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

In this issue

MLN Connects® Provider eNews – Special Edition for July 7, 2016

Physician fee schedule: Proposed 2017 changes

Medicare also expands the diabetes prevention program

On July 7, CMS proposed changes to the physician fee schedule to transform how Medicare pays for primary care through a new focus on care management and behavioral health designed to recognize the importance of the primary care work physicians perform. The rule also proposes policies to expand the diabetes prevention program within Medicare starting January 1, 2018.

The annual physician fee schedule updates payment policies, payment rates, and quality provisions for services provided in calendar year 2017. These services include, but are not limited to visits, surgical procedures, diagnostic tests, therapy services, and specified preventive services. In addition to physicians, the fee schedule pays a variety of practitioners and entities, including nurse practitioners, physician assistants, physical therapists, as well as radiation therapy centers and independent diagnostic testing facilities. Additional policies proposed in the 2017 payment rule include:

- Primary care and care coordination
- Mental and behavioral health
- Cognitive impairment care assessment and planning
- Care for patients with mobility-related impairments

For more information:

- *Proposed Rule (CMS-1654-P)*: Comments due no later than 5 pm on September 6, 2016
- *Fact Sheet*
- *Blog*
- *Diabetes Prevention Program*

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

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

About the 'Medicare B Connection'

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

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

Who receives the *Connection*

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

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

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

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

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

Publication format

The *Connection* is arranged into distinct sections.

- The **Claims** section provides claim submission requirements and tips.
- The **Coverage/Reimbursement** section discusses specific CPT® and HCPCS procedure codes. It is arranged by categories (not specialties). For example, "Mental Health" would present coverage information of interest to psychiatrists, clinical psychologists and clinical social workers, rather than listing articles separately under individual provider specialties. Also presented in this section are changes to the Medicare physician fee schedule, and other pricing issues.

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

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

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

Never miss an appeals deadline again

When it comes to submitting a claims appeal request, *timing is everything*. Don't worry – you won't need a desk calendar to count the days to your submission deadline. Try our *"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.

July update to the correct coding initiative edits

Provider types affected

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

Provider action needed

Change request (CR) 9725 informs MACs about the latest package of correct coding initiatives (CCI) edits, version 22.3, effective October 1, 2016. Make sure that your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) developed the national CCI to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment in Part B claims. The latest package of CCI edits, version 22.3, effective October 1, 2016, will be available via the CMS data center (CDC). A test file will be available on or about August 2, 2016, and a final file will be available on or about August 17, 2016.

Version 22.3 will include all previous versions and updates from January 1, 1996, to the present. In the past, CCI was organized in two tables: column 1/column 2 correct coding edits and mutually exclusive code (MEC) edits. In order to simplify the use of NCCI edit files (two tables), on April 1, 2012, CMS consolidated these two edit files into the column one/column two correct coding edit file. Separate consolidations have occurred for the two practitioner NCCI edit files and the two NCCI edit files used for OCE. It will only be necessary to search the column 1/column 2 correct coding edit file for active or previously deleted edits.

CMS no longer publishes a mutually exclusive edit file on its website for either practitioner or outpatient hospital services, since all active and deleted edits will appear in the single column 1/column 2 correct coding edit file on each website. The edits previously contained in the mutually exclusive edit file are **not** being deleted but are being moved to the column 1/column 2 correct coding edit file. Refer to the *CMS NCCI web page* for additional information.

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

Additional information

The official instruction, CR 9725, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3561CP.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* on the CMS website under - How Does It Work.

The CMS NCCI web page is available at *https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html*.

MLN Matters® Number: MM9725
Related Change Request (CR) #: CR 9725
Related CR Release Date: July 15, 2016
Effective Date: October 1, 2016
Related CR Transmittal #:R3561CP
Implementation Date: October 3, 2016

TECENTRIQ™ – billing instructions

On May 18, 2016, the U. S. Food and Drug Administration approved atezolizumab (TECENTRIQ™ injections, Genentech, Inc.) for the treatment of patients with locally advanced or metastatic urothelial carcinoma who: Have disease progression during or following platinum-containing chemotherapy or have disease progression within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy.

The recommended dose and schedule for TECENTRIQ™ is 1200 mg administered as an intravenous infusion over 60 minutes every three weeks until disease progression or unacceptable toxicity.

Submit

- **HCPCS code:** J9999
- **Diagnoses:** C65.1-C65.9 (Malignant neoplasm of renal pelvis), or C66.1-C66.9 (Malignant neoplasm of the ureter), or C67.0-C67.9 (Malignant neoplasm of the bladder), or C68.0-C68.9 (Malignant neoplasm of other and unspecified urinary organs).

Narrative field or electronic equivalent

Name of the drug, strength, and dosage.

Preventing duplicate claim denials

Providers are responsible for all claims submitted to Medicare under their provider number. Preventable duplicate claims are counterproductive and costly, and continued submission to Medicare may lead to program integrity action.

Please share this information with your billing companies, vendors and clearing houses: Claim system edits search for duplicate, suspect duplicate and repeat services, procedures and items within paid, finalized, pending and same claim details in history. Duplicate claims and claim lines are automatically denied. Suspect duplicate claims and claim lines are suspended and reviewed by the Medicare administrative contractor (MAC) to make a determination to pay or deny. *Click here for additional information*.

Medicare correct coding rules include the appropriate use of condition codes and/or modifiers. When you submit a claim for multiple instances of a service, procedure or item, the claim should include an appropriate modifier to indicate that the service, procedure or item is not a duplicate. Note that the modifier should be added to the second through subsequent line items for the repeat service, procedure or item. (An example is listed below.) In many instances, this will allow the claim to process and pay, if applicable.

However, in some instances, even if an appropriate modifier is included, the claim may deny as a duplicate, based on medically unlikely edits (MUEs). MUEs are maximum units of service that are typically reported for a service, medical procedure or item, under most instances, for a beneficiary on a single date of service. Note that these duplicate denials may not always be considered preventable. *Click here for information on MUEs, including appeal rights*.

Review your billing procedures and software, and use appropriate modifiers, as applicable. The following are examples of modifiers that may be used on your claim to identify that the service, procedure or item is not a duplicate. Please review the *Current Procedural Terminology (CPT®) codebook* for a complete list of modifiers.

- **Modifier 59**: Service or procedure by the same provider, distinct or independent from other services, performed on the same day. Services or procedures that are normally reported together but are appropriate to be billed separately under certain circumstances. Refer to *MLN Matters®* article *SE1418* for more details on the use of modifier 59, including numerous coding examples.
- The Centers for Medicare & Medicaid Services (CMS) established four new modifiers, effective January 1, 2015, to define subsets of modifier 59. Refer to *MLN Matters®* article *MM8863* for details.
- **Modifier 76**: Repeat service or procedure by the same provider, subsequent to the original service or procedure.
- **Modifier 91**: Repeat clinical diagnostic laboratory tests. This modifier is added only when additional test results are medically necessary on the same day.
  - **Example**: Laboratory submits Medicare claim for four glucose; blood, reagent strip tests (CPT® code 82948).
    - **Line 1**: 82948
    - **Line 2**: 82948 and modifier 91
    - **Line 3**: 82948 and modifier 91
    - **Line 4**: 82948 and modifier 91
- **Modifiers RT** (right side) and **LT** (left side): Append applicable modifier to the procedure code, even if the diagnosis indicates the exact site of the procedure.
  - **Example**: Provider submits Medicare claim for diagnosis code M1711 (unilateral primary osteoarthritis, right knee) and/or diagnosis code M1712 (unilateral primary osteoarthritis, left knee). Modifier RT should be added to the procedure code billed with diagnosis code M1711. Modifier LT should be added to the procedure code billed with diagnosis code M1712.

Note: All claims submitted to Medicare should be supported by documentation in the patient's medical record.

Sources: CMS *MLN Matters®* MM8121, CMS internet-only manual (IOM), Publication 100-04, Chapter 1, Section 120-Detection of duplicate claims,

CMS *MLN Matters®* MM8863 and the American Medical Association's (AMA) *2013 Current Procedural Terminology (CPT®) codebook*.

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Clinical Trials

Allogeneic hematopoietic stem cell transplantation

***Note**: This article was revised July 5, 2016, due to an updated change request (CR). That CR added clarifying language and identified the appropriate FISS responsibility. The revision also included clarifying language for references to the "NCD Manual", under Summary of Changes. The transmittal number, CR release date and link to the transmittal also changed. All other information remains the same. This information was previously published in the May 2016 Medicare B Connection, pages 6-8.*

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

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/*

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Hospital and ASC: Proposed OPPS changes for 2017

On July 6, CMS proposed updated payment rates and policy changes in the hospital outpatient prospective payment system (OPPS) and ambulatory surgical center (ASC) payment system. Several of the proposed policy changes would improve the quality of care Medicare patients receive by better supporting their physicians and other health care providers. These proposals are based on feedback from stakeholders, including beneficiary and patient advocates, as well as health care providers, including hospitals, ambulatory surgical centers and the physician community.

Proposed changes include:

- Addressing physicians' concerns regarding pain management
- Focusing payments on patients rather than setting
- Improving patient care through technology
- Emphasizing health outcomes that matter to the patient

CMS estimates that the updates in the proposed rule would increase OPPS payments by 1.6 percent and ASC payments by 1.2 percent in 2017.

For more information:

- *Proposed Rule (CMS-1656-P)*: Comments due no later than 5 pm on September 6, 2016
- *Fact Sheet*

See the full text of this excerpted *CMS press release* (issued July 6).

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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

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 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

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 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**
- 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

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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 *http://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.

