Medicare B
CONNECTION

A Newsletter for MAC Jurisdiction 9 Providers

January 2013

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Providers welcome major improvements to the Internet-based PECOS system

Health care providers seeking to enroll in Medicare or update their information can more easily do so thanks to major improvements to Medicare's Provider Enrollment, Chain and Ownership System (PECOS).

Internet-based PECOS facilitates the Medicare provider enrollment process by giving health care providers a more efficient alternative to submitting and updating their enrollment in Medicare. Based on feedback from the medical community in 2012, the Centers for Medicare & Medicaid Services (CMS) expanded the types and number of transactions providers may conduct through PECOS.

PECOS advantages

Providers who move or change any of their practice information are required to update this information with Medicare. Prior to the development of Internet-based PECOS, providers would have to submit paper applications. The upgrades to PECOS have eliminated the need for paper applications for most providers.

One of the biggest benefits providers and their authorized delegate will notice from the recent enhancements to PECOS is the ability to provide an electronic signature and submit supporting documentation for provider enrollment.

Providers will notice other benefits including:

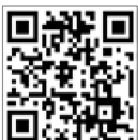
- A simplified screen view called "My Enrollments" showing a provider's enrollment information;
- Provider/supplier's enrollment information pertaining to their last electronic submission; and
- View new or in-progress applications that display the provider's enrollment information as its being edited in PECOS

PECOS tools to use

On the "My Enrollments" page, providers and their delegates can generate reassignment reports displaying up to 50 records of assigned benefits. In addition, CMS has updated the tutorial videos on the PECOS homepage to illustrate how to take advantage of the system improvements.

Links to get started in PECOS

More information about provider enrollment is available on the CMS website. CMS has highlighted the advantages of using Internet-based PECOS and established a dedicated page for providers to register for the first time or login to the PECOS system.



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

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

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About the *Medicare B Connection*

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

Important notifications that require communication in between publications will be posted to the First Coast Medicare provider education website *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 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.

Advance beneficiary notices

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

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

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

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

Patient liability notice

The Centers for Medicare & Medicaid Services' (CMS) has developed the Advance Beneficiary Notice of Noncoverage (ABN) (Form CMS-R-131), formerly the "Advance Beneficiary Notice." Section 50 of the *Medicare Claims Processing Manual* provides instructions regarding the notice that these providers issue to beneficiaries in advance of initiating, reducing, or terminating what they believe to be noncovered items or services. The ABN must meet all of the standards found in Chapter 30. Beginning March 1, 2009, the ABN-G and ABN-L was no longer valid; and notifiers must use the revised Advance Beneficiary Notice of Noncoverage (CMS-R-131). Section 50 of the *Medicare Claims Processing Manual* is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c30.pdf#page=44.*

Reproducible copies of Form CMS-R-131 ABNs (in English and Spanish) and other BNI information may be found at *http://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html*.

ABN modifiers

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

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

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

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

GA modifier and appeals

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

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

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

Quarterly update to the correct coding initiative edits, version 19.0, effective January 1, 2013

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8135 which informs Medicare contractors about the quarterly updates to correct coding initiative (CCI) edits. The last quarterly release of the edit module was issued in October 2012.

Make sure that your billing staffs are aware of these changes. See the *Background* and *Additional information* sections of this article for further details regarding these changes.

Background

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

The coding policies developed are based on coding conventions defined in the:

- American Medical Association's (AMA's) *Current Procedural Terminology®* (*CPT®*) Manual
- National and local policies and edits
- Coding guidelines developed by national societies
- Analysis of standard medical and surgical practice, and by
- Review of current coding practice.

The latest package of CCI edits, version 19.0, is effective January 1, 2013, and includes all previous versions and updates from January 1, 1996, to the present. It will be organized in the following two tables:

- Column 1/ Column 2 Correct Coding Edits
- Mutually Exclusive Code (MEC) Edits

Additional information about CCI, including the current CCI and MEC edits, is available at *http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html*.

Additional information

The official instruction, CR 8135, issued to your carrier and A/B MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2617CP.pdf*.

If you have any questions, please contact your carrier or A/B MAC at their toll-free number, which may be found at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html*.

MLN Matters® Number: MM8135
Related Change Request (CR) #: CR 8135
Related CR Release Date: December 21, 2012
Effective Date: January 1, 2013
Related CR Transmittal #: R2617CP
Implementation Date: January 7, 2013

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Ambulance

Ambulance inflation factor for CY 2013 and productivity adjustment

Provider types affected

This *MLN Matters*® article is intended for providers and suppliers of ambulance services who bill Medicare carriers, fiscal intermediaries (FIs), or Part A/B Medicare administrative contractors (A/B MACs) for those services provided to Medicare beneficiaries.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 8156 to alert providers of the updates to the ambulance inflation factor (AIF) for calendar year (CY) 2013 so that Medicare carriers, FIs, and A/B MACs can accurately determine the payment amounts for ambulance services. The AIF for CY 2013 is 0.8 percent. Please ensure that your billing staffs are aware of this 2013 AIF.

Background

Section 1834(l) (3) (B) of the Social Security Act (the Act) provides the basis for updating the payment limits that carriers, FIs, and A/B MACs use to pay for the claims that you submit for ambulance services. Specifically, this section of the Act provides for a yearly payment update that is equal to the percentage increase in the urban consumer price index (CPI-U), for the 12-month period ending with June of the prior year.

On March 23, 2010, Section 3401 of the Affordable Care Act amended Section 1834(l)(3) of the Act to require that specific prospective payment system and fee schedule update factors be adjusted by changes in economy-wide productivity. The statute defines the productivity adjustment to be equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity (MFP) (as projected by the Secretary for the 10-year period ending with the applicable fiscal year, cost reporting period, or other annual period). The MFP for CY 2013 is 0.90 percent and the CPI-U for 2013 is 1.70 percent. According to the Affordable Care Act, the CPI-U is reduced by the MFP, even if this reduction results in a negative AIF update. Therefore, the AIF for CY 2013 is 0.80 percent.

Note: Part B coinsurance and deductible requirements apply to payments under the ambulance fee schedule.

Additional information

You can find the official instruction, CR 8156, issued to your carrier, FI, or A/B MAC by visiting *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2620CP.pdf*.

If you have any questions, please contact your carrier, FI, or A/B MAC at their toll-free number, which may be found at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html*.

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Ambulatory Surgery Center

January 2013 update of the ambulatory surgery center payment system

Provider types affected

This *MLN Matters*® article is intended for ambulatory surgery centers (ASCs) submitting claims to Medicare contractors (carriers or Part B Medicare administrative contractors (B MACs)), for ASC payment system-paid services provided to Medicare beneficiaries.

What you need to know

Change request (CR) 8148, from which this article is taken, describes changes to, and billing instructions for, payment policies implemented in the January 2013 ASC payment system update. It also includes updates to the Healthcare Common Procedure Coding System (HCPCS).

Included in CR 8148 are calendar year (CY) 2013 payment rates for separately payable drugs and biologicals, including long descriptors for newly created Level II HCPCS codes for drugs and biologicals (ASC DRUG files), and the CY 2013 ASC payment rates for covered surgical and ancillary services (ASCFS file).

Many ASC payment rates under the ASC payment system are established using payment rate information in the Medicare physician fee schedule (MPFS). The payment files associated with CR 8148 reflect the most recent changes to CY 2013 MPFS payment. You can learn more about the MPFS at *http://www.cms.gov/apps/physician-fee-schedule/*.

Key points of CR 8148

New procedure codes

CMS is establishing one new HCPCS procedure code for ASC use effective January 1, 2013. The following table provides a listing of the descriptor and payment indicator (PI) for the new code.

New HCPCS procedure code – effective January 1, 2013

HCPCS	Effective date	Short descriptor	Long descriptor	CY2013 PI
G0458	01-01-13	LDR pros brachy comp rat	Low dose rate (ldr) prostate brachytherapy services, composite rate	G2

Billing for drugs, biologicals, and radiopharmaceuticals

Reporting HCPCS codes for all drugs, biologicals, and radiopharmaceuticals

CMS strongly encourages ASCs to report charges for all separately payable drugs and biologicals, using the correct HCPCS codes for the items used. Many HCPCS codes, including those for drugs, biologicals, and radiopharmaceuticals, have undergone changes in their HCPCS and *CPT*® code descriptors that will be effective in CY 2013. In addition, several temporary HCPCS C-codes have been deleted effective December 31, 2012, and replaced with permanent HCPCS codes in CY 2013.

Further, you should pay close attention to accurate billing for units of service consistent with the dosages contained in the long descriptors of the active CY 2013 HCPCS codes. You should not report HCPCS codes and separate charges for drugs and biologicals that receive packaged payment through the payment for the associated covered surgical procedure.

HCPCS payment updates are posted quarterly at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html*.

Drugs and biologicals with payment based on average sales price – effective January 1, 2013

Payments for separately payable drugs and biologicals based on the average sales prices (ASPs) are updated quarterly, as later quarter ASP submissions become available. Effective January 1, 2013, payment rates for many covered ancillary drugs and biologicals have (OPPS)/ASC final rule with comment period, as a result of the new ASP calculations based on sales price submissions from the third quarter of CY 2012. In cases where adjustments to payment rates are necessary, the updated payment rates will be incorporated in the January 2013 release of the ASC DRUG file. CMS is not publishing the updated payment rates in this CR implementing the

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ASC *(continued)*

January 2013 update of the ASC payment system. However, the updated payment rates effective January 1, 2013 for covered ancillary drugs and biologicals can be found in the January 2013 update of the ASC Addendum BB, at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html*.

New CY 2013 HCPCS codes and dosage descriptors for certain drugs, biologicals, and radiopharmaceuticals

For CY 2013, several new HCPCS codes have been created for reporting drugs and biologicals in the ASC setting, where there have not previously been specific codes available. These new codes are listed in the following table.

New CY 2013 HCPCS codes effective for certain drugs, biologicals, and radiopharmaceuticals – effective January 1, 2013

CY 2013 HCPCS code	CY 2013 Long descriptor	CY 2013 PI
C9294	Injection, taliglucerase alfa, 10 units	K2
C9295	Injection, carfilzomib, 1 mg	K2
C9296	Injection, ziv-aflibercept, 1 mg	K2
J1744	Injection, icatibant, 1 mg	K2
J2212	Injection, methylnaltrexone, 0.1 mg	K2
J7315	Mitomycin, opthalmic, 0.2 mg	N1

Discontinued CY 2012 HCPCS and other changes to CY 2013 HCPCS for certain drugs, biologicals, and radiopharmaceuticals

The following table notes those drugs, biologicals, and radiopharmaceuticals that have undergone changes in their HCPCS codes and/or their long descriptors. Each product's CY 2012 HCPCS code and CY 2012 long descriptors are noted in the two left-hand columns, and the CY 2013 HCPCS code and long descriptors are noted in the adjacent right-hand columns.

Effective December 31, 2012, the type of service (TOS) F (ambulatory surgical center) records for HCPCS C9279, C9286-C9289, C9366, C9368, C9369, J1051, J8561, and Q2045-Q2048 will be removed to prevent claims from incorrectly processing as ASC approved services for dates of service (DOS) on/after January 1, 2013.

Discontinued CY 2012 HCPCS and other CY 2013 HCPCS and *CPT* code changes for certain drugs, biologicals, and radiopharmaceuticals – effective January 1, 2013

CY 2012 HCPCS code	CY 2012 Long descriptor	CY 2013 HCPCS code	CY 2013 Long descriptor
C9286	Injection, belatacept, 1 mg	J0485	Injection, belataccept, 1 mg
C9287	Injection, brentuximab vedotin, 1 mg	J9042	Injection, brentuximab vedotin, 1 mg
C9288	Injection, centruroides (scorpion) immune f(ab)2 (equine), 1 vial	J0716	Injection, centruroides immune f(ab)2, up to 120 milligrams
C9289	Injection, asparaginase erwinia chrysanthemi, 1,000 international units (i.u.)	J9019	Injection, asparaginase (Erwinaze), 1,000 IU
C9366	EpiFix, per square centimeter	Q4131	Epifix, per square centimeter
C9368	Grafix core, per square centimeter	Q4132	Grafix core, per square centimeter
C9369	Grafix prime, per square centimeter	Q4133	Grafix prime, per square centimeter
J8561	Everolimus, oral, 0.25 mg	J7527	Everolimus, oral, 0.25 mg
J9020	Injection, asparaginase, 10,000 units	J9020	Injection, Asparaginase, Not Otherwise Specified, 10,000 Units
J9280	Mitomycin, 5 mg	J9280	Injection, mitomycin, 5 mg
Q2045*	Injection, human fibrinogen concentrate, 1 mg	J7178	Injection, human fibrinogen concentrate, 1 mg
Q2046**	Injection, aflibercept, 1 mg	J0178	Injection, aflibercept, 1 mg

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ASC *(continued)*

CY 2012 HCPCS code	CY 2012 Long descriptor	CY 2013 HCPCS code	CY 2013 Long descriptor
Q2048***	Injection, doxorubicin hydrochloride, liposomal, doxil, 10 mg	J9002	Injection, doxorubicin hydrochloride, liposomal, doxil, 10 mg
Q4119	Matristem wound matrix, per square centimeter	Q4119	Matristem wound matrix, psmx, rs, or psm, per square centimeter
Q4128	Flexhd or allopatch hd, per square centimeter	Q4128	Flex hd, allopatch hd, or matrix hd, per square centimeter

*HCPCS code J1680 was replaced with HCPCS code Q2045 effective July 1, 2012. HCPCS code Q2045 was subsequently replaced with HCPCS code J7178, effective January 1, 2013.

**HCPCS code C9291 was replaced with HCPCS code Q2046 effective July 1, 2012. HCPCS code Q2046 was subsequently replaced with HCPCS code J0178, effective January 1, 2013.

***HCPCS code J9001 was replaced with HCPCS code Q2048 effective July 1, 2012. HCPCS code Q2048 was subsequently replaced with HCPCS code J9002, effective January 1, 2013.

Updated payment rates for certain HCPCS codes – effective April 1, 2012, through June 30, 2012

The payment rate for one HCPCS code was incorrect in the April 2012 ASC drug file. The corrected payment rate is listed in the following table and has been included in the revised April 2012 ASC Drug file, effective for services furnished on April 1, 2012, through implementation of the July 2012 update.

Updated payment rates for certain HCPCS codes – effective April 1, 2012, through June 30, 2012

HCPCS code	Short descriptor	Corrected payment rate
Q4112	Cymetra allograft	$271.12

Providers who think they may have received an incorrect payment between April 1, 2012, and June 30, 2012, may request contractor adjustment of the previously processed claims.

Updated payment rates for certain HCPCS codes – effective July 1, 2012, through September 30, 2012

The payment rate for one HCPCS code was incorrect in the July 2012 ASC drug file. The corrected payment rate is listed in the following table; and has been included in the revised July 2012 ASC Drug file, effective for services furnished on July 1, 2012, through implementation of the October 2012 update.

Updated payment rates for certain HCPCS codes – effective July 1, 2012, through September 30, 2012

HCPCS code	Short descriptor	Corrected payment rate
Q4112	Cymetra allograft	$323.65

Providers who think they may have received an incorrect payment between July 1, 2012, and September 30, 2012, may request contractor adjustment of the previously processed claims.

Payment when a device is furnished with no cost or with full or partial credit

For CY 2013, CMS updated the list of ASC covered devices and device intensive procedures that are subject to the no cost/full credit and partial credit device adjustment policy. Contractors will reduce the payment for the device implantation procedures listed in Attachment A of CR 8148 by the full device offset amount for no cost/full credit cases.

You must append the modifier "FB" (Item provided without cost to provider, supplier or practitioner, or full credit received for replaced device (including: covered under warranty, replaced due to defect and free samples)) to the HCPCS procedure code when the device furnished without cost or with full credit is listed in Attachment B of CR 8148, and the associated implantation procedure code is listed in Attachment A. CR 8148 is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2626CP.pdf*.

In addition, contractors will reduce the payment for implantation procedures listed in Attachment A of CR 8148 by one half of the device offset amount that would be applied if a device were provided at no cost or with full credit, if the credit to the ASC is 50 percent or more of the device cost. If you receive a partial credit of 50 percent or more of the cost of a device listed in Attachment B, you must append the modifier "FC" (Partial credit received for replaced device) to the associated implantation procedure code if the procedure is listed in Attachment A. You should not submit a single procedure code with both modifiers "FB" and "FC."

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ASC *(continued)*

More information regarding billing for procedures involving no cost/full credit and partial credit devices is available in the *Medicare Claims Processing Manual*, Chapter 14 (Ambulatory Surgical Centers), Section 40.8 (Payment When a Device is Furnished With No Cost or With Full or Partial Credit Beginning January 1, 2008), which you can find at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c14.pdf.

Note: The fact that a drug, device, procedure, or service is assigned a HCPCS code and a payment rate under the ASC payment system does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the program. Carriers/MACs determine whether a drug, device, procedure, or other service meets all program requirements for coverage.

Additional information

The official instruction, CR 8148, issued to your carrier and B MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2626CP.pdf.

It contains the following attachments:

1) Attachment A: POLICY SECTION TABLES
2) Attachment B: CY 2013 ASC COVERED SURGICAL PROCEDURES AND ANCILLARY SERVICES THAT ARE NEWLY PAYABLE IN ASCs
3) Attachment C: CY 2013 ASC PROCEDURES TO WHICH THE NO COST/FULL CREDIT AND PARTIAL CREDIT DEVICE ADJUSTMENT POLICY APPLIES
4) Attachment D: CY 2013 DEVICES FOR WHICH THE “ FB” OR “ FC” MODIFIER MUST BE REPORTED WITH THE ASC PROCEDURE CODE WHEN FURNISHED AT NO COST OR WITH FULL OR PARTIAL CREDIT

If you have any questions, please contact your carrier or B MAC at their toll-free number, which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html.

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Durable Medical Equipment

Calendar year 2013 update for DMEPOS fee schedule

Note: This article was revised on January 14, 2013, to reflect the revised change request (CR) 8133 issued on January 11. The CR release date, transmittal number, and Web address were revised. All other information remains the same. This information was previously published in the December 2012 *Medicare B Connection*, Pages 8-10.

Provider types affected

This *MLN Matters*® article is intended for providers and suppliers submitting claims to Medicare carriers, fiscal intermediaries (FIs), Part A/B Medicare administrative contractors (A/B MACs), or regional home health intermediaries (RHHIs) for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) items or services paid under the DMEPOS fee schedule.

What you need to know

The Centers for Medicare & Medicaid Services (CMS) issued CR 8133 to advise providers of the calendar year (CY) 2013 annual update for the Medicare DMEPOS fee schedule.

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DMEPOS *(continued)*

The instructions include information on the data files, update factors, and other information related to the update of the DMEPOS fee schedule. Be sure your staffs are aware of these updates.

Background and key points of CR 8133

The DMEPOS fee schedules are updated on an annual basis in accordance with statute and regulations. The update process for the DMEPOS fee schedule is located in the *Medicare Claims Processing Manual*, Chapter 23, Section 60, which is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf*.

Payment on a fee schedule basis is required for durable medical equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by Section 1834(a), (h), and (i) of the Social Security Act (the Act). Also, payment on a fee schedule basis is a regulatory requirement at 42 CFR 414.102 for parenteral and enteral nutrition (PEN).

Fee schedule files

The DMEPOS fee schedule file will also be available for state Medicaid agencies, managed care organizations, and other interested parties at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/index.html*.

Healthcare Common Procedure Coding System (HCPCS) codes added/deleted

The following new codes are effective as of January 1, 2013:

- A4435 in the ostomy, tracheostomy, and urological supplies (OS) payment category
- E0670 and E2378 in the inexpensive/routinely purchased (IN) payment category
- L5859, L7902 and L8605 in the prosthetics and orthotics (PO) payment category, and
- V5281 – V5290 (67).

The fee schedule amounts for codes E2378, L5859, L7902 will be established as part of the July 2013 DMEPOS fee schedule update, when applicable. Also when applicable, DME MACs will establish local fee schedule amounts to pay claims for the new codes from January 1, 2013, through June 30, 2013. The new codes are not to be used for billing purposes until they are effective on January 1, 2013.

