Medicare B CONNECTION
medicare.fcso.com
FIRST COAST SERVICE OPTIONS, INC.
A Newsletter for MAC Jurisdiction N Providers
April 2017

In this issue

Payment for moderate sedation services

Provider types affected

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

What you need to know

Change request (CR) 10001 revises existing *Medicare Claims Processing Manual* language to bring the manual in line with current payment policy for moderate sedation and anesthesia services. Providers should refer to the revised *Medicare Claims Processing Manual*, Chapter 12 (Physicians/Nonphysician Practitioners), Sections 50 and 140 for information regarding the reporting of moderate sedation and anesthesia services. The revision is attached to CR 10001. Make sure your billing staff is aware of these revisions.

Key manual changes

General payment rule

The fee schedule amount for physician anesthesia services furnished is, with the exceptions noted, based on allowable base and time units multiplied by an anesthesia conversion factor specific to that locality. The base unit for each anesthesia procedure is communicated to the MACs by means of the Healthcare Common Procedure Coding System (HCPCS) file released annually. The Centers for Medicare & Medicaid Services (CMS) releases the conversion factor annually. The base units and conversion factor are available at *https://www.cms.gov/Center/Provider-Type/Anesthesiologists-Center.html*.

Moderate sedation services furnished in conjunction with and in Support of procedural services

Anesthesia services range in complexity. The continuum of anesthesia services, from least intense to most intense in complexity is as follows: local or topical anesthesia, moderate (conscious) sedation, regional anesthesia and general anesthesia. Moderate sedation is a drug induced depression of consciousness during which the patient responds purposefully to verbal commands, either alone or accompanied by light tactile stimulation. Moderate sedation does not include minimal sedation, deep sedation or monitored anesthesia care.

See **ANESTHESIA**, page 8

Contents

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

Publication staff:

Marielba Cancel
Terri Drury
Maria Murdoch
Mark Willett
Robert Petty

Fax comments about this publication to:

Medicare Publications
904-361-0723

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

About the Medicare B Connection

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

Important notifications that require communication in between publications will be posted to the First Coast Medicare provider education website at *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 (waiver of liability statement on file).

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

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

July update to the NCCI procedure to procedure edits, version 23.2, effective July 1, 2017

Provider types affected

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

Provider action needed

Change request (CR) 10082 informs MACs about the update to the National Correct Coding Initiative (NCCI) procedure to procedure edits (PTP). This notice applies to Chapter 23, Section 20.9 of the *Medicare Claims Processing Manual*. Make sure your billing staffs are aware of these changes.

Background

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

Version 23.2 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 the outpatient code editor (OCE). It will only be necessary to search the column one/column two correct coding edit file for active or previously deleted edits. CMS no longer publishes a mutually exclusive edit file on its website for either practitioner or outpatient hospital services, since all active and deleted edits will appear in the single column one/column two correct coding edit file on each website. The edits previously contained in the mutually exclusive edit file are NOT being deleted but are being moved to the column one/column two correct coding edit file. Refer to the CMS NCCI web page for additional information at *https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html*. 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 10082, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3748CP.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/*.

Document history

Date of Change	Description
April 14, 2017	Initial article released

MLN Matters® Number: MM10082
Related CR Release Date: April 14, 2017
Related CR Transmittal Number: R3748CP
Related Change Request (CR) Number: CR10082
Effective Date: July 1, 2017
Implementation Date: July 3, 2017

Quarterly provider update

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

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

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

Chiropractic Services

Educational resources to assist chiropractors with Medicare billing

Note: *This article was revised on April 7, 2017, to correct a statement under "Coverage, Documentation and Billing". That section included a reference to "220.1.3: Certification and Recertification of Need for Treatment and Therapy Plans of Care." However, chiropractic treatment is not included in that section. All other information is unchanged. This information was previously published in the March 2016 Medicare B Connection, pages 12-13.*

Provider Types Affected

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

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

Provider Action Needed

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

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

Background

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

Enrollment information

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

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

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

Coverage, documentation, and billing

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

MLN Matters® article *MM3449* discusses *Revised Requirements for Chiropractic Billing of Active/Corrective Treatment and Maintenance Therapy, Full Replacement of CR 3063*.

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

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

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

- National Government Services (LCD L33613);
- First Coast Options, Inc (LCD L33840);
- CGS Administrators, LLC (LCD L33982);
- Noridian Healthcare Solutions, LLC (Jurisdiction F) (LCD L34009);
- Noridian Healthcare Solutions, LLC (Jurisdiction E) (LCD 34242);

See **CHIROPRACTIC**, next page

CHIROPRACTIC

previous page

- Wisconsin Physicians Service Insurance Corporation (LCD L34585); and
- Novitas Solutions, Inc (LCD L35424).

The fact sheet *Misinformation on Chiropractic Services*" is designed to provide education on Medicare regulations and policies on chiropractic services to Medicare providers. It includes information on the documentation needed to support a claim submitted to Medicare for medical services.

The *MLN Matters*® article – SE (special edition) 1101 revised *Overview of Medicare Policy Regarding Chiropractic Services* highlights Medicare policy regarding coverage of chiropractic services for Medicare beneficiaries.

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

The *Medicare Claims Processing Manual*, *Chapter 1 General Billing Requirements* includes the following sections which apply to billing for a chiropractor's services:

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

The *Medicare Claims Processing Manual*, Chapter 12 *Physicians/Nonphysician Practitioners*, includes *Section 220*, *Chiropractic Services*. This section explains the documentation requirements when billing for a chiropractor's services. Also the claims processing edits related to payment for a chiropractor's services are explained.

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

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

More resources: A chiropractor is eligible to receive incentive payments under the Physician Quality Reporting System (PQRS), Electronic Prescribing (eRx) Incentive Program, and Electronic Health Record (EHR) Incentive Program. Information on reporting these measures is available in the Physician and Other Enrolled Health Care Professionals pathway.

The *Medicare Claims Processing Manual*, Chapter 23 *Fee Schedule Administration and Coding Requirements*, includes *Section 30*, *Services Paid Under the Medicare Physician's Fee Schedule*. This section explains that a chiropractor is paid under the MPFS.

The booklet *MLN Guided Pathways - Provider Specific Medicare Resources, pages 25-28*, contains many resources useful for chiropractic billing.

Advance beneficiary notice (ABN) information

The *Medicare Benefit Policy Manual*, Chapter 15 *Covered Medical and Other Health Services*," includes reference to advance beneficiary notices (ABNs) in Section *240.1.3*, *Necessity for Treatment.*"

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

The *Medicare Claims Processing Manual*, *Chapter 30*, *Financial Liability Protections*, includes detailed instructions on completing the ABN and use of the GA modifier.

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

Additional information

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

You may want to review the educational video on *Improving the Documentation of Chiropractic Services* which gives a thorough presentation on medical necessity and proper documentation.