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/R3556CP.pdf*. The second transmittal updates the *Medicare NCD Manual* at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R193NCD.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
July 5, 2016	The article was revised due to an updated change request (CR). That CR revised shared system maintainer (SSM) responsibility. The transmittal number, CR release date and link to the transmittal also changed.
May 9, 2016	Initial article release

MLN Matters® Number: MM9620 *Revised*
Related Change Request (CR) #: CR 9620
Related CR Release Date: July 1, 2016
Effective Date: January 27, 2016
Related CR Transmittal #: R193NCD and R3556CP
Implementation Date: October 3, 2016

Durable Medical Equipment

July update for 2016 DMEPOS fee schedule

Provider types affected

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

Provider action needed

Change request (CR) 9642 advises providers of fee schedule amounts for codes in effect on January 1, 2016, and July 1, 2016, for all other changes. The instructions include information on the data files, update factors and other information related to the update of the fee schedule. Make sure your billing staffs are aware of these updates.

Background

The Centers for Medicare & Medicaid Services (CMS) updates the DMEPOS fee schedules on a quarterly basis, when necessary, in order to implement fee schedule amounts for new and existing codes, as applicable, and apply changes in payment policies. The quarterly update process for the DMEPOS fee schedule is located in the *Medicare Claims Processing Manual*, Chapter 23, Section 60 (*https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf*).

Payment on a fee schedule basis is required by the Social Security Act (the Act) for durable medical equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings. Also, payment on a fee schedule basis is a regulatory requirement at 42 CFR lenses (IOLs) inserted in a physician's office. The Act mandates adjustments to the fee schedule amounts for certain items furnished on or after January 1, 2016, in areas that are not competitive bid areas for the items, based on information from competitive bidding programs (CBPs) for DME. The CBP product categories, HCPCS codes and single payment amounts (SPAs) included in each round of the CBP are available on the competitive bidding implementation contractor (CBIC) website (*http://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home*). The changes for 2016 are detailed in MM9431.

Adjusted fee schedule amounts

The DMEPOS and PEN fee schedule files contain HCPCS codes that are subject to the adjusted fee schedule amounts as well as codes that are not subject to the fee

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schedule CBP adjustments. The adjustments to the fee schedule amounts have been phased in for claims with dates of service January 1, 2016, through June 30, 2016, so that each fee schedule amount is based on a blend of 50 percent of the fee schedule amount that would have gone into effect on January 1, 2016, if not adjusted based on information from the CBP, and 50 percent of the adjusted fee schedule amount. As part of this update, for claims with dates of service on or after July 1, 2016, the July quarterly update files include the fee schedule amounts based on 100 percent of the adjusted fee schedule amounts. Information from CBPs that take effect on July 1, 2016 is factored into the adjusted fee schedule amounts effective on July 1, 2016, in accordance with the regulations at 42 CFR 414.210(g)(8).

Fee schedule amounts that are adjusted using information from CBPs will not be subject to the annual DMEPOS covered item update, but will be updated in accordance with 42 CFR 414.210(g)(8) when information from the CBPs is updated. Pursuant to 42 CFR §414.210(g)(4), for items where the single payment amounts (SPAs) from CBPs no longer in effect are used to adjust fee schedule amounts, the SPAs will be increased by an inflation adjustment factor that corresponds to the year in which the adjustment would go into effect (for example, 2016 for this update) and for each subsequent year such as 2017 and 2018.

There are three general methodologies used in adjusting the fee schedule amounts:

1. Adjusted fee schedule amounts for areas within the contiguous United States

The average of SPAs from CBPs located in eight different regions of the contiguous United States are used to adjust the fee schedule amounts for the states located in each of the eight regions. These regional SPAs (RSPAs) are also subject to a national ceiling (110 percent of the average of the RSPAs for all contiguous states plus the District of Columbia) and a national floor (90 percent of the average of the RSPAs for all contiguous states plus the District of Columbia). The methodology applies to enteral nutrition and most DME items furnished in the contiguous United States (those included in more than 10 competitive bidding areas (CBAs)).

Also, the fee schedule amounts for areas within the contiguous United States that are designated as rural areas are adjusted to equal the national ceiling amounts described above. 414.202 define a rural area to be a geographical area represented by a postal ZIP code where at least 50 percent of the total geographical area of the ZIP code is estimated to be outside any metropolitan statistical area (MSA). A rural area also includes any ZIP code within an MSA that is excluded from a CBA established for that MSA.

2. Adjusted fee schedule amounts for areas outside the contiguous United States

Areas outside the contiguous United States (areas such as Alaska, Guam, Hawaii) receive adjusted fee schedule amounts so that they are equal to the higher of the average of SPAs for CBAs in areas outside the contiguous United States (currently only applicable to Honolulu, Hawaii) or the national ceiling amounts described above and calculated based on SPAs for areas within the contiguous United States.

3. Adjusted fee schedule amounts for items Included in 10 or fewer CBAs

DME items included in 10 or fewer CBAs receive adjusted fee schedule amounts so that they are equal to 110 percent of the average of the SPAs for the 10 or fewer CBAs. This methodology applies to all areas, non-contiguous and contiguous.

In order to apply the rural payment rule for areas within the contiguous United States, the DMEPOS fee schedule file is updated to include rural payment amounts for certain HCPCS codes where the adjustment methodology is based on average regional SPAs. Also, on the PEN file, the national fee schedule amounts for enteral nutrition transitions to statewide fee schedule amounts. For parenteral nutrition, the national fee schedule amount methodology remains unchanged.

The ZIP code associated with the address used for pricing a DMEPOS claim determines the rural fee schedule payment applicability for codes with rural and non-rural adjusted fee schedule amounts based on information from the CBPs. ZIP codes for non-contiguous areas are not included in the DMEPOS rural ZIP code file. The DMEPOS rural ZIP code file is updated on a quarterly basis as necessary.

Key points of CR 9642

Public use files (PUFs)

In October 2015, CMS posted sample 2016 DMEPOS and PEN Medicare payment PUFs that were modified to accommodate the adjusted fee schedule amounts effective January 1, 2016. At that time, CMS communicated that different PUF file formats would be used for the January 2016 Excel file update as opposed to the July 2016 update and all subsequent fee schedule updates. CMS has recently determined that it is necessary to retain separate rural fee fields for each state and not transition, beginning July 1, 2016, to one field titled “Contiguous United States rural fee” as previously communicated. Therefore, beginning with the July 2016 update, the July DMEPOS and PEN Excel PUF record layouts will retain the separate rural fees for each state as implemented January 1, 2016. As discussed above, the phase in of adjusted fees are based on 100 percent of the adjusted fee schedule amounts effective July 1, 2016. The rural fee for the contiguous United States, which is equal to the national ceiling amount, applies to all rural areas within the contiguous United States. However, in any case where the application of the adjusted fee methodology results in an increase in the fee schedule amount that would otherwise apply, the rural adjustment for an area/state is not made. Non-contiguous areas are not subject to rural fees under the 2016 DMEPOS fee schedule methodology.

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The 2016 DMEPOS and PEN fee schedules and the July 2016 DMEPOS rural ZIP code file PUFs will be available for state Medicaid agencies, managed care organizations, and other interested parties shortly after the release of the data files at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched*.

KU modifier for complex rehabilitative power wheelchair accessories & seat and back cushions

Section 2 of the Patient Access and Medicare Protection Act (PAMPA) mandates that the adjustments to the 2016 fee schedule amounts for certain DME based on information from CBPs not be applied to wheelchair accessories (including seating systems) and seat and back cushions furnished in connection with Group 3 complex rehabilitative power wheelchairs prior to January 1, 2017. Group 3 complex rehabilitative power wheelchair bases are currently described by codes K0848 through K0864 of the HCPCS.

As a result, the fees for wheelchair accessories and seat and back cushions denoted with the HCPCS modifier 'KU' are included in the July 2016 DMEPOS fee schedule file and are effective for dates of service January 1, 2016, through December 31, 2016. The fee schedule amounts associated with the KU modifier represent the unadjusted fee schedule amounts (the 2015 fee schedule amount updated by the 2016 DMEPOS covered item update factor of -0.4 percent) for these wheelchair accessory codes.

The codes for wheelchair accessories and seat and back cushions affected by this change along with claims processing instructions are available in CR 9520 at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3535CP.pdf*. In accordance with that article, if brought to their attention, MACs may adjust claims for the Group 3 complex rehabilitative power wheelchair accessories referenced in Attachment A of related CR 9520 for dates of service January 1, 2016, through June 30, 2016.

Discontinuation of KE modifier for items in initial round 1 CBP

As part of this update, the fees for certain items included in round 1 CBP, denoted with the HCPCS pricing modifier 'KE', are deleted from the DMEPOS fee schedule file. Program instructions on the implementation of these fees and the list of applicable HCPCS codes were issued via CR 6720, dated November 7, 2008 (see related article *MM6720*).

The KE fees were retained on the fee schedule file for dates of service January 1, 2016, through June 30, 2016, because of the phase-in of the adjusted fee schedule amounts, but are no longer needed.

Reclassification of certain DME included in CBPs

As part of this update, capped rental fees are established for payment of the following 14 HCPCS codes: E0197, E0140, E0149, E0985, E1020, E1028, E2228, E2368, E2369, E2370, E2375, K0015, K0070, and E0955.

For dates of service on or after July 1, 2016, these HCPCS codes are reclassified from the payment category for inexpensive and routinely purchased DME to payment on a capped rental basis in all areas except the nine round 1 re-compete (round 1 2014) CBAs. These changes are made to align the payment with the regulatory definition of routinely purchased equipment. Articles *MM8822* and *MM8566* discuss these program instructions.