For gap-filling purposes, the 2012 deflation factors by payment category are listed in the following table:

Factor	Category
0.477	Oxygen
0.480	Capped rental
0.482	Prosthetics and orthotics
0.611	Surgical dressings
0.665	Parenteral and enteral nutrition

Specific coding and pricing issues

1. The fee schedule amounts for shoe modification codes A5503 through A5507 are adjusted to reflect more current allowed service data. Section 1833(o)(2)(C) of the Act required that the payment amounts for shoe modification codes A5503 through A5507 be established in a manner that prevented a net increase in expenditures when substituting these items for therapeutic shoe insert codes (A5512 or A5513). To establish the fee schedule amounts for the shoe modification codes, the base fees for codes A5512 and A5513 were weighted based on the approximated total allowed services for each code for items furnished during the second quarter of calendar year 2004. For 2013, CMS is updating the weighted average insert fees used to establish the fee schedule amounts for the shoe modification codes with more current allowed service data for each insert code. The base fees for A5512 and A5513 are weighted based on the approximated total allowed services for each code for items furnished during the calendar year 2011. The fee schedule amounts for shoe modification codes A5503 through A5507 are being revised to reflect this change, effective January 1, 2013.

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DMEPOS *(continued)*

2. Effective January 1, 2013, new code L8605 (Injectable bulking agent, dextranomer/hyaluronic acid copolymer implant, anal canal, 1 ML) is being added to the HCPCS code set. This code falls under the claim processing jurisdiction of local carriers rather than the DME MACs. Fee schedule amounts for this code are added as part of this update.

CY2013 fee schedule update factor

For CY 2013, the update factor of 0.8 percent is applied to the applicable CY 2012 DMEPOS fee schedule amounts. In accordance with the statutory Sections 1834(a)(14) and 1886(b)(3)(B)(II) of the Act, the DMEPOS fee schedule amounts are to be updated for 2013 by the percentage increase in the consumer price index (CPI) for all urban (U) consumers (United States city average), CPI-U, for the 12-month period ending with June of 2012, adjusted by the change in the economy-wide productivity equal to the 10-year moving average of changes in annual economy-wide private non-farm business multi-factor productivity (MFP).

The MFP adjustment is 0.9 percent and the CPI-U percentage increase is 1.7 percent. Thus, the 1.7 percentage increase in the CPI-U is reduced by the 0.9 percent MFP adjustment resulting in a net increase of 0.8 percent for the 2013 MFP-adjusted update factor.

2013 update to labor payment rates

2013 fees for HCPCS labor payment codes K0739, L4205, and L7520 are increased 1.7 percent effective for dates of service on or after January 1, 2013, through December 31, 2013, and those rates are as follows:

State	K0739	L4205	L7520	State	K0739	L4205	L7520
AK	$26.92	$30.67	$36.08	MT	$14.29	$21.28	$36.08
NJ	$19.28	$21.28	$28.91	NC	$14.29	$21.30	$28.91
AL	$14.29	$21.30	$28.91	ND	$17.81	$30.61	$36.08
AR	$14.29	$21.30	$28.91	NE	$14.29	$21.28	$40.31
AZ	$17.67	$21.28	$35.57	NH	$15.34	$21.28	$28.91
CA	$21.93	$34.96	$40.75	NJ	$19.28	$21.28	$28.91
CO	$14.29	$21.30	$28.91	NM	$14.29	$21.30	$28.91
CT	$23.87	$21.77	$28.91	NV	$22.77	$21.28	$39.41
DC	$14.29	$21.28	$28.91	NY	$26.32	$21.30	$28.91
DE	$26.32	$21.28	$28.91	OH	$14.29	$21.28	$28.91
FL	$14.29	$21.30	$28.91	OK	$14.29	$21.30	$28.91
GA	$14.29	$21.30	$28.91	OR	$14.29	$21.28	$41.57
HI	$17.67	$30.67	$36.08	PA	$15.34	$21.91	$28.91
IA	$14.29	$21.28	$34.61	PR	$14.29	$21.30	$28.91
ID	$14.29	$21.28	$28.91	RI	$17.03	$21.93	$28.91
IL	$14.29	$21.28	$28.91	SC	$14.29	$21.30	$28.91
IN	$14.29	$21.28	$28.91	SD	$15.97	$21.28	$38.65
KS	$14.29	$21.28	$36.08	TN	$14.29	$21.30	$28.91
KY	$14.29	$27.27	$36.97	TX	$14.29	$21.30	$28.91
LA	$14.29	$21.30	$28.91	UT	$14.33	$21.28	$45.02
MA	$23.87	$21.28	$28.91	VA	$14.29	$21.28	$28.91
MD	$14.29	$21.28	$28.91	VI	$14.29	$21.30	$28.91
ME	$23.87	$21.28	$28.91	VT	$15.34	$21.28	$28.91
MI	$14.29	$21.28	$28.91	WA	$22.77	$31.21	$37.07
MN	$14.29	$21.28	$28.91	WI	$14.29	$21.28	$28.91
MO	$14.29	$21.28	$28.91	WV	$14.29	$21.28	$28.91
MS	$14.29	$21.30	$28.91	WY	$19.92	$28.38	$40.31

2013 national monthly payment amounts for stationary oxygen equipment

CR 8133 implements the 2013 national monthly payment amount for stationary oxygen equipment (HCPCS codes E0424, E0439, E1390, and E1391), effective for claims with dates of service on or after January 1, 2013. As required by statute, the payment amount must be adjusted on an annual basis, as necessary, to ensure budget neutrality of the payment class for oxygen generating portable equipment (OGPE).

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DMEPOS *(continued)*

The updated 2013 monthly payment amount of $177.36 includes the 0.8 percent update factor for the 2013 DMEPOS fee schedule.

Please note that when the stationary oxygen equipment fees are updated, corresponding updates are made to the fee schedule amounts for HCPCS codes E1405 and E1406 for oxygen and water vapor enriching systems. Since 1989, the fees for codes E1405 and E1406 have been established based on a combination of the Medicare payment amounts for stationary oxygen equipment and nebulizer codes E0585 and E0570, respectively.

2013 maintenance and servicing payment for certain oxygen equipment

CR 8133 also updates the 2013 payment amount for maintenance and servicing for certain oxygen equipment.

You can read more about payment for claims for maintenance and servicing of oxygen equipment in *MLN Matters*® articles, MM6792, which is at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6792.pdf* and MM6990, which is at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6990.pdf*.

To summarize, payment for maintenance and servicing of certain oxygen equipment can occur every six months beginning six months after the end of the 36th month of continuous use or end of the supplier's or manufacturer's warranty, whichever is later for either HCPCS code E1390, E1391, E0433, or K0738, billed with the "MS" modifier. Payment cannot occur more than once per beneficiary, regardless of the combination of oxygen concentrator equipment and/or transfilling equipment used by the beneficiary, for any 6-month period.

Per 42 CFR Section 414.210(5) (iii), the 2010 maintenance and servicing fee for certain oxygen equipment was based on 10 percent of the average price of an oxygen concentrator. For CY 2011 and subsequent years, the maintenance and servicing fee is adjusted by the covered item update for DME as set forth in Section1834(a)(14) of the Act. Thus, the 2012 maintenance and servicing fee is adjusted by the 0.8 percent MFP-adjusted covered item update factor to yield CY 2013 maintenance and servicing fee of $68.05 for oxygen concentrators and transfilling equipment.

Additional information

You can find the official instruction, CR 8133, issued to your FI, carrier, RHHI, or A/B MAC by visiting *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2632CP.pdf*.

If you have any questions, please contact your FI, carrier, RHHI, or A/B MAC at their toll-free number, which may be found at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html*.

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

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Find the fee schedule information you need fast - with First Coast's fee schedule lookup, located at *http://medicare.fcso.com/Fee_lookup/fee_schedule.asp.* This exclusive online resource features an intuitive interface that allows you to search for fee information by procedure code. Plus, you can find any associated local coverage determinations (LCDs) with just the click of a button.

2013 DMEPOS jurisdiction listing

This article is informational and is based on change request (CR) 8164 that notifies providers that the spreadsheet containing an updated list of the healthcare common procedure coding system (HCPCS) codes for durable medical equipment Medicare administrative contractor (DME MAC) and Part B local carrier or A/B MAC jurisdictions is updated annually to reflect codes that have been added or discontinued (deleted) each year. The spreadsheet is helpful to billing staff by showing the appropriate Medicare contractor to be billed for HCPCS appearing on the spreadsheet. The spreadsheet for the 2013 jurisdiction list is attached to CR 8164 at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2637CP.pdf*. **Note that deleted codes are valid for dates of service on or before the date of deletion and updated codes are in bold. The jurisdiction list includes codes that are not payable by Medicare. Please consult the Medicare contractor in whose jurisdiction a claim would be filed in order to determine coverage under Medicare.**

HCPCS	Description	Jurisdiction
A0021-A0999	Ambulance services	Local carrier
A4206-A4209	Medical, surgical, and self-administered injection supplies	Local carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A4210	Needle-free injection device	DME MAC
A4211	Medical, surgical, and self-administered injection supplies	Local carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A4212	Non-coring needle or stylet with or without catheter	Local carrier
A4213-A4215	Medical, surgical, and self-administered injection supplies	Local carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A4216-A4218	Saline	Local carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A4220	Refill kit for implantable pump	Local carrier
A4221-A4250	Medical, surgical, and self-administered injection supplies	Local carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A4252-A4259	Diabetic supplies	DME MAC
A4261	Cervical cap for contraceptive use	Local carrier
A4262-A4263	Lacrimal duct implants	Local carrier
A4264	Contraceptive implant	Local carrier
A4265	Paraffin	Local carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A4266-A4269	Contraceptives	Local carrier
A4270	Endoscope sheath	Local carrier
A4280	Accessory for breast prosthesis	DME MAC
A4281-A4286	Accessory for breast pump	DME MAC
A4290	Sacral nerve stimulation test lead	Local carrier
A4300-A4301	Implantable catheter	Local carrier
A4305-A4306	Disposable drug delivery system	Local carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A4310-A4358	Incontinence supplies/urinary supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the local carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME MAC.

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Jurisdiction *(continued)*

HCPCS	Description	Jurisdiction
A4360-A4435	Urinary supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the local carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME MAC.
A4450-A4456	Tape; adhesive remover	Local carrier if incident to a physician's service (not separately payable), or if supply for implanted prosthetic device. If other, DME MAC.
A4458	Enema bag	DME MAC
A4461-A4463	Surgical dressing holders	Local carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A4465-A4466	Non-elastic binder and elastic garment	DME MAC
A4470	Gravlee jet washer	Local carrier
A4480	Vabra aspirator	Local carrier
A4481	Tracheostomy supply	Local carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A4483	Moisture exchanger	DME MAC
A4490-A4510	Surgical stockings	DME MAC
A4520	Diapers	DME MAC
A4550	Surgical trays	Local carrier
A4554	Disposable underpads	DME MAC
A4556-A4558	Electrodes; lead wires; conductive paste service	Local carrier if incident to a physician's (not separately payable). If other, DME MAC.
A4559	Coupling gel	Local carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A4561-A4562	Pessary	Local carrier
A4565	Sling	Local carrier
A4566	Shoulder abduction restrainer	DME MAC
A4570	Splint	Local carrier
A4575	Topical hyperbaric oxygen chamber, disposable	DME MAC
A4580-A4590	Casting supplies & material	Local carrier
A4595	TENS supplies	Local carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A4600	Sleeve for intermittent limb compression device	DME MAC
A4601	Lithium Ion battery for non-prosthetic use	DME MAC
A4604	Tubing for positive airway pressure device	DME MAC
A4605	Tracheal suction catheter	DME MAC
A4606	Oxygen probe for oximeter	DME MAC
A4608	Transtracheal oxygen catheter	DME MAC
A4611-A4613	Oxygen equipment batteries and supplies	DME MAC
A4614	Peak flow rate meter	Local carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A4615-A4629	Oxygen & tracheostomy supplies	Local carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A4630-A4640	DME supplies	DME MAC

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Jurisdiction *(continued)*

HCPCS	Description	Jurisdiction
A4641-A4642	Imaging agent; contrast material	Local carrier
A4648	Tissue marker, implanted	Local carrier
A4649	Miscellaneous surgical supplies	Local carrier if incident to a physician's service (not separately payable), or if supply for implanted prosthetic device or implanted DME. If other, DME MAC.
A4650	Implantable radiation dosimeter	Local carrier
A4651-A4932	Supplies for ESRD	DME MAC (not separately payable)
A5051-A5093	Additional ostomy supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the local carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME MAC.
A5102-A5200	Additional incontinence and ostomy supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the local carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME MAC.
A5500-A5513	Therapeutic shoes	DME MAC
A6000	Non-contact wound warming cover	DME MAC
A6010-A6024	Surgical dressing	Local carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other, DME MAC.
A6025	Silicone gel sheet	Local carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other, DME MAC.
A6154-A6411	Surgical dressing	Local carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other, DME MAC.
A6412	Eye patch	Local carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other, DME MAC.
A6413	Adhesive bandage	Local carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other, DME MAC.
A6441-A6512	Surgical dressings	Local carrier if incident to a physician's service (not separately payable), or if supply for implanted prosthetic device or implanted DME. If other, DME MAC.
A6513	Compression burn mask	DME MAC
A6530-A6549	Compression gradient stockings	DME MAC
A6550	Supplies for negative pressure wound therapy electrical pump	DME MAC
A7000-A7002	Accessories for suction pumps	DME MAC

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Jurisdiction *(continued)*

HCPCS	Description	Jurisdiction
A7003-A7039	Accessories for nebulizers, aspirators, and ventilators	DME MAC
A7040-A7041	Chest drainage supplies	Local carrier
A7042-A7043	Pleural catheter	Local carrier
A7044-A7046	Respiratory accessories	DME MAC
A7501-A7527	Tracheostomy supplies	DME MAC
A8000-A8004	Protective helmets	DME MAC
A9150	Non-prescription drugs	Local carrier
A9152-A9153	Vitamins	Local carrier
A9155	Artificial saliva	Local carrier
A9180	Lice infestation treatment	Local carrier
A9270	Noncovered items or services	DME MAC
A9272	Disposable wound suction pump	DME MAC
A9273	Hot water bottles, ice caps or collars, and heat and/or cold wraps	DME MAC
A9274-A9278 Glucose monitoring	DME MAC	
A9279	Monitoring feature/device	DME MAC
A9280	Alarm device	DME MAC
A9281	Reaching/grabbing device	DME MAC
A9282	Wig	DME MAC
A9283	Foot off loading device	DME MAC
A9284	Non-electric spirometer	DME MAC
A9300	Exercise equipment	DME MAC
A9500-A9700	Supplies for radiology procedures	Local carrier
A9900	Miscellaneous DME supply or accessory	Local carrier if used with implanted DME. If other, DME MAC.
A9901	Delivery	DME MAC
A9999	Miscellaneous DME supply or accessory	Local carrier if used with implanted DME. If other, DME MAC.
B4034-B9999	Enteral and parenteral therapy	DME MAC
D0120-D9999	Dental procedures	Local carrier
E0100-E0105	Canes	DME MAC
E0110-E0118	Crutches	DME MAC
E0130-E0159	Walkers	DME MAC
E0160-E0175	Commodes	DME MAC
E0181-E0199	Decubitus care equipment	DME MAC
E0200-E0239	Heat/cold applications	DME MAC
E0240-E0248	Bath and toilet aids	DME MAC
E0249	Pad for heating unit	DME MAC
E0250-E0304	Hospital beds	DME MAC
E0305-E0326	Hospital bed accessories	DME MAC
E0328-E0329	Pediatric hospital beds	DME MAC
E0350-E0352	Electronic bowel irrigation system	DME MAC
E0370	Heel pad	DME MAC

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Jurisdiction *(continued)*

HCPCS	Description	Jurisdiction
E0371-E0373	Decubitus care equipment	DME MAC
E0424-E0484	Oxygen and related respiratory equipment	DME MAC
E0485-E0486 Oral device to reduce airway collapsibility	DME MAC	
E0487	Electric spirometer	DME MAC
E0500	IPPB machine	DME MAC
E0550-E0585	Compressors/nebulizers	DME MAC
E0600	Suction pump	DME MAC
E0601	CPAP device	DME MAC
E0602-E0604	Breast pump	DME MAC
E0605	Vaporizer	DME MAC
E0606	Drainage board	DME MAC
E0607	Home blood glucose monitor	DME MAC
E0610-E0615	Pacemaker monitor	DME MAC
E0616	Implantable cardiac event recorder	Local carrier
E0617	External defibrillator	DME MAC
E0618-E0619	Apnea monitor	DME MAC
E0620	Skin piercing device	DME MAC
E0621-E0636	Patient lifts	DME MAC
E0637-E0642	Standing devices/lifts	DME MAC
E0650-E0676	Pneumatic compressor and appliances	DME MAC
E0691-E0694	Ultraviolet light therapy systems	DME MAC
E0700	Safety equipment	DME MAC
E0705	Transfer board	DME MAC
E0710	Restraints	DME MAC
E0720-E0745	Electrical nerve stimulators	DME MAC
E0746	EMG device	Local carrier
E0747-E0748	Osteogenic stimulators	DME MAC
E0749	Implantable osteogenic stimulators	Local carrier
E0755	Reflex stimulator	DME MAC
E0760	Ultrasonic osteogenic stimulator	DME MAC
E0761	Electromagnetic treatment device	DME MAC
E0762	Electrical joint stimulation device	DME MAC
E0764	Functional neuromuscular stimulator	DME MAC
E0765	Nerve stimulator	DME MAC
E0769	Electrical wound treatment device	DME MAC
E0770	Functional electrical stimulator	DME MAC
E0776	IV pole	DME MAC
E0779-E0780	External infusion pumps	DME MAC

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Jurisdiction *(continued)*

HCPCS	Description	Jurisdiction
E0781	Ambulatory infusion pump	Billable to both the local carrier and the DME MAC. This item may be billed to the DME MAC whenever the infusion is initiated in the physician's office but the patient does not return during the same business day.
E0782-E0783	Infusion pumps, implantable	Local carrier
E0784	Infusion pumps, insulin	DME MAC
E0785-E0786	Implantable infusion pump catheter	Local carrier
E0791	Parenteral infusion pump	DME MAC
E0830	Ambulatory traction device	DME MAC
E0840-E0900	Traction equipment	DME MAC
E0910-E0930	Trapeze/fracture frame	DME MAC
E0935-E0936	Passive motion exercise device	DME MAC
E0940	Trapeze equipment	DME MAC
E0941	Traction equipment	DME MAC
E0942-E0945	Orthopedic devices	DME MAC
E0946-E0948	Fracture frame	DME MAC
E0950-E1298	Wheelchairs	DME MAC
E1300-E1310	Whirlpool equipment	DME MAC
E1353-E1392	Additional oxygen related equipment	DME MAC
E1399	Miscellaneous DME	Local carrier if implanted DME. If other, DME MAC.
E1405-E1406	Additional oxygen equipment	DME MAC
E1500-E1699	Artificial kidney machines and accessories	DME MAC (not separately payable)
E1700-E1702	TMJ device and supplies	DME MAC
E1800-E1841	Dynamic flexion devices	DME MAC
E1902	Communication board	DME MAC
E2000	Gastric suction pump	DME MAC
E2100-E2101	Blood glucose monitors with special features	DME MAC
E2120	Pulse generator for tympanic treatment of inner ear	DME MAC
E2201-E2397	Wheelchair accessories	DME MAC
E2402	Negative pressure wound therapy pump	DME MAC
E2500-E2599	Speech generating device	DME MAC
E2601-E2633	Wheelchair cushions and accessories	DME MAC
E8000-E8002	Gait trainers	DME MAC
G0008-G0329	Misc. professional services	Local carrier
G0333	Dispensing fee	DME MAC
G0337-G0365	Misc. professional services	Local carrier
G0372	Misc. professional services	Local carrier
G0378-G9186	Misc. professional services	Local carrier
J0120-J3570	Injection	Local carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.
J3590	Unclassified biologicals	Local carrier

