Medicare B CONNECTION

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FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction N Providers

May 2016

In this issue

JW modifier: Drug amount discarded/not administered to any patient

Provider types affected

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

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 9603 to alert MACs and providers of the change in policy regarding the use of the JW modifier for discarded Part B drugs and biologicals.

Effective July 1, 2016, providers are required to:

- Use the JW modifier for claims with unused drugs or biologicals from single use vials or single use packages that are appropriately discarded (except those provided under the competitive acquisition program (CAP) for Part B drugs and biologicals) and
- Document the discarded drug or biological in the patient's medical record when submitting claims with unused Part B drugs or biologicals from single use vials or single use packages that are appropriately discarded

Make sure that your billing staffs are aware of these changes. Remember that the JW modifier is not used on claims for CAP drugs and biologicals.

Background

The *Medicare Claims Processing Manual*, Chapter 17, Section 40 provides policy detailing the use of the JW modifier for discarded Part B drugs and biologicals. The current policy allows MACs the discretion to determine whether to require the JW modifier for any claims with discarded drugs or biologicals, and the specific details regarding how the discarded drug or biological information should be documented.

Be aware in order to more effectively identify and monitor billing and payment for discarded drugs and biologicals, CMS is revising this policy to require the uniform use of the

See **DISCARDED**, page 10

Contents

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

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

About the 'Medicare B Connection'

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

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

Who receives the *Connection*

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

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

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

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

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

Publication format

The *Connection* is arranged into distinct sections.

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

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

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

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

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

Never miss an appeals deadline again

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

Medicare Part B advance beneficiary notices

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

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

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

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

Patient liability notice

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

Limiting the scope of review on redeterminations and reconsiderations of certain claims

***Note**: This article was revised May 9, 2016, to provide updated information regarding redetermination requests received by Medicare administrative contractors (MACs) or qualified independent contractors (QICs) on or after April 18, 2016. This information was previously published in the August 2015 Medicare B Connection, pages 6-7.*

Provider types affected

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

What you need to know

This special edition article is being published by the Centers for Medicare & Medicaid Services (CMS) to inform providers of the clarification CMS has given to the MACs and QICs regarding the scope of review for redeterminations (technical direction letter 160305, which rescinds and replaces technical direction letter 150407). This updated instruction applies to redetermination requests received by a MAC or QIC on or after April 18, 2016, and will not be applied retroactively.

Background

CMS recently provided direction to MACs and QICs regarding the applicable scope of review for redeterminations and reconsiderations for certain claims. Generally, MACs and QICs have discretion while conducting appeals to develop new issues and review all aspects of coverage and payment related to a claim or line item. As a result, in some cases where the original denial reason is cured, this expanded review of additional evidence or issues results in an unfavorable appeal decision for a different reason.

For redeterminations and reconsiderations of claims denied following a complex prepayment review, a complex post-payment review, or an automated post-payment review by a contractor, CMS has instructed MACs and QICs to limit their review to the reason(s) the claim or line item at issue was initially denied. Prepayment reviews occur prior to Medicare payment, when a contractor conducts a review of the claim and/or supporting documentation to make an initial determination. Post-payment review or audit refers to claims that were initially paid by Medicare and subsequently reopened and reviewed by, for example, a zone program integrity contractor (ZPIC), recovery auditor, MAC, or comprehensive error rate testing (CERT) contractor, and revised to deny coverage, change coding, or reduce payment. Complex reviews require a manual review of the supporting medical records to determine whether there is an improper payment. Automated reviews use claims data analysis to identify improper payments. If an appeal involves a claim or line item denied on an automated pre-payment basis, MACs and QICs may continue to develop new issues and evidence at their discretion and may issue unfavorable decisions for reasons other than those specified in the initial determination.

Please note that contractors will continue to follow existing procedures regarding claim adjustments resulting from favorable appeal decisions. These adjustments will process through CMS systems and may suspend due to system edits. Claim adjustments that do not process to payment because of additional system imposed payment limitations, conditions or restrictions (for example, frequency limits or correct coding initiative edits) may result in new denials with full appeal rights. In addition, if a MAC or QIC conducts an appeal of a claim or line item that was denied on pre- or post-payment review because a provider, supplier, or beneficiary failed to submit requested documentation, the contractor will review all applicable coverage and payment requirements for the item or service at issue, including whether the item or service was medically reasonable and necessary. As a result, claims initially denied for insufficient documentation may be denied on appeal if additional documentation is submitted and it does not support medical necessity.

This clarification and instruction applies to redetermination and reconsideration requests received by a MAC or QIC on or after April 18, 2016. It will not be applied retroactively. Appellants will not be entitled to request a reopening of a previously issued redetermination or reconsideration for the purpose of applying this clarification on the scope of review. CMS encourages providers and suppliers to include any audit or review results letters with their appeal request. This will help alert contractors to appeals where this instruction applies.

Additional information

You can find out more about appealing claims decisions in the *Medicare Claims Processing Manual* (Publication 100-04, Chapter 29 (Appeals of Claims Decisions), Section 310.4.C.1. (Conducting the Redetermination (Overview)) at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29.pdf*.

You can also find out more about 1) conducting a redeterminations in 42 CFR 405.948, at *http://www.ecfr.gov/cgi-bin/text-idx?SID=06584dd6a5fc15094e7633ff5f6cb359&mc=true&node=pt42.2.405&rgn=div5#se42.2.405_1948*; and 2) conducting a reconsideration in 42 CFR 405.968 at *http://www.ecfr.gov/cgi-bin/text-idx?SID=06584dd6a5fc15094e7633ff5f6cb359&mc=true&node=pt42.2.405&rgn=div5#se42.2.405_1968*.

MLN Matters® Number: SE1521
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

Clinical Study

Allogeneic hematopoietic stem cell transplantation

Provider types affected

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

Provider action needed

Change request (CR) 9620, from which this article was developed, notifies providers that effective for claims with dates of service on and after January 27, 2016, for the use of allogeneic hematopoietic stem cell transplantation (HSCT) for treatment of multiple myeloma, myelofibrosis, and sickle cell disease is covered by Medicare, but only if provided in the context of a Medicare-approved clinical study meeting specific criteria under the coverage with evidence development (CED) paradigm.

CR 9620 also clarifies the ICD-9 and ICD-10 diagnosis codes for allogeneic HSCT for treatment of myelodysplastic syndromes (MDS) in the context of a Medicare-approved, prospective clinical study under CED. Specifically, for dates of service on or after August 4, 2010, through September 30, 2015, the ICD-9-CM diagnosis codes are 238.72, 238.73, 238.74, or 238.75, and clinical trial ICD-9-CM diagnosis code V70.7. For dates of service on or after October 1, 2015, the ICD-10-CM diagnosis codes are D46.A, D46.B, D46.C, D46.0, D46.1, D46.20, D46.21, D46.22, D46.4, D46.9, or D46.Z AND clinical trial ICD-10-CM diagnosis code Z00.6. Make sure your billing staff is aware of these determinations.

Background

HSCT is a process that includes mobilization, harvesting, and transplant of stem cells and the administration of high-dose chemotherapy and/or radiotherapy prior to the actual transplant. During the process stem cells are harvested from either the patient (autologous) or a donor (allogeneic) and subsequently administered by intravenous infusion to the patient.

Multiple myeloma is a neoplastic plasma-cell disorder. Myelofibrosis is a stem cell-derived hematologic disorder. Sickle cell disease is a group of inherited red blood cell disorders created by the presence of abnormal hemoglobin genes. On April 30, 2015, the Centers for Medicare & Medicaid Services (CMS) accepted a formal request from the American Society for Blood and Marrow Transplantation (ASBMT) to reconsider its policy and expand coverage of allogeneic HSCT for sickle cell disease, Myelofibrosis, multiple myeloma and rare diseases.

Myelodysplastic syndrome (MDS) refers to a group of diverse blood disorders in which the bone marrow does not produce enough healthy, functioning blood cells. On August 4, 2010, CMS issued a final decision stating that allogeneic HSCT for MDS is covered by Medicare only if provided pursuant to a Medicare-approved clinical study under CED. CR 7137 (see the article, MM7137 at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7137.pdf*) provides specific ICD-9 related coding and claim processing requirements regarding this particular coverage decision, and CRs 8197 and 8691 (see MM8197 at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8197.pdf* and MM8691 at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8691.pdf*) provide ICD-10 related coding requirements. On November 30, 2015, CMS accepted a formal request from the National Marrow Donor Program (NMDP) to clarify the list of ICD-9-CM and ICD-10-CM diagnosis codes covered for allogeneic HSCT for the treatment of MDS in the context of a Medicare-approved clinical study under CED.

