Medicare B CONNECTION

FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction 9 Providers February 2014

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Updated mobile applications for open payments

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

What you need to know

The Centers for Medicare & Medicaid Services (CMS) is issuing this article to alert the provider community of updates to the mobile applications (apps), Open Payments Mobile for Industry and Open Payments Mobile for Physicians, implemented as a result of user feedback to CMS. See the *Background* and *Key points* sections of this article for details.

Also, a part of SE1402 is new technical documentation: "The Open Payments QR Code Reader How-To Guide." Included are the technical instructions for creating or importing contact information using a QR code reader and generating a QR code to transfer profile or payment information to other user devices.

Background

In July 2013, CMS released two mobile apps: Open Payments Mobile for Industry and Open Payments Mobile for Physicians. Below are enhancements to the original open payments mobile apps. The changes to the apps include the following:

- Streamlining the menu on the Welcome screen;
- Adding the ability to export all profile data associated with a payment into CSV format; and
- Developing a new function to view reports of payments in bar and pie charts.

The apps are intended to support reporting under the Open Payments program. For more details refer to: *http://www.cms.gov/Regulations-and-Guidance/Legislation/National-Physician-Payment-Transparency-Program/index.html*. For help with the apps contact the CMS helpdesk at *OpenPayments@cms.hhs.gov*.

Key points of SE1402

If you already downloaded the apps, you will need to run an update to take advantage of the new app functionality. To do so, visit either the Google Play™ app store or iOSApple™ app store, look for your available updates, and select the Open Payments apps to download the updates. If you have not yet downloaded the apps, search for open payments in the applicable app store and you'll be prompted to download the newly updated versions.

In response to user feedback, the table below describes the enhancements made to the apps since their initial launch in July 2013. All changes are intuitive and will add elements of ease expected by app users.

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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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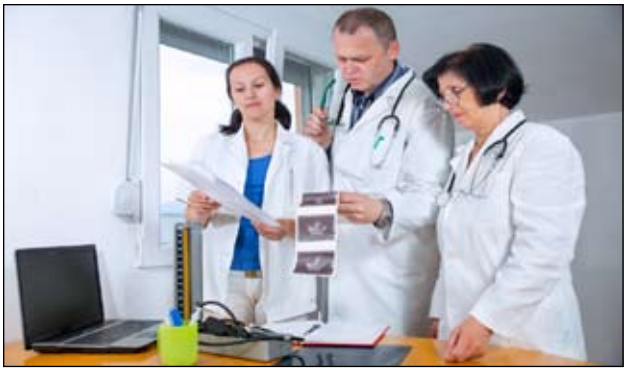
About the *Medicare B Connection*

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 at *http://medicare.fcso.com*. In some cases, additional unscheduled special issues may be posted.

Who receives the Connection

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



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

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

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

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

Publication format

The *Connection* is arranged into distinct sections.

- The **Claims** section provides claim submission requirements and tips.
- The **Coverage/Reimbursement** section discusses specific *CPT*® and HCPCS procedure codes. It is arranged by categories (not specialties). For example, "Mental Health" would present coverage information of interest to psychiatrists, clinical psychologists and clinical social workers, rather than listing articles separately under individual provider specialties. Also presented in this section are changes to the Medicare physician fee schedule, and other pricing issues.
- The section pertaining to **Electronic Data Interchange** (EDI) submission also includes information pertaining to the Health Insurance Portability and Accountability Act (HIPAA).
- The **Local Coverage Determination** section features summaries of new and revised local coverage determinations (LCDs) developed as a result of either local medical review or comprehensive data analysis initiatives.
- The **General Information** section includes fraud and abuse, and national provider identifier topics, plus additional topics not included elsewhere.

In addition to the above, other sections include:

- **Educational Resources**, and
- **Contact information** for Florida, Puerto Rico, and the U.S. Virgin Islands.

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

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

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 (waiver of liability statement on file).

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

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

Part B claims submission under the indirect payment procedure

Provider types affected

This *MLN Matters*® article is intended for entities submitting paper claims under the indirect payment procedure (IPP) to Medicare administrative contractors (MACs), including durable medical equipment Medicare administrative contractors (DME MACs), for services to Medicare beneficiaries.

Provider action needed

Stop – impact to you

This article is based on change request (CR) 8266, which establishes a process for IPP entities to submit paper claims for qualified Part B expenditures, including physician services, supplier services, and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS).

CR 8266 establishes the framework for the IPP process. See SE1406 in this same section for registration instructions

Caution – what you need to know

This article describes the process established for IPP entities to submit paper claims for qualified Part B expenditures for claims processed on or after January 1, 2014.

- IPP claims for DMEPOS, including drugs administered via DME, will continue to be processed by the DME MACs.
- IPP claims for other Part B services, including drugs administered incident to a physician service, will continue to be processed by the Part B MACs.

IPP entities are generally required to adhere to standard Medicare policies and procedures that would apply to a physician or other supplier billing for a Part B item or service. Therefore, such IPP entities are expected to know and comply with the relevant Medicare fee-for-service policies and procedures, which may be found in the "CMS Internet Only Manual" at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html* and such applicable updates commonly published by CMS as transmittals, which may be found at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/index.html*.

Go – what you need to do

- IPP entities and their billing staffs should be aware that CR 8266 directs Medicare contractors to implement the framework needed within the Medicare claim processing system to handle IPP claims.
- You may not begin submitting claims until you are registered and approved to submit IPP claims.
- Watch for a separate CR which will outline the registration process for IPP entities.

Background

The process by which the CMS accepts and processes claims submitted by entities that provide coverage complementary to Medicare Part B is called the IPP. If an entity:

1) meets all of the requirements of the regulation at 42 *Code of Federal Regulations* (CFR) Section 424.66,
2) is registered as an "IPP entity" in accordance with the instructions in *Medicare Program Integrity Manual*, Pub. 100-08, Chapter 15, Section 15.7.9 through 15.7.9.7, and
3) submits claims in accordance with the specifications of CR 8266, then Medicare may pay that IPP entity for Part B items and services furnished to a Medicare beneficiary by a physician or other supplier.

Although the IPP differs in many respects from the direct payment process, the most important features of Medicare Part B coverage policy, fee-for-service payment policy, fee-for-service billing procedures, and related matters adhere to the same Medicare Part B standards to which direct billers are subject. Accordingly, CR 8266 focuses mostly on the differences that the IPP requires and on eliminating potential ambiguities that the IPP might generate.

Though CR 8266 implements the framework needed within the claims processing system to handle IPP claims, IPP entities may not begin submitting claims until they are registered and approved to submit IPP claims. Implementation of the registration process for IPP entities will be handled in a separate CR.

Medicare policy for IPP entities

Because IPP entities do not meet the definition of a "health care provider" (as described in 45 CFR Section 160.103), such entities are not eligible for a national provider identifier (NPI). Therefore, in order to facilitate the submission of IPP entities claims, IPP entities must apply for and receive either a health plan identifier (HPID) or another entity identifier (OEID) as specified by 45 CFR Section 162.

For more information on the HPID and the OEID, go to *http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Affordable-Care-Act/Health-Plan-Identifier.html*.

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IPP *(continued)*

Policies and procedures applicable to claim submission by, and payment to, IPP entities will be different in several aspects from those normally applied to physicians and other suppliers that bill directly for Part B items and services. These IPP-specific policies and procedures follow.

General policies

1. The IPP is available only to an entity that: (1) meets all of the requirements of the regulation at 42 CFR Section 424.66; (2) is registered as an IPP entity in accordance with the instructions in the *Medicare Program Integrity Manual*, Chapter 15, Sections 15.7.9 through 15.7.9.7; and (3) submits IPP claims in accordance with the terms of CR 8266.
2. An IPP entity that submits claims under the IPP is subject to standard Medicare policies and procedures, including but not limited to Medicare Part B coverage policies, payment policies, billing procedures, and related policies and procedures except as specified in this transmittal and all other applicable CMS directives.
3. In the event of an actual or perceived conflict between standard Medicare Part B processes and IPP, the specifications of CR 8266 and any other IPP-specific CRs that may be issued in the future will govern the IPP.
4. IPP entities cannot enter into a participation agreement (Form CMS-460) with Medicare. (Section 1842(h)(1) of the Social Security Act permits only "physicians and suppliers" to enter into participation agreements; an IPP entity does not meet the definition of a "supplier" as described in 42 CFR section 400.202.) Therefore, IPP claims are paid at the non-participating physician/supplier rate, which is 95 percent of the physician fee schedule amount.
5. An IPP entity may choose to file IPP claims for only some items and services, or for some enrollees, or a combination thereof.

Coverage and payment policies

1. All payments to IPP entities shall be made in accordance with general Medicare fee-for-service coverage and payment policies.
2. No payment shall be made to IPP entities for any item or service that is not covered by Medicare Part B on the date of service (DOS).
3. No payment shall be made for any item or service furnished by a physician or other supplier that was not, on the DOS, enrolled in Medicare in the applicable specialty required or permitted for furnishing the item or service.
4. No payment shall be made to an IPP entity for any item or service furnished to an individual who was not entitled to, and enrolled in, Medicare Part B as a beneficiary for the DOS.
5. No payment shall be made to an IPP entity for any item or service if payment is prohibited because a statutory exclusion applies or if payment is otherwise barred under any applicable statutory or regulatory standard.
6. No payment shall be made for any item or service furnished by a "provider", as that term is defined in 42 C.F.R. Section 400.202.
7. No incentive payment shall be made to an IPP entity. Such payments include, but are not necessarily limited to, the following incentive payments: health professional shortage area (HPSA), primary care incentive payment (PCIP), HPSA surgical incentive payment (HSIP), e-Prescribing, physician quality reporting systems (PQRS), and electronic health records (EHR).
8. IPP entities must accept assignment on all IPP claims.
9. Medicare secondary payer rules apply. Medicare will not make payment on an IPP claim when CMS records show that Medicare is not the primary payer for a particular claim.
10. Medicare payment can only be made once for a beneficiary's particular service. If an IPP entity submits a claim for a beneficiary's service that has already been billed to and paid by Medicare (for example, the claim was submitted by a physician before the IPP entity submitted its claim), then Medicare cannot make payment to the IPP entity for that same service. Conversely, if a physician or supplier submits a claim for a beneficiary's service that has already been billed to and paid by Medicare (for example, the claim was submitted by an IPP entity before the physician submitted his claim), then Medicare cannot make payment to the physician for that same service.

IPP billing and claims processing policies

1. Standard claims submission and processing rules will generally apply to IPP billing. The IPP entity must submit claims that conform to Medicare requirements for physicians and other suppliers except as noted in CR 8266. Clarifications and exceptions to standard Medicare claims submission and processing rules are noted below.
2. Standard claims filing jurisdiction rules apply to IPP billing. As such, the location of the IPP entity is irrelevant to establishing claims filing jurisdiction.
    a. Claims for most Part B services, including drugs administered incident to a physician service, will generally be processed by MACs. Claims filing jurisdiction for such claims is based on the location where the service was performed, i.e., where the physician or other supplier performed the service.

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IPP *(continued)*

b. Claims for most DMEPOS items and supplies, including drugs administered via DME, will generally be processed by the DME MACs. Claims filing jurisdiction for most DMEPOS claims is based on the location where the beneficiary permanently resides. Claims for some items of DME, such as implantable devices, must be submitted to the same MAC to which the surgical service claim was submitted. (Although IPP entities are generally permitted to submit some claims under the IPP but not others, if the IPP entity elects to submit a claim for an implantable device under the IPP, the IPP entity must also submit the related surgical claim. Otherwise, the claim for the implanted device will be denied.) CMS publishes an annual DMEPOS jurisdiction list that indicates the claims filing jurisdiction for items of DMEPOS.

3. Standard claims completion and submission rules generally apply to IPP billing. Exceptions are as follows:

   a. The IPP entity must submit all IPP claims on the paper claim form CMS-1500 until such time as an electronic claims submission process is established for IPP claims. MACs will reject and return as unprocessable all IPP claims submitted on any other form or in any other format.

   b. The IPP entity must, on all IPP claims, include its name and address in Item 33 of the CMS-1500.

   c. The IPP entity must include its HPID or OEID in Item 33b of the CMS-1500, preceded by qualifier “XV”. For example, if an IPP entity has an OEID of 2222222222, then the value entered in Item 33b should be “XV2222222222”.

   d. The IPP entity must annotate its tax identification number (TIN) in Item 25 of the CMS-1500.

   e. The IPP entity must include the NPI of the rendering physician or supplier in Item 24J of the CMS-1500.

   f. The IPP entity must include the name and NPI of the ordering or referring physician in Item 17 of the CMS-1500.

   g. The IPP entity must not submit an IPP claim, except a DMEPOS claim, until it is registered as an IPP entity with the appropriate MAC that has claims filing jurisdiction for the IPP claim. The IPP entity must not submit an IPP DMEPOS claim until it is registered as an IPP entity with the national supplier clearinghouse (NSC), at which time the IPP entity may file a DMEPOS claim to the DME MAC having jurisdiction for adjudicating such a claim. Once registered, the IPP entity may file any IPP claim that predates the effective date of its registration as an IPP entity provided the claims meet the timely filing rule specified in 42 CFR Section 424.44.

4. Standard claims processing rules generally apply to IPP billing. The specifications of the business requirements in CR 8266 are controlling, but the following are noted for emphasis.

   d. MACs shall reject and return as unprocessable an IPP claim that is submitted with missing, incomplete, or invalid information, including but not limited to the information specified in paragraph 3, above.

   e. MACs shall append demonstration code “70” to all IPP claims upon receipt. IPP claims shall be identified by the presence of an HPID or OEID belonging to a registered IPP entity in Item 33b of the CMS-1500 claim form.

Medicare secondary payer & coordination of benefits

1. Medicare secondary payer (MSP) rules apply. Medicare will not make primary payment on an IPP claim when CMS records show that Medicare is not the primary payer for a particular claim. MACs will inform beneficiaries regarding the applicability of MSP to IPP initial determinations via Medicare summary notice (MSN) message 29.35.

2. IPP claims are excluded from the national coordination of benefits agreement (COBA) crossover process.

Additional information

The official instruction, CR 8266 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2860CP.pdf*.

If you have any questions, please contact your 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: MM8266
Related Change Request (CR) #: CR 8266
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Related CR Transmittal #: R2860CP
Implementation Date: January 6, 2014

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Registration of entities using the indirect payment procedure

Provider types affected

This *MLN Matters*® special edition (SE) article is intended for entities that may register for indirect payment of claims submitted to Medicare contractors (A/B Medicare administrative contractors (MACs) and durable medical equipment MACs (DME MACs)) for services furnished to Medicare beneficiaries.

What you need to know

Stop – impact to you

Medicare Part B payment otherwise payable to an enrollee for the services of a physician or other supplier who charges on a fee-for-service (FFS) basis may be paid to an entity under the indirect payment procedure (IPP).

Caution – what you need to know

This SE article outlines the IPP registration process for these entities.

Go – what you need to do

Make sure that your billing staffs are aware of the IPP registration process.

Background

Medicare Part B payment otherwise payable to a beneficiary for the services of a physician or other supplier who charges on a fee-for-service basis may be paid to an entity under the IPP if the conditions described in 42 CFR § 424.66 are met.

Under 42 CFR § 424.66, Medicare may pay an "IPP entity" (such as an employer, union, insurance company, retirement home, health care prepayment plan, health maintenance organization, competitive medical plan, or Medicare Advantage plan) for Part B services furnished by a physician or other supplier if the entity meets all of the following requirements:

1. Provides coverage of the service under a complementary health benefit plan (this is, the coverage that the plan provides is complementary to Medicare benefits and covers only the amount by which the Part B payment falls short of the approved charge for the service under the plan);
2. Has paid the person who provided the service an amount (including the amount payable under the Medicare program) that the person accepts as full payment;
3. Has the written authorization of the beneficiary (or of a person authorized to sign claims on his/her behalf under 42 CFR § 424.36) to receive the Part B payment for the services for which the entity pays;
4. Relieves the beneficiary of liability for payment for the service and will not seek any reimbursement from the beneficiary, his/her survivors, or estate;
5. Submits any information that CMS or the contractor may request, including an itemized physician or supplier bill, in order to apply the requirements under the Medicare program; and
6. Identifies and excludes from its requests for payment all services for which Medicare is the secondary payer.

(You can find 42 CFR § 424.66 at *http://www.gpo.gov/fdsys/granule/CFR-2010-title42-vol3/CFR-2010-title42-vol3-sec424-66/content-detail.html*.)

As an illustration, suppose an entity furnishes complementary coverage for its retired union members and is a retiree drug subsidy plan sponsor. The entity may seek to (1) pay in full its retired members' drug benefits and other Part B services, (2) bill the Part B services to Medicare, and (3) receive payment for Medicare claims.

It is important to note that an IPP entity is not a Medicare provider or supplier, is not eligible for a national provider identifier, and cannot enroll in the Medicare program. Nevertheless, it is crucial that Medicare obtain sufficient background information on prospective IPP entities to help ensure the integrity, accuracy, and legitimacy of Medicare payments. Such entities will therefore be required to complete the IPP registration process described below (and in more detail in CR 8284) before they can submit claims via the IPP. CMS will apply the Form CMS-855 process to IPP entities consistent with CMS' authority to request information under 42 CFR § 424.66.

Contractor jurisdiction

Claims for all Part B items and services – other than for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) – must be submitted to the A/B MAC based on where the service was performed or the item was furnished. Almost all claims for DMEPOS must be submitted to the DME MAC based on where the beneficiary resides; however, claims for Medicare-covered implantable devices (although

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Registration *(continued)*

classified as DME) are submitted to the A/B MAC based on where the implant surgery was performed. These jurisdictional rules for claim submission apply to the submission of registration applications.

Registration process

To register as an IPP entity, you must:

1) Complete and submit:
   a. A paper Form CMS-855B application to each A/B MAC to which you intend to submit claims, and/or
   b. A paper Form CMS-855S application to the national supplier clearinghouse (NSC) if you intend to submit claims to a DME MAC.
2) Complete and submit a paper Form CMS-588 (Electronic Funds Transfer (EFT) Agreement) with your Form CMS-855 application.
3) Submit with each Form CMS-855 application an attestation statement signed by an "authorized official" (as that term is defined in 42 CFR § 424.502) certifying that for each claim you submit, all of the requirements of 42 CFR § 424.66 are met. The certification statement on the Form CMS-855 supplements (but does not supplant) the attestation. An IPP entity is bound by the terms of the Form CMS-855 certification statement to the same extent it is bound by the attestation's terms.

(**Note**: Since you may be submitting applications in multiple MAC jurisdictions, it is acceptable to submit a photocopy of a signed attestation rather than an originally signed attestation.)

4) Apply for and receive either a health plan identifier (HPID) or another entity identifier (OEID), furnish it in the appropriate section of the Form CMS-855, and submit actual issuance documentation with each Form CMS-855 application (for example, an issuance notice from the HPID or OEID that includes the number). See CMS' main website at *http://www.cms.gov* for information on how to obtain a HPID or OEID.