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Jurisdiction *(continued)*

HCPCS	Description	Jurisdiction
J7030-J7131	Miscellaneous drugs and solutions	Local carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.
J7178	**Fibrinogen**	**Local carrier**
J7180-J7195	Antihemophilic factor	Local carrier
J7196-J7197	Antithrombin III	Local carrier
J7198	Anti-inhibitor; per I.U.	Local carrier
J7199	Other hemophilia clotting factors	Local carrier
J7300-J7307	Intrauterine copper contraceptive	Local carrier
J7308-J7309	Aminolevulinic acid HCL	Local carrier
J7310	Ganciclovir, long-acting implant	Local carrier
J7311-J731**5**	**Ophthalmic drugs**	Local carrier
J7321-J7326	Hyaluronan	Local carrier
J7330	Autologous cultured chondrocytes, Implant	Local carrier
J7335	Capsaicin	Local carrier
J7500-J7599	Immunosuppressive drugs	Local carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.
J7604-J7699	Inhalation solutions	Local carrier if incident to a physician's service. If other, DME MAC.
J7799	NOC, other than inhalation drugs	Local carrier if incident to a physician's through DME service. If other, DME MAC.
J8498	Anti-emetic drug	DME MAC
J8499	Prescription drug, oral, non chemotherapeutic service	Local carrier if incident to a physician's . If other, DME MAC.
J8501-J8999	Oral anti-cancer drugs	DME MAC
J9000-J9999	Chemotherapy drugs	Local carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.
K0001-K0108	Wheelchairs	DME MAC
K0195	Elevating leg rests	DME MAC
K0455	Infusion pump used for uninterrupted administration of epoprostenal	DME MAC
K0462	Loaner equipment	DME MAC
K0552	External infusion pump supplies	DME MAC
K0601-K0605	External infusion pump batteries	DME MAC
K0606-K0609	Defibrillator accessories	DME MAC
K0669	Wheelchair cushion	DME MAC
K0672	Soft interface for orthosis	DME MAC
K0730	Inhalation drug delivery system	DME MAC
K0733	Power wheelchair accessory	DME MAC
K0738	Oxygen equipment	DME MAC
K0739	Repair or nonroutine service for DME	Local carrier if implanted DME. If other, DME MAC
K0740	Repair or nonroutine service for oxygen equipment	DME MAC

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Jurisdiction *(continued)*

HCPCS	Description	Jurisdiction
K0743-K0746	Suction pump and dressings	DME MAC
K0800-K0899	Power mobility devices	DME MAC
L0112-L4631	Orthotics	DME MAC
L5000-L5999	Lower limb prosthetics	DME MAC
L6000-L7499	Upper limb prosthetics	DME MAC
L7510-L7520	Repair of prosthetic device	Local carrier if repair of implanted prosthetic device. If other, DME MAC.
L7600	Prosthetic donning sleeve	DME MAC
L7900-**L7902**	Vacuum erection system	DME MAC
L8000-L8485	Prosthetics	DME MAC
L8499	Unlisted procedure for miscellaneous prosthetic services	Local carrier if implanted prosthetic device. If other, DME MAC.
L8500-L8501	Artificial larynx; tracheostomy speaking valve	DME MAC
L8505	Artificial larynx accessory	DME MAC
L8507	Voice prosthesis, patient inserted	DME MAC
L8509	Voice prosthesis, inserted by a licensed health care provider	Local carrier for dates of service on or after 10/01/2010. DME MAC for dates of service prior to 10/01/2010
L8510	Voice prosthesis	DME MAC
L8511-L8515	Voice prosthesis	Local carrier if used with tracheoesophageal voice prostheses inserted by a licensed health care provider. If other, DME MAC
L8600-L8699	Prosthetic implants	Local carrier
L9900	Miscellaneous orthotic or prosthetic component or accessory	Local carrier if used with implanted prosthetic device. If other, DME MAC.
M0064-M0301	Medical services	Local carrier
P2028-P9615	Laboratory tests	Local carrier
Q0035	Influenza vaccine; cardio-kymography	Local carrier
Q0081	Infusion therapy	Local carrier
Q0083-Q0085	Chemotherapy administration	Local carrier
Q0091	Smear preparation	Local carrier
Q0092	Portable X-ray setup	Local carrier
Q0111-Q0115	Miscellaneous lab services	Local carrier
Q0138-Q0139	Ferumoxytol injection	Local carrier
Q0144	Azithromycin dihydrate	Local carrier if incident to a physician’s service. If other, DME MAC.
Q0162-Q0181	Anti-emetic	DME MAC
Q0478-Q0506	Ventricular assist devices	Local carrier
Q0510-Q0514	Drug dispensing fees	DME MAC
Q0515	Sermorelin acetate	Local carrier
Q1004-Q1005	New technology IOL	Local carrier
Q2004	Irrigation solution	Local carrier
Q2009	Fosphenytoin	Local carrier
Q2017	Teniposide	Local carrier

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Jurisdiction *(continued)*

HCPCS	Description	Jurisdiction
Q2026-Q2027	Injectable dermal fillers (Effective July 1, 2010)	Local carrier
Q2034-Q2039	Influenza vaccine	Local carrier
Q2043	Sipuleucel-T	Local carrier
Q2049	**Lipodox**	**Local carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.**
Q3001	Supplies for radiology procedures	Local carrier
Q3014	Telehealth originating site facility fee	Local carrier
Q3025-Q3026	Vaccines	Local carrier
Q3031	Collagen skin test	Local carrier
Q4001-Q4051	Splints and casts	Local carrier
Q4074	Inhalation drug	Local carrier if incident to a physician's service. If other, DME MAC.
Q4081	Epoetin	Local carrier
Q4082	Drug subject to Competitive Acquisition Program	Local carrier
Q4100-Q4136	Skin substitutes	Local carrier
Q5001-Q5010	Hospice services	Local carrier
Q9951-Q9954	Imaging agents	Local carrier
Q9955-Q9957	Microspheres	Local carrier
Q9958-Q9969	Imaging agents	Local carrier
R0070-R0076	Diagnostic radiology services	Local carrier
V2020-V2025	Frames	DME MAC
V2100-V2513	Lenses	DME MAC
V2520-V2523	Hydrophilic contact lenses	Local carrier if incident to a physician's service. If other, DME MAC.
V2530-V2531	Contact lenses, scleral	DME MAC
V2599	Contact lens, other type	Local carrier if incident to a physician's service. If other, DME MAC.
V2600-V2615	Low vision aids	DME MAC
V2623-V2629	Prosthetic eyes	DME MAC
V2630-V2632	Intraocular lenses	Local carrier
V2700-V2780	Miscellaneous vision service	DME MAC
V2781	Progressive lens	DME MAC
V2782-V2784	Lenses	DME MAC
V2785	Processing--corneal tissue	Local carrier
V2786	Lens	DME MAC
V2787-V2788	Intraocular lenses	Local carrier
V2790	Amniotic membrane	Local carrier
V2797	Vision supply	DME MAC
V2799	Miscellaneous vision service	DME MAC
V5008-V5299	Hearing services	Local carrier
V5336	Repair/modification of augmentative communicative system or device	DME MAC
V5362-V5364	Speech screening	Local carrier

Source: Pub 100-04, Transmittal 2637, Change request 8164

New HCPCS code for external VADs or any VAD for which payment was not made under Medicare Part A

Provider types affected

This *MLN Matters®* article is intended for hospitals and suppliers of external ventricular assist devices (VADs) or any VAD for which payment was not made under Medicare Part A. Such claims are billed to Medicare contractors (fiscal intermediaries (FIs), carriers and A/B Medicare administrative contractors (MACs)) for services to Medicare beneficiaries.

What you need to know

This article, based on change request (CR) 7888, instructs FIs, carriers, and A/B MACs to implement a new Healthcare Common Procedure Coding System (HCPCS) codes in order to process claims for accessories and supplies for external VADs or any VAD for which payment was not made under Medicare Part A. Make sure that your billing staffs are aware of this change.

Background

The Centers for Medicare & Medicaid Services (CMS) provided instructions to its contractors on processing claims for replacement accessory and supplies for external VADs and for VADs for which payment was not made under Medicare Part A. CR 3931, issued on July 22, 2005, instructed that claims for replacement accessories and supplies for VADs implanted in patients who were not eligible for coverage under Medicare Part A or had other insurance that paid for the device and hospital stay at the time that the device was implanted should be billed using HCPCS code L9900. (See the related *MLN Matters®* article, MM3931, at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm3931.pdf*.) Additionally, in rare instances, replacement accessory and supply claims for external VADs used by patients who are discharged from the hospital or an emergency backup controller for an external VAD were also to be billed using HCPCS code L9900.

Since the implementation of CR 3931, CMS finds that the use of HCPCS code L9900 in the above circumstances presents claims processing issues. CR 7888 enables FIs, carriers, and A/B MACs to make the necessary changes in order to process replacement accessory and supply claims for external VADs or VADs for which payment was not made under Medicare Part A using new HCPCS codes.

New HCPCS code

Payment on a fee schedule basis is required for prosthetic devices by the Social Security Act, Section 1834(h). The following codes are being added to the December 2012 HCPCS code set and are, effective for services on or after April 1, 2013:

Q0507 Miscellaneous Supply Or Accessory For Use With An External Ventricular Assist Device

Q0509 Miscellaneous Supply Or Accessory For Use With Any Implanted Ventricular Assist Device For Which Payment Was Not Made Under Medicare Part A

Effective April 1, 2013, claims for replacement of accessories and supplies for VADs implanted in patients who were not eligible for coverage under Medicare Part A or had other insurance that paid for the device and hospital stay at the time that the device was implanted, but are now eligible for coverage of the replacement supplies and accessories under Medicare Part B, should be submitted using HCPCS code Q0509. Such claims will be manually reviewed.

In rare instances, it may be appropriate to pay for replacement of supplies and accessories for external VADs used by patients who are discharged from the hospital. In addition, in some rare instances, it may be necessary for a patient to have an emergency backup controller for an external VAD. Coverage of these items is at the discretion of your Medicare contractor. Claims for replacement of supplies and accessories used with an external VAD that are furnished by suppliers should be billed to the local carriers. Claims for replacement of supplies and accessories used with an external VAD that are furnished by hospitals and other providers should be billed to the FIs or A/B MACs. Effective April 1, 2013, these items should be billed using code Q0507 so that the claims can be manually reviewed.

In order to clarify the descriptor of miscellaneous VAD accessory and supply code Q0505, the following new code is being added December 2012 to the HCPCS Quarterly Update with an effective date of April 1, 2013:

- Q0508 Miscellaneous Supply or Accessory For Use With An Implanted Ventricular Assist Device

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VAD *(continued)*

Code Q0508 clarifies that the miscellaneous supplies and accessories billed under this code are for use with implanted VADs. Code Q0508 replaces code Q0505 that is discontinued March 31, 2013.

Please note that when determined to be medically necessary, dressings used with VADs are covered under the prosthetic device benefit as a supply necessary for the effective use of the VAD/prosthetic device. Claims for dressings necessary for the effective use of a VAD should be billed using the appropriate miscellaneous VAD supply code, depending upon whether the patient was eligible for coverage under Medicare Part A at the time that the VAD was implanted. The claims processing jurisdiction for dressings used with VADs is identical to that of other VAD replacement supplies and accessories and does not fall under DME MAC jurisdiction.

Additional information

The official instruction, CR 7888, issued to your FI, carrier and A/B MAC regarding this change, may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1159OTN.pdf*.

If you have any questions, please contact your carrier or A/B MAC at their toll-free number, which may be found at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html*.

MLN Matters® Number: MM7888
Related Change Request (CR) #: CR 7888
Related CR Release Date: December 21, 2012
Effective Date: April 1, 2013
Related CR Transmittal #: R1159OTN
Implementation Date: April 1, 2013

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

Laboratory/Pathology

New waived tests

Provider types affected

This *MLN Matters*® article is intended for clinical diagnostic laboratories submitting claims to Medicare contractors (carriers and Part B Medicare administrative contractors (MACs)) for laboratory services.

Provider action needed

This article, based on change request (CR) 8146, informs Medicare contractors 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 its contractors of the new tests so that they can accurately process claims. There are 24 newly added waived tests. Be sure your billing staffs are aware of these changes.

Background

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

Listed below are the latest tests approved by the Food and Drug Administration (FDA) as waived tests under CLIA. The *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 8146 (i.e., *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.

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Waived *(continued)*

CPT code	Effective date	Description
82274QW	April 19, 2012	Medline iFOB One-Step Immunological fecal occult blood test
G0434QW	May 9, 2012	Wondfo multi-drug urine test cup (cup format)
G0434QW	May 9, 2012	Wondfo multi-drug urine test panel (dip card format)
83037QW	May 30, 2012	Bayer A1C Now SelfCheck
G0434QW	July 3, 2012	CLIAwaived Inc. single drug dipstick test
G0434QW	July 3, 2012	CLIAwaived Inc. rapid dip drug test
G0434QW	July 27, 2012	Wondfo Cannabinoids urine test (cup format)
G0434QW	July 27, 2012	Wondfo Cannabinoids urine test (dip card format)
G0434QW	August 2, 2012	Wondfo Amphetamine urine test (cup format)
G0434QW	August 2, 2012	Wondfo Amphetamine urine test (dip card format)
G0434QW	August 2, 2012	Wondfo Oxazepam urine test (cup format)
G0434QW	August 2, 2012	Wondfo Oxazepam urine test (dip card format)
G0434QW	August 2, 2012	Wondfo Secobarbital urine test (cup format)
G0434QW	August 2, 2012	Wondfo Secobarbital urine test (dip card format)
82055QW	August 16, 2012	CLIAwaived Inc. Rapid saliva alcohol test
G0434QW	August 24, 2012	Brannan Medical Corporation Fastect II drug screen dipstick test
G0434QW	August 24, 2012	Brannan Medical Corporation QuickTox drug screen dipcard
G0434QW	August 27, 2012	CLIA waived Inc. instant nicotine detection test
87807QW	September 13, 2012	Alere BinaxNOW RSV card
87804QW	September 13, 2012	Alere BinaxNow influenza A & B card (nasopharyngeal (Np) Swab and nasal wash/aspirate specimens)
82055QW	September 13, 2012	Chematics Inc. Alco-Screen 02 saliva alcohol test
85610QW	September 18, 2012	Roche Diagnostics CoaguChek XS Plus System
81003QW	September 26, 2012,	Acon Laboratories, Inc. Insight U120 urine analyzer
G0434QW	October 5, 2012	Medimpex United Inc. MedimpexQ test multi X drug cup test

Medicare contractors will not search files to either retract payment or retroactively pay claims based on the changes in CR 8146; however, claims should be adjusted if you bring them to your contractor's attention.

Additional information

The official instruction, CR 8146, issued to your carrier and A/B MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2619CP.pdf*.

If you have any questions, please contact your carrier or A/B MAC at their toll-free number, which may be found at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html*.

MLN Matters® Number: MM8146
Related Change Request (CR) #: CR 8146
Related CR Release Date: December 21, 2012
Effective Date: April 1, 2013
Related CR Transmittal #: R2619CP
Implementation Date: April 1, 2013

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Calendar year 2013 annual update for clinical laboratory fee schedule and laboratory services subject to reasonable charge payment

Note: This article was revised on January 10, 2013, to reflect a revised change request (CR) 8132 issued on January 9. In the article, the CR release date, transmittal number, and Web address for accessing the CR were revised. All other information remains the same. This information was previously published in the December 2012 *Medicare B Connection*, Pages 15-18.

Provider types affected

This *MLN Matters®* article is intended for clinical diagnostic laboratories billing Medicare carriers, fiscal intermediaries (FIs), or Part A/B Medicare administrative contractors (A/B MACs) for services provided to Medicare beneficiaries.

What you need to know

The Centers for Medicare & Medicaid Services (CMS) issued CR 8132 which provides instructions to Medicare contractors for the calendar year (CY) 2013 clinical laboratory fee schedule, mapping for new codes for clinical laboratory tests, and updates for laboratory costs subject to the reasonable charge payment. Be sure your billing staffs are aware of these updates.

Background

In accordance with Section 1833(h)(2)(A)(i) of the Social Security Act (the Act), as amended by Section 628 of the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003, and further amended by Section 3401 of the Patient Protection and Affordable Care Act (ACA) of 2010 and the Middle Class Tax Relief and Job Creation Act of 2012, the annual update to the local clinical laboratory fees for CY 2013 is -2.95 percent. The annual update to local clinical laboratory fees for CY 2013 reflects the consumer price index for urban areas (CPI-U) of 1.70 percent less a multi-factor productivity adjustment of 0.9 percentage points and a -1.75 percentage point reduction as described by the ACA legislation, plus a -2.0 percentage point reduction as described by the MCTRJCA. The annual update to payments made on a reasonable charge basis for all other laboratory services for CY 2013 is 1.7 percent (See 42 CFR 405.509(b)(1)). Section 1833(a)(1)(D) of the Act provides that payment for a clinical laboratory test is the lesser of the actual charge billed for the test, the local fee, or the national limitation amount (NLA).

For a cervical or vaginal smear test (pap smear), Section 1833(h)(7) of the Act requires payment to be the lesser of the local fee or the NLA, but not less than a national minimum payment amount (described below). However, for a cervical or vaginal smear test (Pap smear), payment may also not exceed the actual charge. The Part B deductible and coinsurance do not apply for services paid under the clinical laboratory fee schedule.

Key points of CR 8132

National minimum payment amounts

For a cervical or vaginal smear test (pap smear), Section 1833(h)(7) of the Act requires payment to be the lesser of the local fee or the NLA, but not less than a national minimum payment amount. Also, payment may not exceed the actual charge. The CY 2013 national minimum payment amount is $14.53 ($14.97 plus (-2.95) percent update for CY 2013). The following codes are affected for the national minimum payment amount:

88142	*88143*	*88147*	*88148*	*88150*	*88152*
88153	*88154*	*88164*	*88165*	*88166*	*88167*
88174	*88175*	G0123	GO143	G0144	G0145
G0147	G0148	P3000			

National limitation amounts (Maximum)

For tests for which NLAs were established before January 1, 2001, the NLA is 74 percent of the median of the local fees. For tests for which the NLAs are first established on or after January 1, 2001, the NLA is 100 percent of the median of the local fees in accordance with Section 1833(h)(4)(B)(viii) of the Act.

Access to data file

Internet access to the CY 2013 clinical laboratory fee schedule data file will be available after November 21, 2012, at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html*. Other interested parties, such as the Medicaid State agencies, the Indian Health Service, the United Mine Workers, and the Railroad Retirement Board, may use the Internet to retrieve the CY 2013 clinical laboratory fee schedule. It will be available in multiple formats: Excel, text, and comma delimited.

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Clinical *(continued)*

Public comments

On July 16, 2012, CMS hosted a public meeting to solicit input on the payment relationship between CY 2012 codes and new CY 2013 *CPT* codes. Notice of the meeting was published in the Federal Register on May 29, 2012, and on the CMS website approximately June 15, 2012. Recommendations were received from many attendees, including individuals representing laboratories, manufacturers, and medical societies. CMS posted a summary of the meeting and the tentative payment determinations site at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html*. Additional written comments from the public were accepted until September 28, 2012. CMS has posted a summary of the public comments and the rationale for the final payment determinations on the CMS website.

Pricing information

The CY 2013 clinical laboratory fee schedule includes separately payable fees for certain specimen collection methods (codes 36415, P9612, and P9615). The fees have been established in accordance with Section 1833(h)(4)(B) of the Act.

The fees for clinical laboratory travel codes P9603 and P9604 are updated on an annual basis. The clinical laboratory travel codes are billable only for traveling to perform a specimen collection for either a nursing home or homebound patient. If there is a revision to the standard mileage rate for CY 2013, CMS will issue a separate instruction on the clinical laboratory travel fees.

The CY 2013 clinical laboratory fee schedule also includes codes that have a “QW” modifier to both identify codes and determine payment for tests performed by a laboratory having only a certificate of waiver under the Clinical Laboratory Improvement Amendments (CLIA).

Organ or disease oriented panel codes

As in prior years, the CY 2013 pricing amounts for certain organ or disease panel codes and evocative/suppression test codes were derived by summing the lower of the clinical laboratory fee schedule amount or the NLA for each individual test code included in the panel code. The NLA field on the data file is zero-filled.

Mapping information

New code *86386*QW is priced at the same rate as code *86386*, effective January 1, 2012.

New code *83861*QW is priced at the same rate as code *83861*, effective July 1, 2012.

New code *86803*QW is priced at the same rate as code *86803*.