On January 27, 2016, CMS issued a final decision to expand national coverage of items and services necessary for research in an approved clinical study via coverage with evidence development (CED) under Section 1862(a)(1)(E) of the Social Security Act (the Act) for allogeneic HSCT for the following indications:

- Multiple myeloma
- Myelofibrosis
- Sickle cell disease

Refer to the following Medicare manual sections for more information regarding this NCD and further billing instructions specific to this NCD and the business requirements specific to CR 9620:

- Chapter 1, Section 110.23, of the *Medicare NCD Manual*, which is attached to the CR 9620 NCD transmittal at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R191NCD.pdf.*
- Chapter 1, Section 310.1, of the *Medicare NCD Manual*, available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part4.pdf*, and
- Chapter 32, Sections 69 and 90, of the *Medicare Claims Processing Manual*, available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c32.pdf*.

In addition to the diagnosis codes detailed at the beginning of this article, providers need to be aware of the other billing requirements, as follows:

Inpatient claims

For claims submitted on type of bill 11x for discharges on or after January 27, 2016, for HSCT for the treatment of multiple myeloma, myelofibrosis, or sickle cell disease, the claim must show:

See **HSCT**, next page

HSCT

previous page

- An ICD-10-PCS procedure code of 30230G1, 30230Y1, 30233G1, 30233Y1, 30240G1, 30240Y1, 30243G1, 30243Y1, 30250G1,30250Y1, 30253G1, 30253Y1, 30260G1, 30260Y1, 30263G1, or 30263Y1; **and**
- The clinical trial ICD-10-CM code of Z00.6; **and**
- Condition code 30, denoting qualifying clinical trial; **and**
- Value code D4 showing the clinical trial number (assigned by NLM/NIH with an 8-digit clinicaltrials.gov identifier number listed on the CMS website) along with the appropriate ICD-10-diagnosis code of:
  - Multiple myeloma-ICD-10-CM diagnosis code C90.00, C90.01, or C90.02 OR
  - Myelofibrosis-ICD-10-CM diagnosis code C94.40, C94.41, C94.42, D47.4, or D75.81 OR
  - Sickle cell disease-ICD-10-CM diagnosis code D57.00, D57.01, D57.02, D57.1, D57.20, D57.211, D57.212, D57.219, D57.40, D57.411, D57.412, D57.419, D57.80, D57.811, D57.812, or D57.819

Outpatient claims

For claims submitted on type of bill 13x or 85x for dates of service on or after January 27, 2016, for HSCT for the treatment of multiple myeloma, myelofibrosis, or sickle cell disease, the claim must show:

- An HSCT CPT® code of 38240; **and**
- The clinical trial ICD-10-CM code of Z00.6; **and**
- Condition code 30, denoting qualifying clinical trial; **and**
- Value code D4 showing the clinical trial number (assigned by NLM/NIH with an eight-digit clinicaltrials.gov identifier number listed on the CMS website) along with the appropriate ICD-10-diagnosis code of:
  - Multiple myeloma-ICD-10-CM diagnosis code C90.00, C90.01, or C90.02; **or**
  - Myelofibrosis-ICD-10-CM diagnosis code C94.40, C94.41, C94.42, D47.4, or D75.81; **or**
  - Sickle cell disease-ICD-10-CM diagnosis code D57.00, D57.01, D57.02, D57.1, D57.20, D57.211, D57.212, D57.219, D57.40, D57.411, D57.412, D57.419, D57.80, D57.811, D57.812, or D57.819

Method II critical access hospital (CAH) claims

For claims submitted on type of bill 85x with revenue codes 96x, 97x, or 98x for dates of service on or after January 27, 2016, for HSCT for the treatment of multiple myeloma, myelofibrosis, or sickle cell disease, the claim must show:

- An HSCT CPT® code of 38240; **and**
- The clinical trial ICD-10-CM code of Z00.6; **and**
- Condition code 30, denoting qualifying clinical trial; **and**
- Value code D4 showing the clinical trial number (assigned by NLM/NIH with an eight-digit clinicaltrials.gov identifier number listed on the CMS website) along with the appropriate ICD-10-diagnosis code of:
  - Multiple myeloma-ICD-10-CM diagnosis code C90.00, C90.01, or C90.02; **or**
  - Myelofibrosis-ICD-10-CM diagnosis code C94.40, C94.41, C94.42, D47.4, or D75.81; **or**
  - Sickle cell disease-ICD-10-CM diagnosis code D57.00, D57.01, D57.02, D57.1, D57.20, D57.211, D57.212, D57.219, D57.40, D57.411, D57.412, D57.419, D57.80, D57.811, D57.812, or D57.819

Professional claims

For professional claims submitted on type of bill 85x with revenue codes 96x, 97x, or 9x for dates of service on or after January 27, 2016, for HSCT for the treatment of multiple myeloma, myelofibrosis, or sickle cell disease, the claim must show:

- An HSCT CPT® code of 38240; **and**
- The clinical trial ICD-10-CM code of Z00.6; **and**
- The Q0 modifier; **and**
- A place of service code of 19, 21, or 22 along with the appropriate ICD-10-CM diagnosis code of:
  - Multiple myeloma-ICD-10-CM diagnosis code C90.00, C90.01, or C90.02; **or**
  - Myelofibrosis-ICD-10-CM diagnosis code C94.40, C94.41, C94.42, D47.4, or D75.81; **or**
  - Sickle cell disease-ICD-10-CM diagnosis code D57.00, D57.01, D57.02, D57.1, D57.20, D57.211, D57.212, D57.219, D57.40, D57.411, D57.412, D57.419, D57.80, D57.811, D57.812, or D57.819

For all of the above claims types submitted without the requisite coding, MACs will deny the claims using the following messages:

- **Claim adjustment reason code (CARC) 50** - These are non-covered services because this is not deemed a 'medical necessity' by the payer. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- **Remittance advice remarks code (RARC) N386** - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *https://www.cms.gov/mcd/search.asp*. If you do not have web access, you may contact the contractor to request a copy of the NCD.
- **Group code** - patient responsibility (PR) if an advance beneficiary notice (ABN)/hospital notice on non-coverage (HINN), otherwise contractual obligation (CO)

For claims with dates of service prior to the implementation date of CR 9620, MACs shall perform necessary adjustments only when the provider brings such claims to the attention of their MAC.

See **HSCT**, next page

Percutaneous left atrial appendage closure

Provider types affected

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

Provider action needed

Change request (CR) 9638 informs MACs that the Centers for Medicare & Medicaid Services (CMS) issued a national coverage determination (NCD) covering percutaneous left atrial appendage closure (LAAC) through coverage with evidence development (CED) when LAAC is furnished in patients with non-valvular atrial fibrillation (NVAF) and the device has received Food and Drug Administration (FDA) premarket approval (PMA) for that device's FDA-approved indication and meets all the specified conditions. Make sure that your billing staffs are aware of these changes.

Background

LAAC is a strategy to reduce the risk of stroke by closing the left atrial appendage (LAA) in patients with NVAF. Patients with NVAF, an abnormally rapid, irregular heartbeat, are at an increased risk of stroke. Some evidence suggests that many of the strokes attributed to NVAF originate from the LAA. The LAA is a tubular structure that opens into the left atrium of the heart. LAAC with a percutaneously implanted device could be used in patients with NVAF to reduce cardioembolic stroke risk as a potential alternative to oral anticoagulation.

On February 8, 2016, CMS issued an NCD covering percutaneous LAAC through CED when LAAC is furnished in patients with NVAF and the device has received FDA PMA for that device's FDA-approved indication and meets all the specified conditions. Coverage requires that patients must have:

- A CHADS2 score ≥ 2 (congestive heart failure, hypertension, Age >75, diabetes, stroke/transient ischemia attack/thromboembolism) or CHA2DS2-VASc score ≥ 3 (congestive heart failure, hypertension, Age ≥ 65, diabetes, stroke/transient ischemia attack/thromboembolism, vascular disease, sex category)
- A formal shared decision making interaction with an independent non-interventional physician using an evidence-based decision tool on oral anticoagulation in patients with NVAF prior to LAAC. Additionally, the shared decision making interaction must be documented in the medical record
- A suitability for short-term warfarin but deemed unable to take long term oral anticoagulation following the conclusion of shared decision making, as LAAC is only covered as a second line therapy to oral anticoagulants

The NCD lists the criteria for the physician and facility criteria and includes a requirement for a multidisciplinary team to be engaged in patient care.

The patient must be enrolled in, and the multidisciplinary team (MDT) and hospital must participate in a prospective, national, audited registry that: 1) consecutively enrolls LAAC patients and 2) tracks the specified annual outcomes for each patient for a period of at least four years from the time of the LAAC. The registry must address pre-specified research questions, adhere to standards of scientific integrity, and be approved by CMS. Approved registries will be posted at *https://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/LAAC.html*. The process for submitting a registry to Medicare is outlined in the NCD.

For devices and indications that are not approved by FDA, patients must be enrolled in a qualifying FDA-approved randomized controlled trial (RCT). The clinical study must address pre-specified research questions, adhere to standards of scientific integrity, and be approved by

See **LAAC**, next page

HSCT

previous page

Additional information

The official instruction, CR 9620, consists of two transmittals. The first updates the *Medicare Claims Processing Manual* at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3509CP.pdf*. The second transmittal updates the *Medicare NCD Manual* at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R191NCD.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: MM9620
Related Change Request (CR) #: CR 9620
Related CR Release Date: April 29, 2016
Effective Date: January 27, 2016
Related CR Transmittal #: R191NCD and R3509CP
Implementation Date: October 3, 2016

LAAC

previous page

CMS-approved studies will be posted at *https://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/LAAC.html*. The process for submitting a clinical research study to Medicare is outlined in the NCD.