When submitting claims, suppliers in areas outside of round 1 re-compete CBAs that furnish these 14 HCPCS codes on a capped rental basis use the capped rental modifiers KH, KI, and KJ as appropriate. Beginning January 1, 2017, payment for these codes in all geographic areas will be made on a capped rental basis.

Also, certain HCPCS codes for wheelchair options/accessories (E1020, E1028, E2368, E2369, E2370, E2375, K0015, and E0955) that are furnished to be used as part of a complex rehabilitative power wheelchair (wheelchair base codes K0835 – K0864) can be paid under the associated lump sum purchase option set forth in article *MM8566*.

The supplier must give the beneficiary the option of purchasing these accessories at the time they are furnished for initial or replacement. If the beneficiary declines the purchase option, the supplier must furnish the items on a capped rental basis and payment shall be made on a monthly rental basis in accordance with the capped rental payment rules.

Diabetic testing supplies (DTS)

The fee schedule amounts for non-mail order DTS without KL modifier for codes A4233, A4234, A4235, A4236, A4253, A4256, A4258, and A4258 are not updated by the covered item update. In accordance with Section 636(a) of the American Taxpayer Relief Act of 2012, the fee schedule amounts for these codes were adjusted in 2013 so that they were equal to the SPAs for mail order DTS established in implementing the national mail-order CBP under Section 1847 of the Act. The non-mail order payment amounts on the fee schedule file are updated each time the single payment amounts are updated. As part of the this update, the non-mail order payment amounts on the fee schedule file for the above codes will be updated, effective July 1, 2016, using the SPAs established under the National Mail-Order Re-compete CBP.

As part of this update, the DTS mail order (with KL modifier) fee schedules for all states and territories are removed from the DMEPOS fee schedule file. The SPAs calculated under the National Mail-Order CBPs replace the mail order fee schedule amounts for diabetic testing supply codes listed above. The SPAs are available at *http://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home*.

The Northern Mariana Islands are not considered an area eligible for inclusion under a national mail order competitive bidding program. However, in accordance with Section 42 *Code of Federal Regulations* (CFR) 414.210(g)(7), the fee schedule amounts for mail order DTS furnished

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in the Northern Mariana Islands are adjusted to equal 100 percent of the SPAs established under the national mail-order competitive bidding program (79 FR 66232).

Because the Northern Mariana Islands adjustment is subject to the six-month transition phase-in period, the adjusted Northern Mariana Island DTS mail order fees, which were based on 50 percent of the un-adjusted mail order fee schedule amounts and 50 percent of the adjusted mail order SPAs, were provided on the DMEPOS fee schedule file in the Hawaii column of the eight mail-order (KL) DTS codes listed above for dates of service January 1, 2016, through June 30, 2016.

Beginning July 1, 2016, the fully adjusted mail order fees (the SPAs) will apply for mail order DTS furnished in the Northern Mariana Islands. As part of this update, the Northern Mariana Island DTS transition mail-order payment amounts will no longer appear in the Hawaii column of the fee schedule file and the DTS mail order (KL) fee schedules for all states and territories are removed from the DMEPOS fee schedule file as of July 1, 2016.

Specific coding and pricing issues

As part of this update, fees are established for HCPCS codes A6450 and A6451 which were added to the HCPCS file in 2004. Claims for codes A6450 and A6451 with dates of service on or after January 1, 2016, that have already been processed may be adjusted to reflect the newly established fees if brought to your MAC's attention.

Additional information

The official instruction, CR 9642, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3551CP.pdf*.

42 CFR 414.202 is available at *https://www.gpo.gov/fdsys/granule/CFR-2011-title42-vol3/CFR-2011-title42-vol3-sec414-202*.

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.

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Implementation July 5, 2016

Laboratory/Pathology

New waived tests subject to CLIA edits

Provider types affected

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

Provider action needed

Change request (CR) 9678 informs MACs about the changes in the new Clinical Laboratory Improvement Amendments of 1988 (CLIA) waived tests approved by the Food and Drug Administration (FDA). Since these tests are marketed immediately after approval, the Centers for Medicare & Medicaid Services (CMS) must notify its MACs of the new tests to allow them to accurately process claims.

CLIA requires that for each test it performs, a laboratory facility must be appropriately certified. To ensure that Medicare & Medicaid only pay for laboratory tests categorized as waived complexity under CLIA in facilities with a CLIA certificate of waiver, laboratory claims are currently edited at the CLIA certificate level. The Current Procedural Terminology (CPT®) codes that the Centers for Medicare & Medicaid (CMS) considers to be laboratory tests under CLIA (and thus requiring certification) change each year. Make sure your billing staffs are aware of these changes.

Background

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

CPT® code	Effective date	Description
G0434QW	August 21-December 31, 2015	Healgen Scientific LLC, Healgen Multi-Drug Urine Test Dip Card
G0477QW	On and after January 1, 2016	Healgen Scientific LLC, Healgen Multi-Drug Urine Test Dip Card

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CPT® code	Effective date	Description
G0477QW	March 8, 2016	Tanner Scientific Multi-Panel Drug Test Cup
G0477QW	March 18, 2016	Hangzhou Clongene Biotech Co., Ltd. Clungene Marijuana Easy Cup
G0477QW	March 18, 2016	Hangzhou Clongene Biotech Co., Ltd. Clungene Marijuana Split Key Cup
G0477QW	March 18, 2016	Hangzhou Clongene Biotech Co., Ltd. Clungene Marijuana Test Cassette
G0477QW	March 18, 2016	Hangzhou Clongene Biotech Co., Ltd. Clungene Marijuana Test Dip Card
G0477QW	March 18, 2016	Hangzhou Clongene Biotech Co., Ltd. Clungene Metamphetamine Easy Cup
G0477QW	March 18, 2016	Hangzhou Clongene Biotech Co., Ltd. Clungene Metamphetamine Split Key Cup
G0477QW	March 18, 2016	Hangzhou Clongene Biotech Co., Ltd. Clungene Metamphetamine Test Cassette
G0477QW	March 18, 2016	Hangzhou Clongene Biotech Co., Ltd. Clungene Metamphetamine Test Dip Card
G0477QW	March 18, 2016	Hangzhou Clongene Biotech Co., Ltd. Clungene Morphine Easy Cup
G0477QW	March 18, 2016	Hangzhou Clongene Biotech Co., Ltd. Clungene Morphine Split Key Cup
G0477QW	March 18, 2016	Hangzhou Clongene Biotech Co., Ltd. Clungene Morphine Test Cassette
G0477QW	March 18, 2016	Hangzhou Clongene Biotech Co., Ltd. Clungene Morphine Test Dip Card
87338QW	March 22, 2016	Meridian Bioscience Immunocard STAT! HpSA (Stool)
G0477QW	March 31, 2016	Assure Tech Co., Ltd. AssureTech Amphetamine Dip Card
G0477QW	March 31, 2016	Assure Tech Co., Ltd. AssureTech Amphetamine Quick Cup
G0477QW	March 31, 2016	Assure Tech Co., Ltd. AssureTech Amphetamine Strip
G0477QW	March 31, 2016	Assure Tech Co., Ltd. AssureTech Amphetamine Turn-Key Split Cup
G0477QW	March 31, 2016	Assure Tech Co., Ltd. AssureTech Cocaine Dip Card
G0477QW	March 31, 2016	Assure Tech Co., Ltd. AssureTech Cocaine Quick Cup
G0477QW	March 31, 2016	Assure Tech Co., Ltd. AssureTech Cocaine Strip
G0477QW	March 31, 2016	Assure Tech Co., Ltd. AssureTech Cocaine Turn-Key Split Cup
G0477QW	March 31, 2016	Assure Tech Co., Ltd. AssureTech Morphine Dip Card
G0477QW	March 31, 2016	Assure Tech Co., Ltd. AssureTech Morphine Quick Cup
G0477QW	March 31, 2016	Assure Tech Co., Ltd. AssureTech Morphine Strip
G0477QW	March 31, 2016	Assure Tech Co., Ltd. AssureTech Morphine Turn-Key Split Cup
G0477QW	April 21, 2016	Chemtron Biotech, Inc. Chemtrue Multi-Panel Drug Screen Cup Tests

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CPT® code	Effective date	Description
G0477QW	April 21, 2016	Chemtron Biotech, Inc. Chemtrue Multi-Panel Drug Screen Cup with OPI 2000 Tests

The new waived complexity code 87338QW [Qualitative or semiquantitative detection test for helicobacter pylori in stool, multiple-step method] was assigned for the detection of Helicobacter pylori antigens in stool performed using the Meridian Bioscience Immunocard STAT! HpSA (Stool) test.

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

Additional information

The official instruction, CR 9687, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3563CP.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.

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Preventive Services

Medicare coverage of diagnostic testing for Zika virus

Provider types affected

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

Provider action needed

This MLN Matters special edition article informs the public that Medicare covers Zika virus testing under Medicare Part B as long as the clinical diagnostic laboratory test is reasonable and necessary for the diagnosis or treatment of a person's illness or injury. This article reminds laboratories furnishing Zika virus tests to contact their MACs for guidance on the appropriate billing codes to use on claims for Zika virus testing. Furthermore, laboratories should provide resources and cost information as may be requested by the MACs in order for the MACs to establish appropriate payment amounts for the tests.

Background

On February 1, 2016, the World Health Organization (WHO) declared the Zika virus a Public Health Emergency of International Concern (PHEIC)[1]. According to the Centers for Disease Control and Prevention (CDC), the Zika virus disease is a nationally notifiable condition that has caused outbreaks in many countries and territories. The virus is primarily spread through the bite of an infected Aedes species mosquito, although other modes of transmission include mother-to-child transmission, blood transfusion and sexual transmission[2]. Currently there are a few diagnostic tests that can determine the presence of the virus. These tests are available through the CDC and CDC-approved state health laboratories. A small number of tests have been issued an emergency use authorization by the Food and Drug Administration (FDA) and may be available through commercial laboratories.