The following lists new codes to be gap filled:

81201	*81202*	*81203*	*81235*	*81252*	*81253*	*81254*	*81321*	*81322*	*81323*	*81324*	*81325*
81326	*81200*	*81205*	*81206*	*81207*	*81208*	*81209*	*81210*	*81211*	*81212*	*81213*	*81214*
81215	*81216*	*81217*	*81220*	*81221*	*81222*	*81223*	*81224*	*81225*	*81226*	*81227*	*81228*
81229	*81240*	*81241*	*81242*	*81243*	*81244*	*81245*	*81250*	*81251*	*81255*	*81256*	*81257*
81260	*81261*	*81262*	*81263*	*81264*	*81265*	*81266*	*81267*	*81268*	*81270*	*81275*	*81280*
81281	*81282*	*81290*	*81291*	*81292*	*81293*	*81294*	*81295*	*81296*	*81297*	*81298*	*81299*
81300	*81301*	*81302*	*81303*	*81304*	*81310*	*81315*	*81316*	*81317*	*81318*	*81319*	*81330*
81331	*81332*	*81340*	*81341*	*81342*	*81350*	*81355*	*81370*	*81371*	*81372*	*81373*	*81374*
81375	*81376*	*81377*	*81378*	*81379*	*81380*	*81381*	*81382*	*81383*	*81400*	*81401*	*81402*
81403	*81404*	*81405*	*81406*	*81407*	*81408*	*86152*					

The following lists existing codes that are deleted:

83890	*83891*	*83892*	*83893*	*83894*	*83896*	*83897*	*83898*	*83900*	*83901*	*83902*	*83903*
83904	*83905*	*83906*	*83907*	*83908*	*83909*	*83912*	*83913*	*83914*			

New code *82777* is priced at the same rate as code *83520*.
New code *86711* is priced at the same rate as code *86789*.
New code *86828* is priced at the same rate as code *86807*.
New code *86829* is priced at the same rate as code *86808*.
New code *86830* is priced at 7 times the rate of code *83516*.
New code *86831* is priced at 6 times the rate of code *83516*.
New code *86832* is priced at 11 times the rate of code *83516*.

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Clinical *(continued)*

New code *86833* is priced at 10 times the rate of code *83516*.
New code *86834* is priced at 31 times the rate of code *83516*.
New code *86835* is priced at 28 times the rate of code *83516*.
New code *87631* is priced at the same rate as code *87502* plus two times the rate of code *87503*.
New code *87632* is priced at the same rate as code *87502* plus six times the rate of code *87503*.
New code *87633* is priced at the same rate as code *87502* plus 16 times the rate of code *87503*.
New code *87910* is priced at the same rate as code *87902*.
New code *87912* is priced at the same rate as code *87902*.

Laboratory costs subject to reasonable charge payment in CY 2011

For outpatients, the following codes are paid under a reasonable charge basis. The reasonable charge may not exceed the lowest of the actual charge or the customary or prevailing charge for the previous 12-month period ending June 30, updated by the inflation-indexed update. The inflation-indexed update is calculated using the change in the applicable consumer price index for the 12-month period ending June 30 of each year as set forth in 42 CFR 405.509(b)(1). The inflation-indexed update for CY 2013 is 1.7 percent.

Manual instructions for determining the reasonable charge payment can be found in the *Medicare Claims Processing Manual*, Chapter 23, Section 80 through 80.8. If there is sufficient charge data for a code, the instructions permit considering charges for other similar services and price lists. **Note**: The Medicare manuals noted in this article are available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html*.

When services described by the Healthcare Common Procedure Coding System (HCPCS) in the following list are performed for independent dialysis facility patients, *Medicare Claims Processing Manual*, Chapter 8, Section 60.3, instructs that the reasonable charge basis applies. However, when these services are performed for hospital-based renal dialysis facility patients, payment is made on a reasonable cost basis. Also, when these services are performed for hospital outpatients, payment is made under the hospital outpatient prospective payment system.

Blood product codes

These blood codes are:

P9010	P9011	P9012	P9016	P9017	P9019
P9020	P9021	P9022	P9023	P9031	P9032
P9033	P9034	P9035	P9036	P9037	P9038
P9039	P9040	P9044	P9050	P9051	P9052
P9053	P9054	P9055	P9056	P9057	P9058
P9059	P9060				

Also, payment for the following codes are applied to the blood deductible as instructed in the *Medicare General Information, Eligibility and Entitlement Manual*, Chapter 3, Sections 20.5 through 20.5.4:

P9010	P9016	P9021	P9022	P9038	P9039
P9040	P9051	P9054	P9056	P9057	P9058

Note: Biologic products not paid on a cost or prospective payment basis are paid based on Section 1842(o) of the Act. The payment limits based on Section 1842(o), including the payment limits for codes P9041, P9043, P9045, P9046, P9047, and P9048, should be obtained from the Medicare Part B drug pricing files.

Transfusion medicine costs

These codes are:

86850	*86860*	*86870*	*86880*	*86885*	*86886*
86890	*86891*	*86900*	*86901*	*86902*	*86904*
86905	*86906*	*86920*	*86921*	*86922*	*86923*
86927	*86930*	*86931*	*86932*	*86945*	*86950*
86960	*86965*	*86970*	*86971*	*86972*	*86975*
86976	*86977*	*86978*	*86985*		

(continued on next page)

Clinical *(continued)*

Reproductive medicine procedure codes

These codes are:

89250	*89251*	*89253*	*89254*	*89255*	*89257*
89258	*89259*	*89260*	*89261*	*89264*	*89268*
89272	*89280*	*89281*	*89290*	*89291*	*89335*
89342	*89343*	*89344*	*89346*	*89352*	*89353*
89354	*89356*				

Additional information

You can find the official instruction, CR 8132, issued to your FI, carrier, or A/B MAC by visiting *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2630CP.pdf*.

If you have any questions, please contact your FI, carrier, or A/B MAC at their toll-free number, which may be found at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html*.

MLN Matters® Number: MM8132 *Revised*
Related Change Request (CR) #: CR 8132
Related CR Release Date: January 9, 2013
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Related CR Transmittal #: R2630CP
Implementation Date: January 7, 2013

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

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.

Therapy Services

Implementing the claims-based data collection requirement for outpatient therapy services

Note: This article was revised on December 26, 2012, to reflect a revised change request (CR) 8005 issued on December 21. In the article, *CPT* code *96125* was added to the list of evaluation codes and information was added to provide direction for one-time therapy visits. Also, the transmittal numbers and the Web addresses for accessing the CR 8005 transmittals are updated. All other information remains the same. This information was previously published in the December 2012 *Medicare B Connection*, Pages 26-32.

Provider types affected

This *MLN Matters*® article for CR 8005 is intended for physicians, other providers, and suppliers who submit claims to Medicare contractors (carriers, fiscal intermediaries (FIs), A/B Medicare administrative contractors (A/B MACs), and/or regional home health intermediaries (RHHIs)) for outpatient therapy services provided to Medicare beneficiaries.

Provider action needed

This article is based on CR 8005 which implements a new claims-based data collection requirement for outpatient therapy services by requiring reporting with 42 new non-payable functional G-codes and seven new modifiers on claims for physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP) services. Be sure your billing staff are aware of these new requirements.

Background

The Middle Class Tax Relief and Jobs Creation Act of 2012 (MCTRJCA; Section 3005(g); see *http://www.gpo.gov/fdsys/pkg/CRPT-112hrpt399/pdf/CRPT-112hrpt399.pdf*) states that "The Secretary of Health and Human Services shall implement, beginning on January 1, 2013, a claims-based data collection strategy that is designed to assist in reforming the Medicare payment system for outpatient therapy services subject to the limitations of Section 1833(g) of the Social Security Act (42 U.S.C. 1395l(g)). Such strategy shall be designed to provide for the collection of data on patient function during the course of therapy services in order to better understand patient condition and outcomes."

This claims-based data collection system is being implemented to include both 1) the reporting of data by therapy providers and practitioners furnishing therapy services, and 2) the collection of data by the contractors. This reporting and collection system requires claims for therapy services to include nonpayable G-codes and related modifiers. These non-payable G-codes and severity/complexity modifiers provide information about the beneficiary's functional status at:

- The outset of the therapy episode of care
- Specified points during treatment, and
- The time of discharge.

These G-codes and related modifiers are required on specified claims for outpatient therapy services – not just those over the therapy caps.

Application of new coding requirements

This functional data reporting and collection system is effective for therapy services with dates of service on and after January 1, 2013. However, a testing period will be in effect from January 1, 2013, through June 30, 2013, to

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Claims-based *(continued)*

allow providers to use the new coding requirements in order to assure that their systems work. During this time period claims without G-codes and modifiers will be processed.

Note: A separate CR (and related *MLN Matters*® article) will be issued regarding the editing required for claims with therapy services on and after July 1, 2013, at which time Medicare will begin returning and rejecting claims, as applicable, that do not contain the required functional G-code/modifier information.

In order to implement use of these G-codes for reporting function data on January 1, 2013, a new status indicator of "Q" has been created for the Medicare physician fee schedule database (MPFSDB). This new status indicator will identify codes being used exclusively for functional reporting of therapy services. These functional G-codes will be added to the MPFSDB with the new "Q" status indicator. Because these are non-payable G-codes, there will be no relative value units or payment amounts for these codes. The new "Q" status code indicator reads, as follows:

- Status code indicator "Q" –"Therapy functional information code, used for required reporting purposes only."

A separate instruction/article (see *MLN Matters*® article MM8126 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8126.pdf*) was issued to alert providers/suppliers and contractors that these non-payable functional G-codes will be added as "always therapy" codes to the new 2013 therapy code list.

Services affected

The reporting and collection requirements of beneficiary functional data apply to all claims for services furnished under the Medicare Part B outpatient therapy benefit and the PT, OT, and SLP services furnished under the comprehensive outpatient rehabilitation facility (CORF) benefit. They also apply to the therapy services furnished incident to the service of a physician and certain non-physician practitioners (NPPs), including, as applicable, nurse practitioners (NPs), certified nurse specialists (CNSs), and physician assistants (PAs).

Providers and practitioners affected

These reporting requirements apply to the therapy services furnished by the following providers: hospitals, critical access hospitals (CAHs), skilled nursing facilities (SNFs), comprehensive outpatient rehabilitation facilities (CORFs), rehabilitation agencies, and home health agencies (HHAs) (when the beneficiary is not under a home health plan of care). It also applies to the following practitioners: therapists in private practice (TPPs), physicians, and NPPs as noted above.

Function-related G-codes

The following Healthcare Common Procedure Coding System (HCPCS) G-codes are used to report the status of a beneficiary's functional limitations:

Mobility G-code set

- *G8978, Mobility: walking & moving around functional limitation, current status, at therapy episode outset and at reporting intervals.*
  - Short descriptor: Mobility current status
- *G8979, Mobility: walking & moving around functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting.*
  - Short descriptor: Mobility goal status
- *G8980, Mobility: walking & moving around functional limitation, discharge status, at discharge from therapy or to end reporting.*
  - Short descriptor: Mobility D/C status

Changing & maintaining body position G-code set

- *G8981, Changing & maintaining body position functional limitation, current status, at therapy episode outset and at reporting intervals.*
  - Short descriptor: Body pos current status
- *G8982, Changing & maintaining body position functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting*
  - Short descriptor: Body pos goal status

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Claims-based *(continued)*

- *G8983, Changing & maintaining body position functional limitation, discharge status, at discharge from therapy or to end reporting.*
    - Short descriptor: Body pos D/C status

Carrying, moving & handling objects G-code set

- *G8984, Carrying, moving & handling objects functional limitation, current status, at therapy episode outset and at reporting intervals*
    - Short descriptor: Carry current status
- *G8985, Carrying, moving & handling objects functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting*
    - Short descriptor: Carry goal status
- *G8986, Carrying, moving & handling objects functional limitation, discharge status, at discharge from therapy or to end reporting*
    - Short descriptor: Carry D/C status

Self care G-code set

- *G8987, Self care functional limitation, current status, at therapy episode outset and at reporting intervals*
    - Short descriptor: Self care current status
- *G8988, Self care functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting*
    - Short descriptor: Self care goal status
- *G8989, Self care functional limitation, discharge status, at discharge from therapy or to end reporting*
    - Short descriptor: Self care D/C status

Other PT/OT primary G-code set

- *G8990, Other physical or occupational primary functional limitation, current status, at therapy episode outset and at reporting intervals*
    - Short descriptor: Other PT/OT current status
- *G8991, Other physical or occupational primary functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting*
    - Short descriptor: Other PT/OT goal status
- *G8992, Other physical or occupational primary functional limitation, discharge status, at discharge from therapy or to end reporting*
    - Short descriptor: Other PT/OT D/C status

Other PT/OT subsequent G-code set

- *G8993, Other physical or occupational subsequent functional limitation, current status, at therapy episode outset and at reporting intervals*
    - Short descriptor: Sub PT/OT current status
- *G8994, Other physical or occupational subsequent functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting*
    - Short descriptor: Sub PT/OT goal status
- *G8995, Other physical or occupational subsequent functional limitation, discharge status, at discharge from therapy or to end reporting*
    - Short descriptor: Sub PT/OT D/C status

Swallowing G-code set

- *G8996, Swallowing functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals*

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Claims-based *(continued)*

- Short descriptor: Swallow current status

- *G8997, Swallowing functional limitation, projected goal status, at initial therapy treatment/outset and at discharge from therapy*
  - Short descriptor: Swallow goal status
- *G8998, Swallowing functional limitation, discharge status, at discharge from therapy/end of reporting on limitation*
  - Short descriptor: Swallow D/C status

Motor speech G-code Set: (Note: These codes are not sequentially numbered)

- *G8999, Motor speech functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals*
  - Short descriptor Motor speech current status
- *G9186, Motor speech functional limitation, projected goal status at initial therapy treatment/outset and at discharge from therapy*
  - Short descriptor Motor speech goal status
- *G9158, Motor speech functional limitation, discharge status at discharge from therapy/end of reporting on limitation*
  - Short descriptor: Motor speech D/C status

Spoken language comprehension G-code set

- *G9159, Spoken language comprehension functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals*
  - Short descriptor: Lang comp current status
- *G9160, Spoken language comprehension functional limitation, projected goal status at initial therapy treatment/outset and at discharge from therapy*
  - Short descriptor: Lang comp goal status
- *G9161, Spoken language comprehension functional limitation, discharge status at discharge from therapy/ end of reporting on limitation*
  - Short descriptor: Lang comp D/C status

Spoken language expressive G-code set

- *G9162, Spoken language expression functional limitation, current status at time of initial therapy treatment/ episode outset and reporting intervals*
  - Short descriptor: Lang express current status
- *G9163, Spoken language expression functional limitation, projected goal status at initial therapy treatment/ outset and at discharge from therapy*
  - Short descriptor: Lang express goal status
- *G9164, Spoken language expression functional limitation, discharge status at discharge from therapy/end of reporting on limitation*
  - Short descriptor: Lang express D/C status

Attention G-code set

- *G9165, Attention functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals*
  - Short descriptor: Atten current status
- *G9166, Attention functional limitation, projected goal status at initial therapy treatment/outset and at discharge from therapy*
  - Short descriptor Atten goal status

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Claims-based *(continued)*

- *G9167, Attention functional limitation, discharge status at discharge from therapy/end of reporting on limitation*
    - Short descriptor: Atten D/C status

Memory G-code set

- *G9168, Memory functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals*
    - Short descriptor: Memory current status
- *G9169, Memory functional limitation, projected goal status at initial therapy treatment/outset and at discharge from therapy*
    - Short descriptor: Memory goal status
- *G9170, Memory functional limitation, discharge status at discharge from therapy/end of reporting on limitation*
    - Short descriptor: Memory D/C status

Voice G-code set

- *G9171, Voice functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals*
    - Short descriptor Voice current status
- *G9172, Voice functional limitation, projected goal status at initial therapy treatment/outset and at discharge from therapy*
    - Short descriptor Voice goal status
- *G9173, Voice functional limitation, discharge status at discharge from therapy/end of reporting on limitation*
    - Short descriptor: Voice D/C status

Other speech-language pathology G-code set

- *G9174, Other speech language pathology functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals*
    - Short descriptor: Speech lang current status
- *G9175, Other speech language pathology functional limitation, projected goal status at initial therapy treatment/outset and at discharge from therapy*
    - Short descriptor: speech lang goal status
- *G9176, Other speech language pathology functional limitation, discharge status at discharge from therapy/ end of reporting on limitation*
    - Short descriptor: speech lang D/C status

Severity/complexity modifiers

For each non-payable G-code shown above, a modifier must be used to report the severity/complexity for that functional measure. The severity modifiers reflect the beneficiary's percentage of functional impairment as determined by the therapist, physician, or NPP furnishing the therapy services. The beneficiary's current status, the anticipated goal status, and the discharge status are reported via the appropriate severity modifiers. The seven modifiers are defined in the following table below:

Modifier	Impairment limitation restriction
CH	0 percent impaired, limited or restricted
CI	At least 1 percent but less than 20 percent impaired, limited or restricted
CJ	At least 20 percent but less than 40 percent impaired, limited or restricted
CK	At least 40 percent but less than 60 percent impaired, limited or restricted
CL	At least 60 percent but less than 80 percent impaired, limited or restricted
CM	At least 80 percent but less than 100 percent impaired, limited or restricted
CN	100 percent impaired, limited or restricted

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Claims-based *(continued)*

Required reporting of functional G-codes and severity modifiers

The functional G-codes and corresponding severity modifiers listed above are used in the required reporting on specified therapy claims for certain dates of service (DOS). Only one functional limitation shall be reported at a given time for each related therapy plan of care (POC). However, functional reporting is required on claims throughout the entire episode of care; so, there will be instances where two or more functional limitations will be reported for one beneficiary's POC, just not during the same time frame. In these situations, where reporting on the first reported functional limitation is complete and the need for treatment continues, reporting is required for a second functional limitation using another set of G-codes. Thus, reporting on more than one functional limitation may be required for some beneficiaries, but not simultaneously.

Specifically, functional reporting, using the G-codes and modifiers, is required on therapy claims for certain DOS as described below:

- At the outset of a therapy episode of care, i.e., on the DOS for the initial therapy service;
- At least once every 10 treatment days – which is the same as the newly-revised progress reporting period – the functional reporting is required on the claim for services on same DOS that the services related to the progress report are furnished;
- The same DOS that an evaluative procedure, including a re-evaluative one, is submitted on the claim (see below for applicable HCPCS/*CPT* codes);
- At the time of discharge from the therapy episode of care, if data is available; and,
- On the same DOS the reporting of a particular functional limitation is ended, in cases where the need for further therapy is necessary.

As noted above, this functional reporting coincides with the progress reporting frequency, which is being changed through this instruction. Previously, the progress reporting was due every 10th treatment day or 30 calendar days, whichever was less. The new requirement is for the services related to the progress reports to be furnished on or before every 10th treatment day. In the example below, the G-codes for the mobility functional limitation (G8978 - G8980) are used to illustrate the timing of the functional reporting.

- **At the outset of therapy** – the DOS the evaluative procedure is billed or the initial therapy services are furnished:
  - G8978 and G8979, along with the related severity modifiers, are used to report the current status and projected goal status of the mobility functional limitation.
- **At the end of each progress reporting period** – the DOS when the progress report services are furnished:
  - G8978 and G8979, along with the related severity modifiers, are used to report the current status and projected goal status of the mobility functional limitation.
  - This step is repeated as clinically appropriate

At the time the beneficiary is discharged from the therapy episode – the DOS the discharge progress report services are furnished:

- G8979 and G8980, along with the related severity modifiers, are used to report the projected goal and discharge status of the mobility functional limitation.

In the above example, if further therapy is medically necessary once reporting for the mobility functional limitation has ended, the therapist begins reporting on another functional limitation using a different set of G-codes. Reporting of the next functional limitation is required on the DOS of the first treatment day after the reporting was ended for the mobility functional limitation.