LAAC claims with dates of service on or after February 8, 2016, will be billed with temporary level III CPT® code 0281T (percutaneous transcatheter closure of the left atrial appendage with implant, including fluoroscopy, transseptal puncture, catheter placement(s) left atrial angiography, left atrial appendage angiography, radiological supervision and interpretation) and will be MAC-priced. CMS will issue further instructions, once a permanent CPT® level 1 replaces the temporary code.

LAAC is non-covered for the treatment of NVAF when not furnished under CED according to the criteria outlined in the NCD, which is at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R192NCD.pdf*.

Additional billing instructions

On institutional claims (type of bill 11x), hospitals should show:

- ICD-10 procedure code of 02L73DK (occlusion of left atrial appendage with intraluminal device, percutaneous approach)
- A primary diagnosis code of one of the following:
  - I48.0 – Paroxysmal atrial fibrillation
  - I48.1 – Persistent atrial fibrillation
  - I48.2 – Chronic atrial fibrillation
  - I48.91 – Unspecified atrial fibrillation
- A secondary ICD-10 diagnosis code of Z00.6 – Encounter for examination for normal comparison and control in clinical research program
- Condition code 30 (Qualifying clinical trial), and
- Value code D4 – Clinical trial number (assigned by NLM/NIH with an eight-digit clinicaltrials.gov identifier number listed on the CMS website)

MACs will fully reject inpatient claims for LAAC with discharges on or after February 8, 2016, when billed without the appropriate procedure, diagnosis, or clinical trial codes, with the following messages:

- **Claim adjustment reason code (CARC) 50** – These are non-covered services because this is not deemed a "medical necessity" by the payer.
- **Remittance advice remarks code (RARC) N386** – This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *https://www.cms.gov/mcd/search.asp*. If you do not have web access, you may contact the contractor to request a copy of the NCD.
- **Group code** – contractual obligation (CO)

Professional claims with dates of service on or after February 8, 2016, for LAAC under CED will be paid only when billed with the following codes:

- CPT® 0281T
- Primary ICD-10 diagnosis code (one of the following):
  - I48.0 – Paroxysmal atrial fibrillation,
  - I48.1 – Persistent atrial fibrillation,
  - I48.2 – Chronic atrial fibrillation,
  - I48.91 – Unspecified atrial fibrillation
- Place of service code of 21 (inpatient hospital)
- Secondary diagnosis code Z00.6
- Modifier Q0
- Clinical trial number in item 23 of the CMS-1500 form or electronic equivalent

MACs will deny LAAC claims when billed without the appropriate diagnosis codes, with the following messages:

- **CARC 50** – These are non-covered services because this is not deemed a "medical necessity" by the payer. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- **RARC N386** – This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *http://www.cms.hhs.gov/mcd/search.asp*. If you do not have web access, you may contact the contractor to request a copy of the NCD.
- **Group code** – contractual obligation (CO).

MACs will deny claims for LAAC with 0281T with a POS code other than 21 using the following messages:

- **CARC 58** – "Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
- **RARC N386** – "This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *http://www.cms.hhs.gov/mcd/search.asp*. If you do not have web access, you may contact the contractor to request a copy of the NCD."
- **Group code** – contractual obligation (CO).

MACs will return claim lines on professional claims for 0281T as unprocessable when the Q0 modifier is not present using messages:

- **CARC 4**: "The procedure code is inconsistent with the modifier used or a required modifier is missing. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."

See **LAAC**, next page

LAAC

previous page

- **Group code** – contractual obligation (CO)

MACs will return claim lines with 0281T as unprocessable when billed without secondary diagnosis code Z00.6 using the following messages:

- **CARC 16**: "Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)"
- **RARC M76**: "Missing/incomplete/invalid diagnosis or condition."
- **Group code** – contractual obligation (CO)

Finally, failure to include the clinical trial number will result in MACs returning claim lines as unprocessable using the following messages:

- **CARC 16**: "Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)"
- **RARC MA50**: "Missing/incomplete/invalid Investigational Device Exemption number or Clinical Trial number."
- **Group code** – contractual obligation (CO)

Note that MACs will not search their files for claims for LAAC with dates of service on or after February 8, 2016, that were processed prior to implementation of CR 9638. However, they will adjust such claims that you bring to their attention.

Additional information

The official instruction, CR 9638, consists of two transmittals. The first contains the actual NCD and is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R192NCD.pdf*. The second provides the claim processing instructions and it is at available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3515CP.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: MM9638
Related Change Request (CR) #: CR 9638
Related CR Release Date: May 6, 2016
Effective Date: February 8, 2016
Related CR Transmittal #: R192NCD and R3515CP
Implementation Date: October 3, 2016

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Drugs and Biologicals

DISCARDED

From front page

JW modifier for all claims with discarded Part B drugs and biologicals.

Additional information

The official instruction, CR 9603, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3530CP.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: MM9603
Related Change Request (CR) #: CR 9603
Related CR Release Date: May 24, 2016
Effective Date: July 1, 2016
Related CR Transmittal #: R3530CP
Implementation Date: July 5, 2016

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Document History

Document History	Description
May 25, 2016	The article was revised to reflect an updated CR. That CR updated the X-Ref requirement number in the CR's 'Supporting Information' section. In the article, the CR release date, transmittal number and link to the CR was changed. All other information remains the same.

Policy for prolonged drug and biological infusions using an external pump

Provider types affected

This *MLN Matters*® special edition article is intended for all physicians and hospital outpatient departments submitting claims to Medicare administrative contractors (MACs) for prolonged drug and biological infusions started incident to a physician's service using an external pump. **Note that this article does not apply to suppliers' claims submitted to durable medical equipment MACs (DME MACs).**

What you need to know

Medicare pays for drugs and biologicals which are not usually self-administered by the patient and furnished incident to physicians' services rendered to patients while in the physician's office or the hospital outpatient department. In some situations, a hospital outpatient department or physician office may:

- Purchase a drug for a medically reasonable and necessary prolonged drug infusion,
- Begin the drug infusion in the care setting using an external pump,
- Send the patient home for a portion of the infusion, and
- Have the patient return at the end of the infusion period.

In this case, the drug or biological, the administration, and the external infusion pump is billed to your MAC. **However, because prolonged drug and biological infusions started incident to a physician's service using an external pump should be treated as an incident to service, it cannot be billed on suppliers' claims to DME MACs.**

Background

Under Section 1861(s)(2)(A) of the Social Security Act (the Act), Medicare will pay for drugs and biologicals which are furnished incident to a physician's professional service. Under Section 1861(s)(2)(B) of the Act, Medicare will pay for drugs and biologicals which are not usually self-administered by the patient furnished as incident to physicians' services rendered to outpatients. In order for Medicare to pay for a drug or biological under Section 1861(s)(2)(A) or (B) of the Act, the physician or hospital (respectively) must incur a cost for the drug or biological. Generally, the administration of drugs or biologicals covered by Medicare under the incident to benefit (1861(s)(2)(A) and (B)) will start and end while the patient is in the physician's office or the hospital outpatient department under the supervision of a physician.

However, in some situations a hospital or office may purchase a drug for a medically reasonable and necessary prolonged drug infusion, then begin the drug infusion in the care setting using an external pump, send the patient home for a portion of the infusion duration, and have the patient return at the end of the infusion period. In this case, the drug or biological continues to be covered under Section 1861(s)(2)(A) and (B) of the Act and is billable to the MAC even though the entire administration of the drug or biological did not occur in the physician's office or the hospital outpatient department. Also, the drug or biological continues to meet the requirements for the incident to benefit as the physician or hospital incurred a cost for the drug or biological and the administration of the drug began in a physician's office or hospital incident to a physician's service. For the administration of the drug, the physician supervision rules under *42 CFR §410.26*(b)(5) and 42 CFR §410.27 (a)(1)(iv) and *CMS Publication 100-02, Chapter 15*, Section 50.3 apply only while the patient is present in the physician's office or hospital outpatient department. CMS does not provide specific coding guidance; however, appropriate drug administration codes for this situation would describe the services that are provided by the physician or hospital (for example, intravenous infusion, patient monitoring) while the patient is in the office or the outpatient setting.

Medicare's payment for the administration of the drug or biological billed to the MAC will also include payment for equipment used in furnishing the service. Equipment, such as an external infusion pump used to begin administration of the drug or biological that the patient takes home to complete the infusion, is not separately billable as durable medical equipment for a drug or biological paid under the Section 1861(s)(2)(A) and (B) incident to benefit. The MAC may direct use of a code described by Current Procedural Terminology (CPT®) or an otherwise applicable HCPCS code for the drug administration service. If necessary, the MAC may direct use of a miscellaneous code for the drug administration if there is no specified code that describes the drug administration service that also accounts for the cost of equipment that the patient takes home to complete the infusion that they later return to the physician or hospital.