Medicare Part B pays for clinical diagnostic laboratory tests that are reasonable and necessary for the diagnosis or treatment of a person's illness or injury. Presently there are no specific HCPCS codes for testing of the Zika virus; however, laboratories should contact their local MACs for guidance on the appropriate billing codes to use on claims for Zika virus testing. Furthermore, laboratories should provide resources and cost information as may be requested by the MACs in order for the MACs to establish appropriate payment amounts for the tests.

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*

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Medicare coverage of screening for lung cancer with low dose computed tomography

***Note**: This article was revised on June 24, 2016, to add a link to a related article MM9540. That article provides a ICD-10 code that has been added for lung cancer with low dose computed tomography (LDCT). All other information is unchanged. This information was previously published in the November 2015 Medicare B Connection, pages 15-17.*

Provider types affected

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

Provider action needed

Change request (CR) 9246 informs MACs that Medicare covers lung cancer screening with LDCT if all eligibility requirements listed in the national coverage determination (NCD) are met. Make sure that your billing staffs are aware of these changes.

Background

Section 1861(ddd)(1) of the *Social Security Act (the Act)* authorizes the Centers for Medicare & Medicaid Services (CMS) to add coverage of "additional preventive services" through the NCD process. The "additional preventive services" must meet all of the following criteria:

- Be reasonable and necessary for the prevention or early detection of illness or disability;
- Be recommended with a grade of A or B by the United States Preventive Services Task Force (USPSTF); and
- Be appropriate for individuals entitled to benefits under Part A or enrolled under Part B.

CMS reviewed the evidence for lung cancer screening with low dose computed tomography (LDCT) and determined that the criteria listed above were met, enabling CMS to cover this "additional preventive service" under Medicare Part B.

On August 21, 2105, CMS issued NCD 210.14 which provides for Medicare coverage of screening for lung cancer with LDCT. Effective for claims with dates of service on and after February 5, 2015, Medicare beneficiaries must meet all of the following criteria:

- Be 55–77 years of age;
- Be asymptomatic (no signs or symptoms of lung cancer);
- Have a tobacco smoking history of at least 30 pack-years (one pack-year = smoking one pack per day for one year; one pack = 20 cigarettes);
- Be a current smoker or one who has quit smoking within the last 15 years; and,
- Receive a written order for lung cancer screening with LDCT that meets the requirements described in the NCD.

Written orders for lung cancer LDCT screenings must be appropriately documented in the beneficiary's medical record, and must contain the following information:

- Date of birth;
- Actual pack–year smoking history (number);
- Current smoking status, and for former smokers, the number of years since quitting smoking;
- A statement that the beneficiary is asymptomatic (no signs or symptoms of lung cancer); and,
- The national provider identifier (NPI) of the ordering practitioner.

Counseling and shared decision-making visit

Before the first lung cancer LDCT screening occurs, the beneficiary must receive a written order for LDCT lung cancer screening during a lung cancer screening counseling and shared decision-making visit that includes the following elements and is appropriately documented in the beneficiary's medical records:

- Must be furnished by a physician (as defined in Section 1861(r)(1) of the Act) or qualified non-physician practitioner (meaning a physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS) as defined in Section 1861(aa)(5) of the Act); and

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under - How Does It Work.

More information is available in the "Clinical Laboratory Fee Schedule: Payment System Series" at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Clinical-Laboratory-Fee-Schedule-Fact-Sheet-ICN006818.pdf* and in the "CY 2016 Clinical Laboratory Fee Schedule; 16CLAB" at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/clinlab.html*.

1 United States. Centers for Disease Control and Prevention. (2016) About Zika virus. Retrieved from http://www.cdc.gov/Zika/about/index.html.

2 United States. Centers for Disease Control and Prevention. (2016) Zika Virus. Retrieved from http://www.cdc.gov/Zika/about/index.html.

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Implementation Date: N/A

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- Must include all of the following elements:
  - Determination of beneficiary eligibility including age, absence of signs or symptoms of lung cancer, a specific calculation of cigarette smoking pack-years; and if a former smoker, the number of years since quitting;
  - Shared decision-making, including the use of one or more decision aids, to include benefits and harms of screening, follow-up diagnostic testing, over-diagnosis, false positive rate, and total radiation exposure;
  - Counseling on the importance of adherence to annual lung cancer LDCT screening, impact of co-morbidities, and ability or willingness to undergo diagnosis and treatment;
  - Counseling on the importance of maintaining cigarette smoking abstinence if former smoker; or the importance of smoking cessation if current smoker and, if appropriate, furnishing of information about tobacco cessation interventions; and,
  - If appropriate, the furnishing of a written order for lung cancer screening with LDCT.

Written orders for subsequent annual LDCT screens may be furnished during any appropriate visit with a physician or qualified non-physician practitioner (PA, NP, or CNS)

There is also specific criteria that the reading radiologist and radiology imaging facility must meet. The radiology imaging facility must collect and submit data to a CMS-approved registry for each LDCT lung cancer screening performed. The data collected and submitted to a CMS-approved registry must include specific elements. Information regarding CMS-approved registries is posted at: *https://www.cms.gov/Medicare/Medicare-General-Information/MedicareApprovedFacilitie/Lung-Cancer-Screening-Registries.html*.

Coinsurance and deductibles

Medicare coinsurance and Part B deductible are waived for this preventive service.

Health Care Common Procedure Coding System (HCPCS) codes

Effective for claims with dates of service on and after February 5, 2015, the following HCPCS codes are used for lung cancer screening with LDCT:

- **G0296** – Counseling visit to discuss need for lung cancer screening (LDCT) using low dose CT scan (service is for eligibility determination and shared decision making)
- **G0297** – Low dose CT scan (LDCT) for lung cancer screening

In addition to the HCPCS code, these services must be billed with ICD-10 diagnosis code Z87.891 (personal history of tobacco use/personal history of nicotine dependence), ICD-9 diagnosis code V15.82.

Note: Contractors shall apply contractor-pricing to claims containing HCPCS G0296 and G0297 with dates of service February 5, 2015, through December 31, 2015.

Institutional billing requirements

Effective for claims with dates of service on and after February 5, 2015, providers may use the following types of bill (TOBs) when submitting claims for lung cancer screening, HCPCS codes G0296 and G0297: 12x, 13x, 22x, 23x, 71x (G0296 only), 77x (G0296 only), and 85x.

Medicare will pay for these services as follows:

- **Outpatient hospital departments** – TOBs 12x and 13x - based on outpatient prospective payment system (OPPS);
- **Skilled nursing facilities (SNFs)** – TOBs 22x and 23x – based on the Medicare physician fee schedule (MPFS);
- **Critical access hospitals (CAHs)** – TOB 85x – based on reasonable cost;
- **CAH method II** – TOB 85x with revenue code 096x, 097x, or 098x based on the lesser of the actual charge or the MPFS (115 percent of the lesser of the fee schedule amount and submitted charge) for HCPCS G0296 only;
- **Rural health clinics (RHCs)** - TOB 71x - based on the all-inclusive rate for HCPCS G0296 only; and
- **Federally qualified health centers (FQHCs)** – TOB 77x - based on the PPS rate for HCPCS G0296 only.

Note: For outpatient hospital settings, as in any other setting, services covered under this NCD must be ordered by a primary care provider within the context of a primary care setting and performed by an eligible Medicare provider for these services.

Claim adjustment reason codes (CARCs), remittance advice remark codes (RARCs), group codes

MACs will use the following CARCs, RARCs, and group codes when denying payment for LDCT lung cancer screening, HCPCS G0296 and G0297:

Submitted on a TOB other than 12x, 13x, 22x, 23x, 71x, 77x, or 85x:

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

Note: For modifier GZ, MACs will use CARC 50.

For TOBs 71x and 77x when HCPCS G0296 is billed on the same date of service with another visit (this does not apply to initial preventive physical exams for 71x TOBs):

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- **CARC 97** – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- **RARC M15** – Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.

Note: 77x TOBs will be processed through the integrated outpatient code editor under the current process.

- **Group code CO** assigning financial liability to the provider.

Where a previous HCPCS G0297 is paid in history in a 12-month period (at least 11 full months must elapse from the date of the last screening):

- **CARC 119** – Benefit maximum for this time period or occurrence has been reached.
- **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/medicare-coverage-database/overview-and-quick-search.aspx*. If you do not have web access, you may contact the contractor to request a copy of the NCD.
- **Group code CO** assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

Note: For modifier GZ, MACs will use CARC 50.

Because the beneficiary is not between the ages of 55 and 77 at the time the service was rendered (line-level):

- **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."
- **Group code: CO** (contractual obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

Note: For modifier GZ, MACs will use CARC 50.

Because the claim line was not billed with ICD-10 diagnosis Z87.891:

- **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 *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. If you do not have web access, you may contact the contractor to request a copy of the NCD.
- **Group code: CO** assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

Note: For modifier GZ, MACs will use CARC 50.

Additional information

The official instruction, CR 9246, consists of two transmittals:

1. *Transmittal R3374CP*, which updates the *Medicare Claims Processing Manual*; and
2. *Transmittal R185NCD*, which updates the *Medicare NCD Manual*.