Evaluative procedures

The presence of an HCPCS/*CPT* code on a claim for an evaluation or re-evaluation service listed below requires reporting of functional G-code(s) and corresponding modifier(s) for the same date of service:

HCPCS/*CPT* codes requiring functional G-code(s) and corresponding modifier(s)

92506 92597 92607 92608 92610
92611 92612 92614 92616 96105
96125 97001 97002 97003 97004

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Claims-based *(continued)*

When functional reporting is required on a claim for therapy services, two G-codes will generally be required. Two exceptions exist:

1. Therapy services under more than one therapy POC. Claims may contain more than two non-payable functional G-codes when in cases where a beneficiary receives therapy services under multiple POCs (PT, OT, and/or SLP) from the same therapy provider.
2. One-time therapy visit. When a beneficiary is seen and future therapy services are either not medically indicated or are going to be furnished by another provider, the clinician reports on the claim for the DOS of the visit, all three G-codes in the appropriate code set (current status, goal status and discharge status), along with corresponding severity modifiers.

Each reported functional G-code must also contain the following essential line of service information:

- Functional severity modifier in the range CH – CN
- Therapy modifier indicating the discipline of the POC – GP, GO or GN – for PT, OT, and SLP services, respectively
- Date of the corresponding billable service
- Nominal charge, e.g., a penny, for institutional claims submitted to the FIs and A/MACs. For professional claims, a zero charge is acceptable for the service line. If provider billing software requires an amount for professional claims, a nominal charge, e.g., a penny, may be included.

In addition, claims containing any of these functional G-codes must also contain another billable and separately payable (non-bundled) service.

Required tracking and documentation of functional G-codes and severity modifiers

The reported functional information is derived from the beneficiary's functional limitations set forth in the therapy goals, a requirement of the POC, that are established by a therapist, including – an occupational therapist, a speech-language pathologist or a physical therapist – or a physician/NPP, as applicable. The therapist or physician/NPP furnishing the therapy services must not only report the functional information on the therapy claim, but, he/she must track and document the G-codes and modifiers used for this reporting in the beneficiary's medical record of therapy services.

Remittance advice messages

Medicare will return a claim adjustment reason code 246 (This non-payable code is for required reporting only.) and a group code of CO (contractual obligation) assigning financial liability to the provider. In addition, beneficiaries will be informed via Medicare summary notice 36.7 that they are not responsible for any charge amount associated with one of these G-codes.

Additional information

CR 8005 was issued via two transmittals. The first revises the *Medicare Benefit Policy Manual* and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R165BP.pdf*. The second transmittal updates the *Medicare Claims Processing Manual* and it is at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2622CP.pdf*.

If you have any questions, please contact your carriers, FIs, A/B MACs, and RHHIs at their toll-free number, which may be found at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html*.

The following provides additional information and related links for therapy providers and practitioners:

- **CMS Therapy Services Web Page**: The CMS Therapy Services home page is located at *http://www.cms.gov/Medicare/Billing/TherapyServices/index.html*.
- **Therapy services transmittals**: The following CMS Web page lists transmittals that are directed to the therapy services provider community: *http://www.cms.gov/Medicare/Billing/TherapyServices/Therapy-Services-Transmittals.html*

  Note that this list may not include all instructions for which therapy service providers are responsible. For a list of all instructions, view the CMS transmittals Web page under Regulations and Guidance at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2012-Transmittals.html*.
- **Annual therapy update**: You can find and download the Therapy Code List and Dispositions for 2009, 2010, 2011, and 2012 at *http://www.cms.gov/Medicare/Billing/TherapyServices/AnnualTherapyUpdate.html*. The

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Claims-based *(continued)*

additions, changes, and deletions to the therapy code list reflect those made in the applicable year for the Healthcare Common Procedure Coding System and *Current Procedural Terminology, Fourth Edition* (HCPCS/ *CPT*-4).

- **Studies and reports**: Studies and reports (report to Congress, CMS contracted, and other government) relating to utilization and policy for outpatient Part B therapy can be found at *http://www.cms.gov/Medicare/Billing/TherapyServices/Studies-and-Reports.html*.

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Surgery

National coverage determination: Transcatheter aortic valve replacement coding update/policy clarification

Provider types affected

This *MLN Matters®* article is intended for physicians, providers and suppliers submitting claims to Medicare contractors (fiscal intermediaries (FIs), carriers and A/B Medicare administrative contractors (MAC)) for Transcatheter aortic valve replacement (TAVR) services to Medicare beneficiaries.

What you need to know

Change request (CR) 7897, issued September 24, 2012, implemented a new national coverage determination (NCD), TAVR, also known as transcatheter aortic valve implantation (TAVI), a new technology for use in treating aortic stenosis. CR 7897 provided billing/coding instructions that included codes expiring on December 31, 2012. CR 8168 is an update to CR 7897 that implements replacement codes for TAVR claims with dates of service on and after January 1, 2013. Those codes appear in the 2013 physician fee schedule.

CR 8168 also clarifies several policy-related issues regarding use of modifier 62 and the documentation requirements, surgical team criteria, and managed care plan claims processing instructions. Please make sure that your billing staffs are aware of these updates.

Background

TAVR, or TAVI, is a new technology for use in treating aortic stenosis. A bioprosthetic valve is inserted intravascularly using a catheter and implanted in the orifice of the native aortic valve. The procedure is performed in a cardiac catheterization lab or a hybrid operating room/cardiac catheterization lab with advanced quality imaging and with the ability to safely accommodate complicated cases that may require conversion to an open surgical procedure. The interventional cardiologist and cardiothoracic surgeon jointly participate in the intra-operative technical aspects of TAVR.

On May 1, 2012, the Centers for Medicare & Medicaid Services (CMS) issued a NCD covering TAVR under coverage with evidence development (CED). When the procedure is furnished for the treatment of symptomatic aortic stenosis and according to a Food and Drug Administration (FDA) approved indication for use with an approved device, CED requires that each patient be entered into a qualified national registry. In addition, prior to receiving TAVR, face-to-face examinations of the patient are required by two cardiac surgeons to evaluate the patient's suitability for open aortic valve replacement (AVR). The NCD lists criteria for the physician operators and hospitals that must be met prior to beginning a TAVR program and after a TAVR program is established.

According to CR 7897, issued September 24, 2012, TAVR claims with dates of service on and after May 1, 2012, through December 31, 2012, are billed with temporary category III *Current Procedural Terminology®* (*CPT®*)

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Transcatheter *(continued)*
codes *0256T* (*Implantation of catheter-delivered prosthetic aortic heart valve: endovascular approach*); *0257T* (*Implantation of catheter-delivered prosthetic aortic heart valve: open thoracic approach (e.g., transapical, transventricular)*); *0258T* (*Transthoracic cardiac exposure (i.e., sternotomy, thoracotomy, subxiphoid*) for catheter-delivered aortic valve replacement, without cardiopulmonary bypass); and *0259T* (*Transthoracic cardiac exposure (i.e., sternotomy, thoracotomy, subxiphoid*) for catheter-delivered aortic valve replacement, with cardiopulmonary bypass). These codes are contractor-priced.

Billing for TAVR on and after January 1, 2013

TAVR claims with dates of service on and after January 1, 2013, must be billed with five permanent *CPT®* category 1 codes and one temporary category 3 code. These six codes will replace the four temporary codes that expired on December 31, 2012. All other Medicare claims processing instructions as they relate to TAVR and these new codes have been updated accordingly.

Thus, effective for dates of service on and after January 1, 2013, Medicare recognizes the following codes when billing for TAVR:

- *33361 - Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach*
- *33362 - Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open femoral artery approach*
- *33363 - Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open axillary artery approach*
- *33364 - Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open iliac artery approach*
- *33365 - Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transaortic approach (e.g., median sternotomy, mediastinotomy)*
- *0318T Replace aortic valve thoracic*

In addition to these codes, the claim must have a place of service (POS) code of 21 (inpatient hospital) or the claim lines will be denied with a claim adjustment reason code (CARC) of 58 (Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.), a remittance advice remarks code (RARC) of N428 (Not covered when performed in this place of service.) and a group code of CO (contractual obligation).

Also, the claim lines for these procedure codes on professional clinical trial claims must have the modifier Q0 (Investigational clinical service provided in a clinical research study that is in an approved clinical research study) or the lines will be returned with a CARC of 4 (The procedure code is inconsistent with the modifier used or a required modifier is missing. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.), a RARC of N29 (Missing documentation/orders/notes/summary/report/chart.), and the group code of CO.

Similarly, professional claims with one of the above procedure codes must have modifier 62 also or the claim line will be returned with a CARC of 4 (The procedure code is inconsistent with the modifier used or a required modifier is missing. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.), a RARC of N29 (Missing documentation/orders/notes/summary/report/chart.), and the group code of CO.

Finally, the clinical trial claim line must contain the secondary diagnosis code of V70.7 (ICD-10 of Z00.6) or it will be returned with a CARC of 16 (Claim/service lacks information which is needed for adjudication. At least one remark code must be provided (may be comprised of either the NCPDP reject reason code, or remittance advice remark code that is not an ALERT.)), a RARC of M76 (Missing/incomplete/invalid diagnosis or condition.), and the group code of CO.

For claims processed prior to implementation of these changes, your Medicare contractor will adjust such claims but only if you bring such claims to the contractor's attention.

For indications that are not approved by the FDA, patients must be enrolled in qualifying clinical studies. The clinical study must address pre-specified research questions, adhere to standards of scientific integrity, and be approved by CMS. Approved studies will be posted on the CMS website at *http://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/Transcatheter-Aortic-Valve-Replacement-TAVR-.html*. The process for submitting a clinical research study to Medicare is outlined in the NCD.

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Transcatheter *(continued)*

The NCD requires an interventional cardiologist and a cardiothoracic surgeon to jointly participate in the intraoperative technical aspects of TAVR as specified in section 20.32 of the NCD Manual. All TAVR codes must be billed with modifier 62 (two surgeons) with the exception of the three new add-on codes *33367, 33368*, and *33369*, effective January 1, 2013.

For further information, see the *MLN Matters*® article related to CR 7897. That article is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7897.pdf*.

Note: When a Medicare Advantage (MA) plan participant receives TAVR services, the MA plans are responsible for payment. Medicare coverage for TAVR is not under section 310.1 of the *NCD Manual* (Routine Costs in Qualifying Clinical Trials) and it is in these trials that the fee-for-service (FFS) system is responsible for payment.

Additional information

The official instruction, CR 8168, issued to your FI, carrier and A/B MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2628CP.pdf*.

If you have any questions, please contact your FI, carrier or A/B MAC at their toll-free number, which may be found at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html*.

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Related Change Request (CR) #: CR 8168
Related CR Release Date: January 7, 2013
Effective Date: January 1, 2013
Related CR Transmittal #: R2628CP
Implementation Date: April 1, 2013 (except January 25, 2013 for claims sent to carriers/B MACs)

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

General Coverage

The Centers for Medicare & Medicaid Services issues instructions for ICD-10 conversion on national coverage determinations

Provider types affected

This *MLN Matters*® article is intended for all Medicare providers covered under the Health Insurance Portability and Accountability Act (HIPAA), including those submitting claims electronically and those submitting paper claims, to Medicare contractors (fiscal intermediaries (FIs), carriers and A/B Medicare administrative contractors (MACs)) for services to Medicare beneficiaries.

Provider action needed

Stop – impact to you

Beginning October 1, 2014, all providers submitting electronic and paper claims to Medicare contractors must use ICD-10-CM and ICD-10-PSC code sets in appropriate HIPAA standard transactions.

Caution – what you need to know

This article, based on change request (CR) 8109, instructs Medicare contractors and shared system maintainers to both create and update national coverage determination (NCD) hard-coded shared system edits that contain ICD-9 diagnosis codes with comparable ICD-10 diagnosis codes plus all associated coding infrastructure, such as procedure codes, Healthcare Common Procedure Coding System (HCPCS) and *Current Procedural Terminology*® (*CPT*®) codes, denial messages, frequency edits, place of service (POS), type of bill (TOB) and provider specialties, etc. The requirements described reflect the operational changes that are necessary to implement the conversion of the Medicare system diagnosis codes specific to the Medicare national coverage database (NCD) spreadsheets attached to CR 8109.

(continued on next page)

ICD-10 *(continued)*

Go – what you need to do

Make sure that your billing staffs will be able to meet the October 1, 2014, requirement to use ICD-10 code sets in all HIPAA transactions submitted to Medicare. This requirement also applies to paper claims submitted to Medicare.

Background

On October 1, 2014, as required by CMS-40-F, 42 *Code of Federal Regulations* (CFR) 162, dated September 5, 2012, all Medicare claim submissions will convert from the ICD-9 to the ICD-10. The transition will require business and systems changes throughout the health-care industry. All covered entities, as defined by the Health Insurance Portability and Accountability Act (HIPAA), must adhere to the conversion.

In accordance with HIPAA, the Secretary of the Department of Health and Human Services adopted standard medical data code sets for use in standard transactions adopted under this law. According to the ICD-10 final rule, published in the *Federal Register* of January 16, 2009, the Secretary adopted the ICD-10-Clinical Modification (CM) and ICD-10-Procedure Coding System (PCS) code sets for use in appropriate HIPAA standard transactions, including those for submitting health care claims electronically. Entities covered under HIPAA, which include Medicare and its providers submitting claims electronically, are bound by these requirements and must comply. Medicare will also require submitters of paper claims to use ICD-10 codes on their claims according to the same compliance date.

Note: CR 8109 in no way is intended to expand, restrict, or alter existing Medicare national coverage, nor is it intended to minimize the authority granted to MACs in their discretionary implementation of NCDs or local coverage determinations (LCDs). However, where hard-coded edits were not initially implemented due to time and/or resource constraints, doing so at this time will better serve the intent and integrity of national coverage and the Medicare program overall.

General information found in spreadsheets in the attachments

Spreadsheets are attached to CR 8109 indicating certain affected ICD-9 codes and their corresponding ICD-10 codes as they relate to their respective NCDs, in addition to the rest of the coding infrastructure specific to each NCD.

Each spreadsheet contains the following information:

- National coverage determinations (NCD) number
- NCD title
- Internet-Only Manual (IOM) searchable link related to the NCD, and
- Medicare coverage database (MCD) searchable link related to the NCD.

Within each spreadsheet, there are three tabs:

- ICD diagnosis, which includes; ICD-9 CM, ICD-9 DX description, ICD-10 CM, ICD-10 DX description, and any changes (remove, keep, add)
- ICD procedures, which includes; ICD-9, ICD-9 Px description, ICD-10 PCS, ICD-10 PCS description and any changes (remove, keep, add), and
- Rule description:

By Part A: Proposed HCPCS/*CPT*, frequency limitations, type of bill, revenue code, modifier, provider specialty, proposed Medicare summary notice (MSN) message, proposed claim adjustment reason code (CARC) message, and proposed remittance advice remarks code (RARC) message, and

By Part B: Proposed HCPCS/*CPT*, frequency limitations, place of service, modifier, provider specialty, proposed MSN message, proposed CARC message, and proposed RARC message.

Spreadsheets attached to CR 8109 explain the following NCDs by number and title:

20.9 Artificial Hearts

20.20 External Counterpulsation Therapy Severe Angina

20.29 Hyperbaric Oxygen Therapy

90.1 Pharmacogenomic Testing Warfarin

(continued on next page)

ICD-10 *(continued)*

190.11 Home Prothrombin Time/International Normalized Ratio (PT/INR) Monitoring

210.1 Prostate Cancer Screening Tests

210.3 Colorectal Cancer Screening Tests

260.1 Adult Liver Transplantation

260.3.1 Islet Cell Transplantation Clinical Trials

260.5 Intestinal/Multi-Visceral Transplantation

270.1 Electrical Stimulation (ES) and Electromagnetic Therapy for the Treatment of Wounds

Additional information

The official instruction, CR 8109, issued to your FI, carrier, and A/B MAC regarding this change, may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1165OTN.pdf*.

If you have any questions, please contact your FI, carrier, or A/B MAC at their toll-free number, which may be found at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html*.

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Related Change Request (CR) #: CR 8109
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Effective Date: October 1, 2014
Related CR Transmittal #: R1165OTN
Implementation Date: April 1, 2013

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President Obama signs the American Taxpayer Relief Act of 2012

New law includes physician update fix through December 2013

On Wednesday, January 2, 2013, President Obama signed into law the American Taxpayer Relief Act of 2012. This new law prevents a scheduled payment cut for physicians and other practitioners who treat Medicare patients from taking effect January 1, 2013. The new law provides for a zero percent update for such services through December 31, 2013. This provision guarantees seniors have continued access to their doctors by fixing the sustainable growth rate (SGR) through the end of 2013. President Obama remains committed to a permanent solution to eliminating the SGR reductions that result from the existing statutory methodology. The Administration will continue to work with Congress to achieve this goal.

The new law extends several provisions of the Middle Class Tax Relief and Job Creation Act of 2012 (Job Creation Act) as well as provisions of the Affordable Care Act. Specifically, the following Medicare fee-for-service policies (with January 1, 2013, or October 1, 2012, effective dates) have been extended. Also included is Medicare billing and claim processing information associated with the new legislation. Please note that these provisions do not reflect all of the Medicare provisions in the new law, and more information about other provisions will be forthcoming.

Section 601 – Medicare Physician Payment Update: As previously indicated, the new law provides for a zero percent update for claims with dates of service on or after January 1, 2013, through December 31, 2013. The Centers for Medicare & Medicaid Services (CMS) is currently revising the 2013 Medicare physician fee schedule (MPFS) to reflect the new law's requirements as well as technical corrections identified since publication of the final rule in November. For your information, the 2013 conversion factor is $34.0230.

In order to allow sufficient time to develop, test, and implement the revised MPFS, Medicare claims administration contractors may hold MPFS claims with January 2013 dates of service for up to 10 business days (i.e., through January 15, 2013). CMS expects these claims to be released into processing no later than January 16, 2013. The claim hold should have minimal impact on physician/practitioner cash flow because, under current law, clean electronic claims are not paid sooner than 14 calendar days (29 for paper claims) after the date of receipt. Claims with dates of service prior to January 1, 2013, are unaffected. Medicare claims administration contractors will be posting the MPFS payment rates on their websites no later than January 23, 2013.

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Obama *(continued)*

The 2013 Annual Participation Enrollment Program allowed eligible physicians, practitioners, and suppliers an opportunity to change their participation status by December 31, 2012. Given the new legislation, CMS is extending the 2013 annual participation enrollment period through February 15, 2013. Therefore, participation elections and withdrawals must be post-marked on and before February 15, 2013. The effective date for any participation status changes elected by providers during the extension remains January 1, 2013.

Section 602 – Extension of Medicare Physician Work Geographic Adjustment Floor: The 2012 1.0 floor on the physician work geographic practice cost index is extended through December 31, 2013. As with the physician payment update, this extension will be reflected in the revised 2013 MPFS.

Section 603 – Extension Related to Payments for Medicare Outpatient Therapy Services: Section 603 extends the exceptions process for outpatient therapy caps through December 31, 2013. Providers of outpatient therapy services are required to submit the KX modifier on their therapy claims, when an exception to the cap is requested for medically necessary services furnished through December 31, 2013. In addition, the new law extends the application of the cap and threshold to therapy services furnished in a hospital outpatient department (OPD), and counts outpatient therapy services furnished in a critical access hospital towards the cap and threshold. Additional information about the exception process for therapy services may be found in the *Medicare Claims Processing Manual*, Pub 100-04, Chapter 5, Section 10.3: *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c05.pdf*.

The therapy caps are determined for a beneficiary on a calendar year basis, so all beneficiaries began a new cap for outpatient therapy services received on January 1, 2013. For physical therapy and speech language pathology services combined, the 2013 limit for a beneficiary on incurred expenses is $1,900. There is a separate cap for occupational therapy services which is $1,900 for 2013. Deductible and coinsurance amounts applied to therapy services count toward the amount accrued before a cap is reached, and also apply for services above the cap where the KX modifier is used.

Section 603 also extends the mandate that Medicare perform manual medical review of therapy services furnished January 1, 2013, through December 31, 2013, for which an exception was requested when the beneficiary has reached a dollar aggregate threshold amount of $3,700 for therapy services, including OPD therapy services, for a year. There are two separate $3,700 aggregate annual thresholds: (1) physical therapy and speech-language pathology services, and (2) occupational therapy services.