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.

MLN Matters® Number: SE1609
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

Billing external pump for prolonged drug and biological infusions

The Centers for Medicare & Medicaid Services (CMS) recently provided additional clarification to Medicare administrative contractors (MAC) and providers regarding reimbursement for prolonged drug and biological infusions that are started in the office or outpatient hospital and are associated with care that is billed incident to a physician service using an external pump. The complete information can be found in *MLN Matters® SE1609*.

In order for Medicare to pay for a drug or biological under Section 1861(s)(2)(A) or (B) of the Act, the physician or hospital (respectively) must incur a cost for the drug or biological. Generally, the administration of drugs or biologicals covered by Medicare under the "incident to" benefit (1861(s)(2)(A) and (B)) will start and end while the patient is in the physician's office or the hospital outpatient department under the supervision of a physician. However, in some situations a hospital or office may purchase a drug for a medically reasonable and necessary prolonged drug infusion, then begin the drug infusion in the care setting using an external pump, send the patient home for a portion of the infusion duration, and have the patient return at the end of the infusion period. In this case, the drug or biological continues to be covered under Section 1861(s)(2)(A) and (B) of the Act and is billable to the A/B MAC even though the entire administration of the drug or biological did not occur in the physician's office or the hospital outpatient department.

In order for physicians and hospital outpatient departments to receive reimbursement for cost incurred for the services above First Coast ask that the instructions listed below be followed.

Part B physician services

- Please continue to bill any applicable Current Procedural Terminology (CPT®) or HCPCS codes for the drug or biological, and its administration.
- To bill for the use of the external pump, please submit using unlisted CPT® code 96379 for a daily reimbursement of the service.

- CPT® code 96379 should be billed on a single line with a 'FROM' and 'TO' date and the corresponding number of units (days) indicated in the appropriate field.
- The word "pump" must be notated in block 19 on the CMS-1500 claim form or the equivalent segment for electronic claims submissions.
- If you have previously billed the drug and administration and are now needing to bill for the pump, bill only the pump as a new claim. You do not need to rebill the administration and drug codes

Part A hospital outpatient department

- Please continue to bill any applicable CPT® or HCPCS codes for the drug or biological, and its administration.
- To bill for the use of the external pump, please submit using unlisted CPT® code 96379 for a daily reimbursement of the service.
- CPT® code 96379 should be billed according to the date of receipt of the pump with the corresponding number of days indicated in the "Units" field.
- The word "pump" must be notated on page 07 and page 33 as the remark in the fiscal intermediary standard system.
- If adjusting a processed claim within timely filing period follow the normal adjustment process.

Take the time to 'chat' with the website team

You now have the opportunity to save your valuable time by asking your website-related questions online – with First Coast's new Live Chat service.

July update of the HCPCS drug/biological code changes

Provider types affected

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

Provider action needed

Change request (CR) 9636 informs Medicare providers and suppliers that effective for claims with dates of service on or after July 1, 2016, new healthcare common procedure coding system (HCPCS) codes Q9981 (rolapitant, oral, 1mg); Q9982 (flutemetamol f18 diagnostic); and Q9983 (florbetaben f18 diagnostic) will be payable for Medicare. In addition, the HCPCS code set will contain code Q5102 (Inj., infliximab biosimilar), which is effective for dates of service on or after April 5, 2016. Claims for Q5102 must also have the modifier ZB (Pfizer/hospira). Make sure that your billing staffs are aware of these changes.

Background

The HCPCS code set is updated on a quarterly basis and CR 9636 provides that effective July 1, 2016, the HCPCS codes contained in the following table will be established:

HCPCS code	Short description	Long description	Type of service
Q9981	rolapitant, oral, 1mg	Rolapitant, oral, 1 mg	1
Q9982	flutemetamol f18 diagnostic	Flutemetamol F18, diagnostic, per study dose, up o 5 millicuries	4
Q9983	florbetaben f18 diagnostic	Florbetaben f18, diagnostic, per study dose, up to 8.1 millicuries	4

Also, as of July 1, the HCPCS code set will contain code Q5102 (short descriptor – Inj., infliximab biosimilar – and long descriptor – Injection, Infliximab, 10 mg). Code Q5102 will be effective for dates of service on or after April 5, 2016, and will have TOS codes of 1 and P. In addition, claims for Q5102 must also have the modifier ZB (Pfizer/hospira).

Additional information

The official instruction, CR 9636, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3518CP.pdf*.

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

MLN Matters® Number: MM9636
Related Change Request (CR) #: CR 9636
Related CR Release Date: May 6, 2016
Effective Date: July 1, 2016
Related CR Transmittal #: R3518CP
Implementation Date: July 5, 2016

Billing and coverage for drug wastage

First Coast Service Options Inc. (First Coast) will consider payment for the unused and discarded portion of a single-use drug/biological product after administration of the appropriate (reasonable and necessary) dosage for the patient's condition. This applies to drugs priced through the average sales price (ASP) drug/biological program. The Centers for Medicare & Medicaid Services (CMS) encourages physicians, hospitals, and other providers to provide injectable drug therapy incident to a physician's services in a fashion that maximizes efficiency of therapy in a clinically appropriate manner. If a physician, hospital, or other provider must discard the unused portion of a single-use vial or other single-use package after administering a dose/quantity appropriate to the clinical context for a Medicare beneficiary, the program provides payment for the entire portion of drug or biological indicated on the vial or package label.

If less than a complete vial is administered at the time of service, and the unused portion is discarded, drug wastage must be documented in the patient's medical record with the date, time, and quantity wasted. Upon review, any discrepancy between amount administered to the patient and the billed amount will be denied, unless wastage is clearly documented. The amount billed as "wastage" must not be administered to another patient or billed again to Medicare. *All procedures for drug storage, reconstitution and administration should conform to applicable Federal Drug Administration (FDA) guidelines and provider scope of practice*.

Note: For billing purposes, First Coast does not require the use of modifier JW prior to July 1, 2016. Drug wastage is billed by combining on a single line the wastage and administered dosage amount. **Effective July 1, modifier JW is required when billing for drugs discarded or not administered.** Additional information is available in *MLN Matters® article MM9603*.

Source: *CMS IOM, Publication 100-04, Chapter 17, Section 40*
CMS IOM, Publication 100-04, Chapter 23, Section 20.3

Durable Medical Equipment

2016 DMEPOS 2016 DMEPOS HCPCS jurisdiction list

***Note**: This article was revised May 10, 2016, due to a revised change request (CR). The CR revised the jurisdiction for healthcare common procedure coding system (HCPCS) E0781 to durable medical equipment Medicare administrative contractors (DME MAC) only and omitted the local carrier jurisdiction for this code in the attachment to the CR. The CR release date, transmittal number and link to the CR also changed. All other information remains the same. This information, including the complete procedure code listing, was previously published in the January 2016 Medicare B Connection, pages 11-20.*

Provider types affected

This *MLN Matters*® article is intended for providers and suppliers submitting claims to MACs, including DME MACs for DMEPOS services provided to Medicare beneficiaries.

Provider action needed

CR 9481 notifies suppliers that the spreadsheet containing an updated jurisdiction list of HCPCS codes is updated annually to reflect codes that have been added or discontinued (deleted) each year. Changes in Chapter 23, Section 20.3 of the *Medicare Claims Processing Manual* are reflected in the recurring update notification. The spreadsheet for the 2016 DMEPOS jurisdiction list is an Excel® spreadsheet and is available under the Coding Category at *https://www.cms.gov/Center/Provider-Type/Durable-Medical-Equipment-DME-Center.html* and is also attached to CR 9481.

Additional information

The official instruction, CR 9481, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3520CP.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

Date of change	Description
May 10, 2016	The article was revised due to a revised CR. The CR revised the jurisdiction for HCPCS E0781 to DME MAC only and omitted the local carrier jurisdiction for this code in the attachment to the CR. The CR release date, transmittal number and link to the CR also changed.

MLN Matters® Number: MM9481 *Revised*
Related Change Request (CR) #: CR 9481
Related CR Release Date: May 10, 2016
Effective Date: January 1, 2016
Related CR Transmittal #: R3520CP
Implementation Date: February 1, 2016

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Preventive Services

Screening for cervical cancer with human papillomavirus testing — NCD 210.2.1

***Note**: This article was revised April 22, 2016, to correct the G code in two places on pages 2 and 3. The correct code is G0476. All other information remains the same. This information was previously published in the February 2016 Medicare B Connection, page 1.*

Provider types affected

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

Provider action needed

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

Background

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

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

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

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

CMS has determined that the evidence is sufficient to add HPV testing once every five years as an additional preventive service benefit under the Medicare program, for asymptomatic beneficiaries aged 30 to 65 years in conjunction with the Pap smear test. CMS will cover screening for cervical cancer with the appropriate U.S. Food and Drug Administration (FDA)-approved/cleared laboratory tests, used consistent with FDA-approved labeling, and in compliance with the Clinical Laboratory Improvement Act (CLIA) regulations.