Document history

Date of change	Description
4/7/17	The article was revised to correct a statement under the "Coverage, documentation and billing." That section included a reference to "220.1.3: Certification and Recertification of Need for Treatment and Therapy Plans of Care." However, chiropractic treatment is not included in that section.
6/21/16	The article was revised to add a reference and link to an educational video on Improving the Documentation of Chiropractic Services that gives a thorough presentation on medical necessity and proper documentation.
3/16/16	Initial article post

MLN Matters® Number: SE1603 *Revised*
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Drugs & Biologicals

July 2017 quarterly ASP Medicare Part B drug pricing files and revision to prior quarterly pricing files

Provider type 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) 10016 provides the July 2017 quarterly update and instructs MACs to download and implement the July 2017 ASP drug pricing files and, if released by the Centers for Medicare & Medicaid Services (CMS), the revised April 2017, January 2017, October 2016, and July 2016 average sales price (ASP) drug pricing files for Medicare Part B drugs. Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after July 3, 2017, with dates of service July 1, 2017, through September 30, 2017. MACs will not search and adjust claims previously processed unless brought to their attention.

Background

The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply contractors with the ASP and not otherwise classified (NOC) drug-pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the OPPS are incorporated into the outpatient code editor (OCE) through separate instructions.

The following files are related to this most recent update:

- July 2017 ASP and ASP NOC – effective dates of service: July 1, 2017, through September 30, 2017
- April 2017 ASP and ASP NOC – effective dates of service: April 1, 2017, through June 30, 2017
- January 2017 ASP and ASP NOC – effective dates of service: January 1, 2017, through March 31, 2017
- October 2016 ASP and ASP NOC – effective dates of services: October 1, 2016, through December 31, 2016
- July 2016 ASP and ASP NOC – effective dates of service: July 1, 2016, through September 30, 2016

For any drug or biological not listed in the ASP or NOC drug-pricing files, MACs will determine the payment allowance limits in accordance with the policy described in the *Medicare Claims Processing Manual*, Chapter 17, Section 20.1.3, which is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c17.pdf*. For any drug or biological not listed in the ASP or NOC drug-pricing files that is billed with the KD modifier, contractors shall determine the payment allowance limits in accordance with instructions for pricing

See **ASP**, next page

ANESTHESIA

page 1

Practitioners will report the appropriate CPT® and/or HCPCS code that accurately describes the moderate sedation services performed during a patient encounter, which are performed in conjunction with and in support of a procedural service, consistent with CPT® guidance.

Other manual revisions to Sections 50 and 140

There are other minor revisions to these manual sections and those revised manual sections are attached to CR 10001.

Additional information

Your MAC will not search their files to either retract payment for claims already paid or to retroactively pay claims. They will adjust impacted claims that you bring to their attention.

To view the official instruction, CR 10001 issued to your MAC regarding this change, refer to *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3747CP.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/*.

Document history

Date	Description
4/14/17	Initial article released.

MLN Matters® Number: MM10001
Related Change Request (CR) #: CR 10001
Related CR Release Date: April 14, 2017
Effective Date: January 1, 2017
Related CR Transmittal #: R3747CP
Implementation Date: May 15, 2017

Modifier JW – discarded drugs from single-use vials or packages

Effective January 1, 2017, the Centers for Medicare & Medicaid Services (CMS) no longer allows contractor discretion with the use of modifier JW (Discarded drugs or biologicals from single use vials or single use packages). Coverage of discarded Part B drugs and biologicals applies only to single use vials. Multi-use vials are not subject to payment for discarded amounts.

- All providers are required to document unused/ discarded drug or biological wastage in the patient's medical record.
- Claims containing drug wastage must be billed using two separate lines:
  - One line represents the portion/dosage administered to the patient
  - The second line (billed with modifier JW) represents the discarded portion.

The JW modifier is not permitted when the actual dose of the drug or biological administered is less than the billing unit. For example: if 7 mg were administered of a 10 mg single use vial, and the 10 mg represents 1 unit, the administered and discarded amounts cannot be split for billing purposes.

CMS encourages physicians to schedule patients in such a way that they can use drugs and biologicals most efficiently. However, if a physician must discard the remainder of a single use vial or other single use package after administering it to a Medicare patient, the program covers the amount of drug discarded along with the amount administered, up to the amount of the drug or biological as indicated on the vial or package label.

Sources: *MLN Matters® MM9603*; *"Medicare Claims Processing Manual", Chapter 17, Section 40*

ASP

previous page

and payment changes for infusion drugs furnished through an item of durable medical equipment (DME) on or after January 1, 2017, associated with the passage of the 21st Century Cures Act.

Additional information

The official instruction issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3746CP.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/*.

Document history

Date of change	Description
April 7, 2017	Initial article released

MLN Matters® Number: MM10016
Related CR Release Date: April 7, 2017
Related CR Transmittal Number: R3746CP
Related Change Request (CR) Number: 10016
Effective Date: July 1, 2017
Implementation Date: July 3, 2017

Evaluation & Management

Prepayment of evaluation and management code 99285 update

Data analysis pertaining to emergency department evaluation and management services indicates a high comprehensive error rate testing (CERT) error rate. *Current Procedural Terminology* (CPT®) code 99285 has been over-utilized compared to other emergency E&M service codes. Errors identified include inappropriate use of high level emergency department E&M CPT® codes that were down-coded to a lower level of care, and insufficient documentation to support code 99285, which is defined in the CPT® manual as follows:

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

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

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.

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

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

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

Use of emergency department codes in office

Emergency department coding is not appropriate if the site of service is an office or outpatient setting or any sight of service other than an emergency department.

The emergency department codes should only be used if the patient is seen in the emergency department and the services described by the HCPCS code definition are provided. The emergency department is defined as an organized hospital-based facility for the provision of unscheduled or episodic services to patients who present for immediate medical attention.

Use of emergency department codes to bill nonemergency services

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

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

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

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

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

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

If the patient is admitted to the hospital by the patient's personal physician, then the patient's regular physician should bill only the appropriate level of the initial hospital

See **PREPAYMENT**, next page

PREPAYMENT

previous page

care (codes 99221 - 99223) because all evaluation and management services provided by that physician in conjunction with that admission are considered part of the initial hospital care when performed on the same date as the admission. The ED physician who saw the patient in the emergency department should bill the appropriate level of the ED codes.

If the ED physician, based on the advice of the patient's personal physician who came to the emergency department to see the patient, sends the patient home, then the ED physician should bill the appropriate level of emergency department service. The patient's personal physician should also bill the level of emergency department code that describes the service he or she provided in the emergency department. If the patient's personal physician does not come to the hospital to see the patient, but only advises the emergency department physician by telephone, then the patient's personal physician may not bill.

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

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

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

- First Coast's *Evaluation and Management (E/M) services page*, offering links to tools, access to E/M interactive worksheet, FAQs, online learning, and additional resources.
- CMS *internet-only manual (IOM) guidelines* addressing multiple types and settings pertaining to E/M services.

First Coast response

In response to continued CERT errors and risk of improper payments First Coast will implement a prepayment threshold audit for CPT® code 99285 claims submitted on or after **March 7, 2017**, that will apply to all providers within First Coast's Florida jurisdiction.

Fully favorable redetermination decision letters discontinued

Effective March 1, 2017, First Coast Service Options Inc. (First Coast) no longer issues Part B fully favorable redetermination decision letters. Providers will continue to receive a revised remittance advice that will reflect the change(s) made as a result of the redetermination request that was submitted.