Section 604 – Extension of Ambulance Add-On Payments: Section 604 extends the following three Job Creation Act ambulance payment provisions: (1) the 3 percent increase in the ambulance fee schedule amounts for covered ground ambulance transports that originate in rural areas and the 2 percent increase for covered ground ambulance transports that originate in urban areas is extended through December 31, 2013; (2) the provision relating to air ambulance services that continues to treat as rural any area that was designated as rural December 31, 2006, for purposes of payment under the ambulance fee schedule, is extended through June 30, 2013; and (3) the provision relating to payment for ground ambulance services that increases the base rate for transports originating in an area that is within the lowest 25th percentile of all rural areas arrayed by population density (known as the “super rural” bonus) is extended through December 31, 2013.

CMS is currently revising the 2013 Medicare ambulance fee schedule (MAFS) to reflect the new law’s requirements. In order to allow sufficient time to develop, test, and implement the revised MAFS, Medicare claims administration contractors may hold MAFS claims with January 2013 dates of service for up to 10 business days (i.e., through January 15, 2013). CMS expects these claims to be released into processing no later than January 16, 2013. The claim hold should have minimal impact on supplier cash flow because, under current law, clean electronic claims are not paid sooner than 14 calendar days (29 for paper claims) after the date of receipt. Claims with dates of service prior to January 1, 2013, are unaffected.

Suppliers of ambulance services affected by these provisions may continue billing as usual.

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Obama *(continued)*

Section 605 – Extension of Medicare Inpatient Hospital Payment Adjustment for Low-Volume Hospitals: The Affordable Care Act allowed qualifying low-volume hospitals to receive add-on payments based on the number of Medicare discharges. To qualify, the hospital must have less than 1,600 Medicare discharges and be 15 miles or greater from the nearest like hospital. This provision extends the payment adjustment through September 30, 2013, retroactive to October 1, 2012. Be on the alert for further information about implementation of this provision.

Section 606 – Extension of the Medicare-Dependent Hospital (MDH) Program: The MDH program provides enhanced payment to support small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges. This provision extends the MDH program until October 1, 2013, and is retroactive to October 1, 2012. Be on the alert for further information about implementation of this provision.

Be on the alert for more information about the American Taxpayer Relief Act of 2012.

Note: If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser.

Source: CMS PERL 201301-01

Summary of policies in 2013 MPFS final rule and the telehealth originating site facility fee payment amount

Provider types affected

This *MLN Matters*® article is intended for physicians and non-physician practitioners submitting claims to Medicare contractors (carriers, fiscal intermediaries (FIs), or A/B Medicare administrative contractors (A/B MACs)) for services to Medicare beneficiaries.

What you need to know

Change request (CR) 8191, from which this article is taken, summarizes the policies in the calendar year (CY) 2013 Medicare physician fee schedule (MPFS) final rule and announces the telehealth originating site facility fee payment amount. Section 1848(b)(1) of the Social Security Act (the Act) requires the Secretary to establish by regulation before November 1 of each year, fee schedules that establish payment amounts for physicians' services for the subsequent year. You should make sure that your staff is aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) issued a final rule with comment period on November 1, 2012, that updates payment policies and Medicare payment rates for services furnished by physicians and non-physician practitioners (NPPs) who are paid under the MPFS in CY 2013.

The final rule addresses:

- Medicare public comments on payment policies that were originally displayed on July 6, 2012, and published in the *Federal Register* on July 30, 2012: "Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2013;" and
- Interim final values established in the CY 2013 MPFS final rule with comment period (originally displayed on November 1, 2012, and published in the *Federal Register* on November 16, 2012). It assigns interim final values for new and revised codes for CY 2013; and requests comments on these values, which it will accept until December 31, 2012.

Since publication of the final rule, Congress has averted the statutorily required reduction in Medicare's physician fee schedule through the American Taxpayer Relief Act of 2012. A separate CR addresses revisions required by that legislation.

Summary of policies in the CY 2013 MPFS

1. Payment increases to primary care physicians in 2013

The 2013 MPFS includes a new policy to pay a physician or non-physician practitioner to coordinate a patient's care in the 30 days following a hospital or skilled nursing facility (SNF) stay. CMS believes that recognizing the work of community physicians and practitioners in treating a patient following discharge from a hospital or nursing facility will ensure better continuity of care for these patients, and help reduce patient readmissions.

(continued on next page)

Final rule *(continued)*

2. The rule's changes in care coordination payment and other changes are expected to increase payment to family practitioners by seven percent and other primary care practitioners between three and five percent.

Implementation of the physician value-based payment modifier

The 2013 MPFS continues the careful implementation of the physician value-based payment modifier by phasing in application of the modifier and enabling physicians in larger groups to choose how to participate. The value modifier provides differential Medicare payments to physicians based on a comparison of the quality and cost of care furnished to beneficiaries.

The statute allows CMS to phase in the value modifier over three years, from 2015 to 2017. For 2015, the final rule applies the value modifier to groups of physicians with 100 or more eligible professionals, a change from the proposed rule, which would have set the group size at 25 or above. This change was adopted to gain experience with the methodology and approach before expanding to smaller groups.

The final rule also provides an option for these groups of physicians to choose how the value modifier is calculated based on whether they participate in the Physician Quality Reporting System (PQRS). For physicians and groups of physicians who elect to participate in 2015, common sense incentives will improve the care that beneficiaries receive; physicians with higher quality and lower costs will be paid more, and those with lower quality and higher costs will be paid less. The performance period for the application of the value modifier in CY 2015 was previously established as CY 2013 in the CY 2012 MPFS final rule, which you can find at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html*.

3. Aligning quality reporting across programs

The 2013 MPFS continues CMS' efforts to align quality reporting across programs in order to reduce burden and complexity. It makes changes to the PQRS and the Electronic Prescribing (eRx) Incentive Program (the two quality reporting programs applicable to the MPFS) and updates the Medicare Electronic Health Records (EHR) Incentive Pilot Program.

These changes will simplify reporting and align the various programs' quality reporting approaches so they support the national quality strategy.

4. Enhancing the Physician Compare Website

The 2013 MPFS lays out the next steps to enhance the Physician Compare website, including posting names of practitioners who (as part of the Million Hearts campaign) successfully report measures to prevent heart disease. Please note that these are recommended measures under PQRS as well.

5. Expanding access to services that non-physicians practitioners can provide

The 2013 MPFS expands access to services that can be provided by non-physician practitioners. It allows Medicare to pay: 1) certified registered nurse anesthetists (CRNAs) for providing all services that they are permitted to furnish under state law (i.e. to the full extent of their state scope of practice); and 2) For portable x-rays ordered by nurse practitioners (NPs), physician assistants (PAs) and other non-physician practitioners.

6. Payment for molecular pathology services

The 2013 MPFS explains how Medicare will pay for molecular pathology services—the next innovation of clinical laboratory tests that will foster the development of personalized medicine. These tests will be paid under the clinical laboratory fee schedule (CLFS), with the 2013 payment set by the gap filling method.

7. Face-to-face encounter as a condition of payment for certain items

The 2013 MPFS requires a face-to-face encounter as a condition of payment for certain durable medical equipment (DME) items for orders written on, or after, July 1, 2013.

8. Implementation of a claims-based data collection strategy

Section 3005(g) of the Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA) requires CMS to implement a claims-based data collection strategy on January 1, 2013; to gather information on: 1) Beneficiary function and condition, 2) Therapy services furnished, and 3) Outcomes achieved. CMS will use this information to assist in reforming the Medicare payment system for outpatient therapy services.

Details about this data collection can be found in CR 8005. You can find the associated *MLN Matters®* articles, MM8005, "Implementing the Claims-Based Data Collection Requirement for Outpatient Therapy Services — Section 3005(g) of the Middle Class Tax Relief and Jobs Creation Act (MCTRJCA) of 2012," at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8005.pdf*.

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Final rule *(continued)*

9. Multiple procedure payment reduction (MPPR) - Also for CY 2013, an MPPR will apply a 25 percent reduction to the technical component (TC) of the second and subsequent diagnostic cardiovascular service, and a 20 percent reduction to the TC of the second and subsequent diagnostic ophthalmology service; furnished by the same physician (or physicians in the same group practice) to the same beneficiary, on the same day. CR 7848 discusses this 2013 MPPR in full detail, and you can find the associated *MLN Matters*® article: MM7848, "Multiple Procedure Payment Reduction (MPPR) on the Technical Component (TC) of Diagnostic Cardiovascular and Ophthalmology Procedures," at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7848.pdf*.

10. Telehealth originating site facility fee payment amount update

Section 1834(m)(2)(B) of the Act establishes the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001, through December 31 2002, at $20. For telehealth services provided on or after January 1 of each subsequent CY, the telehealth originating site facility fee is increased by the percentage increase in the Medicare economic index (MEI) as defined in Section 1842(i)(3) of the Act.

The MEI increase for 2013 is 0.8 percent. Therefore, for CY 2013, the payment amount for HCPCS code Q3014 (Telehealth originating site facility fee) is 80 percent of the lesser, of the actual charge, or $24.43 as described by Healthcare Common Procedure Coding System (HCPCS) code Q3014. (The beneficiary is responsible for any unmet deductible amount and Medicare coinsurance).

More information on CY 2013 changes in telehealth can be found in CR 7900. You can review the associated *MLN Matters*® article: MM7900, "Expansion of Medicare Telehealth Services for Calendar Year (CY) 2013," at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7900.pdf*.

Additional information

For more information and access to the CY 2013 final rule, go to the "Physician Fee Schedule" available at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html*.

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Related Change Request (CR) #: CR 8191
Related CR Release Date: January 9, 2013
Effective Date: January 1, 2013
Related CR Transmittal #: R2631CP
Implementation Date: January 7, 2013

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2013 reasonable charge fees

The Centers for Medicare & Medicaid Services change request (CR) 8051 provides instructions for the 2013 annual update for clinical laboratory fee schedule and laboratory services subject to reasonable charge payment.

Code	Allowance
A4565	$8.26
Q4001	$47.00
Q4002	$177.62
Q4003	$33.75
Q4004	$116.86
Q4005	$12.45
Q4006	$28.05
Q4007	$6.23
Q4008	$14.02
Q4009	$8.31
Q4010	$18.70
Q4011	$4.15
Q4012	$9.36

Code	Allowance
Q4013	$15.13
Q4014	$25.51
Q4015	$7.57
Q4016	$12.75
Q4017	$8.75
Q4018	$13.94
Q4019	$4.38
Q4020	$6.98
Q4021	$6.47
Q4022	$11.68
Q4023	$3.25
Q4024	$5.84
Q4025	$36.29

Code	Allowance
Q4026	$113.30
Q4027	$18.15
Q4028	$56.67
Q4029	$27.75
Q4030	$73.05
Q4031	$13.87
Q4032	$36.52
Q4033	$25.88
Q4034	$64.38
Q4035	$12.94
Q4036	$32.20
Q4037	$15.79
Q4038	$39.56

Code	Allowance
Q4039	$7.91
Q4040	$19.77
Q4041	$19.20
Q4042	$32.78
Q4043	$9.61
Q4044	$16.39
Q4045	$11.15
Q4046	$17.93
Q4047	$5.56
Q4048	$8.97
Q4049	$2.03

Source: CR 8051

Remittance advice remark and claims adjustment reason code, MREP, and PC Print update

Provider types affected

This *MLN Matters*® article is intended for physicians, other providers, and suppliers submitting claims to Medicare contractors (fiscal intermediaries (FIs), carriers, regional home health intermediaries (RHHIs), durable medical equipment Medicare administrative contractors (DME/MACs) and A/B MACs) for services to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 8154 which instructs Medicare contractors and shared system maintainers (SSMs) to make programming changes to incorporate new, modified, and deactivated claim adjustment reason codes (CARCs) and remittance advice remark codes (RARCs) that have been added since the last recurring code update. It also instructs Medicare system maintainers to update PC Print and Medicare Remit Easy Print (MREP) software. Make sure that your billing staffs are aware of these changes. See the *Background* and *Additional information* sections of this article for further details regarding these changes.

Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA; see *http://www.gpo.gov/fdsys/pkg/PLAW-104publ191/pdf/PLAW-104publ191.pdf*), instructs health plans to be able to conduct standard electronic transactions adopted under HIPAA using valid standard codes. Medicare policy states that CARCs and appropriate RARCs that provide either supplemental explanation for a monetary adjustment or global policy information that generally applies to the adjudication process are required in remittance advice (RA) and coordination of benefits (COB) transactions. For transaction 835 (Health Care Claim Payment/Advice) and standard paper remittance advice (RA), there are two code sets – CARC and RARC – that must be used to report payment adjustments, appeal rights, and related information. If there is any adjustment, the appropriate group code must be reported as well. Additionally, CARC and RARC must be used for transaction 837 COB.

The CARC and RARC changes that impact Medicare are usually requested by the Centers for Medicare & Medicaid Services (CMS) staff in conjunction with a policy change. If a modification has been initiated by an entity other than CMS for a code currently used by Medicare, then Medicare contractors must either use the modified code or another code if the modification makes the modified code inappropriate to explain the specific reason for adjustment.

Medicare contractors stop using codes that have been deactivated on or before the effective date specified in the comment section (as posted on the Washington Publishing Company (WPC) website). In order to comply with any deactivation, Medicare may have to stop using the deactivated code in original business messages before the actual “Stop Date” posted on the WPC website because the code list is updated three times a year and may not align with the Medicare release schedule.

Note that a deactivated code used in derivative messages must be accepted, even after the code is deactivated, if the deactivated code was used before the deactivation date by a payer or payers who adjudicated the claim before Medicare. Medicare contractors must stop using any deactivated reason and/or remark code past the deactivation date whether the deactivation is requested by Medicare or any other entity.

The regular code update CR will establish the implementation date for all modifications, deactivations, and any new code for Medicare contractors. If another specific CR has been issued by another CMS component with a different implementation date, the earlier of the two dates will apply for Medicare implementation. If any new or modified code has an effective date past the implementation date specified in CR 8154, Medicare contractors must implement on the date specified on the WPC website.

The discrepancy between the dates may arise because the WPC website gets updated only three times a year and may not match the CMS schedule for releasing its system updates.

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RARC *(continued)*

CR 8154 lists only the changes that have been approved since the last code update CR (CR 8029, Transmittal 2521, issued on August 17, 2012), and does not provide a complete list of codes for these two code sets.

The WPC website (see *http://www.wpc-edi.com/Reference*) has four listings available of codes by status for both CARC and RARC.

1. **Show All**: All codes including current, to be deactivated and deactivated codes are included in this listing.
2. **Current**: Only currently valid codes are included in this listing.
3. **To Be Deactivated**: Only codes to be deactivated at a future date are included in this listing.
4. **Deactivated**: Only codes with prior deactivation effective dates are included in this listing.

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

The CARC and RARC changes reflected by CR 8154 are as follows:

New codes – CARC

Code	Code narrative	Effective date
244	Payment reduced to zero due to litigation. Additional information will be sent following the conclusion of litigation. To be used for Property & Casualty only.	9/30/2012
245	Provider performance program withhold.	9/30/2012
246	This non-payable code is for required reporting only.	9/30/2012
247	Deductible for Professional service rendered in an Institutional setting and billed on an Institutional claim. Notes: For Medicare bundled payment use only, under the Patient Protection and Affordable Care Act (PPACA).	9/30/2012
248	Coinsurance for Professional service rendered in an Institutional setting and billed on an Institutional claim. Notes: For Medicare bundled payment use only, under the Patient Protection and Affordable Care Act (PPACA).	9/30/2012
249	This claim has been identified as a resubmission. (Use only with Group Code CO)	9/30/2012
250	The attachment content received is inconsistent with the expected content.	9/30/2012
251	The attachment content received did not contain the content required to process this claim or service	9/30/2012
252	An attachment is required to adjudicate this claim/service. At least one remark code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	9/30/2012
W3	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. For use by Property and Casualty only.	9/30/2012
W4	Workers' Compensation Medical Treatment Guideline Adjustment.	9/30/2012
Y1	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for P&C Auto only. Start: 09/30/2012	9/30/2012

(continued on next page)

RARC *(continued)*

Code	Code narrative	Effective date
Y2	Payment adjusted based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for P&C Auto only. Start: 09/30/2012	9/30/2012
Y3	Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for P&C Auto only.	9/30/2012

Modified codes – CARC

Code	Modified narrative	Effective date
18	Duplicate claim/service. This change effective 1/1/2013: Exact duplicate claim/service (Use only with Group Code OA)	1/1/2013
23	The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)	9/30/2012
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability). This change effective 7/1/2013: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability)	9/30/2012
133	The disposition of the claim/service is pending further review. This change effective 1/1/2013: The disposition of the claim/service is pending further review. (Use only with Group Code OA)	9/30/2012
136	Failure to follow prior payer's coverage rules. (Use Group Code OA). This change effective 7/1/2013: Failure to follow prior payer's coverage rules. (Use only with Group Code OA)	7/1/2013
173	Service was not prescribed by a physician. This change effective 7/1/2013: Service/equipment was not prescribed by a physician.	7/1/2013
201	Workers' Compensation case settled. Patient is responsible for amount of this claim/service through WC 'Medicare set aside arrangement' or other agreement. (Use group code PR). This change effective 7/1/2013: Workers Compensation case settled. Patient is responsible for amount of this claim/service through WC 'Medicare set aside arrangement' or other agreement. (Use only with Group Code PR)	7/1/2013
209	Per regulatory or other agreement. The provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected. (Use Group code OA) This change effective 7/1/2013: Per regulatory or other agreement. The provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected. (Use only with Group code OA)	7/1/2013
217	Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. (Note: To be used for Property and Casualty only)	9/30/2012
220	The applicable fee schedule/fee database does not contain the billed code. Please resubmit a bill with the appropriate fee schedule/fee database code(s) that best describe the service(s) provided and supporting documentation if required. (Note: To be used for Property and Casualty only)	9/30/2012

(continued on next page)

RARC *(continued)*

Code	Modified narrative	Effective date
221	Workers' Compensation claim is under investigation. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). This change effective 7/1/2013: Claim is under investigation. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). (Note: To be used by Property & Casualty only)	9/30/2012
226	Information requested from the Billing/Rendering Provider was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) This change effective 7/1/2013: Information requested from the Billing/Rendering Provider was not provided or not provided timely or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	7/1/2013
229	Partial charge amount not considered by Medicare due to the initial claim Type of Bill being 12X. Note: This code can only be used in the 837 transaction to convey Coordination of Benefits information when the secondary payer's cost avoidance policy allows providers to bypass claim submission to a prior payer. Use Group Code PR. This change effective 7/1/2013: Partial charge amount not considered by Medicare due to the initial claim Type of Bill being 12X. Note: This code can only be used in the 837 transaction to convey Coordination of Benefits information when the secondary payer's cost avoidance policy allows providers to bypass claim submission to a prior payer. (Use only with Group Code PR)	7/1/2013
236	This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative. This change effective 7/1/2013: This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee	7/1/2013
238	Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period (use Group Code PR). This change effective 7/1/2013: Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period. (Use only with Group Code PR)	7/1/2013

Deactivated codes – CARC: None

New codes – RARC

Code	Code narrative	Effective date
N560	The pilot program requires an interim or final claim within 60 days of the Notice of Admission. A claim was not received.	11/1/2012
N561	The bundled claim originally submitted for this episode of care includes related readmissions. You may resubmit the original claim to receive a corrected payment based on this readmission.	11/1/2012
N562	The provider number of your incoming claim does not match the provider number on the processed Notice of Admission (NOA) for this bundled payment.	11/1/2012
N563	Missing required provider/supplier issuance of advance patient notice of non-coverage. The patient is not liable for payment for this service.	11/1/2012

(continued on next page)

RARC *(continued)*

Code	Code narrative	Effective date
N564	Patient did not meet the inclusion criteria for the demonstration project or pilot program.	11/1/2012
N565	Alert: This procedure code requires a modifier. Future claims containing this procedure code must include an appropriate modifier for the claim to be processed.	11/1/2012
N566	Alert: This procedure code requires functional reporting. Future claims containing this procedure code must include an applicable non-payable code and appropriate modifiers for the claim to be processed.	11/1/2012

Modified codes – RARC

Code	Modified narrative	Effective date
M39	The Note: (Modified 2/1/04, 4/1/07, 11/1/09) Related to N563	11/1/2012
M137	Part B coinsurance under a demonstration project or pilot program.	11/1/2012

Deactivated codes – RARC

Code	Narrative	Effective date
N553	Payment adjusted based on a Low Income Subsidy (LIS) retroactive coverage or status change.	11/1/2012

MLN Matters® Number: MM8154
Related Change Request (CR) #: CR 8154
Related CR Release Date: December 21, 2012
Effective Date: April 1, 2013
Related CR Transmittal #: R2618CP
Implementation Date: April 1, 2013

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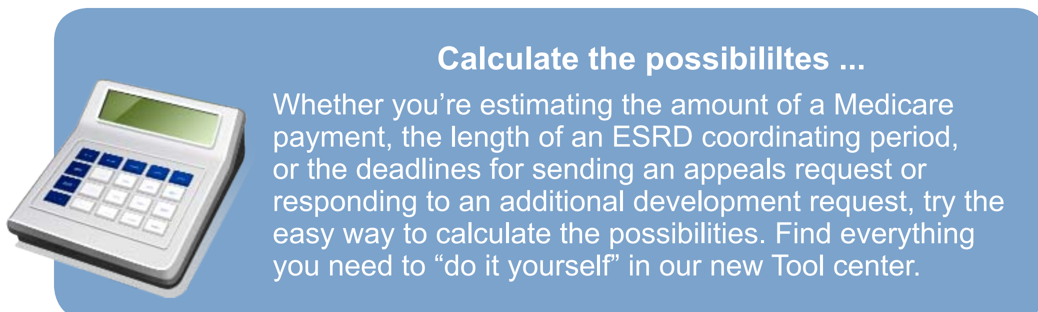

Prompt payment interest rate revision

Medicare must pay interest on clean claims if payment is not made within the applicable number of calendar days (i.e., 30 days) after the date of receipt. The applicable number of days is also known as the payment ceiling. For example, a clean claim received on March 1, 2013, must be paid before the end of business on March 31, 2013.