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
June 24, 2016	The article was revised to add a link to a related article *MM9540*. That article provides a ICD-10 code that has been added for lung cancer screening with low dose computed tomography (LDCT).
	Initial article post

MLN Matters® Number: MM9246 *Revised*
Related Change Request (CR) #: 9246
Related CR Release Date: October 15, 2015
Effective Date: February 5, 2015
Related CR Transmittal #: R3374CP and R185NCD
Implementation Date: January 4, 2016

General Coverage

Responding to additional documentation requests (ADRs)

First Coast Service Options (First Coast) frequently requires a clinical review of documentation to determine the medical necessity of services. It is the goal of First Coast to ensure that providers are properly reimbursed for medically reasonable and necessary services. When documentation is required, an ADR is mailed to the provider.

Prior to responding to the ADR, providers should:

- Verify patient and/or claim form billing information matches what is requested within the ADR letter
- Ensure legible and appropriate signatures are included in the documentation

Timeframe for submission of documentation:

- The Centers for Medicare & Medicaid Services (CMS) allows 45 calendar days to submit the documentation
  - The 45-day timeframe begins with the date of the ADR letter
  - Allow sufficient time for documentation to be mailed, received, and matched to the claim in question
  - Claims are set to automatically deny on day 46 when documentation has not been received

Methods of responding to ADR:

- By mail: See ADR letter for mailing address and instructions
- Secure Provider Online Tool (SPOT)
  - *Secure Messaging*
- *Fax with cover sheet*
- *esMD*

First Coast must be able to clearly identify the author of the medical record:

- When the initial response to an ADR does not contain appropriate signatures, a second ADR will be sent

requesting the signature log and/or attestation statement. See our *physician signature requirements for medical record documentation* simulation for examples of a signature log and attestation statement.

  - If the signature is missing, an attestation statement must be included to authenticate who authored or contributed to the record
  - If the signature is illegible, an attestation statement or signature log must be included to authenticate who authored or contributed to the record
  - Response to the request for an attestation or signature log must be received within 20 calendar days from the date of the second request, whether by phone contact or letter.

When documentation is submitted timely, CMS requires the contractor to make a claim determination within 30 calendar days.

Source: *Medicare Learning Network (MLN®) Matters*: *MM8583* and *MM6698*; *CMS Internet-Only Manual (IOM), Publication 100-08, Chapter 3*

Correct your claims on the 'SPOT'

The SPOT offers registered users the time-saving advantage of not only viewing claim data online but also the option of correcting clerical errors on their eligible Part B claims quickly, easily, and securely – online.

A physician's guide to Medicare's home health certification, including the face-to-face encounter

***Note**: This article was rescinded July 19, 2016, because the information was not current. See MLN Matters® articles SE1436 (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1436.pdf) and MM9119 (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9119.pdf) for current information on home health certification requirements. This information was previously published in the May 2012 Medicare B Connection, pages 21-22.*

MLN Matters® Number: SE1219 *Rescinded*

Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: January 1, 2011
Related CR Transmittal #: N/A
Implementation Date: N/A

Home health face-to-face encounter - a new home health certification requirement

***Note**: This article was rescinded July 19, 2016, because the information was not current. See MLN Matters® articles SE1436 (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1436.pdf) and MM9119 (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9119.pdf) for current information on home health certification requirements. This information was previously published in the December 2010 Medicare B Connection, pages 28-29.*

MLN Matters® Number: SE1038 *Rescinded*

Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: January 1, 2011
Related CR Transmittal #: N/A
Implementation Date: N/A

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.*

Implement operating rules - phase III ERA EFT: CORE 360 uniform use of claim CARC, RARC, and CAGC rule - update from CAQH CORE

Provider types affected

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

Provider action needed

This article is based on change request (CR) 9696 which instructs MACs and Medicare's shared system maintainers (SSMs) to update systems based on the CORE 360 Uniform Use of claim adjustment reason codes (CARC), remittance advice remark codes (RARC), and claim adjustment group code (CAGC) rule publication. These system updates reflect the committee on operating rules for information exchange (CORE) code combination list for June 2016. Make sure that your billing staff is aware of these changes. In addition, if you use the PC Print or Medicare Remit Easy Print (MREP) software supplied by your MAC, be sure to obtain the updated version of that software when it is available.

Background

The Department of Health and Human Services (HHS) adopted the Phase III Council for Affordable Quality Healthcare (CAQH) CORE electronic funds transfer (EFT) and electronic remittance advice (ERA) operating rule set that was implemented on January 1, 2014, under the Affordable Care Act.

The Health Insurance Portability and Accountability Act (HIPAA) amended the Act by adding Part C—Administrative Simplification—to Title XI of the Social Security Act, requiring the Secretary of HHS to adopt standards for certain transactions to enable health information to be exchanged more efficiently and to achieve greater uniformity in the transmission of health information. More recently, the National Committee on Vital and Health Statistics (NCVHS) reported to the Congress that the transition to Electronic Data Interchange (EDI) from paper has been slow and disappointing.

Through the Affordable Care Act, Congress sought to promote implementation of electronic transactions and achieve cost reduction and efficiency improvements by creating more uniformity in the implementation of standard transactions by mandating the adoption of a set of operating rules for each of the HIPAA transactions.

CAQH CORE lists the June 2016 version on the *code combination list* website. This update includes CARC and RARC updates as posted at the *Washington Publication Company (WPC) website* on or about March 1, 2016. This

will also include updates based on Market Based Review (MBR) that the CAQH CORE conducts once a year to accommodate code combinations that are currently being used by Health Plans including Medicare as the industry needs them.

Medicare can use any code combination if the business scenario is not one of the four CORE defined business scenarios. With the four CORE defined business scenarios, Medicare must use the code combinations from the lists published by CAQH CORE.

Additional information

The official instruction, CR 9696, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3558CP.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. The WPC website is at *http://www.wpc-edi.com/reference/*. The CAQH CORE code combination list is available at *http://www.caqh.org/CORECodeCombinations.php*.

MLN Matters® Number: MM9696
Related Change Request (CR) #: CR 9696
Related CR Release Date: July 1, 2016
Effective Date: October 1, 2016
Related CR Transmittal #: R3558CP
Implementation Date: October 3, 2016

Remittance advice remark and claim adjustment reason code and MREP and PC Print 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.

Provider action needed

Change request (CR) 9695 informs MACs about the changes that update the remittance advice remark code (RARC) and claim adjustment reason code (CARC) lists, and CR 9695 calls for an update to the Medicare Remit Easy Print (MREP) and PC Print. Make sure that your billing staffs are aware of these changes. If you use the MREP and/or PC Print software, be sure to obtain the latest version that is released on or before October 3, 2016.

Background

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

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

CR 9695 is a code update notification indicating when updates to CARC and RARC lists are made available on the Washington Publishing Company (WPC) website. Medicare's standard system maintainers (SSMs) have the responsibility to implement code deactivation, making sure that any deactivated code is not used in original business messages and allowing the deactivated code in derivative messages. SSMs must make sure that Medicare does not report any deactivated code on or after the effective date for deactivation as posted on the WPC website. If any new or modified code has an effective date past the implementation date specified in CR 9695, MACs must implement on the date specified on the WPC website at *http://wpc-edi.com/Reference/*.

A discrepancy between the dates may arise as the WPC website is only updated three times a year and may not match the CMS release schedule.

Additional information

The official instruction, CR 9695, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3562CP.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: MM9695
Related Change Request (CR) #: CR 9695
Related CR Release Date: July 15, 2016
Effective Date: October 1, 2016
Related CR Transmittal #: R3562CP
Implementation Date: October 3, 2016

Where do I find...

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

Correction of remark code information

Provider types affected

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

What you need to know

Change request (CR) 9641 updates the *Medicare Claims Processing Manual*" Chapter 30, to make corrections to remittance advice codes and general punctuation and grammar corrections. All remittance advice messaging must follow a prescribed set of rules. Specifically, claim adjustment reason codes (CARCs) and remittance advice remark codes (RARCs) may only be used in specified combinations laid out by the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE), the designated Standards Development Organization (SDO). The CARC and RARC code sets are available via the Washington Publishing Company (WPC) at *http://www.wpc-edi.com/Reference*.

Additional information

The official instruction, CR 9641, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3560CP.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: MM9641
Related Change Request (CR) #: CR 9641
Related CR Release Date: July 15, 2016
Effective Date: October 17, 2016
Related CR Transmittal #: R3560CP
Implementation Date: October 17, 2016

Disclaimer: This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT® only copyright 2015 American Medical Association.

Before you file an appeal...

Each month, thousands of medical providers send written inquiries to First Coast Service Options Inc. (First Coast) to check the status of an appealed claim. Unfortunately, many of these appeals and subsequent inquiries are submitted on claims that were ineligible for appeal.

Before you appeal a denied claim, check out *these resources*.

General Information

Protecting patient personal health information

Provider types affected

This *MLN Matters*® article is intended for physicians, including physician group practices, that are covered entities under the Health Insurance Portability and Accountability Act (HIPAA) using electronic systems to store personal health information (PHI) of their Medicare patients.

Provider action needed

This *MLN Matters*® special edition article reminds physicians of the HIPAA requirement to protect the confidentiality of the PHI of their patients. Recently, the Centers for Medicare & Medicaid Services (CMS) learned of a potential security breach in which someone was *offering for sale over 650,000 records* of orthopedic patients. Remember that a covered entity must notify the Secretary of Health and Human Services if it discovers a breach of unsecured protected health information. See *45 C.F.R. § 164.408*. Also, keep abreast of any issues that your business associates, especially those entities that provide you with hardware and/or software support for your patient electronic health records. Be sure they are required to report any actual or potential security breaches to you, especially threats that compromise patient PHI.

Background

CMS is providing this information in response to a recent report from the cyber health working group. This group recently reported the detection of an offer to sell six databases, three of which were databases that appeared to be orthopedic databases. Providers need to be extremely conscious of their systems security, especially with systems that connect to the internet.