Laboratory/Pathology

Changes to the laboratory NCD edit software for July 2017

Provider type affected

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

What you need to know

This article is based on change request (CR) 10036, which announces the changes that will be included in the July 2017 quarterly release of the edit module for clinical diagnostic laboratory services. This is a recurring update notification that applies to *Chapter 16*, Section 120.2, of the *Medicare Claims Processing Manual*. Make sure your billing staffs are aware of these changes.

Background

The national coverage determinations (NCDs) for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee and the final rule was published November 23, 2001. Nationally uniform software was developed and incorporated in the Medicare shared systems so that laboratory claims subject to one of the 23 NCDs (*Medicare National Coverage Manual*, *Sections 190.12 - 190.34*) were processed uniformly throughout the nation effective April 1, 2003.

In accordance with Chapter 16, S120.2, Publication 100-04, the laboratory edit module is updated quarterly as necessary to reflect ministerial coding updates and substantive changes to the NCDs developed through the NCD process. The changes are a result of coding analysis decisions developed under the procedures for maintenance of codes in the negotiated NCDs and biannual updates of the ICD-10-CM codes.

CR 10036 communicates requirements to shared system maintainers (SSMs) and contractors notifying them of changes to the laboratory edit module to update it for changes in laboratory NCD code lists for July 2017.These changes become effective for services furnished on or after October 1, 2016, and are as follows:

- ICD-10-CM code R73.03 will be added to the list of ICD-10-CM codes that are covered by Medicare for the glycated hemoglobin/glycated protein (190.21) NCD.
- ICD-10-CM code R73.03 will be removed from the list of ICD-10-CM codes that are covered by Medicare for the hepatitis panel/acute hepatitis panel (190.33) NCD.

Additional information

The official instruction issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3738CP.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/*.

Document history

Date of change	Description
March 20, 2017	Initial article released

MLN Matters® Number: MM10036
Related CR Release Date: March 17, 2017
Related CR Transmittal Number: R3738CP
Related Change Request (CR) Number: CR10036
Effective Date: October 1, 2016
Implementation Date: July 3, 2017

CMS updates list of new CLIA waived tests

***Note**: This article was revised April 3, 2017, to reflect the revised change request (CR) 9956 issued March 30, 2017. In the article, the CR release date, transmittal number, and the Web address for CR 9956 are revised. All other information remains the same. The CR was revised to correct CPT® drug test code from 80305 to 80305QW in the attachment to CR 9956. This information was previously published in the February 2017 Medicare B Connection, pages 14-15.*

Provider types affected

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

Provider action needed

CR 9956 informs MACs of 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 MACs of the new tests so that they can accurately process claims. Make sure that your billing staffs are aware of these CLIA-related changes.

Background

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

Current Procedural Terminology (CPT®) codes for the following new tests must have the modifier QW to be recognized as a waived test. However, the tests mentioned on the first page of the list attached to CR 9956 (CPT® codes: 81002, 81025, 82270, 82272, 82962, 83026, 84830, 85013, and 85651) do not require a QW modifier to be recognized as a waived test.

The CPT® code, effective date and description for the latest tests approved by the FDA as waived tests under CLIA are the following:

- G0477QW [from July 7, 2016, to December 31, 2016], 80305QW [on and after January 1, 2017], July 7, 2016, TransMed Company, CLIA Screen In-Vitro Multi-Drug Urine Test Dip Card
- G0477QW [from July 7, 2016, to December 31, 2016], 80305QW [on and after January 1, 2017], July 7, 2016, TransMed Company, CLIA Screen In-Vitro Multi-Drug Urine Test Dip Cup
- 82274QW, G0328QW, July 27, 2016, Pinnacle BioLabs Second Generation FIT Fecal Occult Blood (FOB) Self-Test {Cassette}
- G0477QW [from August 11, 2016, to December 31, 2016], 80305QW [on and after January 1, 2017], August 11, 2016, Nobel Medical Inc., AEON Multi-Drug Urine Test Cup
- G0477QW [from August 11, 2016, to December 31, 2016], 80305QW [on and after January 1, 2017], Nobel Medical Inc., August 11, 2016, AEON Multi-Drug Urine Test Dip Card
- 82274QW, G0328QW, September 6, 2016, ProAdvantage Immunochemical Fecal Occult Blood Test
- 87880QW, September 16, 2016, Cardinal Health Strep A Cassette Rapid Test
- G0477QW [from September 16, 2016, to December 31, 2016], 80305QW [on and after January 1, 2017], September 16, 2016, Premier Biotech, Inc., MDETOX Multi-Drug Urine Test Cup
- G0477QW [from September 16, 2016, to December 31, 2016], 80305QW [on and after January 1, 2017], September 16, 2016, Premier Biotech, Inc., MDETOX Multi-Drug Urine Test Dip Card
- 81003QW, October 7, 2016. Moore Medical LLC mooremedical U120 Urine Analyzer
- 87633QW, October 7, 2016, BioFire Diagnostics, FilmArray 2.0 EZ Configuration Instrument (Viral and Bacterial Nucleic Acids) {Nasopharyngeal Swabs}
- 87804QW, October 7, 2016, BioSign Flu A+B {Nasal and nasopharyngeal swabs}
- G0477QW [from October 24, 2016, to December 31, 2016], 80305QW [on and after January 1, 2017], October 24, 2016, Identify BioSciences Inc., Identifi Multi-Panel Drug Test Cups (Urine) {Cup Format}
- G0477QW [from October 25, 2016, to December 31, 2016], 80305QW [on and after January 1, 2017], October 25, 2016, UCP Biosciences, Inc. U-Card Drug Test Screen (Urine) {Card Format}
- G0477QW [from October 25, 2016, to December 31, 2016], 80305QW [on and after January 1, 2017], October 25, 2016, UCP Biosciences, Inc. U-Cup Drug Test Screen (Urine) {Cup Format}
- G0477QW [from October 26, 2016, to December 31, 2016], 80305QW [on and after January 1, 2017], Intrinsic Interventions Inc., Vista Flow
- 87804QW, November 15, 2016, LifeSign LLC, Status Flu A+B
- 87804QW, November 21, 2016, Sekisui Diagnostics LLC, OSOM Ultra Flu A&B Test
- G0477QW [from November 23, 2016, to December 31, 2016], 80305QW [on and after January 1, 2017], November 23, 2016, Medical Distribution Group Inc., Identify Diagnostics Drug Test Cards (UPC Biosciences, Inc.)
- G0477QW [from November 23, 2016, to December 31, 2016], 80305QW [on and after January 1, 2017], November 23, 2016, Medical Distribution Group Inc., Identify Diagnostics Drug Test Cups (UPC Biosciences, Inc.)

See **CLIA**, next page

CLIA

previous page

- 87804QW, November 25, 2016, OraSure QuickFlu Rapid A+B Test {Nasal and Nasopharyngeal Swabs

The HCPCS code G0477 [Drug tests(s), presumptive, any number of drug classes; any number of devices or procedures, (eg, immunoassay) capable of being read by direct optical observation only (eg, dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service] was discontinued 12/31/2016. The new HCPCS code 80305 [Drug test(s), presumptive, any number of drug classes, any number of devices or procedures (eg, immunoassay); capable of being read by direct optical observation only (eg, dipsticks, cups, cards, cartridges) includes sample validation when performed, per date of service] was effective 1/1/2017. HCPCS code 80305QW describes the waived testing previously assigned the code G0477QW. All tests in the attachment that previously had HCPCS G0477QW are now assigned 80305QW.