(5) You need not:
   a. Submit licensure or certification information
   b. Report medical record storage information
   c. Pay an application fee
   d. Submit a Form CMS-460 (Medicare Participating Physician or Supplier Agreement) e. Meet the DMEPOS (i) supplier standards, (ii) accreditation requirements, (iii) surety bond requirements, or (iv) liability insurance requirements

Processing of registration applications

Upon receipt of your Form CMS-855 registration application, the Medicare contractor will begin processing it. This includes:

   a. Ensuring that the application is complete
   b. Verifying the information on the application
   c. Ensuring that the attestation described above is submitted, signed by an authorized official, and contains the required language
   d. As needed, asking you for additional or clarifying information to determine whether you are in compliance with the provisions of 42 CFR § 424.66 and all other requirements. It is important that you furnish such information to the Medicare contractor promptly. Failure to do so may result in the rejection of your application.
   e. Assigning the appropriate specialty code.

If the Medicare contractor and CMS determine that you meet all requirements, the Medicare contractor will (1) establish an effective date of registration; (2) send you an approval letter via regular mail or e-mail, and (3) assign a provider transaction identification number (PTAN). Please note that after you are registered as an IPP entity, the Medicare contractor (consistent with 42 CFR § 424.66(a)) may request additional information to confirm your continued compliance with all requirements. Moreover, an IPP entity is required to submit to the Medicare contractor all changes to its Form CMS-855 information in accordance with the terms of its signed Form CMS-855 certification statement.

If the Medicare contractor and CMS determine that you do not meet all requirements, your application will be denied. You will receive a letter outlining (1) the specific reason(s) for the denial and (2) your appeal rights.

Additional information

Please review CR 8284 for more detailed information regarding the registration process. CR 8284 is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R502PI.pdf*.

If you have any questions, please contact your Medicare contractor 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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Non-physician specialty code for indirect payment procedure billers

Provider types affected

This *MLN Matters*® article is intended for non-physician practitioners submitting claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

Provider action needed

Effective October 1, 2013, the Centers for Medicare & Medicaid Services (CMS) will use physician specialty code C2 as the primary and/or secondary specialty code for the indirect payment procedure (IPP) billers. IPP billers should self-designate their Medicare specialty on the appropriate Form CMS-855 application when they register in the Medicare program. Specialty codes are used by CMS for programmatic and claims processing purposes.

Background

Certain health benefit plans furnish Medicare complementary coverage for their members. If such an entity qualifies as an IPP biller under 42 CFR section 424.66[i], which may be viewed at *http://www.gpo.gov/fdsys/pkg/CFR-2010-title42-vol3/pdf/CFR-2010-title42-vol3-sec424-66.pdf*, it may seek payment in the Medicare fee-for-service program for Part B items and services furnished to a Medicare beneficiary by a physician or other supplier. CR 8282 announces that CMS established a new non-physician specialty code of C2 (indirect payment procedure), effective October 1, 2013. The Provider Enrollment, Chain and Ownership System (PECOS) and MACs will recognize and use this new specialty code.

Additional information

The official instruction, CR 8282 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2721CP.pdf*. A related transmittal that updates the *Medicare Financial Management Manual* is *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R221FM.pdf*.

If you have any questions, please contact your 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 CR Transmittal #: R2721CP and R221FM
Implementation Date: October 7, 2013

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Medicare fee-for-service claim processing guidance for implementing ICD-10 – reissue of MM7492

Provider types affected

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

Provider action needed

For dates of service on and after October 1, 2014, entities covered under the Health Insurance Portability and Accountability Act (HIPAA) are required to use the ICD-10 code sets in standard transactions adopted under HIPAA. The HIPAA standard health care claim transactions are among those for which ICD-10 codes must be used for dates of service on and after October 1, 2014. As a result of change request (CR) 7492 (and related *MLN Matters*® article MM7492), guidance was provided on processing certain claims for dates of service near the original October 1, 2013, implementation date for ICD-10. This article updates MM7492 to reflect the October 1, 2014, implementation date. Make sure your billing and coding staffs are aware of these changes.

Key points of SE1408

General reporting of ICD-10

As with ICD-9 codes today, providers and suppliers are still required to report all characters of a valid ICD-10 code on claims. ICD-10 diagnosis codes have different rules regarding specificity and providers/suppliers are required to submit the most specific diagnosis codes based upon the information that is available at the time. Please refer to *http://www.cms.gov/Medicare/Coding/ICD10/index.html* for more information on the format of ICD-10 codes. In addition, ICD-10 procedure codes (PCs) will only be utilized by inpatient hospital claims as is currently the case with ICD-9 procedure codes.

General claim submissions information

ICD-9 codes will no longer be accepted on claims (including electronic and paper) with FROM dates of service (on professional and supplier claims) or dates of discharge/through dates (on institutional claims) on or after October 1, 2014. Institutional claims containing ICD-9 codes for services on or after October 1, 2014, will be returned to provider (RTP) as unprocessable.

Likewise, professional and supplier claims containing ICD-9 codes for dates of services on or after October 1, 2014, will also be returned as unprocessable. You will be required to re-submit these claims with the appropriate ICD-10 code. A claim cannot contain both ICD-9 codes and ICD-10 codes. Medicare will RTP all claims that are billed with both ICD-9 and ICD-10 diagnosis codes on the same claim. For dates of service prior to October 1, 2014, submit claims with the appropriate ICD-9 diagnosis code. For dates of service on or after October 1, 2014, submit with the appropriate ICD-10 diagnosis code.

Likewise, Medicare will also RTP all claims that are billed with both ICD-9 and ICD-10 procedure codes on the same claim. For claims with dates of service prior to October 1, 2014, submit with the appropriate ICD-9 procedure code. For claims with dates of service on or after October 1, 2014, submit with the appropriate ICD-10 procedure code. Remember that ICD-10 codes may only be used for services provided on or after October 1, 2014. Institutional claims containing ICD-10 codes for services prior to October 1, 2014, will be RTP. Likewise, professional and supplier claims containing ICD-10 codes for services prior to October 1, 2014, will be returned as unprocessable. Please submit these claims with the appropriate ICD-9 code.

Claims that span the ICD-10 implementation date

The Centers for Medicare & Medicaid Services (CMS) has identified potential claims processing issues for institutional, professional, and supplier claims that span the implementation date; that is, where ICD-9 codes are effective for the portion of the services that were rendered on September 30, 2014, and earlier and where ICD-10 codes are effective for the portion of the services that were rendered October 1, 2014, and later. In some cases, depending upon the policies associated with those services, there cannot be a break in service or time (i.e., anesthesia) although the new ICD-10 code set must be used effective October 1, 2014. The following tables provide further guidance to providers for claims that span the periods where ICD-9 and ICD-10 codes may both be applicable.

(continued on next page)

ICD-10 *(continued)*

Table A – institutional providers

Bill type(s)	Facility type/services	Claim processing requirement	Use FROM or THROUGH date
11x	Inpatient hospitals (incl. TERFHA hospitals, prospective payment system (PPS) hospitals, long term care hospitals (LTCHs), critical access hospitals (CAHs)	If the hospital claim has a discharge and/or through date on or after 10/1/14, then the entire claim is billed using ICD-10.	THROUGH
12x	Inpatient Part B hospital services	Split claims - require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2014, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014, and later.	FROM
13x	Outpatient hospital	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with DOS through 9/30/2014, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014, and later.	FROM
14x	Non-patient laboratory services	Split claims - require providers split the claim so all ICD-9 codes remain on one claim with DOS through 9/30/2014, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014, and later.	FROM
18x	Swing beds	If the [swing bed or SNF] claim has a discharge and/or through date on or after 10/1/14, then the entire claim is billed using ICD-10.	THROUGH
21x	Skilled nursing (Inpatient Part A)	If the [swing bed or SNF] claim has a discharge and/or through date on or after 10/1/14, then the entire claim is billed using ICD-10.	THROUGH
22x	Skilled nursing facilities (inpatient Part B)	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with DOS through 9/30/2014, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014, and later.	FROM
23x	Skilled nursing facilities (outpatient)	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with DOS through 9/30/2014, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014, and later.	FROM
32x	Home health (inpatient Part B)	Allow HHAs to use the payment group code derived from ICD-9 codes on claims which span 10/1/2014, but require those claims to be submitted using ICD-10 codes.	THROUGH
3x2	Home health – request for anticipated rayment (RAPs)*	* Note - RAPs can report either an ICD-9 code or an ICD-10 code based on the one (1) date reported. Since these dates will be equal to each other, there is no requirement needed. The corresponding final claim, however, will need to use an ICD-10 code if the HH episode spans beyond 10/1/2014.	*See Note

(continued on next page)

ICD-10 *(continued)*

Bill type(s)	Facility type/services	Claim processing requirement	Use FROM or THROUGH date
34x	Home health – (outpatient)	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with DOS through 9/30/2014, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014, and later.	FROM
71x	Rural health clinics	Split claims - require providers split the claim so all ICD-9 codes remain on one claim with DOS through 9/30/2014, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014, and later.	FROM
72x	End-stage renal disease (ESRD)	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with DOS through 9/30/2014, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014, and later.	FROM
73x	Federally qualified health clinics (prior to 4/1/10)	N/A – Always ICD-9 code set.	N/A
74x	Outpatient therapy	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with DOS through 9/30/2014, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014, and later.	FROM
75x	Comprehensive outpatient rehab facilities	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with DOS through 9/30/2014, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014, and later.	FROM
76x	Community mental health clinics	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with DOS through 9/30/2014, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014, and later.	FROM
77x	Federally qualified health clinics (effective 4/4/10)	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with DOS through 9/30/2014, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014, and later.	FROM
81x	Hospice-hospital	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with DOS through 9/30/2014, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014, and later.	FROM
82x	Hospice – non-hospital	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with DOS through 9/30/2014, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014, and later.	FROM
83x	Hospice–hospital-based	N/A	N/A
85x	Critical access hospital	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with DOS through 9/30/2014, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014, and later.	FROM

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ICD-10 *(continued)*

Table B: Special outpatient claim processing circumstances

Scenario	Claim processing requirement	Use FROM or THROUGH Date
3-day /1-day payment window	Since all outpatient services (with a few exceptions) are required to be bundled on the inpatient bill if rendered within three (3) days of an inpatient stay; if the inpatient hospital discharge is on or after 10/1/2014, the claim must be billed with ICD-10 for those bundled outpatient services.	THROUGH

Table C: Professional claims

Type of claim	Claim processing requirement	Use FROM or THROUGH Date
All anesthesia claims	Anesthesia procedures that begin on 9/30/14 but end on 10/1/14, are to be billed with ICD-9 diagnosis codes and use 9/30/14, as both the FROM and THROUGH date.	FROM

Table D: Supplier claims

Supplier type	Claim processing requirement	Use FROM or THROUGH/TO Date
DMEPOS	Billing for certain items or supplies (such as capped rentals or monthly supplies) may span the ICD-10 compliance date of 10/1/14 (i.e., the FROM date of service occurs prior to 10/1/14, and the TO date of service occurs after 10/1/14).	FROM

Additional information

You may also want to review SE1239 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1239.pdf*. SE1239 announces the revised ICD-10 implementation date of October 1, 2014.

If you have any questions, please contact your 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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Implementation Date: N/A

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Drugs and Biologicals

April 2014 quarterly ASP Medicare Part B drug pricing files and revisions to prior quarterly pricing files

Provider types affected

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

Provider action needed

Medicare will use the April 2014 quarterly average sales price (ASP) Medicare Part B drug pricing files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after April 1, 2014, with dates of services from April 1, 2014, through June 30, 2014.

Change request (CR) 8607, from which this article is taken, instructs Medicare contractors to implement the April 2014 ASP Medicare Part B drug pricing file for Medicare Part B drugs, and if they are released by the Centers for Medicare & Medicaid Services (CMS), to also implement the revised January 2014, October 2013, July 2013, and April 2013 files. Make sure your billing personnel are aware of these changes.

Background

The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply contractors with the ASP and not otherwise classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the outpatient prospective payment system (OPPS) are incorporated into the outpatient code editor (OCE) through separate instructions that can be located in the *Medicare Claims Processing Manual*, Chapter 4, Section 50 Outpatient PRICER.

The following table shows how the quarterly payment files will be applied:

Files	Effective for dates of service
April 2014 ASP and ASP NOC	April 1, 2014, through June 30, 2014
January 2014 ASP and ASP NOC	January 1, 2014, through March 31, 3014
October 2013 ASP and ASP NOC	October 1, 2013, through December 31, 2013
July 2013 ASP and ASP NOC	July 1, 2013, through September 30, 2013
April 2013 ASP and ASP NOC	April 1, 2013, through June 30, 2013

Additional information

The official instruction, CR 8607, issued to your MAC regarding this change, may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2863CP.pdf*.

If you have any questions, please contact your 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 8607
Related CR Release Date: January 24, 2014
Effective Date: April 1, 2014
Related CR Transmittal #: R2863CP
Implementation Date: April 7, 2014

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Billing drugs and biologicals

Drugs and biologicals should be billed in multiples of the dosage specified in the Healthcare Common Procedure Coding System (HCPCS) long descriptor. The number of units billed should be assigned based on the dosage increment specified in the HCPCS long descriptor and correspond to the actual amount of the drug administered to the patient, including any appropriate discarded drug waste. If the drug dose used in the care of a patient is not a multiple of the HCPCS code dosage descriptor, the provider rounds to the next highest units.

As outlined in the Centers for Medicare & Medicaid (CMS) *Medicare Claims Processing Manual*, Publication 100-04, Chapter 17 Sections 10 and 40.

Drugs are billed in multiples of the dosage specified in the HCPCS code long descriptor. If the drug dose used in the care of a patient is not a multiple of the HCPCS code dosage descriptor, the provider rounds to the next highest unit based on the HCPCS long descriptor for the code in order to report the dose provided.

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Billing *(continued)*

If the full dosage provided is less than the dosage for the HCPCS code descriptor specifying the minimum dosage for the drug, the provider reports one unit of the HCPCS code for the minimum dosage amount.

The CMS encourages physicians, hospitals and other providers and suppliers to care for and administer to patients in such a way that they can use drugs or biologicals most efficiently, in a clinically appropriate manner.

When a physician, hospital or other provider or supplier must discard the remainder of a single use vial or other single use package after administering a dose/quantity of the drug or biological to a Medicare patient, the program provides payment for the amount of drug or biological discarded as well as the dose administered, up to the amount of the drug or biological as indicated on the vial or package label.

Multi use vials are not subject to payment for discarded amount of drug or biological.

Documentation requirements

Documentation in the medical record should include:

- Name of drug
- Date administered
- Time administered
- Amount given (gram, microgram, international unit, etc.)
- Route (intravenous, intramuscular, subcutaneous, etc.)
- Quantity of drug wastage as applicable.
- Name and credentials of person administering drug

For further details on billing drugs and biologicals please refer to the *Medicare Claim Processing Manual, Publication 100-04, Chapter 17*.

Common working file editing for vaccines furnished at hospice – correction

Provider types affected

This *MLN Matters*® article is intended as an update for non-hospice providers furnishing vaccines to hospice beneficiaries and submitting claims to Medicare administrative contractors (MACs).

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 8620 to alert providers that any provider may furnish vaccines to hospice beneficiaries. Be sure your billing staffs are aware of this change.

When CR 8098, Transmittal 1298, was published, effective October 1, 2013, it denied claims for vaccines furnished to hospice patients that were provided by anyone other than the patient's hospice provider. This was to enforce the statement in the *Medicare Claims Processing Manual*, Chapter 18, Section 10.2.4 that vaccines "may be covered when furnished by the hospice." CMS has determined that this enforcement is too restrictive, since the manual does not say "only when furnished by the hospice." CR 8620 removes the changes made to Medicare systems in CR 8098, in order to allow any provider to furnish vaccines to hospice beneficiaries.

Key points

- Your MAC will allow professional claims for vaccines (influenza, PPV, and hepatitis B) and vaccine administration containing modifier GW when the date of service falls within a hospice election.
- Your MAC will adjust vaccine claims with dates of service on or after October 1, 2013, which were previously rejected due to a hospice election, if you bring such claims to your MAC's attention.

Additional information

The official instruction, CR 8620, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1339OTN.pdf*.

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

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Effective Date: October 1, 2013
Related CR Transmittal #: R1339OTN
Implementation: April 7, 2014

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Durable Medical Equipment

2014 DMEPOS code jurisdiction list

Provider types affected

This *MLN Matters*® article is intended for suppliers submitting claims to Medicare contractors (durable medical equipment Medicare administrative contractors (DME MACs) and Part A/B MACs (formerly carriers) for DMEPOS services provided to Medicare beneficiaries.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 8565 to notify suppliers that the spreadsheet containing an updated list of HCPCS codes for DME MAC, carrier, or B MAC jurisdictions is updated annually to reflect codes that have been added or discontinued (deleted) each year. The spreadsheet is helpful to billing staffs by showing the appropriate Medicare contractor to be billed for HCPCS codes appearing on the spreadsheet. The spreadsheet for the 2014 DMEPOS jurisdiction list is an Excel® spreadsheet and is available under the Coding Category at *http://www.cms.gov/Center/Provider-Type/Durable-Medical-Equipment-DME-Center.html*. It is also attached to CR 8565, which is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2861CP.pdf*.

Additional information

The official instruction, CR 8565 issued to your DME MAC, or A/B MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2861CP.pdf*. The Excel® spreadsheet for the 2014 jurisdiction list is also attached to CR 8565.

If you have any questions, please contact your DME MAC 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 8565
Related CR Release Date: January 24, 2014
Effective Date: January 1, 2014
Related CR Transmittal #: R2861CP
Implementation: February 25, 2014

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2014 DMEPOS jurisdiction listing

This article is informational and is based on change request (CR) 8565 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 2014 jurisdiction list is attached to CR 8565 at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2861CP.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.

Code	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.

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DMEPOS *(continued)*

Code	Description	Jurisdiction
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.
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
A4555-A4558	Electrodes; lead wires; conductive paste	Local carrier if incident to a physician's service (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
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

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DMEPOS *(continued)*

Code	Description	Jurisdiction
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
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.

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DMEPOS *(continued)*

Code	Description	Jurisdiction
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
A7003-A7039	Accessories for nebulizers, aspirators, and ventilators	DME MAC
A7040-A7041	Chest drainage supplies	Local carrier
A7042-A7043	Pleural catheter	Local carrier
A7044-A7047	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

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DMEPOS *(continued)*

Code	Description	Jurisdiction
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
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	IPPS 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-E0770	Stimulation devices	DME MAC
E0776	IV pole	DME MAC
E0779-E0780	External infusion pumps	DME MAC

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DMEPOS *(continued)*

Code	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
E1352-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-G9360	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.