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

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

In addition, you should be aware of the following:

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

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

- Claim adjustment reason code (CARC) 119 – "Benefit maximum for this time period or occurrence has been reached;"
- Remittance advice remark code (RARC) N386 – "This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *www.cms.gov/mcd/search.asp*. If you do not have web access, you may contact the contractor to request a copy of the NCD;"
- Group code "CO" if the claim contains a GZ modifier to denote a signed advance beneficiary notice (ABN) is not on file or with group code "PR" (patient responsibility) if the claim has a GA modifier to show a signed ABN is on file.

See **HPV**, next page

HPV

previous page

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

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

- CARC 6 – "The procedure/revenue code is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present;"
- RARC N129 – "Not eligible due to the patient's age;"
- Group code "CO" if the claim contains a GZ modifier to denote a signed advance beneficiary notice (ABN) is not on file or with group code "PR" (patient responsibility) if the claim has a GA modifier to show a signed ABN is on file.

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

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

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

- CARC 167 – "This (these) diagnosis(es) is (are) not covered. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present;"
- RARC N386 – "This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *www.cms.gov/mcd/search.asp*. If you do not have web access, you may contact the contractor to request a copy of the NCD;" and
- Group code CO.
- This NCD does not change current policy as it relates to screening for pap smears and pelvic exams as described in the *Medicare NCD Manual*, Section 210.2, or in the *Medicare Claims Processing Manual*, Chapter 18, Section 30, which you can find at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part4.pdf*.

Additional information

The official instruction, CR 9434, was issued to your MAC via two transmittals. The first updates the *NCD Manual* and is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R189NCD.pdf* and the second transmittal updates the *Medicare Claims Processing Manual* and it is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3460CP.pdf*.

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

Document history

- This article was revised April 22, 2016, to correct the reference to G0476 in two places on pages 2 and 3. The original article mentioned G4076, which is incorrect. All references should have shown G0476.

MLN Matters® Number: MM9434 *Revised*
Related Change Request (CR) #: CR 9434
Related CR Release Date: February 5, 2016
Effective Date: July 9, 2015
Implementation Date: July 5, 2016 (CWF analysis and design), October 3, 2016 (CWF coding, testing and Implementation, MCS and FISS implementation; January 3, R3460CP 2017 (requirement 9434-04.8.2), March 7, 2016 (non-shared MAC edits)
Related CR Transmittal #: R189NCD and R3460CP

Update to Internet-Only Manual Publication 100-04, Chapter 18, Section 30.6

Provider types affected

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

Provider action needed

CR 9606 advises the MACs of an update to the *Medicare Claims Processing Manual*, Chapter 18, Section 30.6. CR 9606 updates the manual by replacing an incorrect diagnosis code for screening of cervical cancer with HPV testing. The manual shows an incorrect ICD-10 code of Z12.92 and the correct ICD-10 code is Z12.72 (encounter for screening for malignant neoplasm of the vagina). Make sure that your billing staffs are aware of this change.

Additional information

The official instruction, CR 9606, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3522CP.pdf*. The updated manual section is attached to the CR.

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: MM9606
Related Change Request (CR) #: CR 9606
Related CR Release Date: May 13, 2016
Effective Date: June 14, 2016
Related CR Transmittal #: R3522CP
Implementation Date: June 14, 2016

General Coverage

Medicare coverage of substance abuse services

Provider types affected

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

What you need to know

While there is no distinct Medicare benefit category for substance abuse treatment, such services are covered by Medicare when reasonable and necessary. The Centers for Medicare & Medicaid Services (CMS) provides a full range of services, including those services provided for substance abuse disorders. This article summarizes the available services and provides reference links to other online Medicare information with further details about these services.

Background

Services for substance abuse disorders are available under Medicare, as long as those services are reasonable and necessary. These services include:

Inpatient treatment

- Inpatient treatment would be covered if reasonable and necessary.
- Professional services provided during that care would be paid either:
  - as part of the inpatient stay (for professional services provided by clinicians not recognized for separate billing, for instance peer counselors), or
  - separately, to the professional billing for the provided services if they are recognized under Part B and considered separate from the inpatient stay (for instance, physicians, and NPPs within their state scopes of practice).
- Any medication provided as part of inpatient treatment would be bundled into the inpatient payment and not paid separately.

Outpatient treatment

- Similar to inpatient treatment, coverage of outpatient treatment would depend on the provider of the services.
- Pursuant to the Social Security Act, Medicare does not recognize substance abuse treatment facilities as an independent provider type, nor is there an integrated payment for the bundle of services those providers may provide (either directly, or incident to a physician's service).
- Coverage and payment would be on a service by service basis for those services that are recognized by Medicare. For instance, Medicare could pay for counseling by an enrolled licensed clinical social worker, psychologist or psychiatrist.

See **ABUSE**, next page

ABUSE

From previous page

- Some services could be provided by auxiliary personnel incident to a physician's services.
- Medications used in an outpatient setting that are not usually self-administered may be covered under Part B if they meet all Part B requirements.

Partial hospitalization program (PHP)

The PHP is an intensive outpatient psychiatric day treatment program that is furnished as an alternative to inpatient psychiatric hospitalization. This means that without the PHP services, the person would otherwise be receiving inpatient psychiatric treatment. Patients admitted to a PHP must be under the care of a physician who certifies and re-certifies the need for partial hospitalization and require a minimum of 20 hours per week of PHP therapeutic services, as evidenced by their plan of care. PHPs may be available in your local hospital outpatient department and Medicare certified community mental health center (CMHCs). PHP services include:

- Individual or group psychotherapy with physicians, psychologists, or other mental health professionals authorized or licensed by the state in which they practice (for example, licensed clinical social workers, clinical nurse specialists, certified alcohol and drug counselors);
- Occupational therapy requiring the skills of a qualified occupational therapist. Occupational therapy, if required, must be a component of the physicians treatment plan for the individual;
- Services of other staff (social workers, psychiatric nurses, and others) trained to work with psychiatric patients;
- Drugs and biologicals that cannot be self-administered and are furnished for therapeutic purposes (subject to limitations specified in 42 CFR 410.29);
- Individualized activity therapies that are not primarily recreational or diversionary. These activities must be individualized and essential for the treatment of the patient's diagnosed condition and for progress toward treatment goals;
- Family counseling services for which the primary purpose is the treatment of the patient's condition;
- Patient training and education, to the extent the training and educational activities are closely and clearly related to the individuals care and treatment of his/her diagnosed psychiatric condition; and
- Medically necessary diagnostic services related to mental health treatment.

Similar to inpatient and individual outpatient treatment, coverage of PHP services would depend on the provider of the services.

MLN Matters® special edition article *SE1512* titled "Partial Hospitalization Program (PHP) Claims Coding & 2015 per Diem Payment Rates" is intended for hospitals and Community Mental Health Centers (CMHCs) that submit claims to MACs for PHP services provided to Medicare beneficiaries. In SE1512, CMS reminds hospitals and CMHCs that provide PHP services to follow existing claim coding requirements given in the *Medicare Claims Processing Manual* (Chapter 4, Section 260) at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf*.

Coverage and payment would be for those PHP services that are recognized by Medicare. For instance, Medicare could pay for psychotherapy by an enrolled licensed clinical psychologist or psychiatrist.

Substance abuse treatment by suppliers of services

There are individuals under the Medicare Part B program who are authorized as suppliers of services that are eligible to furnish substance abuse treatment services providing the services are reasonable and necessary and fall under their State scope of practice.

These suppliers of services include:

- Physicians (medical doctor or doctor of osteopathy);
- Clinical psychologists;
- Clinical social workers;
- Nurse practitioners;
- Clinical nurse specialists;
- Physician assistants; and,
- Certified nurse-midwives.

Screening, brief intervention, and referral to treatment (SBIRT) services

SBIRT is an early intervention approach that targets individuals with nondependent substance use to provide effective strategies for intervention prior to the need for more extensive or specialized treatment. This approach differs from the primary focus of specialized treatment of individuals with more severe substance use, or those who meet the criteria for diagnosis of a substance use disorder.

SBIRT services aim to prevent the unhealthy consequences of alcohol and drug use among those who may not reach the diagnostic level of a substance use disorder, and helping those with the disease of addiction enter and stay with treatment. You may easily use SBIRT services in primary care settings, enabling you to systematically screen and assist people who may not be seeking help for a substance use problem, but whose drinking or drug use may cause or complicate their ability to successfully handle health, work, or family issues. For more information on the Medicare's SBIRT services, refer to Medicare's fact sheet, "Screening, Brief Intervention, and Referral to Treatment (SBIRT) Services" at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/SBIRT_Factsheet_ICN904084.pdf*.

See **ABUSE**, next page

ABUSE

From previous page

SBIRT consists of three major components:

1. Structured assessment (Medicare) or screening (Medicaid): Assessing or screening a patient for risky substance use behaviors using standardized assessment or screening tools;
2. Brief intervention: Engaging a patient showing risky substance use behaviors in a short conversation, providing feedback and advice; and
3. Referral to treatment: Providing a referral to brief therapy or additional treatment to patients whose assessment or screening shows a need for additional services.