The new waived complexity code 87633QW [Infectious agent detection by nucleic acid (DNA or RNA); respiratory virus (eg, adenovirus, influenza virus, coronavirus, metapneumovirus, parainfluenza virus, respiratory syncytial virus, rhinovirus), multiplex reverse transcription and amplified probe technique, multiple types or subtypes, 12-25 targets] was assigned for the testing performed by BioFire Diagnostics, FilmArray 2.0 EZ Configuration Instrument (Viral and Bacterial Nucleic Acids) {Nasopharyngeal Swabs}.

The attachment to CR 9956 has been re-organized. HCPCS codes with more than 20 test systems listed in previous transmittal attachments will now not mention the specific waived complexity test system. Instead, there will be a generic test system name and a statement to refer to the FDA waived analytes internet site (*http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfClia/analyteswaived.cfm*) for the specific test system name. The HCPCS codes mentioned on the attachment that will now only be mentioned in a generic manner are G0477QW (80305QW effective 1/1/2017), 81003QW, 82274QW, G0328QW, 86308QW, 86318QW, and 87880QW. For these codes, future new waived test transmittals will only mention the specific name of the latest FDA test system in the transmittal and not be included in the attachment.

MACs will not search their files to either retract payment or retroactively pay claims based on these changes. However, MACs should adjust claims that you bring to their attention.

Additional Information

The official instruction, CR 9956, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3741CP.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/*.

Document history

January 20, 2017 – Initial article release.

April 3, 2017 – The article was revised to reflect the revised CR 9956 issued March 30, 2017. In the article, the CR release date, transmittal number, and the Web address for CR 9956 are revised. All other information remains the same. The CR was revised to correct CPT® drug test code from 80305 to 80305QW in the attachment to CR 9956.

MLN Matters® Number: MM9956 *Revised*
Related Change Request (CR) #: CR 9956
Related CR Release Date: March 30, 2017
Effective Date: April 1, 2017
Related CR Transmittal #: R3741CP
Implementation Date: April 3, 2017

Medicare Learning Network®

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

Affordable Care Act - Operating Rules - Requirements for Phase II and Phase III Compliance for Batch Processing

The Centers for Medicare & Medicaid Services (CMS) is in the process of implementing operating rules adopted under Section 1104 of the Affordable Care Act (ACA). The Secretary of the Department of Health & Human Services (HHS) named the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) as the authoring entity of the phase I, II, and III operating rules. The operating rules are intended to provide additional direction and clarification to the electronic data interchange (EDI) standard adopted under the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

CMS is currently in the process of implementing the batch requirements for the phase II rules for the claim status inquiry and response, and health care claim payment advice.

HIPAA transactions are referred to in the following manner:

- 276: ASC X12 health care claim status request
- 277: ASC X12 health care information status notification
- 835: ASC X12 health care claim payment/advice

Change request (CR) 9358 requires the MACs to implement a solution to comply with this rule including the use of X.509 client certificates over Secure Socket Layer (SSL) effective April 1, 2017. The solution must be able to receive and post the batch 276/277 and 835 claim payment advice transactions using the public internet. In order to be able to perform these transactions the trading partners must be in compliance with HTTPS CAQH CORE rules. Click *here* for information on the CAQH CORE Connectivity Rule 270 version 2.2.0. For additional information on the CAQH CORE rules click *here*.

First Coast Service Options Inc. (First Coast) will make updates to its EDI enrollment procedures, forms and trading partners' management system for connectivity using the HTTPS CAQH CORE requirements.

Please note that enrollment for these two transactions is optional and must be at the trading partner level. Providers can continue to use their current method of transmission for these and any other EDI transactions.

Source: *MLN Matters® Number MM9358*

Revised CMS-588: Electronic funds transfer authorization agreement

Providers and suppliers must use the revised CMS-588 form (electronic funds transfer authorization agreement) beginning January 1, 2018. The revised form will be posted on the CMS forms list (*https://go.usa.gov/xX3Sa*) by early summer. Medicare administrative contractors will accept both the current and revised versions of the CMS-588 through December 31, 2017. Visit the Medicare provider-supplier enrollment webpage (*https://go.usa.gov/xXCWk*) for more information about Medicare enrollment and the electronic funds transfer (EFT) requirements.

Changes to the form include:

- New indicator shows if the EFT is for an individual or a group/organization/corporation in parts 1 and 2 (reason for submission and account holder information)
- Now optional to list the financial institution's contact person
- Four digits added to the *Provider's/Supplier's/Indirect Payment Procedure Entity's Account Number with Financial Institution*, making it consistent with the industry standard

Next generation accountable care organization – AIPBP implementation

Provider types affected

This *MLN Matters*® article is intended for physicians, hospitals, and other providers who are participating in next generation accountable care organization (NGACOs) model and submitting claims to Medicare administrative contractors (MACs) under the all-inclusive population-based payment (AIPBP) alternate payment mechanism for certain services for Medicare beneficiaries.

Provider action needed

Special edition (SE) article SE17011 reminds providers of the implementation of the AIPBP payment mechanism for participating ACOs.

Background

The NGACO model offers ACOs the option to participate in a payment mechanism called AIPBP under which the ACO takes on responsibility for entering into payment arrangements with its providers and paying claims, in place of claims being paid by Medicare's fee-for-service (FFS) systems. The goal of AIPBP is to establish a monthly cash flow for AIPBP-participating ACOs and a mechanism for ACOs to enter payment arrangements with next generation participants and preferred providers. Conceptually, AIPBP builds on population-based payments (PBP) in the Pioneer ACO model and available in the NGACO model, but enables even greater flexibility in establishing payment relationships between the ACO and its providers.

Under AIPBP, participating ACOs will receive a monthly lump-sum payment outside of the FFS system and be responsible for paying next generation participants and preferred providers with whom they have entered into written AIPBP Payment Arrangement agreements. The monthly payment will be based on an estimation of the care that will be provided to aligned beneficiaries in the performance year by AIPBP-participating providers.

Reconciliation will occur following the performance year to true up the monthly payments (based on estimation) versus what AIPBP-participating providers would have been paid under FFS.

All participating providers will continue to submit FFS claims to CMS, which will fully adjudicate the claims, but will not make payment to providers who have agreed to participate in AIPBP except for add-on payments for inpatient hospitals (specifically operating outlier payments, operating disproportionate share hospital [DSH] payments, operating indirect medical education [IME] payments, Medicare new technology payments, and Islet isolation cell transplantation payments.).

ACOs had an annual election to participate in AIPBP from among three alternate payment mechanisms in 2017; the ACO's providers/suppliers and preferred providers will agree to participate on a provider-by-provider basis (that is, not all providers/suppliers, or preferred providers will have claims reduced up to 100 percent). All AIPBP-participating providers will receive a 100-percent reduction to their claims if they see an aligned beneficiary, unless that aligned beneficiary has opted out of medical claims data sharing with the ACO or if the claim is for substance abuse-related services. If an AIPBP-participating provider sees a beneficiary not aligned to an ACO, they would not receive the reduction.