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DMEPOS *(continued)*

Code	Description	Jurisdiction
J3590	Unclassified biologicals	Local carrier
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	Contraceptives	Local carrier
J7308-J7309	Aminolevulinic acid hcl	Local carrier
J7310	Ganciclovir, long-acting implant	Local carrier
J7311-J7316	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 through DME	Local carrier if incident to a physician's service. If other, DME MAC.
J8498	Anti-emetic Drug	DME MAC
J8499	Prescription drug, oral, non chemotherapeutic	Local carrier if incident to a physician's service. 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 ronroutine service for oxygen equipment	DME MAC
K0743-K0746	Suction pump and dressings	DME MAC

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DMEPOS *(continued)*

Code	Description	Jurisdiction
K0800-K0899	Power mobility devices	DME MAC
K0900	Custom DME, other than wheelchair	DME
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.
Q0161-Q0181	Anti-emetic	DME MAC
Q0478-Q0509	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
Q2026-Q2028	Injectable dermal fillers	Local carrier
Q2034-Q2039	Influenza vaccine	Local carrier
Q2043	Sipuleucel-T	Local carrier

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DMEPOS *(continued)*

Code	Description	Jurisdiction
Q2049-Q2050	Doxorubicin	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
Q3027-Q3028	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-Q4149	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: CR 8565

Evaluation and Management

Prepayment review for initial and subsequent hospital evaluation and management services *CPT*® codes *99223* and *99233*

First Coast Service Options Inc. (First Coast) recently conducted data analysis due to the high comprehensive error rate testing (CERT) error rates for evaluation and management services pertaining to *Common Procedural Terminology*® (*CPT*®) codes *99223* (initial hospital visit) and *99233* (subsequent hospital visit). The CERT November 2014 forecasting report indicates a projected error rate of 44 percent for *CPT*® code *99223* and a projected error rate of 34.5 percent for *CPT*® code *99233*. The data indicates that the specialty of internal medicine is the primary contributor to the CERT error rate: internal medicine error rates are currently trending at 32 percent for *CPT*® code *99233* and 40 percent for *CPT*® code *99223*.

Documentation requirements

The American Medical Association (AMA) *CPT*® manual defines code *99223* as follows:

Initial hospital care, per day, for the evaluation and management of a patient, which requires these three key components:

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

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring an admission are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital unit.

The AMA *CPT*® manual defines code *99233* as follows:

Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components:

- *A detailed interval history ;*
- *A detailed examination;*
- *Medical decision making of high complexity*

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family needs. Usually, the patient is unstable or has developed a significant new problem. Typically, 35 minutes are spent at the bedside and on the patient's hospital unit.

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

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

First Coast's actions

In responses to the high percentage of error rates and the continual risks of improper payments associated with hospital care visits billed by internal medicine specialists, First Coast will be implementing a prepayment medical review edit for *CPT*® codes *99223* and *99233* billed by internal medicine specialty. The new edit will be based on a predetermined percentage of claims in an effort to reduce the error rates for these hospital services.

Observation care codes may not be billed for hospital inpatients

The appropriate hospital visit codes should be used when billing for inpatient services. Steps will be taken by A/B Medicare administrative contractors to prepare and implement the non-payment of claim lines after detection of observation care codes billed for a beneficiary who is currently receiving inpatient care services. Edits will be implemented on or about January 20, 2014, in the multi-carrier system (MCS) only.

Laboratory/Pathology

Codes subject to and excluded from Clinical Laboratory Improvement Amendments edits

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8567 which informs MACs about changes to Healthcare Common Procedure Coding System (HCPCS) codes that are new for 2014 and are subject to CLIA edits. The CLIA regulations require a facility to be appropriately certified for each test performed. Make sure your billing staffs are aware of these changes.

Background

The Clinical Laboratory Improvement Amendments (CLIA) regulations require a facility to be appropriately certified for each test performed. To ensure that Medicare and Medicaid only pay for laboratory tests performed in certified facilities, each claim for a HCPCS code that is considered a CLIA laboratory test is currently edited at the CLIA certificate level.

The HCPCS codes are considered a laboratory test under CLIA change each year. Contractors need to be informed about the new HCPCS codes that are both subject to CLIA edits and excluded from CLIA edits.

The HCPCS codes listed below are new for 2014 and are subject to CLIA edits. The list does not include new HCPCS codes for waived tests or provider-performed procedures. The HCPCS codes listed below require a facility to have either a CLIA certificate of registration (certificate type code 9), a CLIA certificate of compliance (certificate type code 1), or a CLIA certificate of accreditation (certificate type code 3). A facility without a valid, current, CLIA certificate, with a current CLIA certificate of waiver (certificate type code 2) or with a current CLIA certificate for provider-performed microscopy procedures (certificate type code 4) must not be permitted to be paid for these tests.

- G0461 - Immunohistochemistry or immunocytochemistry, per specimen; first single or multiplex antibody stain
- G0462 - Immunohistochemistry or immunocytochemistry, per specimen; each additional single or multiplex antibody stain (list separately in addition to code for primary procedure)
- *80155* - Caffeine level
- *80159* - Clozapine level
- *80169* - Everolimus level
- *80171* - Gabapentin level
- *80175* - Lamotrigine level
- *80177* - Levetiracetam level
- *80180* - Mycophenolate (mycophenolic acid) level
- *80183* - Oxcarbazepine level
- *80199* - Tiagabine level
- *80203* - Zonisamide level
- *81287* - MGMT (O-6-methylguanine-DNA methyltransferase) gene analysis
- *81504* - Genetic profiling on oncology biopsy lesions
- *81507* - DNA analysis using maternal plasma
- *87661* - Infectious agent detection by nucleic acid (dna or rna); trichomonas vaginalis, amplified probe technique

In 2014, there was one new HCPCS code for immunohistochemistry or immunocytochemistry [i.e., *88343* - Immunohistochemistry or immunocytochemistry, each separately identifiable antibody per block, cytologic preparation, or hematologic smear; each additional separately identifiable antibody per slide (list separately in addition to code for primary procedure)]. The testing described by this code is subject to the CLIA

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CLIA *(continued)*

regulations. It is not payable by Medicare in 2014. Therefore, this new code was not included in CR 8567.

Additional information

The official instruction, CR 8567 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads /R2857CP.pdf*.

If you have any questions, please contact your 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: MM8567
Related Change Request (CR) #: CR 8567
Related CR Release Date: January 17, 2014
Effective Date: January 1, 2014
Related CR Transmittal #: R2857CP
Implementation Date: April 7, 2014

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Changes to the laboratory national coverage determination software for ICD-10 codes

Note: This article was revised on February 4, 2014, to reflect the revised change request (CR) 8494, issued on January 31, 2014. In the article, the transmittal number, CR release date, and the Web address for accessing the CR are revised. All other information remains the same. This information was previously publication in the November 2013 *Medicare B Connection*, Page 15.

Provider types affected

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

Provider action needed

CR 8494, from which this article is taken, provides that the laboratory national coverage determination (NCD) edit software will be updated to accommodate the processing of the International Classification of Diseases, Tenth Revision (ICD-10) diagnosis codes. This is a follow-up to CR 8202 Changes to the Laboratory National Coverage Determination (NCD) Software for ICD-10 (dated February 1, 2013), that extended the ICD-9 to ICD-10 implementation date to October 1, 2014. (You can find this CR at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1174OTN.pdf*.

Background

In accordance with the *Medicare Claims Processing Manual*, Chapter 16 (Laboratory Services), Section 120.2 (Implementation and Updates of Negotiated National Coverage Determinations (NCDs) for Clinical Diagnostic Laboratory Services), the laboratory edit module is updated quarterly as necessary to reflect ministerial coding updates and substantive changes to the NCDs developed through the NCD process. The changes are a result of coding analysis decisions developed under the procedures for maintaining codes in the negotiated NCDs and for biannual updates of the ICD-9-CM codes.

CR 8494, from which this article is taken, instructs the Medicare shared systems maintainers to update the laboratory NCD edit software to accommodate the processing of the ICD-10 diagnosis codes. There are no updates to the laboratory NCD code lists for this quarter.

Additional information

The official instruction, CR 8494 issued to your A/B MAC regarding this change, may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2865CP.pdf*.

If you have any questions, please contact your 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: MM8494 *Revised*
Related Change Request (CR) #: CR 8494
Related CR Release Date: January 31, 2014
Effective Date: October 1, 2014
Related CR Transmittal #: R2865CP
Implementation Date: January 6, 2014

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Radiology

Medicare NCD for beta amyloid positron emission tomography in dementia and neurodegenerative disease

Provider types affected

This *MLN Matters*® article is intended for physicians and other providers who submit claims to Medicare A/B Medicare administrative contractors (A/B MACs) for services provided to Medicare beneficiaries with dementia or neurodegenerative disease.

What you need to know

Effective for claims with dates of service on or after, September 27, 2013, the Centers for Medicare & Medicaid Services (CMS) will only allow coverage for PET Aβ imaging (one PET Aβ scan per patient) through coverage with evidence development (CED) to: (1) develop better treatments or prevention strategies for alzheimer's disease (AD), or, as a strategy to identify subpopulations at risk for developing AD, or (2) resolve clinically difficult differential diagnoses (e.g., frontotemporal dementia (FTD) versus AD) where the use of PET Aβ imaging appears to improve health outcomes, when the patient is enrolled in an approved clinical study under CED.

Background

After careful consideration, effective for claims with dates of service on or after September 27, 2013, CMS believes that the evidence is insufficient to conclude that PET Aβ imaging improves health outcomes for Medicare beneficiaries with dementia or neurodegenerative disease. However, there is sufficient evidence that the use of PET Aβ imaging could be promising in certain scenarios. Therefore, Medicare will only allow coverage for PET Aβ imaging (one PET Aβ scan per patient) through CED to:

1. Develop better treatments or prevention strategies for AD, or, as a strategy to identify subpopulations at risk for developing AD, or
2. Resolve clinically difficult differential diagnoses (e.g., FTD versus AD) where the use of PET Aβ imaging appears to improve health outcomes, when the patient is enrolled in an approved clinical study under CED.

Health outcomes may include the following:

1. Avoidance of unnecessary or potentially harmful treatment or tests
2. Improving, or slowing the decline of, quality of life (to include maintenance of independence) and cognitive and functional status
3. Survival

Outcomes may be short-term (e.g., related to meaningful changes in clinical management) or long-term (e.g., related to dementia outcomes).

A list of ICD-9 and corresponding ICD-10 codes for beta amyloid for dementia and neurodegenerative diseases is in the following table.

ICD-9 codes	Corresponding ICD-10 codes
290.0 Senile dementia, uncomplicated	F03.90 Unspecified dementia without behavioral disturbance
290.10 Presenile dementia, uncomplicated	F03.90 Unspecified dementia without behavioral disturbance
290.11 Presenile dementia with delirium	F03.90 Unspecified dementia without behavioral disturbance
290.12 Presenile dementia with delusional features	F03.90 Unspecified dementia without behavioral disturbance
290.13 Presenile dementia with depressive features	F03.90 Unspecified dementia without behavioral disturbance

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PET *(continued)*

ICD-9 codes	Corresponding ICD-10 codes
290.20 Senile dementia with delusional features	F03.90 Unspecified dementia without behavioral disturbance
290.21 Senile dementia with depressive features	F03.90 Unspecified dementia without behavioral disturbance
290.3 Senile dementia with delirium	F03.90 Unspecified dementia without behavioral disturbance
290.40 Vascular dementia, uncomplicated	F01.50 Vascular dementia without behavioral disturbance
290.41 Vascular dementia with delirium	F01.51 Vascular dementia with behavioral disturbance
290.42 Vascular dementia with delusions	F01.51 Vascular dementia with behavioral disturbance
290.43 Vascular dementia with depressed mood	F01.51 Vascular dementia with behavioral disturbance
294.10 Dementia in conditions classified elsewhere without behavioral disturbance	F02.80 Dementia in other diseases classified elsewhere without behavioral disturbance
294.11 Dementia in conditions classified elsewhere with behavioral disturbance	F02.81 Dementia in other diseases classified elsewhere with behavioral disturbance
294.20 Dementia, unspecified, without behavioral disturbance	F03.90 Unspecified dementia without behavioral disturbance
294.21 Dementia, unspecified, with behavioral disturbance	F03.91 Unspecified dementia with behavioral disturbance
331.11 Pick's Disease	G31.01 Pick's disease
331.19 Other Frontotemporal dementia	G31.09 Other frontotemporal dementia
331.6 Corticobasal degeneration	G31.85 Corticobasal degeneration
331.82 Dementia with Lewy Bodies	G31.83 Dementia with Lewy bodies
331.83 Mild cognitive impairment, so stated	G31.84 Mild cognitive impairment, so stated
780.93 Memory Loss	R41.1 Anterograde amnesia R41.2 Retrograde amnesia R41.3 Other amnesia (Amnesia NOS, Memory loss NOS)
V70.7 Examination for normal comparison or control in clinical research	Z00.6 Encounter for examination for normal comparison and control in clinical research program

Effective for claims with dates of service on or after September 27, 2013, MACs will return to provider/return as unprocessable claims for PET Aβ imaging, through CED during a clinical trial, not containing the following:

- Condition code 30, (for institutional claims only)
- Modifier Q0 and/or modifier Q1 as appropriate
- ICD-9 dx code V70.7/ICD-10 dx code Z00.6 (on either the primary/secondary position)
- A PET HCPCS code 78811 or 78814;
- Dx codes (see list in table above); and
- Aβ HCPCS code A9586 or A9599.

MACs will return as unprocessable claims for PET Aβ imaging using the following messages:

- Claim adjustment reason code (CARC) 4: The procedure code is inconsistent with the modifier used or a required modifier is missing. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- Remittance advice remark code (RARC) N517: Resubmit a new claim with the requested information.
- RARC N519: Invalid combination of HCPCS modifiers.

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PET *(continued)*

For claims with dates of service on or after September 27, 2013, Medicare will deny/reject claims for more than one PET Aβ scan; HCPCS code A9586 or A9599, in a patient's lifetime.

MACs will line-item deny claims for PET Aβ, HCPCS code A9586 or A9599, where a previous PET Aβ, HCPCS code A9586 or A9599 is paid in history using the following messages:

- CARC 149: "Lifetime benefit maximum has been reached for his service benefit category."
- RARC N587: "Policy benefits have been exhausted."
- Group code: PR, assigning financial liability to the beneficiary if a claim is received with occurrence code 32 indicating a signed ABN is on file, or occurrence code 32 is present with modifier GA.
- Group code: CO, assigning financial liability to the provider if a claim is received with a GZ modifier indicating no signed ABN is on file.

Note that MACs will not automatically adjust claims processed prior to implementation of CR 8526, but they will adjust such claims that you bring to their attention.

Note: Each new beta amyloid radiopharmaceutical will require a separate code. Therefore, for the interim period, HCPCS code A9599 (Radiopharmaceutical for beta-amyloid positron emission tomography (PET) imaging, diagnostic, per study dose) shall be used with an effective date of January 1, 2014. After a new beta amyloid radiopharmaceutical is approved for a separate, individual HCPCS code, a subsequent CR will be issued to update this NCD policy.

Note: Contractors should refer to the business requirements in CR 8526 well as:

General clinical trial billing requirements

- Publication 100-03, Chapter 1, Section 310, and
- Publication 100-04, Chapter 32, Section 69.

Coverage requirements of beta amyloid PET in neurodegenerative disease and dementia

- See Publication 100-03, *NCD Manual*, Chapter 1, Section 220.6.20

Claim processing instructions

- Publication 100-04, *Claims Processing Manual*, Chapter 13, Section 60.12

Additional information

The official instruction, CR 8526, is in two transmittals issued to your A/B MAC. The first transmittal updates the *National Coverage Determinations Manual* and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R160NCD.pdf*. The second transmittal updates the *Medicare Claims Processing Manual* and it is at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2871CP.pdf*.

If you have any questions, please contact your A/B MAC contractor 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: MM8526
Related Change Request (CR) #: CR 8526
Related CR Release Date: February 6, 2014
Effective Date: September 27, 2013
Related CR Transmittal #: 2871CP/160NCD
Implementation July 7, 2014

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Flourodeoxyglucose PET for solid tumors

Provider types affected

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

What you need to know

This article is based on change request (CR) 8468, which advises you that, effective for claims with dates of service on and after June 11, 2013, the Centers for Medicare & Medicaid Services (CMS) will cover three flourodeoxyglucose positron emission tomography (FDG PET) scans (without the coverage with evidence development (CED) requirement) when used to guide subsequent management of anti-tumor treatment strategy after completion of initial anti-cancer therapy for the same cancer diagnosis. Coverage of any additional FDG PET scans (that is, beyond three) used to guide subsequent management of anti-tumor treatment strategy after completion of initial anti-cancer therapy for the same diagnosis will be determined by the local MACs. Make sure that your billing staffs are aware of these changes.

Background

CMS was asked to reconsider Section 220.6, of the *National Coverage Determinations (NCD) Manual*, to end the prospective data collection requirements across all oncologic indications of FDG PET in the context of this document. The term FDG PET includes PET/computed tomography (CT) and PET/magnetic resonance (MRI).

CMS is revising the *NCD Manual*, Section 220.6.17, to reflect that CMS has ended the CED requirement for 18 fluorodeoxyglucose FDG PET and PET/CT and PET/MRI for all oncologic indications contained in Section 220.6.17 of the *NCD Manual*. This removes the current requirement for prospective data collection by the National Oncologic PET Registry (NOPR) for oncologic indications for FDG (HCPCS A9552) only.

Effective for services performed on or after June 11, 2013:

- The CED requirement has ended and modifier -Q0/-Q1, along with condition code 30 (institutional claims only), or V70.7 (both institutional and practitioner claims) are no longer required.
- MACs shall pay FDG PET claims for subsequent management, identified by CPT codes 78608, 78811, 78812, 78813, 78814, 78815, or 78816, modifier PS, HCPCS A9552, and the same cancer dx code, which exceeded three FDG PET scans when the KX modifier is included on the claim line.
- MACs will not search their files to identify claims processed prior to implementation of CR 8468; however, they will adjust such claims that you bring to their attention.

MACs will deny subsequent treatment strategy (PS modifier) claims for FDG PET, which exceeded three FDG PET scans when a KX modifier is not included on the claim line using the following:

- **Claim adjustment reason code (CARC) 96**: "Non-covered charge(s). Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
- **Remittance advice remarks code N435**: "Exceeds number/frequency approved/allowed within time period without support documentation."
- **Group code CO** assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file; or,
- **Group code PR** assigning financial liability to the beneficiary if a claim is received with a GA modifier indicating a signed ABN is on file.

Note: For clarification purposes, as an example, each, different, cancer dx is allowed 1 initial treatment strategy (PI modifier) PET scan and three subsequent treatment strategy (PS modifier) PET scans without the KX modifier. The fourth PET scan and beyond for the same cancer dx will always require the KX modifier. If a different cancer dx is reported, that cancer dx will allow the same scenario as above, one initial, three subsequent, no KX modifier required, four or more for same dx requires a KX modifier.