The interest rate is determined by the applicable rate on the day of payment. This rate is determined by the Treasury Department on a six-month basis, effective every January and July 1. Providers may access the Treasury Department Web page *http://fms.treas.gov/prompt/rates.html* for the correct rate. The interest period begins on the day after payment is due and ends on the day of payment.

The new rate of 1.375 percent is in effect through June 30, 2013.

Interest is not paid on:

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

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

Source: Publication 100-04, Chapter 1, Section 80.2.2

2013 Annual Participation Enrollment Program

The Centers for Medicare & Medicaid Services is extending the 2013 Annual Participation Enrollment Program. The participation **enrollment period will now end February 15, 2013, instead of December 31, 2012**. Additional information regarding this and other changes specified in the American Taxpayer Relief Act of 2012 is available at *http://medicare.fcso.com/fee_news/249096.asp*.

Manual updates to clarify inpatient rehabilitation facility claim processing

Provider types affected

This *MLN Matters*® article is intended for physicians and providers (including inpatient rehabilitation facilities (IRFs)) submitting claims to Medicare contractors (fiscal intermediaries (FIs), carriers, and A/B Medicare administrative contractors (MACs)) for inpatient rehabilitation services to Medicare beneficiaries.

Provider action needed

Change request (CR) 8127, from which this article is taken, updates the *Medicare Claims Processing Manual*, Chapter 3 (Inpatient Hospital Billing), to clarify key components of inpatient rehabilitation facility (IRF) claim processing. These changes are intended only to clarify the existing policies and there are no system or policy changes.

Background

The changes that CR 8127 makes to the manual are clarifications of existing policy. The entire manual revision is attached to CR 8127. Key manual changes of interest to IRFs are summarized as follows:

Medicare IRF classification requirements

A facility paid under the IRF prospective payment system (PPS) is always subject to verification that it continues to meet the criteria for exclusion from the Inpatient PPS (IPPS). Your FI or MAC provides the Centers for Medicare & Medicaid Services (CMS) regional office (RO) with data for determining the classification status of each facility and the RO reviews the IRF's classification status each year. A determination that a facility either is or is not classified as an IRF takes effect only at the start of a facility's cost reporting period and applies to that entire cost reporting period. If a facility fails to meet the criteria necessary to be paid under the IRF PPS, but meets the criteria to be paid under the IPPS, it may be paid under the IPPS.

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IRF *(continued)*

If a patient is admitted to a facility that is being paid under the IRF PPS, but is discharged from the facility when it is no longer being paid under the IRF PPS, then payment to the facility will be made from the applicable payment system that is in effect for the facility at the time the patient is discharged.

For cost reporting periods beginning on or after July 1, 2005, the IRF must have served an inpatient population of whom at least 60 percent required intensive rehabilitative services for treatment of one or more of the medical conditions specified in the revised manual Section 140.1.1C. See CR 8127 for a list of these criteria.

Additional criteria for inpatient rehabilitation units

Inpatient rehabilitation units must also meet additional criteria to be paid under the IRF PPS. These criteria are detailed in Section 140.1.2 of the revised manual, as attached to CR 8127.

Verification process used to determine if IRF meets classification criteria

For cost reporting periods beginning on or after July 1, 2005, the compliance threshold that must be met is 60 percent. Thus, for all compliance review periods beginning on or after January 1, 2013 (except in the case of new IRFs), the compliance review period will be one continuous 12-month time period beginning four months before the start of a cost reporting period and ending four months before the beginning of the next cost reporting period. For complete details of the verification process, see the revised Section 140.1.3 of the manual, which is attached to CR 8127.

New IRFs

An IRF hospital or IRF unit is considered new if it has not been paid under the IRF PPS for at least five calendar years. A new IRF will be considered new from the point that it first participates in Medicare as an IRF until the end of its first full 12-month cost reporting period.

A new IRF must provide written certification that the inpatient population it intends to serve will meet the certification requirements. The written certification is effective for the first full 12-month cost reporting period that occurs after the IRF begins being paid under the IRF PPS, and for any cost reporting period of not less than 1 month and not more than 11 months occurring between the date the IRF begins being paid under the IRF PPS and the start of the IRF's first full 12-month cost reporting period.

Changes in the status of an IRF unit

For purposes of payment under the IRF PPS, the status of an IRF unit may be changed from not excluded from the IPPS to excluded from the IPPS only at the start of a cost reporting period. If an IRF unit is added to a hospital after the start of a cost reporting period, it cannot be excluded from the IPPS before the start of the hospital's next cost reporting period.

The status of an IRF unit may be changed from excluded from the IPPS to not excluded from the IPPS at any time during a cost reporting period, but only if the hospital notifies the FI/MAC and the RO in writing of the change at least 30 days before the date of the change. In addition, the hospital must maintain the information needed to accurately determine which costs are and are not attributable to the IRF unit. A change in the status of a unit from excluded to not excluded that is made during a cost reporting period must remain in effect for the remainder of that cost reporting period.

New IRF beds

Any IRF beds that are added to an existing IRF must meet all applicable state certificates of need and state licensure laws. New IRF beds may be added one time at any time during a cost reporting period and will be considered new for the rest of that cost reporting period. A full 12-month cost reporting period must elapse between the delicensing or decertification of IRF beds in an IRF hospital or IRF unit and the addition of new IRF beds to that IRF hospital or IRF unit. Before an IRF can add new beds, it must receive written approval from the appropriate CMS RO, so that the CMS RO can verify that a full 12-month cost reporting period has elapsed since the IRF has had beds delicensed or decertified.

Change of ownership or leasing

If an IRF hospital (or a hospital that has an IRF unit) undergoes a change of ownership or leasing, as defined in 42 CFR 489.18, the IRF (or IRF unit of a hospital) retains its excluded status and will continue to be paid under the IRF PPS before and after the change of ownership or leasing if the new owner(s) of the IRF hospital (or the hospital with an IRF unit) accept assignment of the previous owners' Medicare provider agreement and the IRF continues to meet all of the requirements for payment under the IRF PPS. Note that an IRF's payment status under the IRF PPS is a Medicare classification status, which cannot be separated from its host hospital and therefore cannot be purchased outside of the purchase of its host hospital.

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IRF *(continued)*

If the new owner(s) do not accept assignment of the previous owners' Medicare provider agreement, the IRF is considered to be voluntarily terminated and the new owner(s) may re-apply to the Medicare program to operate a new IRF, under the requirements for new IRFs.

Mergers

If an IRF hospital (or a hospital with an IRF unit) merges with another hospital and the owner(s) of the merged hospital accept assignment of the IRF hospital's provider agreement (or the provider agreement of the hospital with the IRF unit), then the IRF hospital or IRF unit retains its excluded status and will continue to be paid under the IRF PPS before and after the merger, as long as the IRF hospital or IRF unit continues to meet all of the requirements for payment under the IRF PPS. Note that an IRF's payment status under the IRF PPS is a Medicare classification status, which cannot be separated from its host hospital and therefore cannot be merged with another entity outside of the merger with its host hospital.

If the owner(s) of the merged hospital do not accept assignment of the IRF hospital's provider agreement (or the provider agreement of the hospital with the IRF unit), then the IRF hospital or IRF unit is considered voluntarily terminated and the owner(s) of the merged hospital may re-apply to the Medicare program to operate a new IRF under the requirements for new IRFs.

Full-time equivalent (FTE) resident cap

Effective for cost reporting periods beginning on or after October 1, 2011, the IRF FTE resident caps may be temporarily adjusted to reflect interns and residents added because of another IRF's closure or the closure of another IRF's residency training program. An IRF is only eligible for the temporary cap adjustment if training the additional interns and residents would cause the IRF to exceed its FTE resident cap. In addition, an IRF that closes a medical residency training program must agree to temporarily reduce its FTE cap before other IRFs can receive temporary adjustments to their caps for training the IRF's interns and residents. IRFs may qualify for the temporary cap adjustment for cost reporting periods beginning on or after October 1, 2011, if they are already training interns and residents displaced by IRF closures or residency training program closures that occurred prior to October 1, 2011.

Outliers

The Social Security Act provides the Secretary of Health & Human Services with the authority to make payments in addition to the basic IRF prospective payments for cases incurring extraordinarily high cost. A case qualifies for outlier payment if the estimated cost of the case exceeds the adjusted outlier threshold. CMS calculates the adjusted outlier threshold by adding the IRF PPS payment for the case (that is, the case-mix group (CMG) payment adjusted by all of the relevant facility-level adjustments) and the adjusted threshold amount (also adjusted by all of the relevant facility-level adjustments). Then, CMS calculates the estimated cost of the case by multiplying the IRF's overall cost-to-charge ratio (CCR) by the Medicare-allowable covered charge. If the estimated cost of the case is higher than the adjusted outlier threshold, CMS makes an outlier payment for the case equal to 80 percent of the difference between the estimated cost of the case and the outlier threshold.

The adjusted threshold amount and upper threshold CCR are set forth annually in the IRF PPS notices published in the *Federal Register*.

Additional information

The official instruction, CR 8127 issued to your FI, carrier, or A/B MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2638CP.pdf*. As previously mentioned, you can find the updated *Medicare Claims Processing Manual*, Chapter 3 (Inpatient Hospital Billing) as an attachment to this CR.

If you have any questions, please contact your carrier or A/B MAC at their toll-free number, which may be found at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html*.

MLN Matters® Number: MM8127
Related Change Request (CR) #: CR 8127
Related CR Release Date: January 18, 2013
Effective Date: April 22, 2013
Related CR Transmittal #: R2638CP
Implementation Date: April 22, 2013

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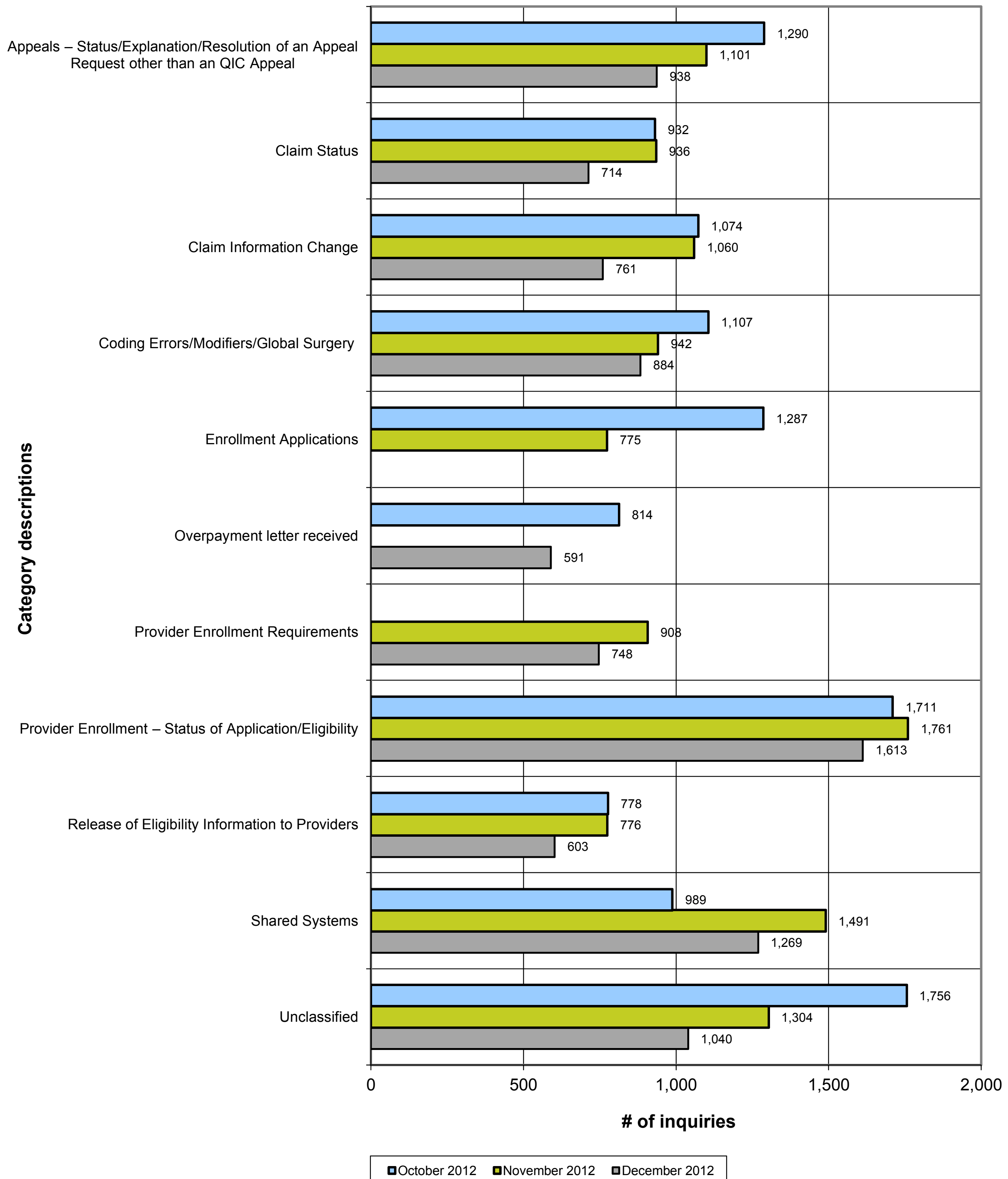
Top inquiries, denials, and return unprocessable claims

The following charts provide the most frequent inquiries, denials, and return unprocessable claims (RUC) submitted to First Coast Service Options Inc. (First Coast), by providers in Florida, Puerto Rico, and the U.S. Virgin Islands during October-December 2012.

For tips and resources to help providers avoid or reduce the amount of time spent on many of these issues, refer to the Inquiries and Denials section of our website at *http://medicare.fcso.com/Inquiries_and_denials/index.asp*.

Part B top inquiries for October-December 2012



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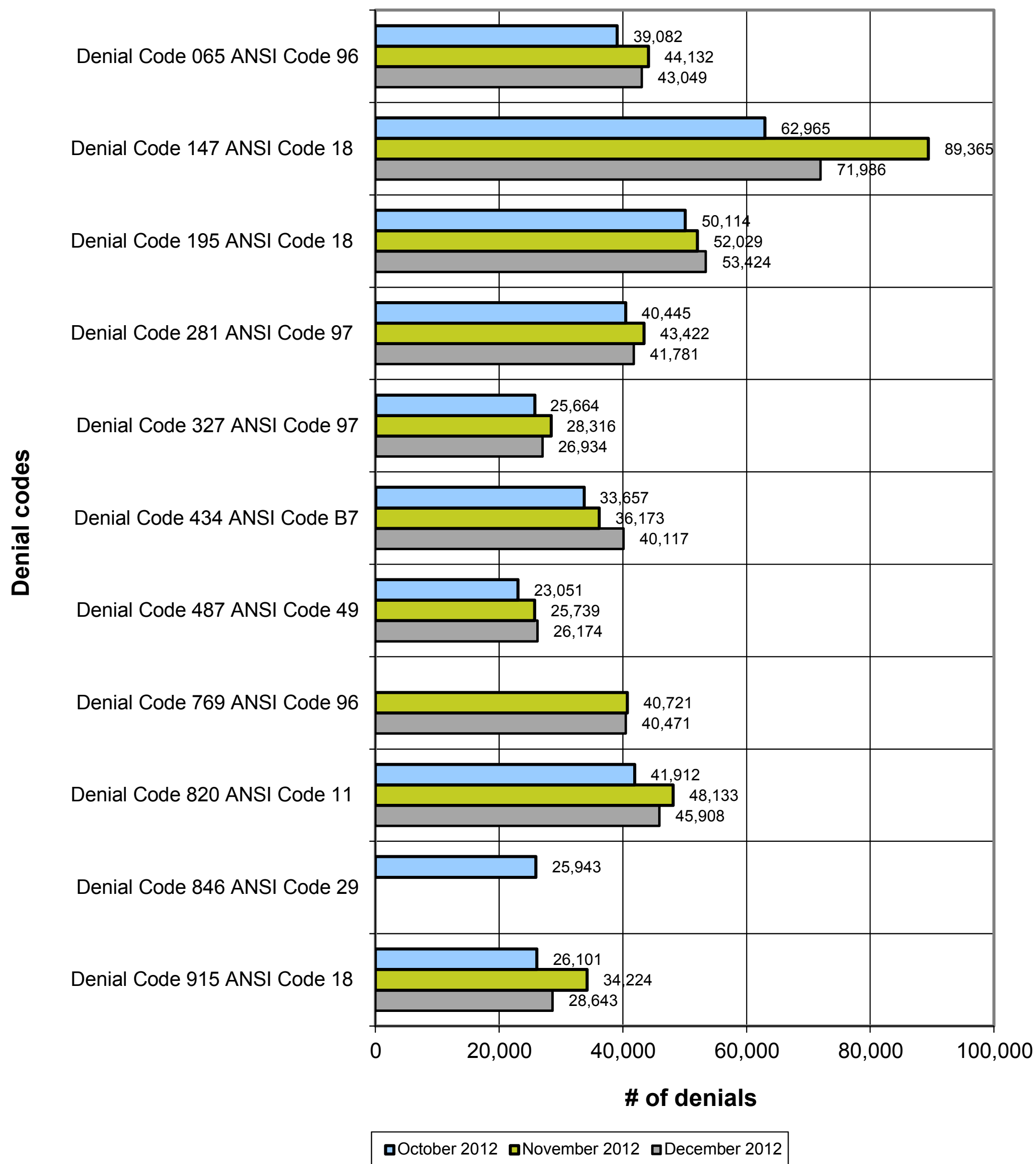

What to do when your claim is denied

Before contacting customer service, check claim status though the IVR. The IVR will release necessary details around claim denials.

Ensure all information on a claim is correct before submitting to Medicare. Example: The date(s) of service (DOS) on the claim should correspond to the number of units/days being billed.

Refer to the *Claim completion FAQs*, *Billing issues FAQs*, and *Unprocessable FAQs* on the First Coast Medicare provider website for additional information on why claims may deny and how to correct this.

You may also refer to the *Top Part B claim denials* and *RUCs* tip sheets for tips and resources on correcting and avoiding certain claim denials.