The first component to the SBIRT process is assessment or screening which uses tools including the World Health Organization's Alcohol Use Disorders Identification Test (AUDIT) Manual and the Drug Abuse Screening Test (DAST). For more information on SBIRT assessment and screening tools, as well as examples of tools, visit *http://www.integration.samhsa.gov/clinical-practice/sbirt/screening*.

Medicare covers only reasonable and necessary SBIRT services that meet the requirements of diagnosis or treatment of illness or injury (that is, when the service is provided to evaluate and/or treat patients with signs/symptoms of illness or injury) per the Social Security Act (Section 1862(a)(1)(A); see *https://www.ssa.gov/OP_Home/ssact/title18/1862.htm*).

Medicare pays for medically reasonable and necessary SBIRT services furnished in physicians' offices (by physicians and non-physician practitioners) and outpatient hospitals. In these settings, you assess for and identify individuals with, or at-risk for, substance use-related problems and furnish limited interventions/treatment. To bill Medicare, suppliers of SBIRT services must be:

- Licensed or certified to perform mental health services by the State in which they perform the services;
- Qualified to perform the specific mental health services rendered; and
- Working within their state scope of practice act.

Medicare pays for these services under the Medicare physician fee schedule (PFS) and the hospital outpatient prospective payment system (OPPS). For more information on Medicare's payment for SBIRT services, refer to the *Medicare Claims Processing Manual* (Chapter 4, Section 200.6) at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf*.

Drugs used to treat opioid dependence

Medicare Part D sponsors must include coverage for Part D drugs, either by formulary inclusion or via an exception, when medically necessary for the treatment of opioid dependence. Coverage is not limited to single entity products such as Subutex®, but must include combination products when medically necessary (for example, Suboxone®). For any new enrollees, CMS requires sponsors to have a transition policy to prevent any unintended interruptions in pharmacologic treatment with Part D drugs during their transition into the benefit. This transition policy, along with CMS' non-formulary exceptions/appeals requirements, should ensure that all Medicare enrollees have timely access to their medically necessary Part D drug therapies for opioid dependence.

A Part D drug is defined, in part, as "a drug that may be dispensed only upon a prescription." Consequently, methadone is not a Part D drug when used for treatment of opioid dependence because it cannot be dispensed for this purpose upon a prescription at a retail pharmacy. (NOTE: Methadone is a Part D drug when indicated for pain). State Medicaid Programs may continue to include the costs of methadone in their bundled payment to qualified drug treatment clinics or hospitals that dispense methadone for opioid dependence.

See the *Medicare Prescription Drug Benefit Manual* (Chapter 6, Section 10.8 (Drugs Used to Treat Opioid Dependence)) at *https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/downloads/chapter6.pdf*.

Note: Medicare covers diagnostic clinical laboratory services that are reasonable and necessary for the diagnosis or treatment of an illness or injury. For beneficiaries being treated for substance abuse, testing for drugs of abuse when reasonable and necessary can help manage their treatment. Information on the clinical laboratory fee schedule is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Clinical-Laboratory-Fee-Schedule-Fact-Sheet-ICN006818.pdf*.

Additional information

Providers may want to review the following resources:

- "Mental Health Services" booklet: see *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Mental-Health-Services-Booklet-ICN903195.pdf*.
- "Summary of Medicare Reporting and Payment of Services for Alcohol and/or Substance (Other than Tobacco) Abuse Structured Assessment and Brief Intervention (SBIRT) Services;" see *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1013.pdf*.
- National coverage determinations (NCDs): Inpatient Hospital Stays for the Treatment of Alcoholism (130.1); Outpatient Hospital Services for Treatment of Alcoholism (130.2); Chemical & Electrical Aversion Therapy for Treatment of Alcoholism (130.3, 130.4); Treatment of Alcoholism and Drug Abuse in a Freestanding Clinic (130.5); Treatment of Drug Abuse (Chemical Dependency) (130.6); Withdrawal Treatments for Narcotic Addictions (130.7): See *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part2.pdf*.
- "Medicaid Program Integrity What Is a Prescriber's Role in Preventing the Diversion of Prescription

See **ABUSE**, next page

ABUSE

From previous page

Drugs?" fact sheet: See *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Drug-Diversion-ICN901010.pdf*.

- "Effective Strategies for Addressing Overutilization and Abuse of Prescription Drugs in Medicare Part D": See *https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/AHIP_Overutilization_Strategies_CMS_-10192015.pdf*.
- "New Medicare Part D Opioid Drug Mapping Tool Available": See *https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2015-Press-releases-items/2015-11-03.html*.
- "Prescription Drug Monitoring Programs: A Resource to Help Address Prescription Drug Abuse and Diversion": See *https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/se1250.pdf*.
- "Calendar Year (CY) 2016 Clinical Laboratory Fee Schedule (CLFS) Final Determinations" (includes 2016 coding and policy information for drugs of abuse): See *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Downloads/CY2016-CLFS-Codes-Final-Determinations.pdf*.
- *MLN Matters*® Number: SE1105 (Medicare drug screen testing): See *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1105.pdf*.
- The Prescription Opioid Epidemic (CCSQ grand rounds webinar); see *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Downloads/The-Prescription-Opioid-Epidemic.pdf*.

MLN Matters® Number: SE1604
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

Coding revisions to national coverage determinations – 8th maintenance update

Provider types affected

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

Provider action needed

CR 9631 is the 8th maintenance update of International Classification of Diseases, Tenth Revision (ICD-10) conversions and other coding updates specific to national coverage determinations (NCDs). The majority of the NCDs in cluded are a result of feedback received from previous ICD-10 NCD CRs, specifically CR 7818, CR 8109, CR 8197, CR 8691, CR 9087, CR 9252, and CR 9540, while others are the result of revisions required to other NCD-related CRs released separately. Review *MLN Matters*® articles *MM7818*, *MM8109*, *MM8197*, *MM8691*, *MM9087*, *MM9252*, and *MM9540* for information pertaining to these CR's.

Background

The translations from ICD-9 to ICD-10 are not consistent one-to-one matches, nor are all ICD-10 codes appearing in a complete general equivalence mappings (GEMS) guide or other mapping guides appropriate when reviewed against individual NCD policies. In addition, for those policies that expressly allow MAC discretion, there may be changes to those NCDs based on current review of those NCDs against ICD-10 coding. For these reasons, there

may be certain ICD-9 codes that were once considered appropriate prior to ICD-10 implementation that are no longer considered acceptable.

No policy-related changes are included with these updates. Any policy-related changes to NCDs continue to be implemented via the current, long-standing NCD process. Updated NCD coding spreadsheets related to CR 9631 are available at *https://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/CR9631.zip*.

Edits to ICD-10 and other coding updates specific to NCDs will be included in subsequent, quarterly releases as needed. No policy-related changes are included with these

See **NCD**, next page

NCD

From previous page

updates. Any policy-related changes to NCDs continue to be implemented via the current, long-standing NCD process.

To be specific, CR 9631 makes adjustments to the following NCDs:

- NCD 20.4 -Implantable Automatic Defibrillators
- NCD 20.7 -Percutaneous Transluminal Angioplasty (PTA)
- NCD 20.9 - Artificial Hearts
- NCD 20.29 - Hyperbaric Oxygen Therapy
- NCD 50.3 - Cochlear Implants
- NCD 110.18 - Aprepitant
- NCD 210.3 - Colorectal Cancer Screening
- NCD 220.4 - Mammography
- NCD 230.9 - Cryosurgery of Prostate
- NCD 260.9 - Heart Transplants
- NCD 210.4 - Smoking/Tobacco-Use Cessation Counseling
- NCD 210.4.1 - Counseling to Prevent Tobacco Use

Additional information

The official instruction, CR 9631, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1665OTN.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: MM9631
Related Change Request (CR) #: CR 9631
Effective Date: October 1, 2016 - unless noted differently in CR 9631
Related CR Release Date: May 13, 2016
Related CR Transmittal #: R1665OTN
Implementation Date: October 3, 2016

Coding revisions to national coverage determinations – 7th maintenance update

Provider types affected

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

What you need to know

Change request (CR) 9540 is the 7th maintenance update of the International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10) conversions and other coding updates specific to national coverage determinations (NCDs). Edits to ICD-10 and other coding updates specific to NCDs will be included in subsequent, quarterly releases as needed. No policy-related changes are included with these updates. Any policy-related changes to NCDs continue to be implemented via the current, long-standing NCD process.

Background

The majority of the NCDs included are a result of feedback received from previous ICD-10 NCD CRs, specifically, CR 7818, CR 8109, CR 8197, CR 8691, CR 9087, and CR 9252. You may review the corresponding *MLN Matters*® articles MM7818, MM8109, MM8197, MM8691, MM9087, and MM9252 for these CRs on the Centers for Medicare & Medicaid Services (CMS) website. Some are the result of revisions required to other NCD-related CRs released separately.