Note: The only exception to the above frequency is with dx 185.0, prostate cancer, which is non-covered for initial treatment strategy. Therefore, all PI modifiers for 185.0 would be denied, and PS modifiers would follow the same frequency as all other cancer dx codes.

For claims with dates of service on or after July 7, 2014, contractors shall deny subsequent treatment strategy (PS modifier) claims for oncologic FDG PET scans when no initial treatment strategy (PI modifier) claim is present in history when appropriate. CWF will begin counting at this point. The prostate cancer exception above applies.

MACs shall deny subsequent treatment strategy (PS modifier) claims for oncologic FDG PET scan claims when no initial treatment strategy (PI modifier) claim is present in history using the following:

- **CARC B5**: "Coverage/program guidelines were not met or were exceeded."
- **RARC N640**: "Exceeds number/frequency approved/allowed within time period."
- **Group code PR** assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file.
- **Group code CO** assigning financial liability to the

(continued on next page)

FDG *(continued)*

provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

Note: Providers should refer to Attachment A of CR 8468 for appropriate oncologic diagnosis codes.

Please refer to MM6632, issued on October 16, 2009, available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6632.pdf*, and MM7148, issued September 24, 2010, available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7148.pdf*, for previous information on this coverage.

Additional information

The official instruction, CR 8468, was issued to your MAC via two transmittals. The first transmittal updates the *National Coverage Determinations Manual* and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R162NCD.pdf*. The second transmittal is at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2873CP.pdf* and that transmittal updates the *Medicare Claims Processing Manual*.

If you have any questions, please contact your 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 CR Transmittal #: R2873CP/R162NCD
Implementation Date: March 7, 2014: Non-shared System Edits, July 7, 2014: Shared System Edits

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Psychiatric Services

Psychiatry and psychotherapy services

This article has been rescinded in order to be revised. It will be published again when the revisions are completed.

MLN Matters® Number: SE1407 *Rescinded*
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

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Surgery

National coverage determination (NCD) for single chamber and dual chamber permanent cardiac pacemakers

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8525 which allows payment for nationally covered implanted permanent cardiac pacemakers, single chamber or dual chamber, for the indications outlined in the *Medicare National Coverage Determinations Manual* (Chapter 1, Part 1, Section 20.8, Cardiac Pacemakers) and the *Medicare Claims Processing Manual* (Chapter 32, Section 320, Billing Requirements for Cardiac Pacemakers: Single and Dual Chamber) which were revised by and included as attachments to CR 8525. CR 8525 is effective for claims with dates of service on or after August 13, 2013.

Make sure that your billing personnel know about these changes.

Background

Permanent cardiac pacemakers refer to a group of self-contained, battery operated, implanted devices that send electrical stimulation to the heart through one or more implanted leads. Single chamber pacemakers typically target either the right atrium or right ventricle. Dual chamber pacemakers stimulate both the right atrium and the right ventricle.

The implantation procedure is typically performed under local anesthesia and requires only a brief hospitalization. A catheter is inserted into the chest, and the pacemaker's leads are threaded through the catheter to the appropriate chamber(s) of the heart. The surgeon then makes a small "pocket" in the pad of the flesh under the skin on the upper portion of the chest wall to hold the power source. The pocket is then closed with stitches.

On August 13, 2013, the Centers for Medicare & Medicaid Services (CMS) issued a national coverage determination (NCD). In this NCD, CMS concluded that implanted permanent cardiac pacemakers, single chamber or dual chamber, are reasonable and necessary for the treatment of non-reversible symptomatic bradycardia due to sinus node dysfunction and second and/or third degree atrioventricular block. Symptoms of bradycardia are symptoms that can be directly attributable to a heart rate less than 60 beats per minute (for example: syncope, seizures, congestive heart failure, dizziness, or confusion).

The following indications are covered for implanted permanent single chamber or dual chamber cardiac pacemakers:

1. Documented non-reversible symptomatic bradycardia due to sinus node dysfunction.
2. Documented non-reversible symptomatic bradycardia due to second degree and/or third degree atrioventricular block.

The following indications are non-covered for implanted permanent single chamber or dual chamber cardiac pacemakers:

1. Reversible causes of bradycardia such as electrolyte abnormalities, medications or drugs, and hypothermia.
2. Asymptomatic first degree atrioventricular block.
3. Asymptomatic sinus bradycardia.
4. Asymptomatic sino-atrial block or asymptomatic sinus arrest.
5. Ineffective atrial contractions (e.g., chronic atrial fibrillation or flutter, or giant left atrium) without symptomatic bradycardia.
6. Asymptomatic second degree atrioventricular block of Mobitz Type I unless the QRS complexes

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Pacemaker *(continued)*

are prolonged or electrophysiological studies have demonstrated that the block is at or beyond the level of the His Bundle (a component of the electrical conduction system of the heart).

7. Syncope of undetermined cause.
8. Bradycardia during sleep.
9. Right bundle branch block with left axis deviation (and other forms of fascicular or bundle branch block) without syncope or other symptoms of intermittent atrioventricular block.
10. Asymptomatic bradycardia in post-myocardial infarction patients about to initiate long-term beta-blocker drug therapy.
11. Frequent or persistent supraventricular tachycardias, except where the pacemaker is specifically for the control of tachycardia.
12. A clinical condition in which pacing takes place only intermittently and briefly, and which is not associated with a reasonable likelihood that pacing needs will become prolonged.

MACs will determine coverage under the Social Security Act (Section 1862(a)(1)(A); see *http://www.ssa.gov/OP_Home/ssact/title18/1862.htm*) for any other indications for the implantation and use of single chamber or dual chamber cardiac pacemakers that are not specifically addressed in this NCD.

Note: MACs will accept the inclusion of the KX modifier on the claim line(s) as an attestation by the practitioner and/or provider of the service that documentation is on file verifying the patient has non-reversible symptomatic bradycardia (symptoms of bradycardia are symptoms that can be directly attributable to a heart rate less than 60 beats per minute (for example: syncope, seizures, congestive heart failure, dizziness, or confusion)).

Other key notes for billing

- MACs will pay professional claims for implanted permanent cardiac pacemakers, single chamber or dual chamber, provided the claim contains at least one of the *Current Procedural Terminology*® (*CPT*®) codes of *33206, 33207*, or *33208* and one of the following ICD-9_CM/ICD-10-CM diagnostic codes, and only when the claim is submitted with the KX modifier:
  - 426.0/I44.2
  - 426.12/I44.1
  - 426.13/I44.1
  - 427.81/I49.5, or
  - 746.86/Q24.6
- The following diagnosis codes can be covered at contractor discretion if submitted with at least one of the *CPT*® codes and at least one of the diagnosis codes listed above along with the KX modifier:
  - 426.10 Atrioventricular block, unspecified/ I44.30 Unspecified atrioventricular block
  - 426.4 Right bundle branch block/ I45.10 Unspecified right bundle-branch block / I45.19 Other right bundle branch block
  - 427.0 Paroxysmal supraventricular tachycardia/ I47.1 Supraventricular tachycardia
- Contractors will return claim lines if the KX modifier is not present using the following message:
  - Claim adjustment reason code (CARC) 4: The procedure code is inconsistent with the modifier used or a required modifier is missing.
  - Remittance advice remarks code (RARC) N517: Resubmit a new claim with the requested information.
- Effective for claims with dates of service on or after August 13, 2013, MACs will pay outpatient institutional claims for implanted permanent cardiac pacemakers, single chamber or dual chamber, (codes C1785, C1786, C2619, or C2620) provided the claim contains the KX modifier, and contains at least one of the *CPT*® codes *33206, 33207*, or *33208*, **and** one of the following ICD-9_CM/ICD-10-CM diagnostic codes :
  - 426.0/I44.2
  - 426.12/I44.1
  - 426.13/I44.1
  - 427.81/I49.5, or
  - 746.86/Q24.6
- MACs will return outpatient institutional claims for implanted permanent cardiac pacemakers that do not meet the preceding requirements.
- The following diagnosis codes can be covered at contractor discretion if submitted with at least one of the *CPT*® codes and diagnosis codes listed above:
  - 426.10 Atrioventricular block, unspecified/ I44.30 Unspecified atrioventricular block
  - 426.4 Right bundle branch block/ I45.10 Unspecified right bundle-branch block / I45.19 Other right bundle branch block
  - 427.0 Paroxysmal supraventricular tachycardia/ I47.1 Supraventricular tachycardia
- Effective for claims with dates of service on or after August 13, 2013, MACs will pay inpatient claims for implanted permanent cardiac pacemakers, single chamber or dual chamber, provided the claim contains one of the following ICD-9/ICD-10 diagnosis **and** procedure codes:
  - 37.81/0JH604Z, 0JH634Z, 0JH804Z, 0JH834Z, 37.82/0JH605Z, 0JH635Z, 0JH805Z, 0JH835Z, or 37.83/0JH606Z,

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Pacemaker *(continued)*

0JH636Z, 0JH806Z, 0JH836Z, **and**

- 426.0/I44.2, 426.12/I44.1,
- 426.13/I44.1, 427.81/I49.5, or 746.86/Q24.6

- The following diagnosis codes can be covered at contractor discretion if submitted with at least one of the *CPT*® codes and diagnosis codes listed above:
  - 426.10 Atrioventricular block, unspecified/ I44.30 Unspecified atrioventricular block
  - 426.4 Right bundle branch block/ I45.10 Unspecified right bundle-branch block / I45.19 Other right bundle branch block
  - 427.0 Paroxysmal supraventricular tachycardia/ I47.1 Supraventricular tachycardia

In addition, be aware of the following:

- MACs will deny claims for implanted dual chamber for one of the following CPT® codes: *33206*, *33207*, or *33208* and contains at least one of the following ICD-9-CM/ICD-10-CM diagnosis codes (even if submitted with at least one of the acceptable diagnosis codes listed above):
  - 426.11/I44.0
  - 427.31/I48.1/I48.2/I48.91
  - 427.32/I48.2/I48.3/I48.4/ or I48.91
  - 427.89/I49.8/ R00.1
  - 780.2/R55

MACs will use the following messages when denying claims for implanted permanent cardiac pacemakers, single chamber or dual chamber, containing one of the following HCPCS and/or *CPT*® codes: C1785, C1786, C2619, C2620, *33206*, *33207*, or *33208*, **and** at least one diagnosis code from the list of ICD-9/ICD-10 diagnosis codes above:

- CARC 96: Non-covered charge(s).
- RARC N569: Not covered when performed for the reported diagnosis.
- Group code CO (contractual obligation), if claim received with GZ modifier indicating no signed advance beneficiary notice (ABN) is on file or group code PR (patient responsibility) if occurrence code 32 indicating a signed ABN is on file or occurrence code 32 with modifier GA is present.

NCDs are binding on all MACs and contractors with the Federal government that review and/or adjudicate claims, determinations, and/or decisions, quality improvement organizations, qualified independent contractors, the Medicare appeals council, and administrative law judges (ALJs). An NCD that expands coverage is also binding on a Medicare advantage organization. In addition, an ALJ may not review an NCD. (See the Social Security Act, Section 1869(f)(1)(A)(i), at *http://www.ssa.gov/OP_Home/ssact/title18/1869.htm*.)

Additional information

The official instruction, CR 8525, was issued to your MACs regarding this change via two transmittals. The first is the transmittal that updates the *NCD Manual* and it is available at may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R161NCD.pdf*. The second transmittal updates the *Medicare Claims Processing Manual* and it is at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2872CP.pdf*.

If you have any questions, please contact your MACs 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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Medicare fee-for-service ICD-10 testing approach

Provider types affected

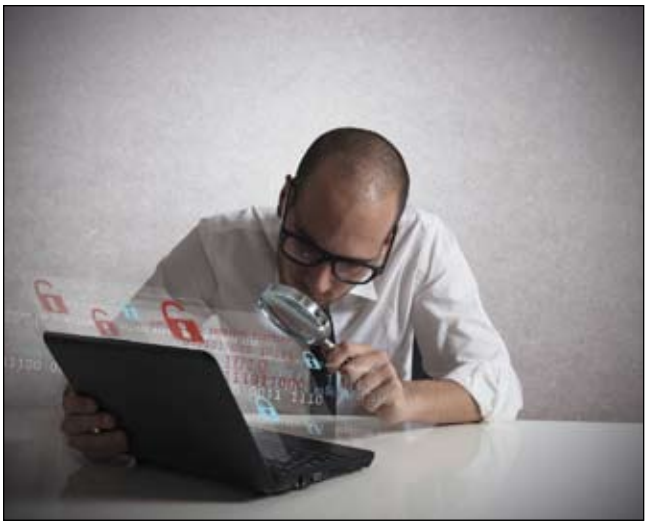
This article is intended for all physicians, providers, and suppliers submitting claims to Medicare administrative contractors (MACs), including home health & hospice MACs (HH&H MACs), and durable medical equipment MACs (DME MACs)) for services provided to Medicare beneficiaries.

Provider action needed

For dates of service on and after October 1, 2014, entities covered under the Health Insurance Portability and Accountability Act (HIPAA) are required to use the ICD-10 code sets in standard transactions adopted under HIPAA. The HIPAA standard health care claim transactions are among those for which ICD-10 codes must be used for dates of service on and after October 1, 2014. Be sure you are ready. This *MLN Matters*® special edition article is intended to convey the testing approach that the Centers for Medicare & Medicaid Services (CMS) is taking for ICD-10 implementation.

Background

The implementation of International Classification of Diseases, 10th Edition (ICD-10) represents a significant code set change that impacts the entire health care community. As the ICD-10 implementation date of October 1, 2014, approaches, CMS is taking a comprehensive four-pronged approach to preparedness and testing to ensure that CMS as well as the Medicare fee-for-service (FFS) provider community is ready.



When "you" is used in this publication, we are referring to the FFS provider community.

The four-pronged approach includes:

- CMS internal testing of its claims processing systems;
- Provider-initiated Beta testing tools;
- Acknowledgement testing; and
- End-to-end testing.

Each approach is discussed in more detail below.

CMS internal testing of its claim processing systems

CMS has a very mature and rigorous testing program for its Medicare FFS claim processing systems that supports the implementation of four quarterly releases per year. Each release is supported by a three-tiered and time-sensitive testing methodology:

- Alpha testing is performed by each FFS claims processing system maintainer for eight weeks;
- Beta testing is performed by a separate integration contractor for eight weeks; and
- Acceptance testing is performed by each MAC for four weeks to ensure that local coverage requirements are met and the systems are functioning as expected.

CMS began installing and testing system changes to support ICD-10 in 2011. As of October 1, 2013, all Medicare FFS claim processing systems were ready for ICD-10 implementation. CMS continues to test its ICD-10 software changes with each quarterly release.

Provider-initiated Beta testing tools

To help you prepare for ICD-10, CMS recommends that you leverage the variety of Beta versions of its software that include ICD-10 codes as well as national coverage determination (NCD) code crosswalks to test the readiness of your own systems. The following testing tools are available for download:

- NCDs converted from International Classification of Diseases, 9th Edition (ICD-9) to ICD-10 located at *http://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html*. The ICD-10 Medicare Severity-Diagnosis Related Groups (MS-DRGs) conversion project (along with payment logic and software replicating the current MS-DRGs), which used the General Equivalence Mappings to convert ICD-9 codes to International

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Testing *(continued)*

Classification of Diseases, 10th Edition, Clinical Modification (ICD-10-CM) codes, located at *http://cms.hhs.gov/Medicare/Coding/ICD10/ICD-10-MS-DRG-Conversion-Project.html*. On this Web page, you can also find current versions of the ICD-10-CM MS-DRG grouper, Medicare code editor (available from National Technical Information Service), and *MS-DRG Definitions Manual* that will allow you to analyze any payment impact from the conversion of the MS-DRGs from ICD-9-CM to ICD-10-CM codes and to compare the same version in both ICD-9-CM and ICD-10-CM; and

- A pilot version of the October 2013 integrated outpatient code editor (IOCE) that utilizes ICD-10-CM located at *http://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/Downloads/ICD-10-IOCE-Code-Lists.pdf*. The final version of the IOCE that utilizes ICD-10-CM is scheduled for release in August 2014.

Crosswalks for local coverage determinations (LCDs) will be available April 2014.

If you will not be able to complete the necessary systems changes to submit claims with ICD-10 codes by October 1, 2014, you should investigate downloading the free billing software that CMS offers from their MACs. The software has been updated to support ICD-10 codes and requires an internet connection. Alternatively, many MACs offer provider Internet portals, and some MACs offer a subset of these portals that you can register for to ensure that you have the flexibility to submit professional claims this way as a contingency.

Acknowledgement testing

CMS offered ICD-10 acknowledgement testing from March 3–7, 2014. This testing allowed all providers, billing companies, and clearinghouses the opportunity to determine whether CMS will be able to accept their claims with ICD-10 codes. While test claims were not adjudicated, the MACs returned an acknowledgment to the submitter (a 277A) that confirms whether the submitted test claims were accepted or rejected. For more information about acknowledgement testing, refer to the information on your MAC's website.

CMS is exploring offering other weeks of acknowledgement testing after it analyzes the results of the March 2014 testing week.

End-to-end testing

In summer 2014, CMS will offer end-to-end testing to a small sample group of providers. Details about the end-to-end testing process will be disseminated at a later date.

End-to-end testing includes the submission of test claims to CMS with ICD-10 codes and the provider's receipt of a remittance advice (RA) that explains the adjudication of the claims. The goal of this testing is to demonstrate that:

- Providers or submitters are able to successfully submit claims containing ICD-10 codes to the Medicare FFS claim systems;
- CMS software changes made to support ICD-10 result in appropriately adjudicated claims (based on the pricing data used for testing purposes); and
- Accurate RAs are produced.

The small sample group of providers who participated in end-to-end testing were selected to represent a broad cross-section of provider types, claims types, and submitter types.

If you have any questions, please contact your MAC at their toll-free number, which may be found at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/index.html*.

MLN Matters® Number: SE1409
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: October 1, 2014
Related CR Transmittal #: N/A
Implementation Date: N/A

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Claim status category and claim status codes update

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8582 which informs Medicare contractors about the changes to claim status category codes and claim status codes. Make sure that your billing personnel are aware of these changes.

Background

The Health Insurance Portability and Accountability Act (HIPAA) requires all health care benefit payers to use only claim status category codes and claim status codes approved by the National Code Maintenance Committee in the X12 276/277 health care claim status request and response format adopted as the standard for national use (e.g. previous HIPAA named versions included 004010X093A1). These codes explain the status of submitted claim(s). Proprietary codes may not be used in the X12 276/277 to report claim status. The National Code Maintenance Committee meets at the beginning of each X12 trimester meeting (February, June, and October) and makes decisions about additions, modifications, and retirement of existing codes. The codes sets are available at *http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-category-codes/* and *http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-codes/*.