Additional information

The report on the advertised sale of patient databases is available at *http://hothardware.com/news/hacker-reportedly-infiltrates-three-us-healthcare-companies-offers-650000-patient-records-for-sale*.

45 CFR 164.408 is available at *https://www.gpo.gov/fdsys/granule/CFR-2011-title45-vol1/CFR-2011-title45-vol1-sec164-408*.

Information on reporting breaches of security is available at *http://www.hhs.gov/hipaa/for-professionals/breach-notification/breach-reporting/index.html*.

MLN Matters® Number: SE1616
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

Provider minute videos for Part A and Part B providers and DMEPOS suppliers

The *Medicare Learning Network*® has a series of the *Centers for Medicare & Medicaid (CMS) provider minute videos* on compliance for Part A and Part B providers and durable medical equipment, prosthetics, orthotic, and supplies (DMEPOS) suppliers. These videos have tips to help you properly submit claims with sufficient documentation in order to receive correct payment the first time.

Fax machine settings can lead to "timed-out" claim denials

First Coast Service Options (First Coast) is experiencing an increase in claim denials due to providers not responding timely to additional development requests (ADRs). If you have received this type of claim denial even though you responded via fax by the due date, your fax machine settings may be causing these unnecessary denials. First Coast identified this as an issue particularly for providers faxing documentation to multiple ADRs during the same time period.

When documentation is required to continue processing claims, an ADR letter is sent and the provider has 45 days to respond. If the records are not received timely, the claim automatically denies on day 46. The messages for these timed-out claim denials include:

- Part A: Reason codes 56900 or 39721
- Part B: Claim adjustment reason code (CARC) CO 50 with remittance advice remark code (RARC) M127
- Part B: CARC CO 226 with RARC N517

Check your fax settings

If you have received these types of denials but have responded by fax timely, the issue may be the batch setting for your fax machine or fax system. If the batch setting is active, transmissions will batch, or bundle, all documents sent to the same destination number within a specific time frame as one transmission. This occurs even if you scan and receive confirmation pages separately for each fax transmission because your fax machine/system holds the records in its memory for a period of time.

First Coast's automated imaging process receives batch transmissions as only one submission. This means that only the first claim of the batch submission is controlled and received as timely. Documents for other ADRs included in the batched submission are not controlled, which causes the claims to eventually time out and deny.

Avoid using batch transmissions when responding to ADRs

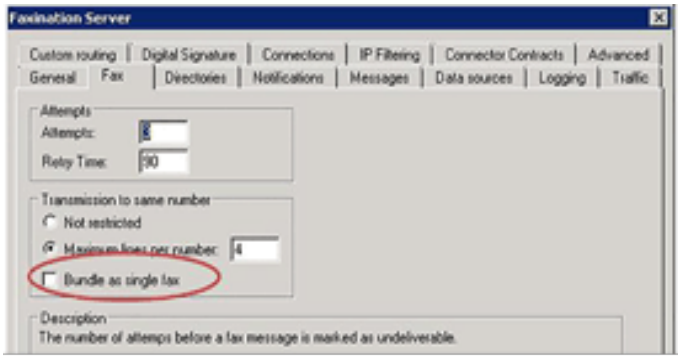
First Coast must receive the documents for each ADR separately to be matched to the appropriate claim timely; therefore, providers should ensure that batch transmissions are not occurring when faxing. Some fax machine models allow the # key to be pressed at the end of your document(s) scanning for each ADR, which signals the machine to finish the transmission before starting the next one. However, every machine is different, so check the user manual or contact the manufacturer's customer service for assistance on deactivating the batch setting. At the end of this article, we provide examples with technical details for certain types of fax systems or manufacturers.

Please DO NOT contact First Coast's Customer Service department for assistance with your faxination setting.

Another option for preventing claim denials is to utilize First Coast's SPOT (Secure Provider Online Tool) to respond to ADRs for claims on prepayment medical reviews. For instructions on how to respond to ADRs through SPOT, please review the *SPOT: User Guide*. If you don't already have a SPOT account, visit the *SPOT page* to learn about requesting one.

Examples with technical details for certain fax machines/systems

1. Faxination server installation:



2. Ricoh multi-function device:

Batch Transmission

If you send a fax message by Memory Transmission and there is another fax message waiting in memory to be sent to the same destination, that message is sent along with your message. Several fax messages can be sent with a single call, thus eliminating the need for several several separate calls. This helps save communication costs and reduces transmission time.

Fax messages for which the transmission time has been set in advance are sent by Batch Transmission when time is reached.

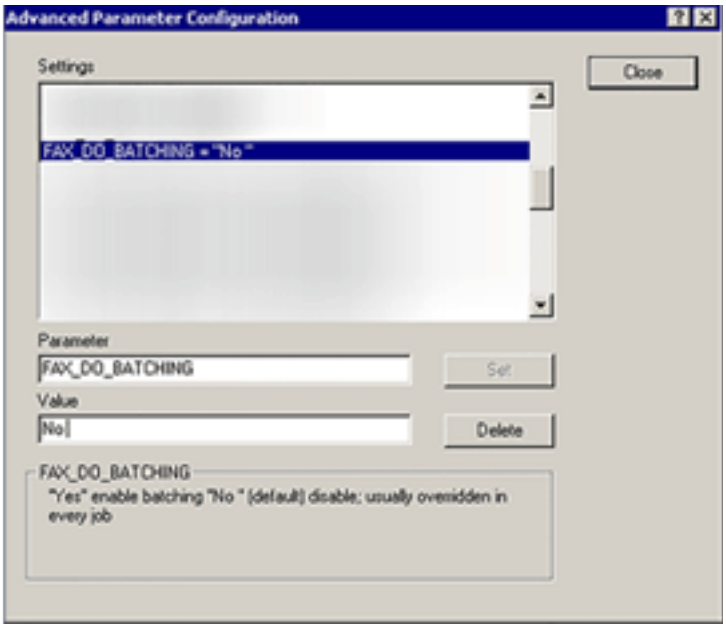
Note

- You can switch this function on or off with User Parameters. See p. 85 "User Parameters" (Switch06, Bit4).

Note also that the switches and bits listed above may vary from machine to machine.

3. Biscom fax service:

- Set "FAX_DO_BATCHING" to "No" under the Advanced Parameter Configurations



Processing time frames for enrollment applications

As the Medicare administrative contractor (MAC) for jurisdiction N (JN), First Coast Service Options Inc. (First Coast) is not only responsible for processing Medicare claims but also for processing enrollment applications for providers and suppliers located in Florida, Puerto Rico, and the U.S. Virgin Islands.

The Centers for Medicare & Medicaid Services (CMS) has established the following timeliness standards for contractors responsible for processing enrollment applications within their assigned jurisdictions:

- PECOS web applications (initial enrollment with no site visit) – 80 percent must be processed within **45 days**
- Paper-based applications (initial enrollment with no site visit) – 80 percent must be processed within **60 days**
- Paper-based applications (initial enrollment with site visit) – 80 percent must be processed within **80 days**
- Paper-based applications (changes to enrollment record or reassignment) – 80 percent must be processed within **60 days**

First Coast provider enrollment average YTD processing times (through June 30)		
	Part A	**Part B**
PECOS web applications		
No development	11 days	34 days
With development	18 days	48 days
Paper applications		
No development	13 days	44 days
With development	35 days	68 days

Factors affecting total processing times

Although First Coast processes each enrollment application as quickly as possible, the following key factors may affect the total processing time needed:

- **Provider type:**
  - **Part A** – institutional providers
  - **Part B** – physicians, non-physician practitioners, clinics, and group practices

Shortest processing times: *Enrollment applications for Part B providers and suppliers*

- **Application type:**
  - **PECOS web application** – an electronic enrollment application submitted through *the Internet-based Provider Enrollment, Chain, and Ownership System (PECOS) website*.
  - **Paper-based application** – a paper enrollment application that is printed and submitted through the mail.

Shortest processing times: *PECOS web applications*

- **Development required:**
  - **No development** – the enrollment application (paper-based or electronic) is accurate, complete, and is submitted with all *required support documentation*.
  - **With development** – the enrollment application (paper-based or electronic) falls into one or more of the following categories:
    - Contains errors or inconsistencies
    - Incomplete (e.g., missing information or signature)
    - Support documentation missing or insufficient

Shortest processing times: *Enrollment applications that do not require development*

Revised CMS-855R application – Reassignment of Medicare Benefits

Physicians and non-physician practitioners must use the revised CMS-855R (reassignment of benefits) application beginning January 1, 2017. The revised application will be posted on the CMS forms list (*http://go.usa.gov/cuu5Y*) by mid-summer.

Medicare administrative contractors (MACs) will accept both the current and revised versions of the CMS-855R through December 31, 2016. Visit the Medicare provider-supplier enrollment web page (*http://go.usa.gov/cuujB*) for more information about Medicare enrollment.

The revised form made the primary practice location section optional. However, this information is shared with other programs, such as the physician compare initiative, to help beneficiaries identify your practice.

What you should do with claims returned as unprocessable

First Coast Service Options, Inc. (First Coast) is experiencing a large volume of appeals filed on claims that were returned as unprocessable. Claims that are considered returned as unprocessable are not appealable.

Do not file an appeal

When you file an appeal on an unprocessable claim, First Coast will return the correspondence to you with a letter instructing the provider to refile a new claim. Response letters are typically generated within 60 calendar days after your appeal request was submitted.

Filing an appeal on an unprocessable claim only delays payment and could result in a timely-filing denial if not re-filed with the correct information within the timely-filing period.

How to handle a claim returned as unprocessable

Claims returned as unprocessable will include the MA130 remittance advice message with a corresponding reason code message to denote why the claim was incomplete or invalid.