Providers who do not have an AIPBP payment arrangement with an ACO, whether in the ACO or not, will continue to receive normal FFS reimbursements for all the beneficiaries they treat, including aligned beneficiaries. Medicare systems will continue to view providers and beneficiaries as being FFS.

As mentioned, providers continue to submit all FFS claims to CMS, which will make coverage and liability determinations and assess beneficiary liability. Beneficiary liabilities will be calculated based on what Medicare would have paid in absence of AIPBP, and Medicare summary notices (MSNs) should reflect the amount that would have been paid (as is currently done for PBP). Similarly, Medicare will continue to send remittance notices to AIPBP-participating providers (just as they would receive remittance notices if not participating in AIPBP).

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/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/*.

Document history

Date of change	Description
April 20, 2017	Initial article release.

MLN Matters® Number: SE17011
Article Release Date: April 20, 2017
Related CR Transmittal Number: N/A
Related Change Request (CR) Number: N/A
Effective Date: January 1, 2017
Implementation Date: January 3, 2017

Provider enrollment revalidation – cycle 2

***Note**: This article was revised April 10, 2017, to correct the table under "Revalidation timeline and example." The last row should have stated the date as "November 29 – December 14, 2017." All other information is unchanged. This information was previously published in the March 2017 Medicare B Connection, pages 21-25.*

Provider types affected

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

Provider action needed

Stop – impact to you

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

Caution – what you need to know

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

Go – what you need to do

1. Check *http://go.cms.gov/MedicareRevalidation* for the provider/suppliers due for revalidation;
2. If the provider/supplier has a due date listed, CMS encourages you to submit your revalidation within six months of your due date or when you receive notification from your MAC to revalidate. When either of these occur:
   - Submit a revalidation application through internet-based PECOS located at *https://pecos.cms.hhs.gov/pecos/login.do*, the fastest and most efficient way to submit your revalidation information. Electronically sign the revalidation application and upload your supporting documentation or sign the paper certification statement and mail it along with your supporting documentation to your MAC; or
   - Complete the appropriate CMS-855 application available at *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html*;
   - If applicable, pay your fee by going to *https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do*; and
   - Respond to all development requests from your MAC timely to avoid a hold on your Medicare payments and possible deactivation of your Medicare billing privileges.

Background

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

What's ahead for your next Medicare enrollment revalidation?

Established Due Dates for Revalidation

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

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

  Important: The list identifies billing providers/suppliers only that are required to revalidate. If you are enrolled solely to order, certify, and/or prescribe via the CMS-855O application or have opted out of Medicare, you will not be asked to revalidate and will not be reflected on the list.

- Due dates are established based on your last successful revalidation or initial enrollment

See **REVALIDATE**, next page

REVALIDATE

previous page

(approximately three years for DME suppliers and five years for all other providers/suppliers).

- In addition, the MAC will send a revalidation notice within two-three months prior to your revalidation due date either by email (to email addresses reported on your prior applications) or regular mail (at least two of your reported addresses: correspondence, special payments and/or your primary practice address) indicating the provider/supplier's due date.

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

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

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

Large group coordination

Large groups (200+ members) accepting reassigned benefits from providers/suppliers identified on the CMS list will receive a letter from their MACs listing the providers linked to their group that are required to revalidate for the upcoming six month period. A spreadsheet detailing the applicable provider's Name, national provider identifier (NPI) and Specialty will also be provided. CMS encourages the groups to work with their practicing practitioners to ensure that the revalidation application is submitted prior to the due date. We encourage all groups to work together as only one application from each provider/supplier is required, but the provider must list all groups they are reassigning to on the revalidation application submitted for processing. MACs will have dedicated provider enrollment staff to assist in the large group revalidations.

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

Unsolicited revalidation submissions

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

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

Submitting your revalidation application

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

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

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

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

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

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

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

See **REVALIDATE**, next page

REVALIDATE

previous page

Getting access to PECOS:

To use PECOS, you must get approved to access the system with the proper credentials which are obtained through the Identity and Access Management System, commonly referred to as "I&A". The I&A system ensures you are properly set up to submit PECOS applications. Once you have established an I&A account you can then use PECOS to submit your revalidation application as well as other enrollment application submissions.

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

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

For questions about accessing PECOS (such as login, forgot username/password) or I&A, contact the external user services (EUS) help desk at 1-866-484-8049 or at *EUSSupport@cgi.com*.

Deactivations due to non-response to revalidation or development requests

It is important that you submit a complete revalidation application by your requested due date and you respond to all development requests from your MACs timely. Failure to submit a complete revalidation application or respond timely to development requests will result in possible deactivation of your Medicare enrollment.

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

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

Revalidation timeline and example

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

Action	Timeframe	Example
Revalidation list posted	Approximately six months prior to due date	March 30, 2017
Issue large group notifications	Approximately six months prior to due date	March 30, 2017
MAC sends email/ letter notification	75-90 days prior to due date	July 2-17, 2017
MAC sends letter for undeliverable emails	75-90 days prior to due date	July 2-17, 2017
Revalidation due date		September 30, 2017
Apply payment hold/ issue reminder letter (group members)	Within 25 days after due date	October 25, 2017
Deactivate	60-75 days after due date	November 29 – December 14, 2017

Deactivations due to non-billing

Providers/suppliers that have not billed Medicare for the previous 12 consecutive months will have their Medicare billing privileges deactivated in accordance with 42 CFR §424.540. The effective date of deactivation will be five days from the date of the corresponding deactivation letter issued by the MACs notifying the providers/suppliers of the deactivation action.

Providers/suppliers who Medicare billing privileges are deactivated will be required to submit a new full and complete application in order to reestablish their provider enrollment record and related Medicare billing privileges. The provider/supplier will maintain their original PTAN; however, an interruption in billing will occur during the period of deactivation resulting in a gap in coverage.

Application fees

Institutional providers of medical or other items or services and suppliers are required to submit an application fee for revalidations. The application fee is $560.00 for 2017. CMS has defined "institutional provider" to mean any provider or supplier that submits an application via PECOS or a paper Medicare enrollment application using the CMS-855A, CMS-855B (except physician and non-physician practitioner organizations), or CMS-855S forms.

All institutional providers (that is, all providers except physicians, non-physicians practitioners, physician group practices and non-physician practitioner group practices) and suppliers who respond to a revalidation request must submit the 2017 enrollment fee (reference 42 CFR 424.514) with their revalidation application. You may submit your fee by ACH debit, or credit card. To pay your application fee, go to *https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do* and submit payment as directed. A confirmation screen will display indicating that payment was successfully made. This confirmation screen is your receipt and you should print it for your records. CMS strongly recommends that you include this receipt with

See **REVALIDATE**, next page

REVALIDATE

previous page

your uploaded documents on PECOS or mail it to the MAC along with the certification statement for the enrollment application. CMS will notify the MAC that the application fee has been paid. Revalidations are processed only when fees have cleared.