All code changes approved during the January 2014 committee meeting shall be posted on these sites on or about March 1, 2014. Included in the code lists are specific details, including the date when a code was added, changed, or deleted.

These code changes are to be used in the editing of all X12 276 transactions processed on or after the date of implementation and are to be reflected in X12 277 transactions issued on and after the date of implementation of CR 8582.

Additional information

The official instruction, CR 8582 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads /R2858CP.pdf*.

If you have any questions, please contact your 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: MM8582
Related Change Request (CR) #: CR 8582
Related CR Release Date: January 17, 2014
Effective Date: April 1, 2014
Related CR Transmittal #: R2858CP
Implementation Date: April 7, 2014

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Payments *(continued)*

Enhancement topic	Details – what it does
Changes that apply to both apps (*Open Payments Mobile for Industry and Open Payments Mobile for Physicians*)	
Streamlined "Welcome" screen options	• A number of infrequently used menu options (e.g., "Program Information" and "Change Password") moved from the "Welcome" screen and now appear in a hidden menu. • To access the menu, swipe to the right at the "Welcome" screen.
Reports/Statistics	• A new "Reports/Statistics" button, accessible on the "Welcome" screen, allows the user to create a chart (bar and pie), showing their transfer of value data sorted by physician (within Open Payments Mobile for Industry) or vendor (within Open Payments Mobile for Physicians). • This new chart creation capability will streamline data review.
CSV exporting	• When payment data is exported via CSV format, all profile data for the associated vendor/physician is included in the CSV file (including address, phone number, etc.). • The prior app version included only vendor/physician name in the CSV file. This enhancement will simplify the data review process.
Streamlined "Add Payment" process	• The steps to "Add Payment" are streamlined to allow the user to enter contact information for the vendor or physician, while staying within the "Add Payment" menu. • The prior app version required the user to first enter contact information for the vendor or physician separately, and then go to the ""Add Payment" menu.
Easy payment duplication	• A new button available on the "View Payment" screen allows payment data to be easily duplicated, in case a physician or vendor has multiple occurrences of the same payment. • The only data field that needs to be re-entered is the date.
Vendors/physicians sorted alphabetically	• In "Manage Vendors/Physicians," vendors or physicians are now listed alphabetically. • The prior app version listed vendors and physicians in the order in which they were entered.
Email/print QR code added	• A "share" button is available to email or print a QR code that is generated within the app, for sharing at a later time.
Payment QR code warning added	• After a payment QR code is scanned, a red warning message appears to remind the user to manually add the vendor or physician name to the payment data conveyed in the QR code.
Additional data elements added in "Add Payment" > "Travel & Lodging"	• When nature of payment in "Add Payment" is "Travel & Lodging," the following additional data elements can be entered: city, state, and country of travel (note that these new data elements are required for reporting purposes; but remember, the apps are not used for reporting data, only for tracking it).
Tablet support	• Both apps are optimized for viewing on tablet devices.
Changes that apply to just one app *Open Payments Mobile for Physicians*	
"Manage Companies" added	• Within "Manage Vendors", a new data field allows users to assign vendors to companies when entering new vendor information. • Company information is needed for the "Reports/Statistics" functionality to illustrate all payments by company name.

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Payments *(continued)*

The updated *frequently asked questions* about the mobile apps contain all the details about these enhancements (link to the document above, or visit the "Apps for Tracking Assistance" page on the Open Payments website).

QR code technical guide available for apps: Also now available to support use of the open payments apps is a how-to-guide that explains the technical details associated with how to create quick response (QR) codes usable in the apps. "The Open Payments QR Code Reader How-To Guide" includes detailed, highly technical instructions for creating or importing contact information using a QR code reader, and generating a QR code to transfer profile or payment information to other user's devices.

Additional information

If you have any questions, please contact your A/B MAC contractor 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*.

To review "The Open Payments Mobile Application Quick Response (QR) Code Reader Documentation: A How-To Guide to Create Java Script Object Notation (JSON) QR Code" referenced in this SE1402, see *http://www.cms.gov/Regulations-and-Guidance/Legislation/National-Physician-Payment-Transparency-Program/Downloads/Open-Payments-QR-Code-Reader-How-To-Guide-%5bDecember-2013%5d.pdf*.

To review the series of SE articles leading up to SE1402 see the following:

1. *MLN Matters*® SE1303 "Information on the National Physician Payment Transparency Program: Open Payments," is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1303.pdf*.
2. *MLN Matters*® SE1329 "Mobile Apps for the Open Payments program (Physician Payments Sunshine Act)" is available at: *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1329.pdf*.
3. *MLN Matters*® SE1330 "Open Payments: An Overview for Physicians and Teaching Hospitals" may be found at: *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1330.pdf*.

MLN Matters® Number: SE1402
Related Change Request (CR) #: NA
Related CR Release Date: NA
Effective Date: NA
Related CR Transmittal #: NA
Implementation NA

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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.

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

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8485 which informs MACs about changes necessary to create a new process that insures refunded principal and associated interest amounts can be reported separately on remittance advices and that claim identifiers are used to identify the appropriate claim for which those amounts apply. Make sure that your billing staffs are aware of these changes.

Background

CMS was advised that the current practice of reporting principal and interest amounts for all related claims on the remittance advice (RA) as one lump sum amount was creating problems for the provider community since it was not conducive to the proper posting of payments. CR 8485 instructs the MACs on how to report refunded principal and interest amounts separately and how to use claim identifiers to indicate the appropriate claim for those amounts. Providers should see these changes appear on RAs created after CR 8485 is implemented on July 7, 2014.

Step-by-step instructions on how refunds with interest on previously recouped money are handled (including step(s) required by providers), as well as an example of reporting for the new refund PLB codes, are found in Attachment 1 to this CR.

Additional information

The official instruction, CR 8485 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1342OTN.pdf*.

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

MLN Matters® Number: MM8485
Related Change Request (CR) #: CR 8485
Related CR Release Date: February 6, 2014
Effective Date: July 1, 2014
Related CR Transmittal #: R1342OTN
Implementation Date: July 7, 2014

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Manual correction regarding advance beneficiary notice of noncoverage

Provider types affected

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

What you need to know

This article, based on change request (CR) 8597, provides the removal of language that was erroneously included in CR 8404 and in the *Medicare Claims Processing Manual*, Chapter 30, Sections 50.3 and 50.6.2. It also provides clarified manual instructions regarding home health agency issuance of the advance beneficiary notice of noncoverage (ABN) to dual eligible beneficiaries.

Background

The ABN is an Office of Management and Budget (OMB)-approved written notice issued by providers and suppliers for items and services provided under Medicare Part B, including hospital outpatient services, and

(continued on next page)

ABN *(continued)*

care provided under Part A by home health agencies (HHAs), hospices, and religious non-medical healthcare institutes only.

Key points of CR 8597

- With the exception of durable medical equipment prosthetic, orthotics & supplies (DMEPOS) suppliers, providers and suppliers who are not enrolled in Medicare cannot issue the ABN to beneficiaries. DMEPOS suppliers not enrolled as Medicare suppliers are required by statute to provide ABN notification prior to furnishing any items or services to Medicare beneficiaries.
- An example of an approved customization of the ABN which can be used by providers of laboratory services (sample lab ABN) is now available for download at *http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html*.
- When issuing ABNs to dual eligibles or beneficiaries having a secondary insurer, HHAs are permitted to direct the beneficiary to select a particular option box on the notice to facilitate coverage by another payer. This is an exception to the usual ABN issuance guidelines prohibiting the notifier from selecting one of the options for the beneficiary. When a Medicare claim denial is necessary to facilitate payment by Medicaid or a secondary insurer, HHAs should instruct beneficiaries to select Option 1 on the ABN. HHAs may add a statement in the "Additional Information" section to help a dual eligible better understand the payment situation such as, "We will submit a claim for this care with your other insurance," or "Your Medical Assistance plan will pay for this care." HHAs may also use the *Additional Information* on the ABN to include agency specific information on secondary insurance claims or a blank line for the beneficiary to insert secondary insurance information. Agencies can pre-print language in the *Additional Information* section of the notice.
- Some states have specific rules established regarding HHA completion of liability notices in situations where dual eligibles need to accept liability for Medicare noncovered care that will be covered by Medicaid. Medicaid has the authority to make this assertion under Title XIX of the Act, where Medicaid is recognized as the "payer of last resort", meaning other federal programs like Medicare (Title XVIII) must pay in accordance with their own policies before Medicaid picks up any remaining charges. In the past, some states directed HHAs to select the third checkbox on the HHABN to indicate the choice to bill Medicare. On the ABN, the first check box under the "Options" section indicates the choice to bill Medicare and is similar to the third checkbox on the outgoing HHABN. **Note**: If there has been a state directive to submit a Medicare claim for a denial, HHAs must mark the first check box when issuing the ABN.
- HHAs serving dual eligibles should comply with existing HHABN state policy within their jurisdiction as applicable to the ABN unless the state instructs otherwise. The appropriate option selection for dual eligibles will vary depending on the state's Medicaid directive. If the HHA's state Medicaid office does NOT want a claim filed with Medicare prior to filing a claim with Medicaid, the HHA should direct the beneficiary to choose Option 2.

When Option 2 is chosen based on state guidance, but the HHA is aware that the state sometimes asks for a Medicare claim submission at a later time, the HHA must add a statement in the *Additional Information* box such as "Medicaid will pay for these services. Sometimes, Medicaid asks us to file a claim with Medicare. We will file a claim with Medicare if requested by your Medicaid plan."

Additional information

The official instruction, CR 8597, issued to your MAC regarding this change, may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2878CP.pdf*.

If you have any questions, please contact your 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: MM8597
Related Change Request (CR) #: CR 8597
Related CR Release Date: February 14, 2014
Effective Date: May 15, 2014
Related CR Transmittal #: R2878CP
Implementation Date: May 15, 2014

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NCD Manual language-only update

Provider types affected

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

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 8506 as an informational alert to providers that language-only changes – updates to the *Medicare National Coverage Determinations (NCD) Manual*, Publication 100-03 – were made.

The changes were made to comply with the following:

1. Conversion from ICD-9 to ICD-10
2. Conversion from ASC X12 version 4010 to version 5010
3. Conversion of former contractor types to MACs
4. Other miscellaneous editorial and formatting updates provided for better clarity, correctness, and consistency.

Note: The edits made to the *NCD Manual* are technical/editorial only and in no way alter existing NCD policies.

Background

These edits to *NCD Manual (*Publication 100-03) are part of a CMS-wide initiative to update its manuals and bring them in line with recently released instructions regarding the above-noted subject matter.

Additional information

The official instruction, CR 8506, issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R159NCD.pdf*.

If you have any questions, please contact your 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: MM8506
Related Change Request (CR) #: CR 8506
Related CR Release Date: February 5, 2014
Effective Date: October 1, 2014
Related CR Transmittal #: R159NCD
Implementation: October 1, 2014

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Modifying the daily CWF to MBD file to include diagnosis codes on the HETS 270/271 transactions

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8456, which informs Medicare contractors about changes to the Medicare beneficiary database (MBD) file to include diagnosis codes on the Health Insurance Portability and Accountability Act Eligibility Transaction System (HETS) 270/271 transactions.

The HETS 271 response transaction will include as much Medicare secondary payer (MSP) information as possible to assist providers, physicians, and suppliers to identify which diagnosis codes are relevant to given MSP no-fault, liability, and workers' compensation cases. The diagnosis codes that the provider community will access via the HETS 270/271 process will help you to better determine when Medicare is the secondary payer in association with their patients' current liability, no fault, or workers' compensation incidents that may prompt beneficiaries to seek medical services. Please ensure that your billing staffs are aware of these changes.

Background

The HETS 270/271 process is used by providers, physicians, and other suppliers to receive individual beneficiary eligibility information under the Medicare program, including information found on the CWF MSP auxiliary file. Although most MSP information from the MSP record is currently included on the HETS 271 response transaction, International Classification of Diseases (ICD), Clinical Modification (CM), diagnosis codes are not included. The Centers for Medicare & Medicaid Services (CMS) believes it would be beneficial for CWF to include ICD-CM diagnosis codes, as derived from MSP no-fault, liability, and workers' compensation MSP auxiliary records, on the interface file that it sends to MBD. Through a separate Medicare Advantage Prescription Drug CR, CMS will ensure that the MBD table information that is exchanged with HETS will be modified to include ICD diagnosis codes. Thereafter, the diagnosis codes will be included in the HETS 271 response transaction that CMS makes available to providers, physicians, and suppliers.

Since the HETS 271 response transaction can only accommodate up to 8 diagnosis codes, CR 8456 instructs CWF to send up to 25 iterations of diagnosis codes associated with MSP no-fault, liability, and workers' compensation records for inclusion on the HETS 271 response transaction.

Additional information

The official instruction, CR 8456 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1356OTN.pdf*.

If you have any questions, please contact your 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: MM8456
Related Change Request (CR) #: CR 8456
Related CR Release Date: March 6, 2014
Effective Date: October 1, 2014
Related CR Transmittal #: R1356OTN
Implementation Date: October 6, 2014

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Free mobile applications for open payments

The *Open Payments website* provides instructions on two free mobile applications (apps) to help physicians and health care industry users track their payments and other transfers of value that applicable manufacturers and applicable group purchasing organizations will report under open payments.

HIPAA eligibility transaction system replaces CWF eligibility queries

Note: This article was revised February 10, 2014, adding information regarding change request (CR) 8248 in the *What you need to know* section. Also, clarifications have been made to the last question in the "Frequently asked questions" section. All other information is unchanged. This information was previously published in the May 2013 *Medicare B Connection*, Pages 25-26.

Provider types affected

This *MLN Matters*® special edition article is intended for health care providers, suppliers and their billing agents, software vendors and clearinghouses that use Medicare's common working file (CWF) queries to obtain their patient's Medicare health insurance eligibility information from Medicare contractors (carriers, fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), durable medical equipment Medicare administrative contractors (DME MACs), and/or Part A/B MACs).

Provider action needed

If you currently use CWF queries to obtain Medicare health insurance eligibility information for Medicare fee-for service patients, you should immediately begin transitioning to the Medicare Health Insurance Portability and Accountability Act (HIPAA) Eligibility Transaction System (HETS).

What you need to know

This article describes upcoming changes to Medicare beneficiary health insurance eligibility inquiry services that the Centers for Medicare & Medicaid Services (CMS) will implement in the coming months. In April 2013, access to CWF eligibility query functions implemented in the multi-carrier system (MCS) and ViPS Medicare System (VMS), also referred to as PPTN and VPIQ, was terminated. CMS intends to terminate access to the other CWF eligibility queries implemented in the fiscal intermediary standard system (FISS) direct data entry (DDE), often referred to the HIQA, HIQH, ELGA and ELGH screens and HUQA. **CR 8248 creates the ability for CMS to terminate these queries. While termination was originally scheduled for April 2014, CMS is delaying the date. CMS will provide at least 90 days advanced notice of the new termination date.** This **will not** affect the use of DDE to submit claims or to correct claims and will not impact access to beneficiary eligibility information from Medicare contractor's interactive voice response (IVR) units and/or Internet portals.

Background

In 2005, CMS began offering HETS in a real-time environment to Medicare health care providers, suppliers and their billing agents, software vendors and clearinghouses. HETS is Medicare's health care eligibility benefit inquiry and response electronic transaction, ASCX12 270/271 version 5010, adopted under HIPAA. HETS replaces the CWF queries, and is to be used for the business of Medicare; such as preparing an accurate Medicare claim or determining eligibility for specific services.

Key points

General information

CMS plans to discontinue access to the CWF queries through the shared systems. Medicare providers and their agents that currently access the CWF queries through the shared system screens will need to modify their business processes to use HETS to access Medicare beneficiary eligibility information.

HETS

HETS allows Medicare providers and their agents to submit and receive X12N 270/271 eligibility request and response files over a secure connection. Many Medicare providers and their agents are already receiving eligibility information from HETS. For more information about HETS and how to obtain access to the system, refer to the CMS HETS Help Web page at *http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/HowtoGetConnectedHETS270271.html*.

Frequently asked questions

Are Medicare providers that currently use CWF to obtain beneficiary eligibility information required to switch to HETS?

No, but it is recommended. Providers may also choose to use a Medicare contractor's IVR or Internet portal.

What are the minimum data elements required in order to complete an eligibility search in HETS?

HETS applies search logic that uses a combination of four data elements: Health insurance claim number (HICN), Medicare beneficiary's date of birth, Medicare beneficiary's full last name (including suffix, if applicable), and Medicare beneficiary's full first name. The date of birth and first name are optional, but at least one must be present.

Does HETS return the same eligibility information that is currently provided by the CWF eligibility queries?

Changes are currently underway in HETS to return psychiatric information to authorized providers and to return Hospice period information in the same format as CWF. When these changes are made, HETS will return all of the information provided by the CWF eligibility queries that is needed to process Medicare claims. These changes will be in place before the termination date for the FISS DDE CWF query access.

HETS returns additional information that CWF does not return. For example, HETS returns:

(continued on next page)

HIPAA *(continued)*

- Part D plan number, address and enrollment dates; and.
- Medicare Advantage Organization name, address, website and phone number.

The HETS 270/271 companion guide provides specific details about the eligibility information that is returned in the HETS 271 response. The guide is available at *http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/Downloads/HETS270271CompanionGuide5010.pdf*.

Additional information

If you use a software vendor or clearinghouse to access Medicare beneficiary health insurance eligibility information, you should direct questions to your vendor or clearinghouse. If you have any questions about HETS, please contact the MCARE Help Desk at 1-866-324-7315.

MLN Matters® Number: SE1249 *Revised*
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Implementation Date: N/A

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Last year to earn a PQRS incentive payment

This is the last year eligible professionals (EPs) can earn an incentive payment for satisfactorily reporting physician quality reporting system (PQRS) quality data to the Centers for Medicare & Medicaid Services (CMS), and this year's participation in PQRS will also determine the 2016 PQRS payment adjustment. If you satisfactorily submit PQRS quality measures to CMS using one of the approved reporting options for services provided during the 2014 reporting period, you will qualify to earn an incentive payment. If you qualify, you will receive an incentive payment equal to 0.5 percent of your total estimated Medicare Part B physician fee service (PFS) allowed charges for covered professional services supplied during that same reporting period, and ensure that you will also avoid the 2016 payment adjustment. Steps to participate and earn an incentive:

Step 1: Determine if you are *eligible* to participate.

Step 2: Determine which PQRS reporting method best fits your practice.

An individual EP may choose from the following methods to submit data to CMS:

- Medicare Part B claims
- *Qualified PQRS registry*
- Qualified electronic health record (EHR) product
- Qualified PQRS data submission vendor
- *Qualified clinical data registry (QCDR)*

A group practice may choose from the following methods to submit data to CMS:

- *Qualified PQRS registry*
- GPRO Web interface (for groups of 25+ only)
- Qualified EHR product
- Qualified PQRS data submission vendor
- CG CAHPS CMS-certified survey vendor (for groups of 25+ only)

Step 3: Determine which *measures* to report, and review the specific criteria for the chosen reporting option in order to satisfactorily report. Download the *PQRS Implementation Guide* for helpful resources.