Updated NCD coding spreadsheets related to CR 9540 are available at *https://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/CR9540.zip*. CR 9540 updates the following 14 NCDs:

1. NCD 20.29 - Hyperbaric Oxygen Therapy
2. NCD 90.1 - Pharmacogenomic Testing for Warfarin Response
3. NCD 110.18 - Aprepitant for Chemotherapy-Induced Emesis
4. NCD 150.3 - Bone Mineral Density Studies
5. NCD 160.18 - Vagus Nerve Stimulation for Treatment of Seizures
6. NCD 160.24 - Deep Brain Stimulation for Essential Tremor
7. NCD 210.3 - Colorectal Cancer Screening Tests
8. NCD 210.14 - Screening for Lung Cancer with Low-Dose CT (CR 9246)
9. NCD 230.18 - Sacral Nerve Stimulation for Urinary Incontinence
10. NCD 260.1 - Adult Liver Transplantation (CR 9252, CR 8109)
11. NCD 110.4 - Extracorporeal Photopheresis
12. NCD 20.33 - Transcatheter Mitral Valve Repair (CR 9002, TDL 150341, policy effective August 7, 2014

See **BILLING**, next page

Reporting place of service (POS) codes

Physicians are required to report the place of service (POS) on all health insurance claims they submit to Medicare Part B contractors. The POS code is used to identify where the procedure is furnished. Physicians are paid for services according to the Medicare physician fee schedule (MPFS). This schedule is based on a payment system that includes three major categories, which drive the reimbursement for physician services:

- Practice expense (reflects overhead costs involved in providing service(s))
- Physician work
- Malpractice insurance

To account for the increased practice expense physicians incur by performing services in their offices, Medicare reimburses physicians a higher amount for services performed in their offices (POS code 11) than in an outpatient hospital (POS 22-23) or an ambulatory surgical center (ASC) (POS 24). Therefore, it is important to know the POS also plays a factor in the reimbursement.

Note: Check with individual payers (e.g., Medicare, Medicaid, other private insurance) for reimbursement policies regarding POS codes.

Important facts when filing a claim to Medicare

- The POS is a required field, entered in the 2400 Place of Service Code loop (segment SV105) of the 837P electronic claim or Item 24B on the CMS-1500 paper claim
- The name, address and zip code of where the service(s) were actually performed is required for all POS codes, and is entered in Item 32 on the CMS 1500 claim form or in the corresponding loop on its electronic equivalent
    - Must specify the correct location where the service(s) is performed and billed on the claim, since both the POS and the locality address are components of the MPFS
- If the POS is missing, invalid or inconsistent with procedure code on claim form it will be returned as unprocessable (RUC)
    - For example, POS 21 (inpatient hospital) is not compatible with procedure code 99211 (Establish patient office or other outpatient visit)

Helpful hints for POS codes for professional claims

- Implement internal control systems to prevent incorrect billing of POS codes
- Keep informed on Medicare coverage and billing requirements
    - For example, billing physician's office (POS 11) for a minor surgical procedure that is actually performed in a hospital outpatient department (POS 22) and collecting a higher payment is inappropriate billing and may be viewed as program abuse
- Check these links frequently for revisions to the listing and validate that you are coding according to the most current version.
    - A complete set of the national POS code set and instructions is provided in CMS Internet-only Manual (IOM) Publication 100-04, Chapter 26, Section 10.5 at: *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf*
    - Additional information is available at: *https://www.cms.gov/Medicare/Coding/place-of-service-codes/index.html*

BILLING

From previous page

13. NCD 220.13 - Percutaneous Image-Guided Breast Biospy
14. NCD 220.4 - Mammograms

MACs will adjust any claims already processed, if erroneously impacted by the above changes, if you bring such claims to their attention.

Additional information

The official instruction, CR 9540, issued to your MAC regarding this change is available for download at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1658OTN.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: MM9540
Related Change Request (CR) #: CR 9540
Related CR Release Date: April 29, 2016
Effective Date: July 1, 2016
Related CR Transmittal #: R1658OTN
Implementation Date: July 5, 2016, unless otherwise noted

Manual update to correct remittance advice messages

Provider types affected

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

Provider action needed

If change request (CR) 9578 updates Chapter 1 and Chapter 16 of the *Medicare Claims Processing Manual* to reflect the standard format and to correct any non-compliant remittance advice code combinations. Make sure that your billing staffs are aware of the corrected code combinations.

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. The business scenario for each payment adjustment must be defined, if applicable, and a valid code combination selected for all remittance advice messages.

CR 9578 makes the following code revisions:

1. When a MAC rejects an out of jurisdiction professional claim as unprocessable, the following codes are used:
   - Group code of CO
   - CARC 109, and
   - RARC N104
2. When a MAC rejects misdirected Railroad Retirement Board claims as unprocessable, the following codes are used:
   - Group code of CO
   - CARC 109, and
   - RARC N105
3. When a MAC rejects misdirected United Mine Workers Association claims as unprocessable, the following codes are used:
   - Group code CO
   - CARC 109, and
   - RARC N127
4. In the above three situations, RARC MA130 was used previously, but will no longer be used in these situations.

Additional information

The official instruction, CR 9578 issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3510CP.pdf*. The revised manual Chapters 1 and 16 are attached to CR 9578.

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: MM9578
Related Change Request (CR) #: CR 9578
Related CR Release Date: April 29, 2016
Effective Date: October 1, 2016
Related CR Transmittal #: R3510CP
Implementation Date: October 3, 2016

Take action to combat the flu

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

Processing Issues

Computed tomographic angiography, chest – claims that may have been denied in error (Part B)

Issue

Claims submitted for computed tomographic angiography, chest (CPT® code 71275) between October 1, 2015, and December 28, 2015, may have been denied in error when billed with diagnosis code R07.9 (Chest pain, unspecified).

Resolution

Open. This error was corrected December 28, 2015.

Status/date resolved

Claims processed on or after December 29, 2015, 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.

Reprocessing claims for audiology services

Issue

Effective for dates of service on and after January 1, 2016, new Healthcare Common Procedure Coding System (HCPCS) codes 92537 and 92538 for caloric testing replaced code 92543. These 2016 code changes were inadvertently left off of the audiology code list (*http://go.usa.gov/ctu9h*) until March 31. As a result, some claims for audiologists' services for codes 92537 and 92538 were unintentionally denied. Medicare administrative contractors will automatically reprocess these claims.

Resolution

Medicare administrative contractors will automatically reprocess these claims.

Status/date resolved

Open

Provider action

No action is required by the provider.

Current processing issues

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

General Information

PAP smear risk indicator and dates move to screening auxiliary file

Provider types affected

This *MLN Matters*® article is intended for institutional providers and home health agencies (HHAs) submitting inquiries to Medicare administrative contractors (MACs) for information on Pap smear services provided to Medicare beneficiaries.

What you need to know

Change request (CR) 9188 announces changes to Medicare systems regarding the placement of Pap smear data on Medicare's internal files. The Pap smear data is displayed on the following provider inquiry screens:

- **HIQA**: Healthcare inquiry for Part A for online transactions
- **HIQH**: Healthcare inquiry for Home Health for online transactions
- **ELGA**: Eligibility for Part A
- **ELGH**: Eligibility for Home Health
- **HUQA**: Healthcare Update Inquiry for Part A

The Healthcare Common Procedure Coding System (HCPCS) codes for PAP screening displayed on these screens are P3000, G0123, G0143, G0144, G0145, G0147 and G0148, and the screens can show up to three occurrences per HCPCS.

The other significant change for providers is that on the unformatted provider inquiry, HUQA, PAP information will now be carried in screening data location 4053-4612, instead of 780-784.

Additional information

The official instruction, CR 9188, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1551OTN.pdf*.

See **PAP**, next page

Revisions to private contracting/opt-out manual sections

Provider types affected

This *MLN Matters*® article is intended for physicians and practitioners who are planning to opt-out of Medicare or who have already opted out of Medicare.

Provider action needed

Change request (CR) 9616 alerts physicians and practitioners who signed a valid opt-out affidavit on or after June 16, 2015, that it will automatically renew every two years. CR 9616 revises the *Medicare Benefit Policy Manual* to be consistent with the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) amendments. If physicians and practitioners who filed 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 MACs with which they filed an affidavit in writing at least 30 days prior to the start of the next opt-out period.

Be aware that 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 contractors with which they would have filed claims absent the opt-out.

Background

MACRA amended the private contracting/opt out provisions at Section 1802(b) of the Social Security Act. Prior to the MACRA amendments, the law specified that physicians and practitioners may opt out for a two-year period. Individuals that wished to renew their opt-out at the end of a two-year opt-out period were required to file new affidavits with their MAC. Section 106(a) of the MACRA amended Section 1802(b)(3) of the Social Security Act to require that opt-out affidavits entered into on or after June 16, 2015, automatically renew every two years.