Summary:

- CMS will post the revalidation due dates for the upcoming revalidation cycle on *http://go.cms.gov/MedicareRevalidation* for all providers/suppliers. This list will be refreshed periodically. Check this list regularly for updates.
- MACs will continue to send revalidation notices (either by email or mail) within two-three months prior to your revalidation due date. When responding to revalidation requests, be sure to revalidate your entire Medicare enrollment record, including all reassignment and practice locations. If you have multiple reassignments/billing structures, you must coordinate the revalidation application submission with all parties.
- If a revalidation application is received but incomplete, the MACs will develop for the missing information. If the missing information is not received within 30 days of the request, the MACs will deactivate the provider/supplier's billing privileges.
- If a revalidation application is not received by the due date, the MAC may place a hold on your Medicare payments and deactivate your Medicare billing privileges.
- If the provider/supplier has not billed Medicare for the previous 12 consecutive months, the MAC will deactivate their Medicare billing privileges.
- If billing privileges are deactivated, a reactivation will result in the same PTAN but an interruption in billing during the period of deactivation. This will result in a gap in coverage.
- If the revalidation application is approved, the provider/supplier will be revalidated and no further action is needed.

Additional information

To find out whether a provider/supplier has been mailed a revalidation notice go to *https://go.cms.gov/MedicareRevalidation*.

A sample revalidation letter is available at *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/SampleRevalidationLetter.pdf*. A revalidation checklist is available at *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Revalidations.html*.

For more information about the enrollment process and required fees, refer to *MLN Matters*® article MM7350, which is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7350.pdf*.

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

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

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

For additional information about the enrollment process and internet-based PECOS, please visit the Medicare Provider-Supplier Enrollment web page at *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html*. .

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

Document history

Date of change	Description
April 10, 2017	The article was revised to correct the table under "Revalidation timeline and example". The last row should have stated the date as " November 29-December 14, 2017."
March 15, 2017	The updated article revised the table under "Revalidation timeline and example" and added additional information after that table.
February 22, 2016	Initial article released

MLN Matters® Number: SE1605 *Revised*
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

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.

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*.

Retired LCD

Interferon – retired Part B LCD

LCD ID number: L33913 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on data analysis review of the interferon local coverage determination (LCD), it was determined that the LCD is no longer required and, therefore, is being retired.

Of note, drugs approved for marketing by the Food and Drug Administration (FDA) are considered safe and effective when used for indications specified on the labeling. Label and Off-label Coverage of Outpatient Drugs and Biologicals LCD (L33915) outlines general coverage criteria for drugs approved for marketing by the FDA-labeled use, as well as the off-labeled use in the absence of a national coverage determination (NCD) or a Medicare administrative contractor LCD or published article.

Effective date

This LCD retirement is effective for services rendered **on or after March 31, 2017**. 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*.

Revisions to LCD

B-Scan – revision to the Part B LCD

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

The local coverage determination (LCD) for b-scan was revised to include ICD-10-CM diagnosis code range T85.22XA-T85.22XS under the "ICD-10 Codes that Support Medical Necessity" section of the LCD for CPT® codes 76510, 76512, and 76513.

Effective date

This LCD revision is effective for claims processed **on or after March 23, 2017**, 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*.

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

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

Medicare Learning Network®

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

Cardiac Part A/B local coverage determinations revised

LCD ID number: L33282 and L36209 (Florida, Puerto Rico/U.S. Virgin Islands)

The following local coverage determinations (LCDs) were revised to include ICD-10-CM diagnosis code Z01.810 in the "ICD-10 Codes that Support Medical Necessity" sections of LCD L33282 (Computed tomographic angiography of the chest, heart and coronary arteries) for CPT® codes 75571, 75572, 75573, 75574, and LCD L36209 (Cardiology – non-emergent outpatient testing: exercise stress test, stress echo, mpi spect, and cardiac pet) for CPT® codes 78451, 78452, 78453, and 78454.

Effective date

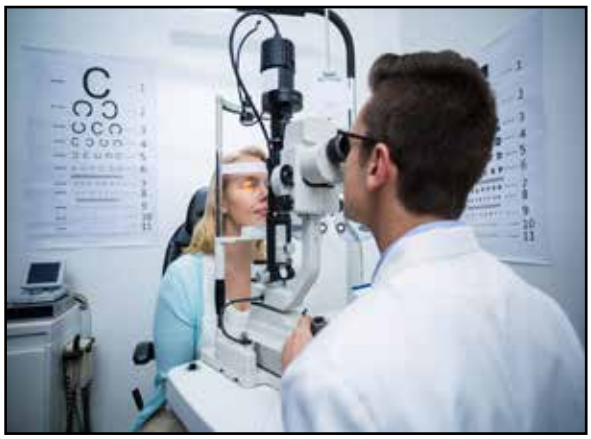
These LCD revisions are effective for claims processed **on or after March 23, 2017**, for services rendered **on or after October 1, 2015**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Optical Part A/B local coverage determinations revised

LCD ID number: L33670 and L34017 (Florida, Puerto Rico/U.S. Virgin Islands)



The following local coverage determinations (LCDs) were revised to include ICD-10-CM diagnosis code range T85.22XA-T85.22XS in the "ICD-10 Codes that Support Medical Necessity" sections of LCD L34017 (Ophthalmoscopy) for *Current Procedural Terminology* (CPT®) codes 92225, 92226 and LCD L33670 (Fundus photography) for CPT® code 92250. In addition, the LCD "Coding Guideline" attachment for LCD L34017 was updated to remove the statement indicating that CPT® codes 92225 and 92226 should not be reported with modifier 50.

Effective date

These LCD revisions are effective for claims processed **on or after March 23, 2017**, for services rendered **on or after October 1, 2015**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Find 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.*

Optical coherence biometry – revision to the Part B LCD "coding guideline" attachment

LCD ID number: L33927 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on the Centers for Medicare & Medicaid Services (CMS) change request (CR) 9977 (Quarterly update to the MPFSDB – April 2017 update), the "coding guideline" attachment to the local coverage determination (LCD) for optical coherence biometry was revised to reflect that the bilateral surgery indicator changed from a "2" (150 percent payment adjustment for bilateral procedure does not apply) to a "3" (the usual payment adjustment for bilateral procedures does not apply).

Effective date

This LCD revision is effective for claims processed **on or after April 3, 2017**, for services rendered **on or after January 1, 2017**. 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*.

Screening and diagnostic mammography – revision to the Part A and Part B LCD

LCD ID number: L36342 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 9861 (ICD-10 Coding Revisions to National Coverage Determination [NCDs]), the LCD was revised to add ICD-10-CM diagnosis codes N61.0 and N61.1 for Healthcare Common Procedure Coding System (HCPCS) codes G0204, G0206, and G0279. Although Current Procedural Terminology (CPT®) codes 77055 and 77056 were deleted effective January 1, 2017, since the addition of diagnosis codes N61.0 and N61.1 is being back-dated to October 1, 2016; these diagnoses are also applicable for CPT® codes 77055 and 77056 for services rendered October 1, 2016-December 31, 2016.