Step 4: Report your quality measures. The number of measures you will have to report varies by reporting method. Be sure to pay attention to requirements for national quality strategy domains.

Additional information

For more information or support on the 2014 PQRS program, please visit the *PQRS incentive program* website or the *help desk*.

Information contained within this article was previously released in an edition of the weekly "CMS MLN Connects ™ Provider e-News."

Inter-jurisdictional reassignments

Provider types affected

This *MLN Matters*® article is intended for physician or non-physician practitioners (NPPs) submitting claims to Medicare administrative contractors (MACs) for services to Medicare beneficiaries.

What you need to know

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 8545 to address situations where a physician or NPP in one MAC jurisdiction reassigns his or her Medicare benefits to an entity located in another MAC's jurisdiction.

Background and key points of CR 8545

The following principles apply if a physician/NPP (reassignor) is reassigning his or her benefits to an entity (reassignee) located in another contractor jurisdiction – a practice that is permissible:

1. The reassignor must be properly licensed or otherwise authorized to perform services in the state in which he or she has his or her practice location. The practice location can be an office or even the individual's home.
2. The reassignor need not – pursuant to the reassignment - enroll in the reassignee's MAC jurisdiction nor be licensed/authorized to practice in the reassignee's state. However, if the reassignor will be performing services within the reassignee's state, the reassignor must enroll with the MAC for – and be licensed/authorized to practice in – that state.
3. The reassignee must enroll in the MAC jurisdictions in which:
   a. It has its own practice location(s); and
   b. The reassignor has his or her practice location(s).
4. In Case 3b above, the reassignee should:
   a. Identify the reassignor's practice location as **its** practice location on its Form CMS-855B;
   b. Select the practice location type as "Other health care facility" and specify "Telemedicine location" in Section 4A of its Form CMS-855B; and
   c. Need not be licensed/authorized to perform services in the reassignor's state.

For example: Suppose Dr. Smith is located in MAC Jurisdiction X and is reassigning his benefits to Jones medical group in MAC Jurisdiction Y. Jones must enroll with X **and** Y, but need not be licensed/authorized to perform services in Dr. Smith's state. However, in Section 4 of the Form CMS-855B it submits to X, Jones must list Dr. Smith's location as its practice location.

Additional information

The official instruction, CR 8545 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R503PI.pdf*.

If you have any questions, please contact your 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*.

To review the Medicare Enrollment Application, Clinics/Group Practices and Certain other Suppliers CMS-855B, you may visit *http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms855b.pdf*.

Inter-jurisdictional *(continued)*

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Implementation: February 25, 2014

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.

2014 Medicare Part B Participating Physician and Supplier Directory

The Medicare Part B Participating Physician and Supplier Directory (MEDPARD) contains names, addresses, telephone numbers, and specialties of physicians and suppliers who have agreed to participate in accepting assignment on all Medicare Part B claims for covered items and services.

The MEDPARD listing may be accessed at *http://medicare.fcso.com/MEDPARD/*.

Source: CMS IOM Publication 100-04, Transmittal 2817, CR 8471

New name, logo for educational task force of Part A and B MACs

During a national teleconference in August 2013, MACs announced the launch of the CERT A/B MAC Contractor Task Force. All Part A and Part B MACs have come together with the intent to educate providers on costly claim denials and billing errors to Medicare. The goal is to collaborate on innovative educational products to reduce the national payment error rate, as measured by the CERT program.

The task force has modified its name to the **CERT A/B MAC Outreach & Education Task Force** to demonstrate the importance on CERT education. This change emphasizes their focus on outreach and education to reduce CERT errors while distinguishing them from other entities working on CERT-related issues. The new name is also reflected in the task force's current logo. All future educational products will have the new name and logo.

Learn about the task force

The CERT A/B MAC Outreach & Education Task Force invites you to learn about its mission and educational plans, as well as access the recording from the first teleconference on August 20, 2013. *Click here*.

The CERT A/B MAC Outreach & Education Task Force looks forward to collaborating for error-free Medicare claims and documentation with providers, associations and societies across the nation.

Participating contractors

- Cahaba Government Benefit Administrators, LLC/J10
- CGS Administrators, LLC/J15
- First Coast Service Options, Inc./J9
- National Government Services, Inc./J6 and JK
- Noridian Healthcare Solutions, LLC/JE and JF
- Novitas Solutions, Inc./JH and JL
- Palmetto GBA/J11
- Wisconsin Physicians Service Insurance Corporation/J5 and J8

Disclaimer: CERT A/B MAC Outreach & Education Task Force is independent from the Centers for Medicare & Medicaid Services (CMS) CERT team and CERT contractors, which are responsible for calculation of the Medicare fee-for-service improper payment rate.

Notification regarding the new Benefits Coordination & Recovery Center

The Centers for Medicare & Medicaid Services (CMS) has restructured its coordination of benefits (COB) and Medicare secondary payer (MSP) recovery activities. COB activities for both group health plans and non-group health plans (that is, liability insurance (including self-insurance), no-fault insurance, and workers' compensation laws or plans) and recovery activities for non-group health plans have been transitioned from the COB contractor and the MSP Recovery Contractor effective February 1, 2014. The new Benefits Coordination & Recovery Center (BCRC) will assume these activities. It is important to note that there will be no change to any of the COB & MSP Recovery (COB&R) processes.

The changes that will impact providers include a new, consolidated customer service phone number and a new Post Office (P.O.) Box for correspondence. BCRC customer service representatives are available Monday through Friday, from 8am to 8pm ET, except holidays, at toll-free lines: 1-855-798-2627 (TTY/TDD: 1-855-797-2627). The new P.O. Box is:

Medicare - MSP General Correspondence
P.O. Box 138897
Oklahoma City, OK 73113-8897

To ensure you have the most current information regarding COB&R activities, you can *sign up* for updates. More information is available on the *COB&R Overview website*. COB&R information specific to provider services may be found on the *Provider Services website*.

Information contained within this article was previously released in an edition of the weekly "CMS MLN Connects ™ Provider e-News."

Implementation of phase 2 edits for ordered/referred items and services

Note: This article was revised February 6, 2014, to modify the answer to question J. The article was previously changed November 6, 2013, to provide updated information regarding the effective date of the edits (January 6, 2014). Additional clarifying information regarding the advance beneficiary notice, claim adjustment reason codes (CARCs) and durable medical equipment (DME) rental equipment has also been updated. Please review the article carefully for these changes. All other information remains the same. This information was previously published in the November 2013 *Medicare B Connection*, Pages 24-31.

Provider types affected

This *MLN Matters*® special edition article is intended for:

- Physicians and non-physician practitioners (including interns, residents, fellows, and those who are employed by the Department of Veterans Affairs (DVA), the Department of Defense (DoD), or the Public Health Service (PHS)) who order or refer items or services for Medicare beneficiaries,
- Part B providers and suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) who submit claims to carriers, Part A/B Medicare administrative contractors (MACs), and DME MACs for items or services that they furnished as the result of an order or a referral, and
- Part A home health agency (HHA) services who submit claims to regional home health intermediaries (RHHIs), fiscal intermediaries (FIs, who still maintain an HHA workload), and A/B MACs.
- Optometrists may only order and refer DMEPOS products/services and laboratory and X-ray services payable under Medicare Part B.

Provider action needed

If you order or refer items or services for Medicare beneficiaries and you do not have a Medicare enrollment record, you need to submit an enrollment application to Medicare. You can do this using the Internet-based Provider Enrollment, Chain, and Ownership System (PECOS) or by completing the paper enrollment application (CMS-855O). Review the *Background* and *Additional information* sections and make sure that your billing staff is aware of these updates.

What you need to know

Phase 1: Informational messaging: Began October 5, 2009, to alert the billing provider that the identification of the ordering/referring provider is missing, incomplete, or invalid, or that the ordering/referring provider is not eligible to order or refer. The informational message on an adjustment claim that did not pass the edits indicated the claim/service lacked information that was needed for adjudication.

Phase 2: Effective January 6, 2014, CMS will turn on the edits to deny Part B clinical laboratory and imaging, DME, and Part A HHA claims that fail the ordering/referring provider edits.

Claims submitted identifying an ordering/referring provider and the required matching NPI is missing will continue to be rejected. Claims from billing providers and suppliers that are denied because they failed the ordering/referring edit will not expose a Medicare beneficiary to liability. Therefore, **an advance beneficiary notice is not appropriate in this situation**. This is consistent with the preamble to the final rule which implements the Affordable Care Act requirement that physicians and eligible professionals enroll in Medicare to order and certify certain Medicare covered items and services, including home health, DMEPOS, imaging and clinical laboratory.

Physicians and others who are eligible to order and refer items or services need to establish their Medicare enrollment record and must be of a specialty that is eligible to order and refer. Physicians and others who are eligible to order and refer items or services need to establish their Medicare enrollment record with a valid NPI and must be of a specialty that is eligible to order and refer. If the ordering/referring provider is listed on the claim, the edits will verify that the provider is enrolled in Medicare. The edits will compare the first four letters of the last name. **When submitting the CMS-1500 or the CMS-1450, please only include the first and last name as it appears on the ordering and referring file found on** *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/MedicareOrderingandReferring.html*. **Middle names (initials) and suffixes (such as MD, RPNA etc.) should not be listed in the ordering/referring fields.**

All enrollment applications, including those submitted over the Internet, require verification of the information reported. Sometimes, Medicare enrollment contractors may request additional information in order to process the enrollment application. Waiting too long to begin this process could mean that your enrollment application may not be processed prior to the implementation date of the ordering/referring phase 2 provider edits.

Background

The Affordable Care Act, Section 6405, "Physicians Who Order Items or Services are required to be Medicare Enrolled Physicians or Eligible Professionals," requires physicians or other eligible professionals to be enrolled in the Medicare Program to order or refer items or services for Medicare beneficiaries. Some physicians or other eligible professionals do not and will not send claims to a Medicare contractor for the services they furnish and therefore may not be enrolled in the Medicare program. Also, effective January 1, 1992, a physician

(continued on next page)

Ordering *(continued)*

or supplier that bills Medicare for a service or item must show the name and unique identifier of the attending physician on the claim if that service or item was the result of an order or referral. Effective May 23, 2008, the unique identifier was determined to be the NPI. The Centers for Medicare & Medicaid Services (CMS) has implemented edits on ordering and referring providers when they are required to be identified in Part B clinical laboratory and imaging, DME, and Part A HHA claims from Medicare providers or suppliers who furnished items or services as a result of orders or referrals.

Below are examples of some of these types of claims:

- Claims from clinical laboratories for ordered tests
- Claims from imaging centers for ordered imaging procedures
- Claims from suppliers of DMEPOS for ordered DMEPOS
- Claims from Part A HHA

Only physicians and certain types of non-physician practitioners are eligible to order or refer items or services for Medicare beneficiaries. They are as follows:

- Physicians (doctor of medicine or osteopathy, doctor of dental medicine, doctor of dental surgery, doctor of podiatric medicine, doctor of optometry, optometrists may only order and refer DMEPOS products/services and laboratory and X-ray services payable under Medicare Part B.)
- Physician assistants
- Clinical nurse specialists
- Nurse practitioners
- Clinical psychologists
- Interns, residents, and fellows
- Certified nurse midwives
- Clinical social workers

CMS emphasizes that generally Medicare will only reimburse for specific items or services when those items or services are ordered or referred by providers or suppliers authorized by Medicare statute and regulation to do so. Claims that a billing provider or supplier submits in which the ordering/referring provider or supplier is not authorized by statute and regulation will be denied as a non-covered service. The denial will be based on the fact that neither statute nor regulation allows coverage of certain services when ordered or referred by the identified supplier or provider specialty.

CMS would like to highlight the following limitations:

- Chiropractors are not eligible to order or refer supplies or services for Medicare beneficiaries. All services ordered or referred by a chiropractor will be denied.
- HHA services may only be ordered or referred by a doctor of medicine (M.D.), doctor of osteopathy (D.O.), or doctor of podiatric medicine (DPM). Claims for HHA services ordered by any other practitioner specialty will be denied.
- Optometrists may only order and refer DMEPOS products/services, and laboratory and X-ray services payable under Medicare Part B.

Questions and answers relating to the edits

1. What are the ordering and referring edits?

The edits will determine if the ordering/referring pProvider (when required to be identified in Part B clinical laboratory and imaging, DME, and Part A HHA claims) (1) has a current Medicare enrollment record and contains a valid NPI (the name and NPI must match), and (2) is of a provider type that is eligible to order or refer for Medicare beneficiaries (see list above).

2. Why did Medicare implement these edits?

These edits help protect Medicare beneficiaries and the integrity of the Medicare program.

3. How and when will these edits be implemented?

These edits were implemented in two phases:

Phase 1: Informational messaging: Began October 5, 2009, to alert the billing provider that the identification of the ordering/referring provider is missing, incomplete, or invalid, or that the ordering/referring provider is not eligible to order or refer. The informational message on an adjustment claim that did not pass the edits indicated the claim/service lacked information that was needed for adjudication. The informational messages used are identified below:

For Part B providers and suppliers who submit claims to carriers:

N264	Missing/incomplete/invalid ordering provider name
N265	Missing/incomplete/invalid ordering provider primary identifier

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Ordering *(continued)*

For adjusted claims, the CARC code 16 (Claim/service lacks information which is needed for adjudication.) is used.

DME suppliers who submit claims to carriers (applicable to 5010 edits):

N544 **Alert**: Although this was paid, you have billed with a referring/ordering provider that does not match our system record. Unless, corrected, this will not be paid in the future

For Part A HHA providers who order and refer, the claims system initially processed the claim and added the following remark message:

N272 Missing/incomplete/invalid other payer attending provider identifier

For adjusted claims the CARC code 16 and/or the RARC code N272 was used.

CMS has taken actions to reduce the number of informational messages.

In December 2009, CMS added the NPIs to more than 200,000 PECOS enrollment records of physicians and non-physician practitioners who are eligible to order and refer but who had not updated their PECOS enrollment records with their NPIs. 1 (add this footer "1 NPIs were added only when the matching criteria verified the NPI.)

On January 28, 2010, CMS made available to the public, via the *Downloads* section of the "Ordering Referring Report" page on the Medicare provider/supplier enrollment website, a file containing the NPIs and the names of physicians and non-physician practitioners who have current enrollment records in PECOS and are of a type/specialty that is eligible to order and refer. The file, called the Ordering Referring Report, lists, in alphabetical order based on last name, the NPI and the name (last name, first name) of the physician or non-physician practitioner. To keep the available information up to date, CMS will replace the report twice a week. At any given time, only one report (the most current) will be available for downloading. To learn more about the report and to download it, go to *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html*; click on "Ordering & Referring Information" (on the left). Information about the report will be displayed.

Phase 2: Effective January 6, 2014, CMS will turn on the phase 2 edits. In phase 2, if the ordering/referring provider does not pass the edits, the claim will be denied. This means that the billing provider will not be paid for the items or services that were furnished based on the order or referral.

Below are the denial edits for Part B providers and suppliers who submit claims to Part A/B MACs, including DME MACs:

254D or 001L Referring/Ordering Provider Not Allowed To Refer/Order

255D or 002L Referring/Ordering Provider Mismatch

CARC code 16 or 183 and/or the RARC code N264, N574, N575 and MA13 shall be used for denied or adjusted claims.

Claims submitted identifying an ordering/referring provider and the required matching NPI is missing (edit 289D) will continue to be rejected. CARC code 16 and/or the RARC code N265, N276 and MA13 shall be used for rejected claims due to the missing required matching NPI.

Below are the denial edits for Part A HHA providers who submit claims:

Reason code	This reason code will assign when:
37236	• The statement "From" date on the claim is on or after the date the phase 2 edits are turned on • The type of bill is '32' or '33' • Covered charges or provider reimbursement is greater than zero but the attending physician NPI on the claim is not present in the eligible attending physician file from PECOS or the attending physician NPI on the claim is present in the eligible attending physician files from PECOS but the name does not match the NPI record in the eligible attending physician files from EPCOS or the specialty code is not a valid eligible code.

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Ordering *(continued)*

Reason code	This reason code will assign when:
37237	• The statement "From" date on the claim is on or after the date the phase 2 edits are turned on • The type of bill is '32' or '33' • The type of bill frequency code is '7' or 'F-P' • Covered charges or provider reimbursement is greater than zero but the attending physician NPI on the claim is not present in the eligible attending physician file from PECOS or the attending physician NPI on the claims is present in the eligible attending physician files from PECOS but the name does not match the NPI record in the eligible attending physician files from PECOS or the specialty code is not a valid eligible code.

Effect of edits on providers

I order and refer. How will I know if I need to take any sort of action with respect to these two edits?

In order for the claim from the billing provider (the provider who furnished the item or service) to be paid by Medicare for furnishing the item or service that you ordered or referred, **you, the ordering/referring provider, need to ensure that:**

a. You have a current Medicare enrollment record.

- If you are not sure you are enrolled in Medicare, you may:
  - i. Check the ordering referring report and if you are on that report, you have a current enrollment record in Medicare and it contains your NPI;
  - ii. Contact your designated Medicare enrollment contractor and ask if you have an enrollment record in Medicare and it contains the NPI; or
  - iii. Use Internet-based PECOS to look for your Medicare enrollment record (if no record is displayed, you do not have an enrollment record in Medicare).
  - iv. If you choose iii, please read the information on the Medicare provider/supplier enrollment Web page about Internet-based PECOS before you begin.

b. If you do not have an enrollment record in Medicare.

- You need to submit **either an electronic application through the use of internet-based PECOS or a paper enrollment application** to Medicare.
  - i. For paper applications – fill it out, sign and date it, and mail it, along with any required supporting paper documentation, to your designated Medicare enrollment contractor.
  - ii. For electronic applications – complete the online submittal process and either e-sign or mail a printed, signed, and dated certification statement and digitally submit any required supporting paper documentation to your designated Medicare enrollment contractor.
  - iii. In either case, the designated enrollment contractor cannot begin working on your application until it has received the signed and dated certification statement.
  - iv. If you will be using Internet-based PECOS, please visit the Medicare provider/supplier enrollment Web page to learn more about the Web-based system before you attempt to use it. Go to *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html*, click on "Internet-based PECOS" on the left-hand side, and read the information that has been posted there. Download and read the documents in the *Downloads* section on that page that relate to physicians and non-physician practitioners. A link to Internet-based PECOS is included on that Web page.
  - v. If you order or refer items or services for Medicare beneficiaries and you do not have a Medicare enrollment record, you need to submit an enrollment application to Medicare. You can do this using Internet-based PECOS or by completing the paper enrollment application (CMS-855O). Enrollment applications are available via Internet-based PECOS or .pdf for downloading from the CMS forms page (*http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/index.html*).

c. You are an opt-out physician and would like to order and refer services. What should you do?