Other key points

- Medicare will make payment for covered, medically necessary services that are ordered or certified by a physician/practitioner who has opted out of Medicare if the ordering or certifying physician/practitioner has acquired a national provider identifier (NPI), reports his/her Social Security number, has a valid opt out affidavit on file with his or her MAC, is of a specialty that is eligible to order and certify and provided that the services are not furnished by another physician/practitioner who has also opted out. For example, if an opt-out physician/practitioner admits a beneficiary to a hospital, Medicare will reimburse the hospital for medically necessary care.
- In order for a private contract with a beneficiary to be effective, the physician/practitioner must be opted out of Medicare. The physician/practitioner's initial two-year opt-out period begins the date the affidavit meeting Medicare requirements is signed, provided the affidavit is filed within 10 days after the physician/practitioner signs his or her first private contract with a Medicare beneficiary.
- When a two-year opt-out period ends, the physician/practitioner must enter into new private contracts with each beneficiary for the new two-year period. The new private contracts must state the expected or known effective date and the expected or known expiration date of the current two-year opt-out period.
- These points and other information are identified in the revised Chapter 15, Section 40 of the *Medicare Benefit Policy Manual*, which is attached to CR 9616.

Additional information

The official instruction, CR 9616, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R222BP.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: MM9616
Related Change Request (CR) #: CR 9616
Related CR Release Date: May 13, 2016
Effective Date: August 15, 2016
Related CR Transmittal #: R222BP
Implementation Date: August 15, 2016

PAP

From previous page

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: MM9188
Related CR Release Date: November 5, 2015
Related CR Transmittal #: R1551OTN
Related Change Request (CR) #: CR 9188

Effective Date: April 4, 2016
Implementation Date: April 4, 2016

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

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

Effective and notice dates

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

Electronic notification

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

More information

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

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

Looking for LCDs?

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

Advance beneficiary notice

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

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

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

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

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

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

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

Revisions to LCDs

B-Scan – revision to the LCD

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

The local coverage determination (LCD) for b-scan was revised to add the following ICD-10-CM diagnosis codes to the "ICD-10 Codes that Support Medical Necessity" section of the LCD: A18.51, A18.53, H05.50- H05.53, H05.821-H05.89, H18.011-H18.069, H18.20-H18.239, H21.40-H21.43, H26.101-H26.139, H30.001-H32, H35.00-H35.09, H35.81-H35.89, H44.50-H44.9, H47.10-H47.149, and Q14.0-Q14.9. In addition, the "ICD-10 Codes that Support Medical Necessity" section of the LCD was revised to change diagnosis code range H15.001 - H15.129 to H15.001 - H15.9 and diagnosis code range H35.171 - H35.32 to H35.171 – H35.469.

Effective date

This LCD revision is effective for claims processed **on or after April 26, 2016**, for services rendered **on or after October 1, 2015**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *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, *click here*.

Amniotic membrane - sutureless placement on the ocular surface – revision to the Part A and Part B LCD

LCD ID number: L36237 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for amniotic membrane – sutureless placement on the ocular surface was revised to add ICD-10-CM diagnosis code ranges H16.121–H16.129 (Filamentary keratitis) and H16.231–H16.239 (Neurotrophic keratoconjunctivitis) for CPT® code 65778 to the "ICD-10 Codes that Support Medical Necessity" section of the LCD.

Effective date

This LCD revision is effective for services rendered **on or after April 6, 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, *click here*.

Your feedback matters

Your opinion is important to us. If you haven't already completed the MAC Satisfaction Indicator (MSI) survey, please take a moment to complete it now. Share your experience with the services we provide. It will take about 10 minutes. You can access the survey by clicking here.

Upcoming provider outreach and educational events

Provider enrollment revalidation – cycle 2

Date: Tuesday, June 21
Time: 11:30 a.m.-12:30 p.m.
Type of Event: Webcast
http://medicare.fcso.com/Events/0338562.asp

E/M coding: Selecting your critical care codes

Date: Thursday, August 18
Time: 3:00-4:30 p.m.
Type of Event: Webcast
http://medicare.fcso.com/Events/0338582.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 April 28, 2016

MLN Connects® Provider eNews for April 28, 2016

View this edition as a PDF

In this edition:

MLN Connects® Events

- How to Register for the 2016 PQRS Group Practice Reporting Option Call — Last Chance to Register
- 2015 Mid-Year QRURs Webcast — Register Now
- New Audio Recordings and Transcripts Available

Other CMS Events

- Comparative Billing Report on Subsequent Nursing Facility E/M Services Webinar
- Comparative Billing Report on Modifiers 24 and 25: General Surgeons Webinar

Medicare Learning Network® Publications and Multimedia

- Acute Care Hospital Inpatient Prospective Payment System Booklet — Revised
- New Educational Web Guides Fast Fact

Announcements

- IRFs: Proposed FY 2017 Payment and Policy Changes
- SNFs: Proposed FY 2017 Payment and Policy Changes
- Hospice Benefit: Proposed FY 2017 Updates to the Wage Index and Payment Rates
- Open Payments: Physician and Teaching Hospital Review and Dispute Period Began April 1
- Nursing Homes, IRFs, and LTCHs: Comment on New Quality Measures by May 6
- Hospitals: Submit Comments on New EHR Measure by May 15
- Next Generation ACO Model Letter of Intent Deadline Extended to May 20
- 2016 PQRS GPRO Registration Open through June 30
- Home Health Quality Reporting Program: Quarterly QAO Interim Reports Available
- 2015 Mid-Year QRURs Available
- Track and Improve Your ICD-10 Progress
- Hand Hygiene Day is May 5

Claims, Pricers, and Codes

- Reprocessing Claims for Audiology Services
- Prolonged Drug and Biological Infusions Using an External Pump

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 May 5, 2016

MLN Connects® Provider eNews for May 5, 2016
View this edition as a PDF

In this edition:

MLN Connects® Events

- MACRA Listening Session: Quality Payment Program Proposed Rule – Register Now
- 2015 Mid-Year QRURs Webcast – Register Now
- New Audio Recordings and Transcripts Available

Medicare Learning Network® Publications and Multimedia

- Medicare Coverage of Substance Abuse Services *MLN Matters*® Article – New
- Medicare Policy Clarified for Prolonged Drug and Biological Infusions Started Incident to a Physician's Service Using an External Pump *MLN Matters*® Article – New

Announcements

- CMS Releases NPRM on the Medicare Access and CHIP Reauthorization Act of 2015
- DMEPOS Competitive Bidding: Round 2 Recompete/ National Mail-Order Recompete Contract Suppliers Announced
- CMS Adds New Quality Measures to Nursing Home Compare
- CMS Publishes Final Rule on Fire Safety Requirements for Certain Health Care Facilities
- CMS Finalizes its Quality Measure Development Plan
- 2017 Medicare Shared Savings Program: Notice of Intent to Apply Period Closes May 31
- New PEPPERs Available for Hospices, SNFs, IRFs, IPFs, CAHs, LTCHs
- CMS to Release a CBR on Podiatry: Nail Debridement and E/M Services in May
- Focusing on Women's Health

Claims, Pricers, and Codes

- Reprocessing of Selected Dialysis Claims

MLN Connects® Provider eNews for May 12, 2016

MLN Connects® Provider eNews for May 12, 2016
View this edition as a PDF

In this edition:

MLN Connects® Events

- 2015 Mid-Year QRURs Webcast – Last Chance to Register

Medicare Learning Network® Publications and Multimedia

- Limiting the Scope of Review on Redeterminations and Reconsiderations of Certain Claims *MLN Matters*® Article – Revised
- Transitional Care Management Services Fact Sheet – Revised
- Section 1011: Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens Fact Sheet – Revised
- DMEPOS Competitive Bidding Program Fact Sheets – Revised

Announcements

- Updates to Data Initiatives Increase Transparency of the Medicare Program
- HHS Awards over $260 Million to Health Centers Nationwide to Build and Renovate Facilities to Serve More Patients
- Open Payments: Physician and Teaching Hospital Review and Dispute Period Ends May 15
- 2016 Electronic Clinical Quality Measures: Updated Files Available
- Teaching Hospitals: Submitting Medicare GME Affiliation Agreements
- May is National Osteoporosis Month

Claims, Pricers, and Codes

- Coinsurance Correction for Certain RHC Claims
- Billing Requirements for RHCs

MLN Connects® Provider eNews for May 19, 2016

MLN Connects® Provider eNews for May 19, 2016
View this edition as a PDF

In this edition:

MLN Connects® Events

- Comparative Billing Report on Psychotherapy and E/M Services Webinar

Medicare Learning Network® Publications and Multimedia

- Part C Appeals: Organization Determinations, Appeals, and Grievances WBT – Revised
- Part D Coverage Determinations, Appeals, and Grievances WBT – Revised
- Resources for Medicare Beneficiaries Booklet – Revised
- How to Use the Searchable Medicare Physician Fee Schedule Booklet – Revised
- Updated *MLN Matters®* Search Indices

Announcements

- 2017 Medicare Shared Savings Program: Notice of Intent to Apply Period Closes May 31
- SNF Value-Based Purchasing Program: Specifications for New Measure
- 2014 PQRS Experience Report Available
- How to Use ICD-10 and Maintain Your Progress
- Talk to Your Patients about Mental Health

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.

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
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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)