Effective date

This LCD revision is effective for claims processed **on or after April 3, 2017**, for services rendered **on or after October 1, 2016**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage

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

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

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

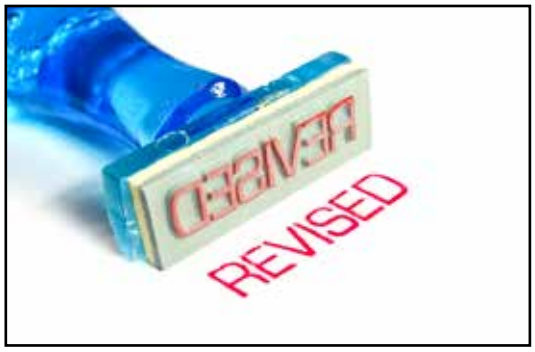
Your feedback matters

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

Susceptibility studies – revision to the Part A and Part B LCD

LCD ID number: L33755 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for susceptibility studies was revised to include ICD-10-CM diagnosis codes Z16.10, Z16.11, Z16.12 and Z16.19 in the "ICD-10 Codes that Support Medical Necessity" section of LCD for CPT® codes 87181, 87184, 87185, 87186, 87187, 87188 and 87190. Additionally, clarifying language referencing the *Medicare National Coverage Determination (NCD) Coding Policy Manual*, Section 190.12 – Urine Culture, Bacterial" was added in the "ICD-10 Codes that Support Medical Necessity" section in the LCD.



Effective date

The LCD revision is effective for claims processed **on or after April 5, 2017**, 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*.

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

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

The local coverage determination (LCD) for viscosupplementation therapy for knee was revised based on Change Request 10005 (April 2017 Update of the Hospital Outpatient Prospective Payment System [OPPS]). The LCD was revised to add HCPCS code J7328 in the "CPT®/HCPCS Codes" and "ICD-10 Codes that Support Medical Necessity" sections of the LCD for Part A.

Effective date

This LCD revision is effective for services rendered **on or after April 1, 2017**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

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.

Upcoming provider outreach and educational events

Medicare Speaks 2017 Miami

Date: Thursday-Friday, May 17-18
Time: 7:30 a.m.-4:15 p.m.
Type of Event: Face-to-face
https://medicare.fcso.com/Medicare_Speaks/0371640.asp

Ask-the-contractor teleconference (ACT): Chronic care management services (B)

Date: Wednesday, June 7
Time: 11:30 a.m.-1:00 p.m.
Type of Event: Webcast
https://medicare.fcso.com/Events/0366842.asp

Note: Unless otherwise indicated, designated times for educational events 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®

The Centers for Medicare & Medicaid Services (CMS) *MLN Connects®* 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® for March 23, 2017

MLN Connects® for March 23, 2017
View this edition as a PDF

News & Announcements

- Connected Care: New Educational Initiative to Raise Awareness of Chronic Care Management
- Quality Payment Program: New Materials
- IRF and LTCH Compare Quarterly Refresh

Provider Compliance

- Preventive Services CMS Provider Minute Video

Upcoming Events

- IMPACT Act: Standardized Patient Assessment Data Activities Call — March 29
- Medicare Shared Savings Program ACO: Preparing to Apply for the 2018 Program Year Call – April 6
- Open Payments: Prepare to Review Reported Data Call – April 13
- Medicare Shared Savings Program ACO: Completing the 2018 Application Process Call – April 19

Medicare Learning Network® Publications & Multimedia

- Provider Enrollment Revalidation: Cycle 2 MLN Matters® Article – Revised
- Medicare-Required SNF PPS Assessments Educational Tool – Revised
- Items and Services Not Covered under Medicare Booklet – Revised

The Medicare Learning Network®, MLN Connects®, and MLN Matters® are registered trademarks of the U.S. Department of Health and Human Services (HHS).

MLN Connects® for March 30, 2017

MLN Connects® for March 30, 2017
View this edition as a PDF

News & Announcements

- MIPS Annual Call for Measures and Activities through June 30
- CMS Voluntary Self-Referral Disclosure Protocol: New Form

Provider Compliance

- Billing For Stem Cell Transplants

Upcoming Events

- MIPS Cost Measure Development Listening Session – April 5
- Medicare Shared Savings Program ACO: Preparing to Apply for the 2018 Program Year Call – April 6
- Open Payments: Prepare to Review Reported Data Call – April 13
- Medicare Shared Savings Program ACO: Completing the 2018 Application Process Call – April 19
- Global Surgery: Required Data Reporting for Post-Operative Care Call – April 25
- Emergency Preparedness Requirements Final Rule Training Call — April 27

Medicare Learning Network® Publications & Multimedia

- NPI: What You Need to Know Booklet – New
- IRF-PAI Call: Video Presentation – New
- ESRD QIP Call: Follow-up Questions and Answers – New
- SNF Consolidated Billing Web-Based Training Course – Revised
- Remittance Advice Resources and FAQs Fact Sheet – Revised
- Reading a Professional Remittance Advice Booklet– Revised
- Medicare Home Health Benefit Booklet — Revised
- MLN Learning Management System – Booklet – Revised
- Medicare Enrollment for Physicians and Other Part B Suppliers Booklet – Reminder
- Medicare Enrollment for Institutional Providers Booklet – Reminder
- Safeguard Your Identity and Privacy Using PECOS Booklet – Reminder

The Medicare Learning Network®, MLN Connects®, and MLN Matters® are registered trademarks of the U.S. Department of Health and Human Services (HHS).

MLN Connects® for April 6, 2017

MLN Connects® for April 6, 2017
View this edition as a PDF

News & Announcements

- Clinical Laboratory Data Reporting: Enforcement Discretion
- Open Payments Program Year 2016 Review and Dispute Period Ends May 15
- MIPS Group Web Interface and CAHPS Reporting: Registration Period Open through June 30
- Home Health and LTCH Quality Reporting Program Review and Correct Reports Available
- 2018 Medicare Shared Savings Program: Notice of Intent to Apply Guidance Document Available
- April Quarterly Provider Update Available
- Help Prevent Alcohol Misuse or Abuse

Provider Compliance

- Lumbar Spinal Fusion CMS Provider Minute Video

Claims, Pricers & Codes

- Home Health Services Pre-Claim Review Demonstration Pause

Upcoming Events

- Open Payments: Prepare to Review Reported Data Call – April 13
- Medicare Shared Savings Program ACO: Completing the 2018 Application Process Call – April 19
- Global Surgery: Required Data Reporting for Post-Operative Care Call – April 25
- Emergency Preparedness Requirements Final Rule Training Call – April 27
- Hospice Quality Reporting Program: Public Reporting Webinar – April 27

Medicare Learning Network® Publications & Multimedia

- Denial of Home Health Payments When Required Patient Assessment Is Not Received: Additional Information MLN Matters® Article – New
- SNF Value-Based Purchasing Call: Audio Recording and Transcript – New
- Dementia Care Call: Audio Recording and Transcript – New
- Reading an Institutional RA Booklet – Revised
- PECOS for Physicians and Non-Physician Practitioners Booklet – Reminder

The Medicare Learning Network®, MLN Connects®, and MLN Matters® are registered trademarks of the U.S. Department of Health and Human Services (HHS)..