If you are a physician who has opted out of Medicare, you may order items or services for Medicare beneficiaries by submitting an opt-out affidavit to a Medicare contractor within your specific jurisdiction. Your opt-out information must be current (an affidavit must be completed every two years, and the NPI is required on the affidavit).

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Ordering *(continued)*

d. You are of a type/specialty that can order or refer items or services for Medicare beneficiaries. When you enrolled in Medicare, you indicated your Medicare specialty. Any physician specialty (Chiropractors are excluded) and only the non-physician practitioner specialties listed above in this article are eligible to order or refer in the Medicare program.

e. I bill Medicare for items and services that were ordered or referred. How can I be sure that my claims for these items and services will pass the ordering/referring provider edits?

- You need to ensure that the physicians and non-physician practitioners from whom you accept orders and referrals have current Medicare enrollment records and are of a type/specialty that is eligible to order or refer in the Medicare program. If you are not sure that the physician or non-physician practitioner who is ordering or referring items or services meets those criteria, it is recommended that you check the ordering referring report described earlier in this article.
- Ensure you are correctly spelling the ordering/referring provider's name.
- If you furnished items or services from an order or referral from someone on the ordering/referring report, your claim should pass the ordering/referring provider edits.
- The ordering/referring report will be replaced twice a week to ensure it is current. It is possible that you may receive an order or a referral from a physician or non-physician practitioner who is not listed in the ordering/referring report but who may be listed on the next report.

f. Make sure your claims are properly completed.

- On paper claims (CMS-1500), in item 17, only include the first and last name as it appears on the ordering and referring file found on *www.CMS.gov*.
- On paper claims (CMS-1450), you would capture the attending physician's last name, first name and NPI on that form in the applicable sections. On the most recent form it would be fields in FL 76.
- On paper claims (CMS-1500 and CMS-1450), do not enter "nicknames", credentials (e.g., "Dr.", "MD", "RPNA", etc.) or middle names (initials) in the ordering/referring name field, as their use could cause the claim to fail the edits.
- Ensure that the name and the NPI you enter for the ordering/referring provider belong to a physician or non-physician practitioner and not to an organization, such as a group practice that employs the physician or non-physician practitioner who generated the order or referral.
- Make sure that the qualifier in the electronic claim (X12N 837P 4010A1) 2310A NM102 loop is a 1 (person). Organizations (qualifier 2) cannot order and refer.

If there are additional questions about the informational messages, billing providers should contact their local A/B MAC, or DME MAC.

Claims from billing providers and suppliers that are denied because they failed the ordering/referring edit shall not expose a Medicare beneficiary to liability. Therefore, **an advance beneficiary notice is not appropriate in this situation**. This is consistent with the preamble to the final rule which implements the Affordable Care Act requirement that physicians and eligible professionals enroll in Medicare to order and certify certain Medicare covered items and services including home health, DMEPOS, imaging and clinical laboratory.

g. What if my claim is denied inappropriately?

If your claim did not initially pass the ordering/referring provider edits, you may file an appeal through the standard claims appeals process or work through your A/B MAC or DME MAC.

h. How will the technical vs. professional components of imaging services be affected by the edits?

Consistent with the Affordable Care Act and 42 CFR 424.507, suppliers submitting claims for imaging services must identify the ordering or referring physician or practitioner. Imaging suppliers covered by this requirement include the following: IDTFs, mammography centers, portable X-ray facilities and radiation therapy centers. The rule applies to the technical component of imaging services, and the professional component will be excluded from the edits. However, if billing globally, both components will be impacted by the edits and the entire claim will deny if it doesn't meet the ordering and referring requirements. It is recommended that providers and suppliers bill the global claims separately to prevent a denial for the professional component.

i. Are the phase 2 edits based on date of service or date of claim receipt?

The phase 2 edits are effective for claims with dates of service on or after January 6, 2014.

j. A Medicare beneficiary was ordered a 13-month DME capped rental item. Medicare has paid claims for rental months 1 and 2. The equipment is in the 3rd rental month at the time the phase 2 denial edits are implemented. The provider who ordered the item has been deactivated. How will the remaining claims be handled?

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Ordering *(continued)*

Claims for capped rental items will continue to be paid for up to 13 months from the physician's date of deactivation to allow coverage for the duration of the capped rental period.

Additional guidance

1. **Terminology**: Part B claims use the term "ordering/referring provider" to denote the person who ordered, referred, or certified an item or service reported in that claim. The final rule uses technically correct terms: 1) a provider "orders" non-physician items or services for the beneficiary, such as DMEPOS, clinical laboratory services, or imaging services and 2) a provider "certifies" home health services to a beneficiary. The terms "ordered" "referred" and "certified" are often used interchangeably within the health care industry. Since it would be cumbersome to be technically correct, CMS will continue to use the term "ordered/referred" in materials directed to a broad provider audience.
2. **Orders or referrals by interns or residents**: The IFC mandated that all interns and residents who order and refer specify the name and NPI of a teaching physician (i.e., the name and NPI of the teaching physician would have been required on the claim for service(s)). The final rule states that state-licensed residents may enroll to order and/or refer and may be listed on claims. Claims for covered items and services from un-licensed interns and residents must still specify the name and NPI of the teaching physician. However, if states provide provisional licenses or otherwise permit residents to order and refer services, CMS will allow interns and residents to enroll to order and refer, consistent with state law.
3. **Orders or referrals by physicians and non-physician practitioners who are of a type/specialty that is eligible to order and refer who work for the Department of Veterans Affairs (DVA), the Public Health Service (PHS), or the Department of Defense (DoD)/Tricare:** These physicians and non-physician practitioners will need to enroll in Medicare in order to continue to order or refer items or services for Medicare beneficiaries. They may do so by filling out the paper CMS-855O or they may use Internet-based PECOS. They will not be submitting claims to Medicare for services they furnish to Medicare beneficiaries.
4. **Orders or referrals by dentists:** Most dental services are not covered by Medicare; therefore, most dentists do not enroll in Medicare. Dentists are a specialty that is eligible to order and refer items or services for Medicare beneficiaries (e.g., to send specimens to a laboratory for testing). To do so, they must be enrolled in Medicare. They may enroll by filling out the paper CMS-855O or they may use Internet-based PECOS. They will not be submitting claims to Medicare for services they furnish to Medicare beneficiaries.

Additional information

For more information about the Medicare enrollment process, visit *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html* or contact the designated Medicare contractor for your state. Medicare provider enrollment contact information for each state can be found at *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/Contact_list.pdf*.

The *Medicare Learning Network*® (*MLN*®) fact sheet titled, "Medicare Enrollment Guidelines for Ordering/Referring Provider," is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_OrderReferProv_factSheet_ICN906223.pdf*.

Note: You must obtain a national provider identifier (NPI) prior to enrolling in Medicare. Your NPI is a required field on your enrollment application. Applying for the NPI is a separate process from Medicare enrollment. To obtain an NPI, you may apply online at *https://nppes.cms.hhs.gov/NPPES/Welcome.do*. For more information about NPI enumeration, visit *http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/NationalProvIdentStand/index.html*.

Additional article updates

MLN Matters® article MM7097, "Eligible Physicians and Non-Physician Practitioners Who Need to Enroll in the Medicare Program for the Sole Purpose of Ordering and Referring Items and Services for Medicare Beneficiaries," is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7097.pdf*.

MLN Matters® article MM6417, "Expansion of the Current Scope of Editing for Ordering/Referring Providers for Claims Processed by Medicare Carriers and Part B Medicare Administrative Contractors (MACs)," is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6417.pdf*.

MLN Matters® article MM6421, "Expansion of the Current Scope of Editing for Ordering/Referring Providers for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers' Claims Processed by Durable Medical Equipment Medicare Administrative Contractors (DME MACs)," is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6421.pdf*.

MLN Matters® article MM6129, "New Requirement for Ordering/Referring Information on Ambulatory Surgical

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Ordering *(continued)*

Center (ASC) Claims for Diagnostic Services," is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6129.pdf*.

MLN Matters® article MM6856, "Expansion of the Current Scope for Attending Physician Providers for free-standing and provider-based Home Health Agency (HHA) Claims processed by Medicare Regional Home Health Intermediaries (RHHIs), is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6856.pdf*.

MLN Matters® article SE1311, " Opting out of Medicare and/or Electing to Order and Refer Services" is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1311.pdf* informs ordering and referring providers about the information they must provide in a written affidavit to their Medicare contractor when they opt-out of Medicare.

If you have questions, please contact your Medicare carrier, Part A/B MAC, or DME MAC, at their toll-free numbers, 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: SE1305 *Revised*
Related CR #: 6421, 6417, 6696, 6856
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: R642OTN, R643OTN, R328PI, and R781OTN
Implementation Date: N/A

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.

Get ready for ICD-10

On October 1, 2014, the health care industry will transition from ICD-9 to ICD-10 codes for diagnoses and inpatient procedures.

This transition is going to change how you do business—from registration and referrals to superbills and software upgrades. But that change doesn't have to be overwhelming.

The Centers for Medicare & Medicaid Services has the following resources to help your practice prepare for the transition.

Online ICD-10 guide

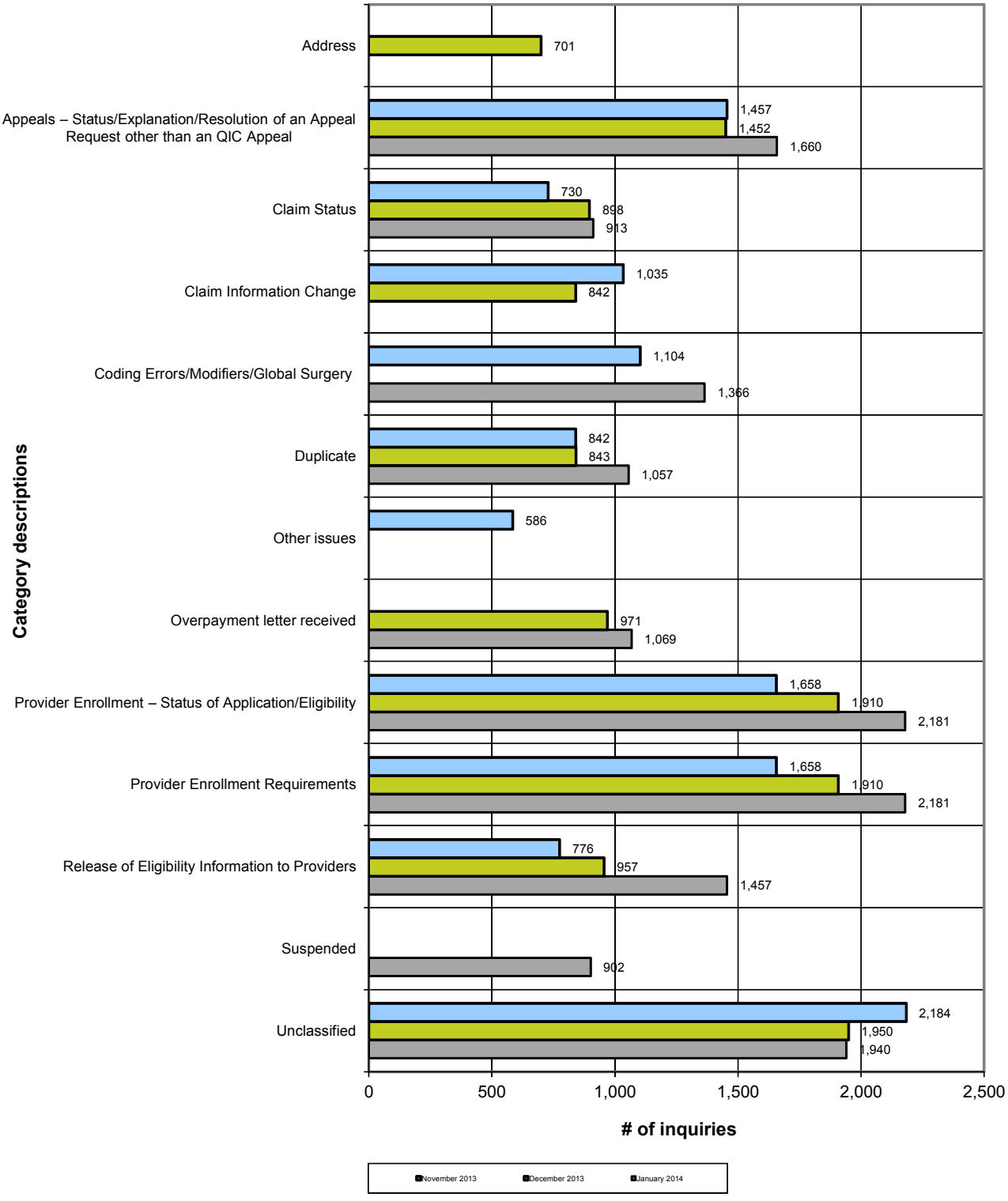
ICD-10 basics for large medical practices

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 November 2013-January 2014.

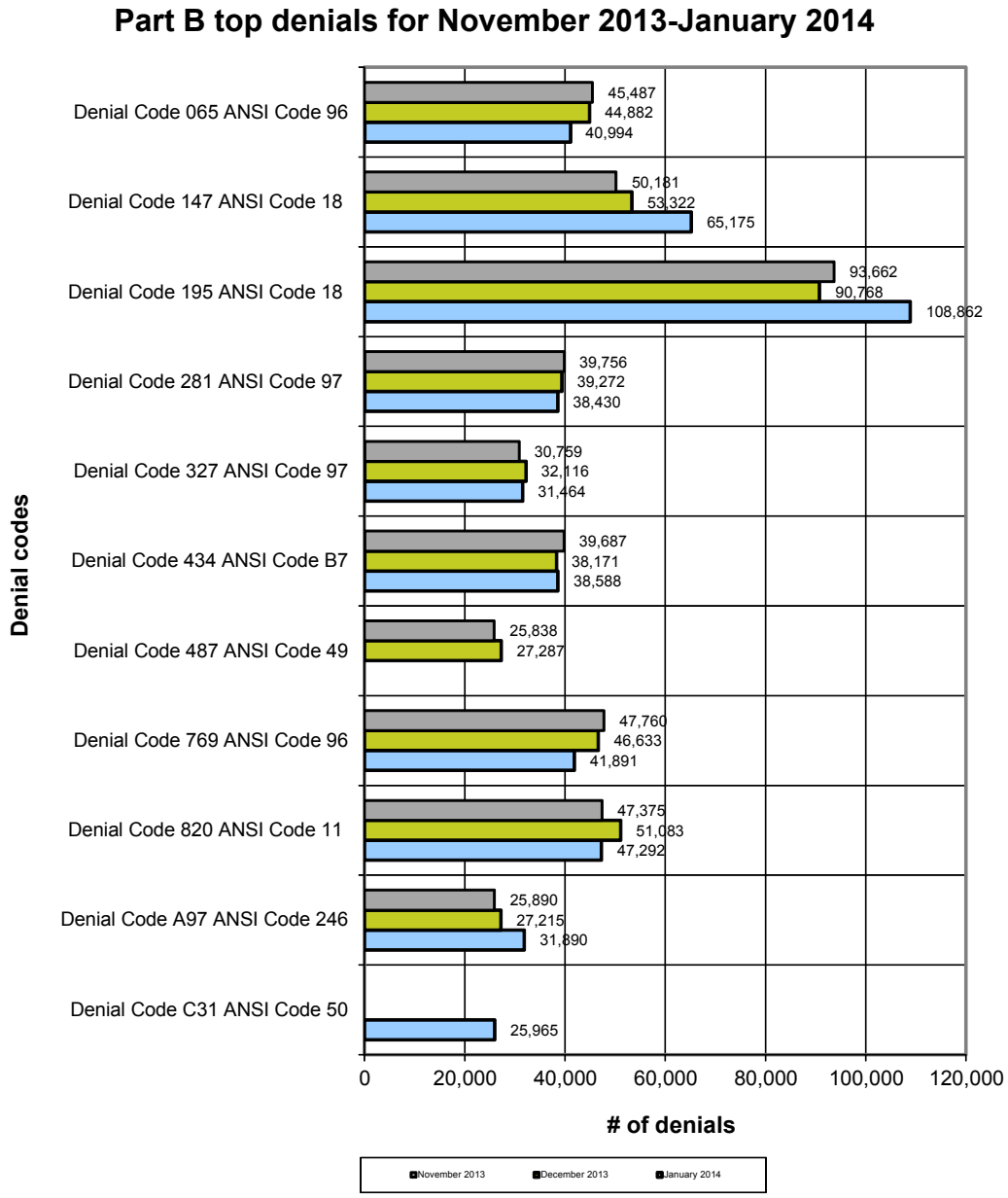
For tips and resources to help providers avoid or reduce the amount of time spent on many of these issues, refer to the Inquiries and Denials section of our website at *http://medicare.fcso.com/Inquiries_and_denials/index.asp*.

Part B top inquiries for November 2013-January 2014



(continued on next page)

Top *(continued)*



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.