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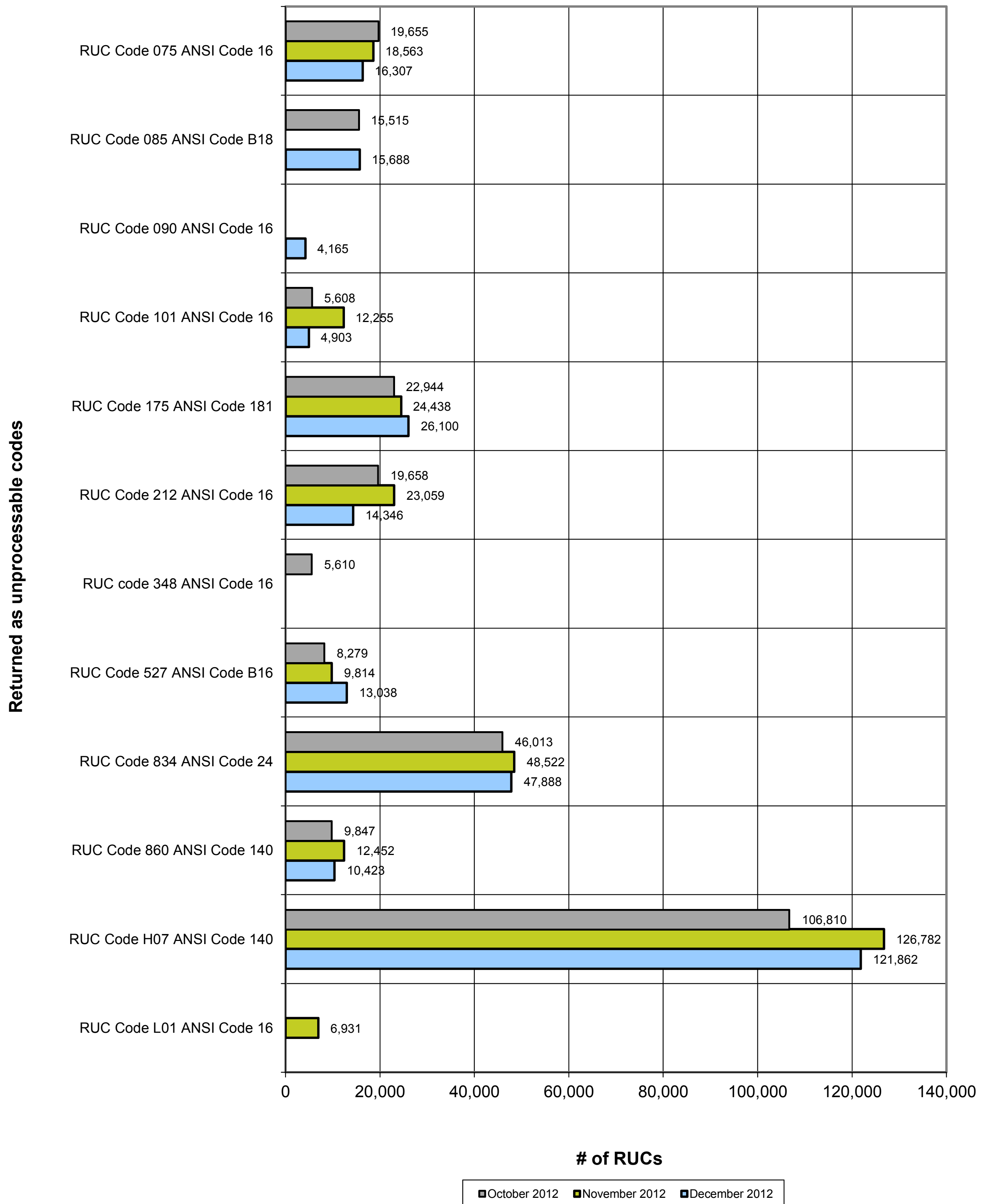

This section of *Medicare B Connection* features summaries of new and revised local coverage determinations (LCDs) developed as a result of either local medical review or comprehensive data analysis initiatives. These initiatives are designed to ensure the appropriateness of medical care and to make sure that the Medicare administrative contractor (MAC) jurisdiction 9 (J9) 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

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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.

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.

Revisions to LCDs

J0897: Bisphosphonates (intravenous [IV]) and monoclonal antibodies in the treatment of osteoporosis and their other indications – revision to the LCD

LCD ID number: L32100 (Florida/Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for bisphosphonates (intravenous [IV]) and monoclonal antibodies in the treatment of osteoporosis and their other indications was most recently revised May 1, 2012. Since that time, a revision was made under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD to add the new Food and Drug Administration (FDA) approved indication "Treatment to increase bone mass in men with osteoporosis at high risk for fracture" for Prolia®. In addition, the "Document Requirements," "Utilization Guidelines," and "Sources of Information and Basis for Decision" sections of the LCD were updated.

Effective date

This LCD revision is effective for services rendered **on or after September 1, 2012**. 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 "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

Note: To review active, future, and retired LCDs for jurisdiction 9 (J9), please *click here*.

NCSVCS: Noncovered services (*0311T*) – revision to the LCD

LCD ID number: L29288 (Florida)
LCD ID number: L29398 (Puerto Rico/U.S. Virgin Islands)

First Coast Service Options Inc. has made an additional revision to the local coverage determination (LCD) for noncovered services based on change request (CR) 7909 (2013 Healthcare Common Procedure Coding System [HCPCS] annual update). *CPT*® code *93799* (Noninvasive assessment of central blood pressure [e.g., SphygmoCor System/Device]) has been removed from the "*CPT*/HCPCS Codes, Local Noncoverage Decisions-Procedures" section of the LCD and replaced with *CPT*® code *0311T*.

Effective date

This LCD revision is effective for claims processed **on or after January 29, 2013**, for services rendered **on or after January 1, 2013**. 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 "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

Note: To review active, future, and retired LCDs for jurisdiction 9 (J9), please *click here*.

77055: Screening and diagnostic mammography – revision to the LCD

LCD ID number: L29328 (Florida)
LCD ID number: L29329 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for screening and diagnostic mammography was most recently revised January 1, 2013. Since that time, a revision was made under the "*CPT*/HCPCS Codes" and "Documentation Requirements" sections of the LCD to remove instructions related to modifier-GH and include instructions for modifier-GG based on the *Medicare Claims Processing Manual*, Chapter 18, Section 20.2-20.6. In addition, the "Coding Guidelines" attachment was revised to update the instructions for modifier-GH and add instructions for modifier-GG.

Effective date

This LCD revision is effective for claims processed **on or after March 11, 2013**, for services rendered **on or after January 1, 2002**. 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 "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

Note: To review active, future, and retired LCDs for jurisdiction 9 (J9), please *click here*.

92132: Scanning computerized ophthalmic diagnostic imaging (SCODI) – revision to the LCD

LCD ID number: L29276 (Florida)
LCD ID number: L29473 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for scanning computerized ophthalmic diagnostic imaging (SCODI) was most recently revised October 1, 2011. Since that time, the LCD has been revised based on an external reconsideration request. The "ICD-9 Codes that Support Medical Necessity" section of the LCD was revised to add ICD-9-CM codes V58.69 and V67.51 with an asterisk as these diagnosis codes apply to *CPT*® code *92134* only. The "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD was revised to add the following indication: "Monitoring patients for the development of chloroquine (CQ) and/or hydroxychloroquine (HCQ) retinopathy. Patients being treated with CQ and/or HCQ should receive a baseline examination within the first year of treatment and an annual follow-up after five years of treatment. For higher-risk patients, annual testing may begin immediately (without a five-year delay)." In addition, the "Sources of Information and Basis for Decision" section of the LCD was updated.

Effective date

This LCD revision is effective for services rendered **on or after January 29, 2013**. 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 "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

Note: To review active, future, and retired LCDs for jurisdiction 9 (J9), please *click here*.

93312: Transesophageal echocardiogram – revision to the LCD

LCD ID number: L29294 (Florida)
LCD ID number: L29401 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for transesophageal echocardiogram was most recently revised October 1, 2011. Since that time, the LCD has been revised based on an external reconsideration request. The "ICD-9 Codes that Support Medical Necessity" section of the LCD was revised to add ICD-9-CM codes 427.31 and 427.32. The "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD was revised to add the following indication: "Arrhythmias – assessment of patients with certain cardiac arrhythmias [atrial fibrillation, atrial flutter] for which the results of the test will influence treatment decisions. Transesophageal echocardiogram (TEE) may complement transthoracic echocardiography particularly to assess for left atrial thrombus." In addition, the "Sources of Information and Basis for Decision" section of the LCD was updated.

Effective date

This LCD revision is effective for services rendered **on or after January 29, 2013**. 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 "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

Note: To review active, future, and retired LCDs for jurisdiction 9 (J9), please *click here*.

Find fees faster: Try First Coast's fee schedule lookup

Now you can find the fee schedule information you need faster than ever before with First Coast's redesigned fee schedule lookup, located at *http://medicare.fcso.com/Fee_lookup/fee_schedule.asp.* This exclusive online resource features an intuitive interface that allows you to search for fee information by procedure code. Plus, you can find any associated local coverage determinations (LCDs) with just the click of a button.

Educational Events

Upcoming provider outreach and educational events February – March 2013

E/M under review: 99215 and critical care

When: Wednesday, February 20
Time: 11:30 a.m.-1:00 p.m.

Medifest 2013 Fort Lauderdale; Building a stronger Medicare community through education

When: Tuesday-Wednesday, March 12-13
Time: 8:00 a.m.-4:30 p.m.
Type of event**:** Face-to-face

Note: Unless otherwise indicated, all First Coast educational offerings are considered to be "ask-the-contractor" events, "webcast" type of event, designated times are stated as ET, and the focus is to Florida, Puerto Rico, and the U.S. Virgin Islands.

Two easy ways to register

Online – Visit our provider training website at *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 our 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.

Additional Resources

CMS Medicare Provider e-News

The Centers for Medicare & Medicaid Services (CMS) Medicare Provider e-News 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. To improve consistency and to streamline operations in messaging to the FFS provider community across all Medicare information channels, CMS conducted a pilot that ended September 30, 2012; however, CMS has extended it until further notice. The following are links to the latest e-News:

- CMS e-News for Wednesday, January 4, 2013 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-01-04-Enews.pdf*
- 'CMS Medicare FFS Provider e-News': January 10, 2013 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-01-10-Enews.pdf*
- 'CMS Medicare FFS Provider e-News': January 17, 2013 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-01-17-eNews.pdf*
- 'CMS Medicare FFS Provider e-News': January 24, 2013 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-01-24-eNews.pdf*

Source: CMS PERL 201301-02, 201301-03, 201301-04, 201301-05

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.*

Mail directory

Claims submissions

Routine paper claims
Medicare Part B
P. O. Box 2525
Jacksonville, FL 32231-0019

Participating providers
Medicare Part B participating providers
P. O. Box 44117
Jacksonville, FL 32231-4117

Chiropractic claims
Medicare Part B chiropractic unit
P. O. Box 44067
Jacksonville, FL 32231-4067

Ambulance claims
Medicare Part B ambulance dept.
P. O. Box 44099
Jacksonville, FL 32231-4099

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

ESRD claims
Medicare Part B ESRD claims
P. O. Box 45236
Jacksonville, FL 32232-5236

Communication

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

Fair hearing requests
Medicare hearings
P.O. Box 45156
Jacksonville FL 32232-5156

Freedom of Information Act
Freedom of Information Act requests
P.O. Box 2078
Jacksonville, Florida 32231

Administrative law judge hearing
Q2 Administrators, LLC
Part B QIC South Operations
P.O. Box 183092
Columbus, Ohio 43218-3092
Attn: Administration manager

Status/general inquiries
Medicare Part B correspondence
P. O. Box 2360
Jacksonville, FL 32231-0018

Overpayments
Medicare Part B financial services
P. O. Box 44141
Jacksonville, FL 32231-4141

Durable medical equipment (DME)

DME, orthotic or prosthetic claims
Cigna Government Services
P.O. Box 20010
Nashville, Tennessee 37202

Electronic media claims (EMC)

Claims, agreements and inquiries
Medicare EDI
P. O. Box 44071
Jacksonville, FL 32231-4071

Additional development

Within 40 days of initial request:
Medicare Part B Claims
P. O. Box 2537
Jacksonville, FL 32231-0020

Over 40 days of initial request: Submit the charge(s) in question, including information requested, as you would a new claim, to:
Medicare Part B Claims
P. O. Box 2525
Jacksonville, FL 32231-0019

Miscellaneous

Provider participation and group membership issues; written requests for UPINs, profiles & fee schedules:
Medicare Enrollment
P. O. Box 44021
Jacksonville, FL 32231-4021

Provider change of address:
Medicare Enrollment
P. O. Box 44021
Jacksonville, FL 32231-4021
and
Provider Enrollment Department
Blue Cross Blue Shield of Florida
P. O. Box 41109
Jacksonville, FL 32203-1109

Provider education

Educational purposes and review of customary/prevailing charges or fee schedule:
Medicare Part B
Provider Outreach and Education
P. O. Box 2078
Jacksonville, FL 32231-0048

Education event registration:
Medicare Part B
Medicare Education and Outreach
P. O. Box 45157
Jacksonville, FL 32232-5157

Limiting charge issues:
Processing errors:
Medicare Part B
P. O. Box 2360
Jacksonville, FL 32231-0048

Refund verification:
Medicare Part B
Compliance Monitoring
P. O. Box 2078
Jacksonville, FL 32231-0048

Medicare claims for Railroad retirees:
Palmetto GBA
Railroad Medicare Part B
P. O. Box 10066
Augusta, GA 30999-0001

Fraud and abuse
First Coast Service Options Inc.
Complaint Processing Unit
P. O. Box 45087
Jacksonville, FL 32232-5087

Phone numbers

Providers

Toll-Free
Customer Service:
1-866-454-9007

Interactive Voice Response (IVR):
1-877-847-4992

Email address: *AskFloridaB@fcso.com*

FAX: 1-904-361-0696

Beneficiary
Toll-Free:
1-800-MEDICARE
Hearing Impaired:
1-800-754-7820

Note: The toll-free customer service lines are reserved for Medicare beneficiaries only. Use of this line by providers is not permitted and may be considered program abuse.

Education event registration (not toll-free):

1-904-791-8103

Electronic data interchange (EDI)

1-888-670-0940

Option 1 -Transaction support

Option 2 - PC-ACE support

Option 4 - Enrollment support

Option 5 - 5010 testing

Option 6 - Automated response line

DME, orthotic or prosthetic claims

Cigna Government Services
1-866-270-4909

Medicare Part A

Toll-Free:
1-888-664-4112

Medicare websites

Provider

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

Centers for Medicare & Medicaid Services
www.cms.gov

Beneficiaries

Centers for Medicare & Medicaid Services
www.medicare.gov

Mail directory

Claims, additional development, general correspondence

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

Flu rosters

First Coast Service Options Inc.
P. O. Box 45031
Jacksonville, FL 32232-5031

Electronic data interchange (EDI)

First Coast Service Options Inc.
P. O. Box 44071
Jacksonville, FL 32231-4071

Part B debt recovery, MSP inquiries and overpayments, and cash management

First Coast Service Options Inc.
P.O. Box 45013
Jacksonville, FL 32232-5013

Provider enrollment

Where to mail provider/supplier applications
Provider Enrollment
P.O. Box 44021
Jacksonville, FL 32231-4021

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

and

Provider Registration Department
Blue Cross Blue Shield of Florida
P. O. Box 41109
Jacksonville, FL 32231-1109

Redeterminations

First Coast Service Options Inc.
P. O. Box 45024
Jacksonville, FL 32232-5091

Redetermination overpayment

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

Freedom of Information Act requests (FOIA)

First Coast Service Options Inc.
P. O. Box 45073
Jacksonville, FL 32232-5073

Congressional inquiries

First Coast Service Options Inc.
Attn: Carla-Lolita Murphy
P. O. Box 2078
Jacksonville, FL 32231-0048

Provider education

Educational purposes and review of customary/prevailing charges or fee schedule:
Medicare Part B
Provider Outreach and Education
P. O. Box 2078
Jacksonville, FL 32231-0048

Education event registration:
Medicare Part B
Medicare Education and Outreach
P. O. Box 45157
Jacksonville, FL 32232-5157

Medicare claims for railroad retirees

Palmetto GBA
Railroad Medicare Part B
P. O. Box 10066
Augusta, GA 30999-0001

Fraud and abuse

First Coast Service Options Inc.
Complaint Processing Unit
P. O. Box 45087
Jacksonville, FL 32232-5087

Local coverage determinations

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

Post pay medical review

First Coast Service Options Inc.
P. O. Box 44288
Jacksonville, FL 32231-4288

Overnight mail and/or other special courier services

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

Medicare websites

Provider

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

Centers for Medicare & Medicaid Services

www.cms.gov

Beneficiaries

Centers for Medicare & Medicaid Services
www.medicare.gov

Phone numbers

Provider customer service

1-866-454-9007

Interactive voice response (IVR)

1-877-847-4992

Email address:
AskFloridaB@fcso.com

FAX: 1-904-361-0696

Beneficiary customer service

1-800-MEDICARE
Hearing Impaired:
1-800-754-7820

Note: The toll-free customer service lines are reserved for Medicare beneficiaries only. Use of this line by providers is not permitted and may be considered program abuse.

Education event registration

1-904-791-8103

Electronic data interchange (EDI)

1-888-670-0940

Option 1 -Transaction support

Option 2 - PC-ACE support

Option 4 - Enrollment support

Option 5 - 5010 testing

Option 6 - Automated response line

DME, orthotic or prosthetic claims

Cigna Government Services
1-866-270-4909

Medicare Part A

Toll-Free:
1-888-664-4112

Addresses

Claims
Additional documentation
General mailing
Congressional mailing
First Coast Service Options Inc.
P.O. Box 45036
Jacksonville, FL 32232-5036

Redeterminations
First Coast Service Options Inc.
P.O. Box 45056
Jacksonville, FL 32232-5056

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

Post-payment medical exams
First Coast Service Options Inc.
P.O. Box 44159
Jacksonville, FL 32231-4159

Freedom of Information Act (FOIA) related requests
First Coast Service Options Inc.
P.O. Box 45092
Jacksonville, FL 32232-5092

Medicare fraud and abuse
First Coast Service Options Inc.
P.O. Box 45087
Jacksonville, FL 32232-5087

Provider enrollment
Mailing address changes
First Coast Service Options Inc.
Provider Enrollment
Post Office Box 44021
Jacksonville, FL 32231-4021

Electronic Data Interchange (EDI)
First Coast Service Options Inc.
P.O. Box 44071
Jacksonville, FL 32231-4071

Flu vaccinated list
First Coast Service Options Inc.
P.O. Box 45031
Jacksonville, FL 32232-5031

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

Debt collection
Overpayments, questions about Medicare as a secondary payer, cash management
First Coast Service Options Inc.
P.O. Box 45040
Jacksonville, FL 32232-5040

Overnight mail and other special handling postal services
First Coast Service Options Inc.
532 Riverside Avenue
Jacksonville, FL 32202-4914

Other Medicare contractors and intermediaries

Durable Medical Equipment Regional Carrier (DMERC)
CIGNA Goverment Services
P. O. Box 20010
Nashville, Tennessee 37202

Regional Home Health & Hospice Intermediary
Palmetto Goverment Benefit Administrators
Medicare Part A
P.O. Box 100238
Columbia, SC 29202-3238

Railroad Medicare
Palmetto Goverment Benefit Administrators
P. O. Box 10066
Augusta, GA 30999-0001

Phone numbers

Providers
Customer service – free of charge
Monday to Friday
8:00 a.m. to 4:00 p.m.
1-877-715-1921

For the hearing and speech impaired (TDD)
1-888-216-8261

Interactive voice response (IVR)
1-877-847-4992

Beneficiary
Customer service – free of charge
1-800-MEDICARE
1-800-633-4227

Hearing and speech impaired (TDD)
1-800-754-7820

Electronic Data Interchange
1-888-875-9779

Educational Events Enrollment
1-904-791-8103

Fax number
1-904-361-0407

Website for Medicare

Providers
First Coast – MAC J9
medicare.fcso.com
medicareespanol.fcso.com

Centers for Medicare & Medicaid Services
www.cms.gov

Beneficiary
Centers for Medicare & Medicaid Services
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 9 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 2012 through September 2013.	40300260	$33		
2013 Fee Schedule – The Medicare Part B Physician and Nonphysician Practitioner Fee Schedules, effective for services rendered January 1 through December 31, 2013, 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:** 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)

Medicare B Connection

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

Attention Billing Manager