MLN Connects® for April 13, 2017

MLN Connects® for April 13, 2017
View this edition as a PDF

News & Announcements

- Accountable Health Communities Model: CMS Selects 32 Participants
- Mapping Medicare Disparities Tool: Identify Disparities in Chronic Disease
- Questions about Medicare Enrollment Revalidation?
- Administrative Simplification: New Fact Sheet and Infographic
- National Healthcare Decisions Day is April 16

Provider Compliance

- Billing for Ambulance Transports

Claims, Pricers & Codes

- April 2017 OPPS Pricer File

Upcoming Events

- Medicare Shared Savings Program ACO: Completing the 2018 Application Process Call — April 19
- Global Surgery: Required Data Reporting for Post-Operative Care Call — April 25
- Emergency Preparedness Requirements Final Rule Training Call — April 27
- IRF, LTCH, SNF QRP Review and Correct Reports Provider Training Webcast — May 2

Medicare Learning Network® Publications & Multimedia

- April 2017 Catalog Available
- Quality Payment Program in 2017: Pick Your Pace Web-Based Training Course — New
- 2017 Medicare Part C and Part D Reporting Requirements and Data Validation Web-Based Training Course — New
- Medicare Quarterly Provider Compliance Newsletter [Volume 7, Issue 3] Educational Tool — New
- IMPACT Act Call: Audio Recording and Transcript — New
- Educational Resources to Assist Chiropractors with Medicare Billing MLN Matters Article — Revised
- Home Health Prospective Payment System Booklet — Revised

The Medicare Learning Network®, MLN Connects®, and MLN Matters® are registered trademarks of the U.S. Department of Health and Human Services (HHS)..

MLN Connects® for April 20, 2017

MLN Connects® for April 20, 2017

View this edition as a PDF

News & Announcements

- 2018 Medicare Shared Savings Program: Submit Notice of Intent to Apply May 1 through 31
- IRF/LTCH/SNF QRP Data Due May 15
- Rural Community Hospital Demonstration: Submit Applications by May 17
- New Quality Payment Program Resources Available
- Revised CMS-588: Electronic Funds Transfer Authorization Agreement
- SNF QRP Quick Reference Guide Now Available
- Beneficiary Notice Initiative: New Email Address for Questions
- April is National Minority Health Month

Provider Compliance

- Psychiatry and Psychotherapy CMS Provider Minute Video

Upcoming Events

- Global Surgery: Required Data Reporting for Post-Operative Care Call — April 25
- Emergency Preparedness Requirements Final Rule Training Call — April 27
- IRF, LTCH, SNF QRP Review and Correct Reports Provider Training Webcast — May 2

Medicare Learning Network® Publications & Multimedia

- Medicare Shared Savings Program Call: Audio Recording and Transcript — New
- Provider Compliance Products Fact Sheet — Revised
- Provider Compliance Tips for Spinal Orthoses Fact Sheet — Revised
- SNF Billing Reference Booklet — Revised

CMS MLN Connects Provider eNews – special edition

Wednesday, April 5, 2017

Home health services pre-claim review demonstration pause

As of April 1, 2017, the pre-claim review demonstration for home health services is paused in Illinois and didn't expand to Florida. We will process claims under normal processing rules. The Centers for Medicare & Medicaid Services will notify providers at least 30 days in advance of further developments related to the demonstration. For more information, see the *Pre-Claim Review Demonstration* web page and *FAQs*.

USVI provider contact center hours of operation effective March 13

Effective Monday, March 13, 2017, the hours of availability for the provider contact center (PCC) for U.S. Virgin Islands providers are as indicated in this article. The hours for calling into First Coast's PCC are 8:00 a.m. - 4:00 p.m. atlantic standard time (AST). This change is due to the beginning of daylight saving time (DST) in the United States.

MSI reminder announcement: There is still time to evaluate our services

There is still time to share your experiences about the services we provide. Please complete the MAC Satisfaction Indicator (MSI) survey. These survey results will help us find ways to better serve you. *https://cfigroup.qualtrics.com/jfe/form/SV_3WeVjGWpc5NQXOJ?MAC_BRNC=9&MAC=JN – First Coast*

Phone numbers

Customer service

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

Education event registration hotline

904-791-8103 (NOT toll-free)

Electronic data interchange (EDI)

888-670-0940

Electronic funds transfers (EFT) (CMS-588)

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

Fax number (for general inquiries)

904-361-0696

Interactive voice response (IVR) system

877-847-4992

Provider enrollment

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

The SPOT help desk

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

Addresses

Claims

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

Redeterminations

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

Redetermination of overpayments

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

Reconsiderations

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

General inquiries

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

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

Provider enrollment

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

Medical policy

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

Medicare secondary payer

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

Electronic data interchange (EDI)

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

Overpayments

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

Medicare Education and Outreach

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

Fraud and abuse

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

Freedom of Information Act requests

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

Overnight mail and/or special courier service

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

Websites

Provider

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

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

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

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

Beneficiaries

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

Phone numbers

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

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

Electronic data interchange (EDI)
888-670-0940

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

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

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

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

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

Addresses

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Websites

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

http://medicare.fcso.com

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

Centers for Medicare & Medicaid Services

https://www.cms.gov

First Coast University

http://www.fcsouniversity.com/

Beneficiaries
Centers for Medicare & Medicaid Services

https://www.medicare.gov

Phone numbers

Customer service

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

Education event registration hotline

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

Electronic data interchange (EDI)

888-875-9779

Electronic funds transfers (EFT) (CMS-588)

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

General inquiries

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

Interactive voice response (IVR) system

877-847-4992

Provider enrollment

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

The SPOT help desk

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

Addresses

Claims

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

Redeterminations

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

Redetermination of overpayments

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

Reconsiderations

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

General inquiries

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

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

Provider enrollment

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

Medical policy

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

Medicare secondary payer

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

Electronic data interchange (EDI)

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

Overpayments

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

Medicare Education and Outreach

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

Fraud and abuse

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

Freedom of Information Act requests

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

Special courier service

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

Websites

Provider

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

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

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

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

Beneficiaries

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

Order form for Medicare Part B materials

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

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

Item	Acct Number	Cost per item	Quantity	Total cost
Part B subscription – The Medicare Part B jurisdiction N publications, in both Spanish and English, are available free of charge online at *http://medicare.fcso.com/Publications_B/index.asp* (English) or *http://medicareespanol.fcso.com/Publicaciones/* (Español). Nonprovider entities or providers who need additional copies may purchase an annual subscription. This subscription includes all issues published from October 2016 through September 2017.	40300260	$33		
2017 fee schedule – The Medicare Part B Physician and Nonphysician Practitioner Fee Schedules, effective for services rendered January 1 through December 31, 2017, are available free of charge online at *http://medicare.fcso.com/Data_files/* (English) or *http://medicareespanol.fcso.com/Fichero_de_datos/* (Español). Additional copies are available for purchase. The fee schedules contain payment rates for all localities. These items do not include the payment rates for injectable drugs, clinical lab services, mammography screening, or DMEPOS items. **Note:** Requests for hard copy paper disclosures will be completed as soon as CMS provides the direction to do so. Revisions to fees may occur; these revisions will be published in future editions of the Medicare Part B publication.	40300270	$12		
Language preference: **English** [ ] **Español** [ ]				
Please write legibly			Subtotal	$
			Tax (***add % for your area***)	$
			Total	$

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

Contact Name: _____

Provider/Office Name: _____

Phone: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

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