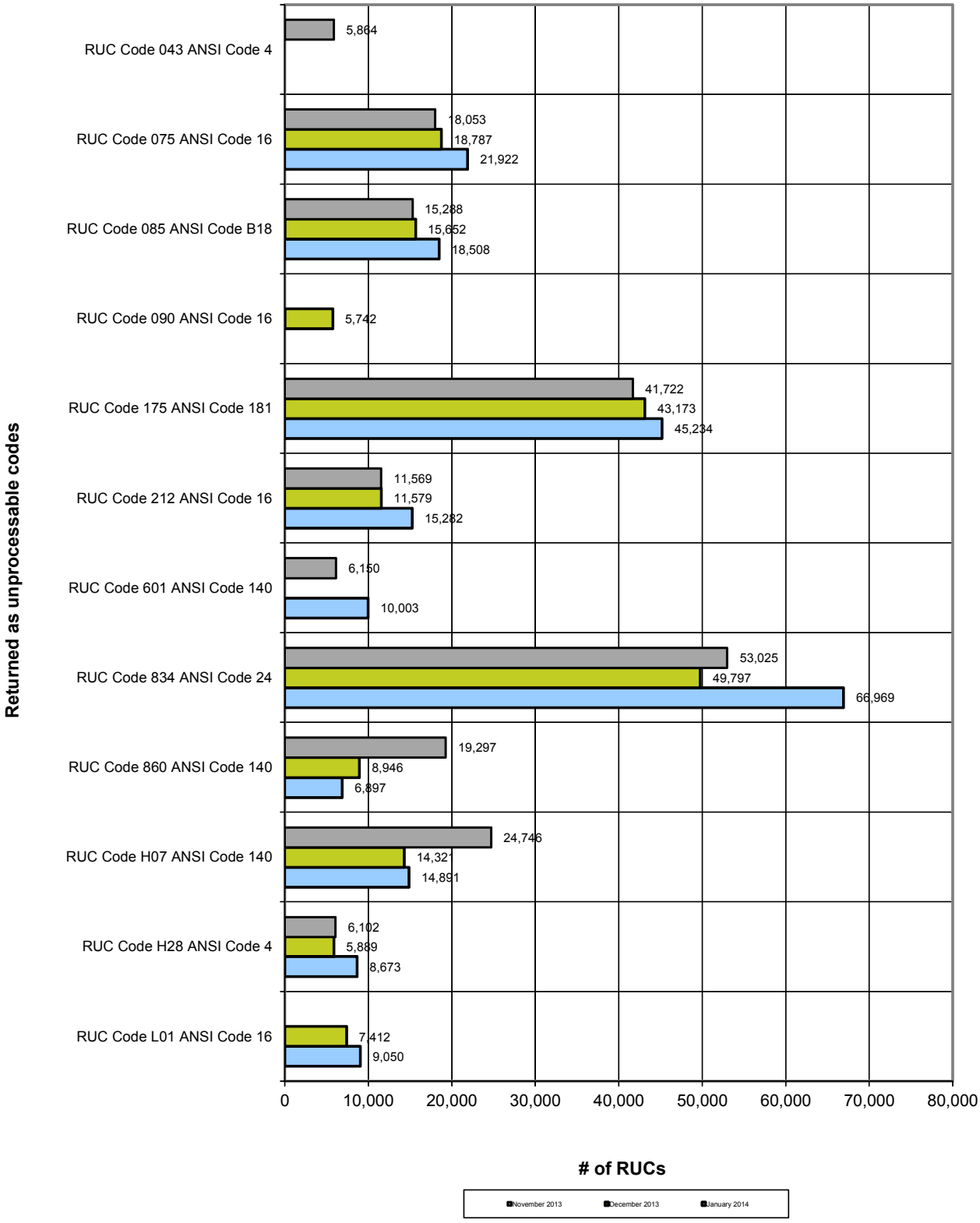
Ensure all information on a claim is correct before submitting to Medicare. Example: The date(s) of service (DOS) on the claim should correspond to the number of units/days being billed.

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.

Top *(continued)*

Part B top return as unprocessable claims for November 2013-January 2014



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

Contents

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.

New LCDs

Genetic testing for lynch syndrome – new LCD

LCD ID number: L34483 (Florida/Puerto Rico/U.S. Virgin Islands)

The Centers for Medicare & Medicaid Services (CMS) via the coverage and analysis department has facilitated a national contractor medical director collaboration workgroup known as, "The local coverage determination (LCD) writers." The workgroup includes medical directors from all of the A/B Medicare administrative contractors (MACs). One of the goals of all MACs is collaboration with other contractors and consensus LCDs is one outcome of this collaboration. In most cases, the contractor medical directors worked with the relevant specialty physicians in developing certain consensus draft LCDs. When a consensus draft LCD is adopted by a contractor, there is no major change to the LCD development process, which includes a 45-day comment period, the finalization of the draft based on comments received from physicians representing their society and/or any stakeholder in the community, and a 45-day notice period. The finalized LCD remains the local contractor's discretion and responsibility.

This new LCD addresses the indications and limitations of coverage and/or medical necessity, *Current Procedural Terminology* (*CPT*®) codes, ICD-9-CM diagnosis codes, and documentation requirements for genetic testing for lynch syndrome.

Effective date

This new LCD is effective for services rendered **on or after March 17, 2014**. 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.

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

Nerve conduction studies and electromyography – new LCD

LCD ID number: L34480 (Florida/Puerto Rico/U.S. Virgin Islands)

The Centers for Medicare & Medicaid Services (CMS) via the coverage and analysis department has facilitated a national contractor medical director collaboration workgroup known as, "The local coverage determination (LCD) writers." The workgroup includes medical directors from all of the A/B Medicare administrative contractors (MACs). One of the goals of all MACs is collaboration with other contractors and consensus LCDs is one outcome of this collaboration. In most cases the contractor medical directors worked with the relevant specialty physicians in developing certain consensus draft LCDs. When a consensus draft LCD is adopted by a contractor, there is no major change to the LCD development process, which includes a 45-comment period, the finalization of the draft based on comments received from physicians representing their society and/or any stakeholder in the community, and a 45-day notice period. The finalized LCD remains the local contractor's discretion and responsibility. The current LCD titled electromyography and nerve conduction studies will be retired when this new LCD becomes effective.

This new LCD addresses the indications and limitations of coverage and/or medical necessity, *Current Procedural Terminology* (*CPT*®)/HCPCS codes, diagnosis codes, documentation requirements, provider training and credentialing, and utilization guidelines for nerve conduction and electromyography studies.

Effective date

This new LCD is effective for services rendered **on or after March 17, 2014**. 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.

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

Retired LCD

Percutaneous vertebroplasty – retired LCD

LCD ID number: L29257 (Florida)
LCD ID number: L29380 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for percutaneous vertebroplasty was most recently revised January 1, 2012. Since that time, the percutaneous vertebroplasty LCD has been combined with the percutaneous vertebral augmentation (formerly kyphoplasty) LCD to align with other Medicare administrative contractors (MACs). The title of the LCD has also been changed to represent both types of procedures and their corresponding *Current Procedural Terminology* (*CPT*®) codes. Therefore, the LCD for percutaneous vertebroplasty is being retired.

Effective date

This LCD retirement is effective for services rendered **on or after March 31, 2014**. 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.

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

Revisions to LCDs

Autonomic function tests – revision to the Part B LCD

LCD ID number: L31461 (Florida/Puerto Rico/U.S. Virgin Islands)

Current Procedural Terminology® (*CPT*®) code *95943* was new for calendar year 2013 and at that time was added to the autonomic function tests (AFT) local coverage determination (LCD) as a result of the annual 2013 Healthcare Common Procedure Coding System (HCPCS) update. It is described as an autonomic function test for simultaneous, independent, quantitative measures of both parasympathetic and sympathetic function. It was created to report when an autonomic function testing does not include beat-to-beat recording, or when testing without the use of a tilt table. It was determined that the clinical validity and clinical utility of these technologies have not been established and the qualifications of the personnel performing the testing are not standardized. Therefore, *CPT*® code *95943* is being removed from the "*CPT*®/HCPCS codes" section of the LCD, and language is being added to the "Limitations" section of the LCD and the coding guidelines attachment indicating it does not meet the medically reasonable and necessary threshold for coverage.

Additionally, *CPT*® code *95924* (AFT with passive tilt testing), also new for calendar year 2013, was also added to the AFT LCD during the annual 2013 HCPCS update; however, the LCD does not specifically address this code. Therefore, the LCD has been revised to include limited indications for this testing.

Effective date

This LCD revision is effective for services rendered **on or after March 24, 2014**. 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.

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

Botulinum toxins – revision to the Part B LCD

LCD ID number: L29088 (Florida)
LCD ID number: L29103 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for botulinum toxins was most recently revised May 10, 2013. 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 off-label indication for Myobloc (rimabotulinumtoxinb) for the treatment of sialorrhea. Also, a revision was made under the "ICD-9 Codes that Support Medical Necessity" section of the LCD, subtitled "Procedure Code J0587-Injection, rimabotulinumtoxinb, 100 units" to add ICD-9-CM diagnosis code 527.7 (Disturbance of salivary secretion).

In addition, the "Sources of Information and Basis for Decision" section of the LCD and "Coding Guidelines" attachment were updated.

Effective date

This LCD revision is effective for claims processed **on or after February 13, 2014**, for services rendered **on or after December 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.

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

Computerized corneal topography – revision to the Part B LCD

LCD ID number: L29122 (Florida)
LCD ID number: L29140 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for computerized corneal topography was effective for services rendered on or after February 2, 2009, for Florida and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands as a Medicare administrative contractor (MAC) LCD for jurisdiction 9 (J9). Since that time, the LCD has been revised to remove the asterisk (*) from diagnosis code 367.22 (Irregular astigmatism) under the "ICD-9 Codes that Support Medical Necessity" section of the LCD eliminating the dual diagnosis requirement and making the ICD-9-CM coding congruent with the text of the LCD.

Effective date

This LCD revision is effective for claims processed **on or after February 13, 2014**. 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.

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

Non-covered services – revision to the Part B LCD

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

The local coverage determination (LCD) for non-covered services was most recently revised January 1, 2014. Since that time, the LCD has been revised. The following Category III *Current Procedural Terminology*® (*CPT*®) codes were evaluated and were determined not to meet the medically reasonable threshold for coverage. Therefore, Category III *CPT*® codes *0329T, 0330T*, *0331T, 0332T, 0333T* and *0334T* were added to the non-covered services LCD and posted for a 45-day comment period extending from October 10, 2013, through November 23, 2013. Comments were received in favor of coverage for Category III *CPT*® code *0334T* (*Sacroiliac joint stabilization for arthrodesis, percutaneous or minimally invasive (indirect visualization), includes obtaining and applying autograft or allograft (structural or morselized), when performed, includes image guidance when performed (e.g., CT or fluoroscopic).*

In determining if a service or procedure reaches the threshold for coverage, this contractor addresses the quality of the evidence per the program integrity manual. When addressing the articles and related information in the public domain, the jurisdiction 9 (J9) Medicare administrative contractor (MAC) reached the determination that

(continued on next page)

Non-covered *(continued)*

available evidence was of moderate to low quality, consisting of small case series, retrospective studies, and review articles reporting limited safety and efficacy data for sacroiliac joint fusion procedures for the treatment of pain-related sacroiliac conditions. Due to the unavailability of high quality evidence, the J9 MAC reiterates that there is insufficient scientific evidence to support use of sacroiliac fusion in treating low back pain due to sacroiliac joint syndrome, and therefore is not considered reasonable and necessary under section 1862(a)(1)(a) of the Social Security Act. The J9 MAC will maintain Category III *CPT*® code *0334T* in its non-covered services LCD.

Any denied claim would have Medicare's appeal rights. The second level of appeal (qualified independent contractor) requires review by a clinician to uphold any denial. Providers should submit for review all the relevant medical documentation and case specific information of merit and/or new information in the public domain.

An interested stakeholder can request a reconsideration of an LCD after the notice period has ended and the draft becomes active. In the case of the non-covered services LCD, the stakeholder may request the list of the articles and related information in the public domain that were considered by the Medical Policy department in making the noncoverage decision. If the stakeholder has new information based on the evaluation of the list of articles and related information, an LCD reconsideration can be initiated. It is the responsibility of the interested stakeholder to request the evidentiary list from the contractor and to submit the additional articles, data, and related information in support of their request for coverage. The request must meet the LCD reconsideration requirements outlined on the website.

Also, any interested party could request CMS to consider developing a national coverage determination (NCD). Of note, if the evidence is not adequate for coverage under Section 1862(a)(1)(A), an item or service may be considered for coverage under the CMS Coverage with Evidence Development (CED) policy in which "reasonable and necessary" is established under 1862(a)(1)(E) of the Act. Under the authority of section 1862(a)(1)(E), the NCD process may result in coverage if the item or service is covered only when provided within a setting in which there is a pre-specified process for gathering additional data, and in which that process provides additional protections and safety measures for beneficiaries, such as those present in certain clinical trials.

Additionally, Category III *CPT*® codes *0254T* and *0255T* were removed from the "Procedures" section of the LCD as they may only be allowed if performed in a clinical trial approved by this contractor. For all claims submitted with Category III *CPT*® codes *0254T* or *0255T* the Q0 or Q1 modifier should be billed to indicate participation in the GORE study.

Effective date

The LCD revision for Category III *CPT*® codes *0329T, 0330T, 0331T 0332T, 0333T* and *0334T* is effective for services rendered **on or after March 17, 2014**. The LCD revision for Category III *CPT*® codes *0254T* and *0255T* is effective for claims processed **on or after January 30, 2014**, for services rendered **on or after December 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.

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

Peripheral nerve blocks – revision to the Part B LCD

LCD ID number: L29258 (Florida)
LCD ID number: L29466 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for peripheral nerve blocks was most recently revised January 1, 2013. Since that time, major revisions were made throughout the entire LCD. The "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD has been revised to clarify indications versus limitations of coverage. In addition, the "*CPT*®/HCPCS Codes," "ICD-9 Codes that Support Medical Necessity," "Documentation Requirements," "Utilization Guidelines," and "Sources of Information and Basis for Decision" sections of the LCD were revised.

Effective date

This LCD revision is effective for services rendered **on or after March 17, 2014**. 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.

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

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

LCD ID number: L29271 (Florida)
LCD ID number: L29472 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for rituximab (Rituxan®) was most recently revised June 08, 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 off-labeled indication of steroid refractory chronic graft-versus host disease. Also, a revision was made under the "ICD-9 Codes that Support Medical Necessity" section of the LCD to add the following dual diagnosis requirement: ICD-9-CM diagnosis code 279.52 must accompany underlying cause ICD-9-CM diagnosis code 996.85 or 996.88. 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 February 13, 2014**. 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.

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

Vertebroplasty, vertebral augmentation; percutaneous – revision to the Part B LCD

LCD ID number: L29209 (Florida)
LCD ID number: L29454 (Puerto Rico/U.S. Virgin Islands)

Data analysis by the program safeguards communication group (PSCG) identified, through a spike billing report, an increase in utilization of percutaneous vertebral augmentation (also referred to as kyphoplasty) represented by *Current Procedural Terminology*® (*CPT*®) codes *22523, 22524*, and *22525*. The Medicare Part B extraction summary system (BESS) statistical medical data obtained showed results above the national average. **Note**: Data results for Puerto Rico and the U.S. Virgin Islands were below the national average for all applicable codes).

Due to the risk for high-dollar claim payment error, the local coverage determination (LCD) for percutaneous vertebral augmentation (formerly kyphoplasty) has been revised to address the limited indications for these services. In addition, First Coast Service Options Inc. (First Coast) took this opportunity to combine the current percutaneous vertebroplasty LCD with the percutaneous vertebral augmentation LCD to align with other Medicare administrative contractors. In addition, the title of the LCD was changed to "vertebroplasty, vertebral augmentation; percutaneous" to represent both types of procedures and their corresponding *CPT*® codes.

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Vertebroplasty *(continued)*

This LCD has been revised to outline indications and limitations of coverage and/or medical necessity, *CPT*® codes, ICD-9-CM diagnosis codes, documentation requirements, and utilization guidelines for percutaneous vertebroplasty and percutaneous vertebral augmentation. In addition, an LCD "Coding Guidelines' attachment was created to provide instructions on coding and billing for all the codes in the revised LCD.

Effective date

This LCD revision is effective for services rendered **on or after March 31, 2014**. First Coast 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.

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

Additional Information

Self-administered drug (SAD) list – Part B: J3590/C9399/Q3026

The self-administered drug (SAD) list was most recently revised June 17, 2013. Since that time, based on the 2014 Healthcare Common Procedure Coding System (HCPCS) annual update, self-administered drug HCPCS code Q3026 (Interferon beta-1a [Rebif®]) was deleted.

Effective for services rendered on or after January 1, 2014, the following HCPCS codes have been added to the Medicare administrative contractor (MAC) for jurisdiction 9 Part B SAD list to replace HCPCS code Q3026.

- J3590/C9399 Injection, Interferon beta 1a, 11 mcg (Rebif®)

The First Coast Service Options Inc. (First Coast) SAD lists are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

Find out first: Subscribe to First Coast eNews

One of the secrets to achieving success as a Medicare provider is access to the right information at the right time. 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.*

Educational Events

Upcoming provider outreach and educational events
March 2014

Medicare Part B changes and regulations
When: Wednesday, March 26
Time: 11:30 a.m.-1:00 p.m.

Medicare Part A/B changes and regulations
When: Thursday, March 27
Time: 1:00 p.m.-2:30 p.m.

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 live training events, we also offer you the advantage of self-paced, free online courses that will allow you and your staff to train when and where it is most convenient for you. In addition, our comprehensive course catalog allows you to find the Medicare training that fits your specific needs, and several of our online courses offer CEUs. Learn more on the First Coast Medicare training website and explore our catalog of online courses.

CMS *MLN Connects*™ Provider eNews

The Centers for Medicare & Medicaid Services (CMS) *MLN Connects*™ Provider eNews is an official *Medicare Learning Network*® (*MLN*®) – branded product that contains a week's worth of news for Medicare fee-for-service (FFS) providers. CMS sends these messages weekly to national health industry provider associations, who then disseminates the e-News to their membership as appropriate.

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:

"MLN Connects™ Provider eNews': January 23, 2014 – *https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2014-01-23-enews.pdf*

"MLN Connects™ Provider eNews': January 30, 2014 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2014-01-30eNews.pdf*

"MLN Connects™ Provider eNews': February 6, 2014 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2014-02-06-Enews.pdf*

"MLN Connects™ Provider eNews': February 13, 2014 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2014-02-13Enews.pdf*

"MLN Connects™ Provider eNews': February 20, 2014 – *http://go.usa.gov/Bfxh*

Online Medicare refreshers

The *Medicare Learning Network*® (MLN) Products Web-Based Training (WBT) courses are designed for self-paced training via the Internet.

These WBT courses provide information on a broad range of Medicare topics for health care professionals and their staff. Many of these courses offer continuing education credits.

Click here to explore the wide away of training opportunities.

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
CGS Administrators, LLC
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

Pending request:
Medicare Part B Claims
P. O. Box 2537
Jacksonville, FL 32231-0020

Denied request for lack of response:
Submit as 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

CGS Administrators, LLC
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

U.S. Virgin Islands Contact Information

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.
Medicare EDI
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

Durable medical equipment (DME)

DME, orthotic or prosthetic claims
CGS Administrators, LLC
P.O. Box 20010
Nashville, Tennessee 37202

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

CGS Administrators, LLC
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.
Medicare EDI
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)
CGS Administrators, LLC
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 Government 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 2013 through September 2014.	40300260	$33		
2014 Fee Schedule – The Medicare Part B Physician and Nonphysician Practitioner Fee Schedules, effective for services rendered January 1 through December 31, 2014, are available free of charge online at *http://medicare.fcso.com/Data_files/* (English) or *http://medicareespanol.fcso.com/Fichero_de_datos/* (Español). Additional copies are available for purchase. The fee schedules contain payment rates for all localities. These items do not include the payment rates for injectable drugs, clinical lab services, mammography screening, or DMEPOS items. **Note:** Requests for hard copy paper disclosures will be completed as soon as CMS provides the direction to do so. Revisions to fees may occur; these revisions will be published in future editions of the Medicare Part B publication.	40300270	$12		
Language preference: **English** [ ] **Español** [ ]				
Please write legibly			Subtotal	$
			Tax (***add % for your area***)	$
			Total	$

Mail this form with payment to:

First Coast Service Options Inc.
Medicare Publications
P.O. Box 406443
Atlanta, GA 30384-6443

Contact Name: _____

Provider/Office Name: _____

Phone: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

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