicaid Services (CMS) change request (CR) 9549 (April 2016 Update of the Hospital Outpatient Prospective Payment System [OPPS]) and CR 9557 (April 2016 Update of the Ambulatory Surgical Center [ASC] Payment System). The LCD was revised to include Healthcare Common Procedure Coding System (HCPCS) code C9471 in the "CPT®/HCPCS Codes", "ICD-10 Codes that support Medical Necessity", and "Utilization Guidelines" sections of the LCD. In addition, the "Sources of Information and Basis for Decision" section of the LCD was updated.

Effective date

This LCD revision is effective for services rendered **on or after April 1, 2016**. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Additional Information

Self-administered drug (SAD) list – revision to the Part A and Part B article: asfotase alfa (Strensiq™) J3490/ J3590/C9399

LCD ID number: A52571 (Florida, Puerto Rico/ U.S. Virgin Islands)

The Centers for Medicare & Medicaid Services (CMS) provide instructions to contractors regarding Medicare payment for drugs and biologicals incident to a physician's service. The instructions also provide contractors with a process for determining if an injectable drug is usually self-administered and therefore not covered by Medicare. Guidelines for the evaluation of drugs for the list of excluded self-administered injectable drugs incident to a physician's service are in the Medicare Benefit Policy Manual, Pub. 100-02, Chapter 15, Section 50.2.

Effective for services rendered **on or after May 23, 2016**, asfotase alfa (Strensiq™) (HCPCS codes J3490/ J3590/C9399) has been added to the MAC Jurisdiction N (JN) SAD list.

The evaluation of drugs for addition to the self-administered drug (SAD) list is an on-going process. Providers are responsible for monitoring the SAD list for the addition or deletion of drugs.

The First Coast Service Options Inc. (First Coast) SAD lists are available at: *http://medicare.fcso.com/Self-administered_drugs/*.

Upcoming provider outreach and educational event June 2016

E/M coding: Emergency department visits

Date: Wednesday, June 1
Time: 3:00-4:30 p.m.
Type of Event: Webcast
http://medicare.fcso.com/Events/0336298.asp

E/M coding: Emergency department visits

Date: Thursday, June 2
Time: 11:30 a.m.-1:00 p.m.
Type of Event: Webcast
http://medicare.fcso.com/Events/0336299.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 March 31, 2016

MLN Connects® Provider eNews for March 31, 2016

View this edition as a PDF

In this edition:

MLN Connects® Events

- Medicare Shared Savings Program ACO: Preparing to Apply for 2017 Call — Last Chance to Register
- 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
- 2016 PQRS Reporting: Avoiding 2018 Negative Payment Adjustments Call — Registration Now Open
- National Partnership to Improve Dementia Care and QAPI Call — Registration Now Open
- New Video Slideshow Available

Medicare Learning Network® Publications and Multimedia

- Basics of Medicare Series of Web-Based Training Courses — New
- Long-Term Care Hospital Prospective Payment System Booklet — Revised
- Medicare Ambulance Transports Booklet — Revised

- Clinical Laboratory Fee Schedule Fact Sheet — Revised
- Hospital Outpatient Prospective Payment System Fact Sheet — Revised

Announcements

- CMS Launches New Effort to Improve Care for Nursing Facility Residents
- Advance Care Planning: New FAQs

Claims, Pricers, and Codes

- Modifications to HCPCS Code Set
- Medicare Payment for PAP Devices

Find out first: Subscribe to First Coast *eNews*

Subscribe to First Coast Service Options *eNews*, to learn the latest Medicare news and critical program changes affecting the provider community. Join as many lists as you wish, in English or Spanish, and customize your subscription to fit your specific needs, line of business, specialty, or topics of interest. So, *subscribe to eNews, and stay informed.*

MLN Connects® Provider eNews for April 7, 2016

MLN Connects® Provider eNews for April 7, 2016

View this edition as a PDF

In this edition:

MLN Connects® Events

- Open Payments 2016: Prepare to Review Reported Data Call — Last Chance to Register
- IMPACT Act: Data Element Library Call — Last Chance to Register
- Medicare Shared Savings Program ACO Application Process Call — Register Now
- 2016 PQRS Reporting: Avoiding 2018 Negative Payment Adjustments Call — Register Now
- National Partnership to Improve Dementia Care and QAPI Call — Register Now

Other CMS Events

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

Medicare Learning Network® Publications and Multimedia

- Medicare Shared Savings Program and Rural Providers Fact Sheet — Revised
- ACOs: What Providers Need to Know Fact Sheet — Revised
- Improving Quality of Care for Medicare Patients: ACOs Fact Sheet — Revised
- Federally Qualified Health Center Fact Sheet – Revised
- Critical Access Hospital Booklet — Revised
- DMEPOS Information for Pharmacies Fact Sheet — Reminder
- Safeguard Your Identity and Privacy Using PECOS Fact Sheet — Reminder

Announcements

- Comprehensive Care for Joint Replacement Model Launched
- CMS Invites QIN-QIOs to Submit Special Innovation Projects
- Open Payments: Physician and Teaching Hospital Review and Dispute Period Began April 1
- Join the Million Hearts® Model: Letter of Intent due April 15
- CMS to Release a CBR on Modifiers 24 and 25 for General Surgeons in April
- 2016 PQRS GPRO Registration Open through June 30
- 2015 Mid-Year QRURs Available
- Find Information on the SNF Value-Based Purchasing Program
- April Quarterly Provider Update Available
- Help Prevent Alcohol Misuse or Abuse

Claims, Pricers, and Codes

- April 2016 Outpatient PPS Pricer File Available

MLN Connects® Provider eNews for April 14, 2016

MLN Connects® Provider eNews for April 14, 2016

View this edition as a PDF

In this edition:

MLN Connects® Events

- Medicare Shared Savings Program ACO Application Process Call — Last Chance to Register
- 2016 PQRS Reporting: Avoiding 2018 Negative Payment Adjustments Call — Last Chance to Register
- National Partnership to Improve Dementia Care and QAPI Call — Register Now
- How to Register for the 2016 PQRS Group Practice Reporting Option Call — Registration Now Open
- 2015 Mid-Year QRURs Webcast — Registration Open

Other CMS Events

- Learn about the SNF Value-Based Purchasing Program at Open Door Forum
- IRF Quality Reporting Program Provider Training

Medicare Learning Network® Publications and Multimedia

- Enforcement of the PHP 20 Hours per Week Billing Requirement *MLN Matters*® Article — New
- Updates to Medicare's Organ Acquisition and Donation Payment Policy *MLN Matters*® Article — New
- CMS Provider Minute: CT Scans Video — New
- *Medicare Learning Network* LM/POS FAQs Booklet — New
- Medicare Quarterly Provider Compliance Newsletter Educational Tool — New
- Provider Enrollment Requirements for Writing Prescriptions for Medicare Part D Drugs *MLN Matters*® Article — Revised
- ICD-10-CM Diagnosis Codes for Bone Mass Measurement *MLN Matters*® Article — Revised
- Medicare Secondary Payer Provisions Web-Based Training Course — Revised

See **eNews**, next page

MLN Connects® Provider eNews for April 21, 2016

MLN Connects® Provider eNews for April 21, 2016

View this edition as a PDF

In this edition:

MLN Connects® Events

- National Partnership to Improve Dementia Care and QAPI Call — Last Chance to Register
- How to Register for the 2016 PQRS Group Practice Reporting Option Call — Register Now
- 2015 Mid-Year QRURs Webcast — Register Now
- New Audio Recording and Transcript Available

Other CMS Events

- Hospice Quality Reporting Program Webinar
- EHR Incentive Programs: March HIMSS16 Presentations

Medicare Learning Network® Publications and Multimedia

- Screening Pap Tests and Pelvic Examinations Booklet — New
- Hospital Value-Based Purchasing Program Fact Sheet — Revised

Announcements

- Hospital Inpatient PPS and LTCH PPS Proposed Rule for FY 2017
- Check Your 2015 Open Payments Data
- IRF Quality Reporting Program Data Submission Deadline: May 15 — Updated
- LTCH Quality Reporting Program Data Submission Deadline: May 15 — Updated
- 2017 Medicare Shared Savings Program: Notice of Intent to Apply Due by May 31
- CMS to Release a Comparative Billing Report on Psychotherapy and E/M Services in May
- 2016 Clinical Quality Measure Electronic Reporting: Updated Files
- April is STI Awareness Month: Talk, Test, Treat

Claims, Pricers, and Codes

- Rural Health Clinic Claims Processing Incorrectly

eNews

From previous page

- Infection Control: Injection Safety Web-Based Training Course — Revised

Announcements

- CMS Launches Largest-Ever Multi-Payer Initiative to Improve Primary Care in America
- Submit Comments on QRDA Implementation Guide for HQR by April 18
- IRF Quality Reporting Program Data Submission Deadline: May 15
- LTCH Quality Reporting Program Data Submission Deadline: May 15
- 2016 eCQMs Annual Update Available
- EHR Incentive Programs 2016 Program Requirements: New Resources
- ICD-10 Coding Resources
- National Healthcare Decisions Day is April 16
- April is National Minority Health Month

Claims, Pricers, and Codes

- April 2016 OPPS Pricer File Update
- Updates to HCPCS Code Set

Phone numbers

Customer service

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

Education event registration hotline

904-791-8103 (NOT toll-free)

Electronic data interchange (EDI)

888-670-0940

Electronic funds transfers (EFT) (CMS-588)

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

Fax number (for general inquiries)

904-361-0696

Interactive voice response (IVR) system

877-847-4992

Provider enrollment

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

The SPOT help desk

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

Addresses

Claims

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

Redeterminations

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

Redetermination of overpayments

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

Reconsiderations

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

General inquiries

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

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

Provider enrollment

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

Medical policy

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

Medicare secondary payer

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

Electronic data interchange (EDI)

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

Overpayments

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

Medicare Education and Outreach

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

Fraud and abuse

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

Freedom of Information Act requests

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

Overnight mail and/or special courier service

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

Websites

Provider

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

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

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

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

Beneficiaries

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

Phone numbers

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

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

Electronic data interchange (EDI)
888-670-0940

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

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

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

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

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

Addresses

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Websites

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

http://medicare.fcso.com

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

Centers for Medicare & Medicaid Services

https://www.cms.gov

First Coast University

http://www.fcsouniversity.com/

Beneficiaries
Centers for Medicare & Medicaid Services

https://www.medicare.gov

Phone numbers

Customer service

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

Education event registration hotline

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

Electronic data interchange (EDI)

888-875-9779

Electronic funds transfers (EFT) (CMS-588)

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

General inquiries

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

Interactive voice response (IVR) system

877-847-4992

Provider enrollment

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

The SPOT help desk

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

Addresses

Claims

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

Redeterminations

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

Redetermination of overpayments

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

Reconsiderations

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

General inquiries

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

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

Provider enrollment

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

Medical policy

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

Medicare secondary payer

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

Electronic data interchange (EDI)

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

Overpayments

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

Medicare Education and Outreach

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

Fraud and abuse

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

Freedom of Information Act requests

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

Special courier service

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

Websites

Provider

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

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

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

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

Beneficiaries

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

Order form for Medicare Part B materials

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

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

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** [ ] **Español** [ ]				
Please write legibly			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)