Review these *frequently-asked questions* to determine why First Coast was not able to process the claim.

Resubmit a corrected claim.

The Medicare guidelines for unprocessable claims can be found in the *Medicare Claims Processing Manual* (100-04), Chapter 1, Section 80.3. See *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf*.

The Medicare guidelines for completion of form CMS-1500 can be found in the *Medicare Claims Processing Manual* (100-04), Chapter 26, Section 10. See *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf*.

Communication letters to top providers that file appeals on unprocessable claims

First Coast will be sending communication letters to providers in the future who submit appeals on unprocessable claims. These letters will provide details on the number of appeals requests received on unprocessable claims by the applicable providers.

Prompt payment interest rate revision

Medicare must pay interest on clean claims if payment is not made within the applicable number of calendar days (i.e., 30 days) after the date of receipt. The applicable number of days is also known as the payment ceiling. For example, a clean claim received March 1, 2016, must be paid before the end of business March 31, 2016.

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

The new rate of 1.875 percent is in effect through December 31, 2016.

Interest is not paid on:

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

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

New non-physician specialty code for dentist

***Note**: This article was revised June 24, 2016, due to an updated change request (CR). The update changed the effective date to January 1, 2017, but the effective date for MCS remains July 1, 2016, the full implementation date to January 3, 2017, but the implementation date for MCS remains July 5, 2016. All other information remains the same. This information was previously published in the February 2016 Medicare B Connection, Page 20.*

Provider types affected

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

Provider action needed

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

Background

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

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

Additional information

Helpful tip: The multi-carrier system (MCS) is Medicare's claims processing system that MACS use to process professional claims.

The official instruction, CR 9355, issued to your MAC regarding this change consists of two transmittals. The first revises the *Medicare Claims Processing Manual* and it is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3547CP.pdf*. The second transmittal updates the *Medicare Financial Management Manual* and it is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R269FM.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
June 24, 2016	The article was revised due to an updated CR. The update change the effective date to January 1, 2017, but the effective date for MCS remains July 1, 2016, the full implementation date to January 3, 2017, but for MCS the implementation date remains July 5, 2016.
January 31, 2016	Initial article post

MLN Matters® Number: MM9355 *Revised*
Related Change Request (CR) #: CR 9355
Related CR Release Date: June 22, 2016
Effective Date: July 1, 2016 for MCS; January 1, 2017 for MACs
Related CR Transmittal #: R3547CP and R269FM
Implementation Date: July 5, 2016, for MCS; January 3, 2017, for MACs

Processing Issues

Reprocessing of HCPCS code G0472

Issue

Healthcare Common Procedure Coding System (HCPCS) code G0472 (Hepatitis C antibody screening, for individuals at high risk and other covered indications) was denied in error from January 5, 2015 through May 31, 2016, for beneficiaries born between 1945-1965.

Resolution

Medicare administrative contractors (MACs) have updated their systems to correct this problem and will reprocess denied claims.

Status/date resolved

Open. The system was corrected on June 1, 2016; mass adjustments are being performed by the MACs to reprocess affected claims.

Provider action

None.

Current processing issues

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

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

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

Effective and notice dates

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

Electronic notification

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

More information

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

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

Looking for LCDs?

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

Advance beneficiary notice

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

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

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

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

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

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

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

New LCDs

Chiropractic services – new Part A and Part B LCD

LCD ID number: L36617 (Florida, Puerto Rico/ U.S. Virgin Islands)

Medicare coverage of chiropractic service is specifically limited by statute with the requirements explicitly outlined in the Centers for Medicare & Medicaid Services (CMS) publications and manuals.

Medicare administrative contractors (MACs) have historically implemented chiropractic services local coverage determination (LCD) as an educational tool to further emphasize requirements for the diagnosis, treatment, documentation, and billing of chiropractic services. Given the implementation of ICD-10 diagnoses coding effective October 1, 2015, and the focus of CMS and its contractors on aligning education tools used to improve the documentation of services by a chiropractor described as means of manual manipulation of the spine to correct a subluxation of an individual, MAC JN has recently retired the Chiropractic services LCD and has developed a new LCD to address this service.

Additionally, the November 2015 comprehensive error rate testing (CERT) forecasting report for claims reviewed from the sampling period July 2013 to June 2014 showed chiropractic services in Florida as of August 12, 2015, were ranked third in the nation based on the projected error rate with an error rate of 66.2 percent (up from 44.0 percent the previous year). An excerpt from First Coast Service Options, Inc. (First Coast) medical review strategy indicated: Maintenance services billed as active treatment continues to be an issue for payment errors in chiropractic services; after the CMS implementation of an acute treatment modifier (AT) that allows providers to differentiate maintenance from active treatment on submitted claims.

Therefore, chiropractic services LCD has been created to addresses indications and limitations of coverage and/ or medical necessity, limitations, Current Procedural Terminology® (CPT®) codes, ICD-10 Codes that Support Medical Necessity, documentation guidelines, and utilization guidelines for this service.

Of note: The use of an ICD-10-CM code listed in the LCD as a primary diagnosis does not assure coverage of a service. The service must be reasonable and necessary in the specific case and must meet the criteria specified in the determination. The level of the subluxation must be specified on the claim and must be listed as the primary diagnosis. The neuromusculoskeletal condition necessitating the treatment should be listed as the secondary diagnosis. Secondary neuromuscular ICD 10 diagnosis codes should support the medical necessity of short, moderate, and long term treatment. All diagnosis codes must be coded to the highest level of specificity, and the primary diagnosis must be supported by x-ray or documented by physical examination. Chiropractic physicians submitting claims for beneficiaries receiving excessive services (chiropractic manipulative treatments) in a month (acute care) or over a year (chronic care) are likely to come under pre or post payment medical review.

Effective date

This LCD is effective for services rendered on or after September 12, 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*.

Retired LCDs

Amifostine (Ethyol®) – retired Part A and Part B LCD

LCD ID number: L33262 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on an annual review of the local coverage determination (LCD), it was determined that the amifostine (Ethyol®) LCD is no longer required and, therefore, was retired.

Effective date

This LCD retirement is effective for services rendered **on or after July 5, 2016**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Revisions to LCDs

Bone mineral density studies – revision to the Part A and Part B LCD

LCD ID number: L36356 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on the Centers for Medicare & Medicaid Services (CMS) *MLN Matters*® article SE1525, the local coverage determination (LCD) for bone mineral density studies was revised to remove ICD-10-CM diagnosis code M85.80 (Other specified disorders of bone density and structure, unspecified site) under the "ICD-10 Codes that Support Medical Necessity" section of the LCD for Current Procedural Terminology (CPT®) codes 77080 (Dual energy X-ray absorptiometry [DXA], bone density study, 1 or more sites; axial skeleton [eg, hips pelvis, spine]) and 77085 (Dual energy X-ray absorptiometry [DXA], bone density study, 1 or more sites; axial skeleton [eg, hips, pelvis, spine], including vertebral fracture assessment).

Effective date

This LCD revision is effective for claims processed **on or after June 2, 2016**, for services rendered **on or after October 1, 2015**, for Part A and for claims processed on or after **June 6, 2016**, for services rendered **on or after October 1, 2015**, for Part B. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Colorectal cancer screening – revision to the Part A and Part B LCD

LCD ID number: L36355 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for colorectal cancer screening was revised based on the Centers for Medicare & Medicaid Services (CMS) change request (CR) 9540 (NCD 210.3). ICD-10-CM diagnosis codes Z12.11 (Encounter for screening for malignant neoplasm of colon) and Z12.12 (Encounter for screening for malignant neoplasm of rectum) were added to the "ICD-10 Codes that Support Medical Necessity" section of the LCD for CPT® code 81528.

Effective date

This LCD revision is effective for claims processed **on or after July 5, 2016**, for services rendered **on or after January 1, 2016**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage

database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Learn the secrets to billing Medicare correctly

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

Genetic testing for Lynch syndrome – revision to the Part A and Part B LCD

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

The local coverage determination (LCD) for genetic testing for Lynch syndrome (L34912) was revised to add Current Procedural Terminology (CPT®) code 81435 to the "CPT/ HCPCS Codes" section of the LCD under Group 2 codes.

As stated in the LCD, providers must follow a stepped approach to meet the reasonable and necessary criteria. To progress to each subsequent step, refer to the indications detailed in the policy.

Effective date

This LCD revision is effective for services rendered **on or after June 28, 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*.

Hemophilia clotting factors – revision to the LCD

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

The local coverage determination (LCD) for hemophilia clotting factors was revised to include Idelvion® [coagulation factor IX (recombinant), albumin fusion protein indicated in children and adults with hemophilia B (congenital Factor IX deficiency)]. HCPCS codes C9399 and J7199 were added under the "CPT®/HCPCS Codes" section, and diagnosis code D67 was added to the "ICD-10 Codes that Support Medical Necessity" section. The "Sources of Information and Basis for Decision" section was also updated.

Effective date

This LCD revision is effective for claims processed **on or after July 11, 2016**, for dates of service rendered **on or after March 4, 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*.

Hyperbaric oxygen (HBO) therapy – revision to the Part A and Part B LCD

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

The local coverage determination (LCD) for hyperbaric oxygen (HBO) therapy (L36504) was revised to provide further clarification regarding coverage of HBO treatment for skin grafts, osteomyelitis treatment, including reference to change request (CR) 1138, emergency equipment in facilities and the utilization of healthcare common procedure coding system (HCPCS) G0277. The clarifications do not affect coverage.

In addition, based on CR 9540, the link to the Centers for Medicare & Medicaid Services (CMS) covered diagnoses codes has been changed.

Effective date

The effective date for the revision to provide further clarification regarding coverage of HBO treatment is for dates of service **on and after April 11, 2016**. The LCD revision based on CR 9540 is effective date claims processed **on or after July 5, 2016**, for dates of service **on and 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*.

Independent diagnostic testing facility (IDTF) – revision to the Part B LCD

LCD ID number: L33910 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on a reconsideration request, the independent diagnostic testing facility (IDTF) local coverage determination (LCD) coding guidelines (L33910) were revised to remove the limits recognizing only certifying boards affiliated with the American Board of Medical Specialty (ABMS) for supervising and interpreting tests. In the "Credentialing Matrix" section of the coding guidelines, an asterisk was added to the applicable Current Procedural Terminology® (CPT®) codes and language clarifying the asterisked was also added. The following language was added: *American Board of Medical Specialty (ABMS), American Osteopathic Association (AOA) specialty, or subspecialty certification.

Effective date

This LCD revision is effective for claims processed **on or after June 28, 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*.

Noncovered services – revision to the Part A and Part B LCD

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

The local coverage determination (LCD) for noncovered services was revised to remove Current Procedural Terminology (CPT®) code 0405T from the "CPT/HCPCS Codes" section of the LCD under the subtitle "Procedures for Part A and "Procedures for Part B" and add CPT® code 0405T to the "CPT/HCPCS Codes" section of the LCD under the subtitle "Procedures for Part B only" as the OPPS payment status indicator is a "B" (Not paid under OPPS).

Effective date

This LCD revision is effective for claims processed **on or after July 25, 2016**, for services rendered **on or after January 1, 2016**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Reduction mammoplasty – revision to the Part B LCD

LCD ID number: L33939 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for reduction mammoplasty was revised to add ICD-10-CM diagnosis codes L26, L30.4, L54, L92.0, L95.1, L98.2, M40.202-M40.209, M54.89 and Z42.1 to the "ICD-10 Codes that Support Medical Necessity" section of the LCD for Current Procedural Terminology (CPT®) code 19318.

Effective date

This LCD revision is effective for claims processed **on or after July 25, 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*.

Rituximab (Rituxan®) – revision to the Part A and Part B LCD

LCD ID number: L33746 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on a reconsideration request the, "Indications and Limitations of Coverage and/or Medical Necessity" section of the local coverage determination (LCD) for rituximab (Rituxan®) has been updated to add the off-labeled indication of neuromyelitis optica, a rare, relapsing and debilitating disease. Also, the "ICD-10 Codes that Support Medical Necessity" section of the LCD was updated to add ICD-10-CM diagnosis code G36.0. Additionally, the "Documentation Requirements" and "Sources of Information and Basis for Decision" sections of the LCD were updated.

Effective date

This LCD revision is effective for services rendered on or after July 28, 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*.

Scanning computerized ophthalmic diagnostic imaging (SCODI) – revision to the Part A and Part B LCD

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

The local coverage determination (LCD) for scanning computerized ophthalmic diagnostic imaging (SCODI) was revised to add ICD-10-CM diagnosis code Z03.89 (Encounter for observation for other suspected diseases and conditions ruled out) for use with CPT® code 92134 in the "ICD-10 Codes that Support Medical Necessity" section of the LCD.

Effective date

This LCD revision is effective for claims processed **on or after July 22, 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, please *click here*.

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

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

The local coverage determination (LCD) for vitamin D; 25 hydroxy, includes fraction(s), if performed was revised to add ICD-10-CM diagnosis codes M85.811, M85.812, M85.821, M85.822, M85.831, M85.832, M85.841, M85.842, M85.851, M85.852, M85.861, M85.862, M85.871, M85.872, M85.88, and M85.89 under the "ICD-10 Codes that Support Medical Necessity" section of the LCD for CPT® code 82306.

Effective date

This LCD revision is effective for claims processed **on or after June 30, 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*.

Upcoming provider outreach and educational events

E/M coding: Selecting your critical care codes

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

Ask-the-contractor Teleconference (ACT): NCCI General Coding Guidelines & Resources

Date: Wednesday, August 24
Time: 10:00-11:30 a.m.
Type of Event: Webcast
http://medicare.fcso.com/Events/0338499.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 June 30, 2016

MLN Connects® Provider eNews for June 30, 2016

View this edition as a PDF

In this edition:

News & Announcements

- ESRD and DMEPOS: Proposed Updates to CY 2017 Policies and Payment Rates
- Home Health Agencies: Proposed Payment Changes for CY 2017
- July 2016 DMEPOS Fee Schedules Available
- Moratoria Provider Services and Utilization Data Tool
- EHR Incentive Program: Hardship Exception Applications Due by July 1
- CMS to Release a CBR on Physician Assistant Use of Modifier 25 in July
- Updated Inpatient and Outpatient Data Available

Claims, Pricers & Codes

- 2017 ICD-10-CM and ICD-10-PCS Files Available

Upcoming Events

- Clinical Diagnostic Laboratory Test Payment System Final Rule Call — July 6
- DMEPOS Competitive Bidding Program Round 2 Recompete Webinars — July 7 and 12
- Quality Measures and the IMPACT Act Call — July 7
- SNF Quality Reporting Program Call — July 12
- Comparative Billing Report on Diabetic Testing Supplies Webinar — July 27

Medicare Learning Network® Publications & Multimedia

- Medicare Coverage of Diagnostic Testing for Zika Virus *MLN Matters*® Article — New
- Recovering Overpayments from Providers Who Share TINs *MLN Matters*® Article — New
- Implementation of Section 2 of the PAMPA *MLN Matters*® Article — New
- Physician Compare Call: Audio Recording and Transcript — New
- SBIRT Services Fact Sheet — Reminder
- Remittance Advice Resources and FAQs Fact Sheet — Reminder

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.

MLN Connects® Provider eNews for July 7, 2016

MLN Connects® Provider eNews for July 7, 2016

View this edition as a PDF

In this edition:

News & Announcements

- HHS Announces Physician Groups Selected for an Initiative Promoting Better Cancer Care
- Open Payments Program Posts 2015 Financial Data
- Hospice CAHPS® Exemption for Size Deadline: August 10
- Help Us Improve Access to DMEPOS
- Revised CMS-855R Application: Reassignment of Medicare Benefits
- July Quarterly Provider Update Available
- Rule Gives Providers/Employers Improved Access to Information for Better Patient Care

Claims, Pricers & Codes

- Modifications to HCPCS Code Set

Upcoming Events

- SNF Quality Reporting Program Call — July 12

Medicare Learning Network® Publications & Multimedia

- Medicare Quarterly Provider Compliance Newsletter Educational Tool — New
- Subscribe to the Medicare Learning Network Educational Products and MLN Matters® Electronic Mailing Lists

MLN Connects® Provider eNews for July 14, 2016

MLN Connects® Provider eNews for July 14, 2016

View this edition as a PDF

In this edition:

Editor's Note:

This week's eNews includes a new section on Provider Compliance, highlighting common billing errors. Check out the first message in this series on chiropractic services and learn how to bill Medicare correctly the first time.

News & Announcements

- New Hospice Report Available July 17
- Clinical Laboratory Fee Schedule Resources
- HIPAA Administrative Simplification Enforcement and Testing Tool
- 2017 QRDA Hospital Quality Reporting Implementation Guide, Schematrons, and Sample File
- Upcoming *Medicare Learning Network*® Website Redesign

Provider Compliance

- Chiropractic Services: High Improper Payment Rate within Medicare FFS Part B

Upcoming Events

- ESRD QIP: Reviewing Your Facility's PY 2017 Performance Data Call — August 2
- IRF Quality Reporting Program Provider Training — August 9 and 10
- PQRS Feedback Reports and Informal Review Process for Program Year 2015 Results Call — August 10
- LTCH Quality Reporting Program Provider Training — August 11

Medicare Learning Network® Publications & Multimedia

- Medicare Billing Certificate Program for Part A Providers WBT — Revised
- Medicare Billing Certificate Programs for Part B Providers WBT — Revised
- Complying With Medicare Signature Requirements Fact Sheet – Revised
- DMEPOS Accreditation Fact Sheet — Revised
- Medicare Enrollment Guidelines for Ordering/Referring Providers Fact Sheet — Reminder

MLN Connects® Provider eNews for July 21, 2016

MLN Connects® Provider eNews for July 21, 2016

View this edition as a PDF

In this edition:

Editor's Note:

Our *Medicare Learning Network* (*MLN*®) website is updated to improve your access to education resources and make finding what you need easier. We hope you will take a look and share your thoughts with us. Learn more in this week's eNews.

News & Announcements

- Improved Medicare Learning Network Website
- IRF Quality Reporting Program Data Submission Deadline: August 15
- LTCH Quality Reporting Program Data Submission Deadline: August 15
- Hospice Quality Reporting: Reconsideration Period Ends Soon
- SNF Readmission Measure: Top 10 Things You Should Know
- Enhanced Administrative Simplification Website

Provider Compliance

- CMS Provider Minute: CT Scans Video

Claims, Pricers & Codes

- Billing for Nursing Visits in Home Health Shortage Areas by an RHC or FQHC

Upcoming Events

- ESRD QIP: Reviewing Your Facility's PY 2017

Performance Data Call — August 2

- PQRS Feedback Reports and Informal Review Process for Program Year 2015 Results Call — August 10

Medicare Learning Network® Publications & Multimedia

- Clinical Labs Call: Audio Recording and Transcript — New
- IMPACT Act Call: Audio Recording and Transcript — New
- Medicare Podiatry Services: Information for FFS Health Care Professionals Fact Sheet — Revised
- Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians Booklet — Revised
- How to Use the National Correct Coding Initiative Tools Booklet — Revised

Check the status of claim redeterminations online

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

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

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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

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

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

Beneficiaries

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

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