Medicare B CONNECTION

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FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction N Providers

June 2016

In this issue

October update to 2016 codes used for skilled nursing facility consolidated billing enforcement

Provider types affected

This *MLN Matters*® article is for physicians, providers, and suppliers submitting claims to all Medicare administrative contractors (MACs) for services to Medicare beneficiaries who are in a Part A skilled nursing facility (SNF) stay.

Provider action needed

This article is based on change request (CR) 9688 updates to the lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the consolidated billing provision of the SNF prospective payment system (PPS). Changes to Current Procedure Terminology (CPT®)/HCPCS codes and Medicare physician fee schedule designations will be used to revise CWF edits to allow MACs to make appropriate payments in accordance with policy for SNF consolidated billing in the *Medicare Claims Processing Manual*, Chapter 6, Section 20.6 at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c06.pdf*. Make sure your staffs are aware of these updates.

Background

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of HCPCS codes that are excluded from the consolidated billing (CB) provision of the SNF PPS. Services excluded from SNF PPS and CB may be paid to providers, other than SNFs, for beneficiaries, even when in a SNF stay. Services not appearing on the exclusion lists submitted on claims to MACs, including durable medical equipment MACs (DME MACs), will not be paid by Medicare to any providers other than a SNF. For non-therapy services, SNF CB applies only when the services are furnished to a SNF resident during a covered Part A stay; however, SNF CB applies to physical and occupational therapies and speech-language pathology services whenever they are furnished to a SNF resident, regardless of whether Part A covers the stay. In order to assure proper payment in all settings, Medicare systems must edit for services provided to SNF beneficiaries both included and excluded from SNF CB.

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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.

Publication staff:
Liliana Chaves-Merchan
Terri Drury
Sofia Lennie
Mark Willett
Robert Petty

Fax comments about this publication to:

Medicare Publications
904-361-0723

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

About the 'Medicare B Connection'

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

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

Who receives the *Connection*

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

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

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

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

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

Publication format

The *Connection* is arranged into distinct sections.

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

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

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

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

Never miss an appeals deadline again

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

Medicare Part B advance beneficiary notices

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

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

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

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

Patient liability notice

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

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

ABN modifiers

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

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

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

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

GA modifier and appeals

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

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

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

Ambulatory Surgical Center

July 2016 update of the ambulatory surgical center payment system

Provider types affected

This *MLN Matters*® article is intended for ambulatory surgical center (ASC) submitting claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 9668 informs MACs about changes to and billing instructions for various payment policies implemented in the July 2016 ASC payment system update. As appropriate, this notification also includes updates to the Healthcare Common Procedure Coding System (HCPCS). Make sure that your billing staffs are aware of these changes.

Background

Included in CR 9668 are updates to the ASC payment system, payment rates for separately payable drugs and biologicals, including descriptors for newly created level II HCPCS codes for drugs and biologicals (ASC DRUG files), ASC billing edits, and the 2016 ASC payment rates for covered surgical and ancillary services (ASCFS file). There is also an update to Chapter 14, Section 10 of the *Medicare Claims Processing Manual*, which is attached to CR 9668.

Key changes in CR 9668

1. Billing instructions for intensity modulated radiation therapy (IMRT) planning

Payment for the services identified by Current Procedural Terminology® (CPT®) codes 77280, 77285, 77290, 77295, 77306 through 77321, 77331, and 77370 are already included in the ASC payment for CPT® code 77301 (IMRT planning). Effective, July 1, 2016, these codes should not be reported by ASCs in addition to CPT® code 77301 when provided as part of the development of the IMRT plan.

2. Upper eyelid blepharoplasty and blepharoptosis repair

The Centers for Medicare & Medicaid Services (CMS) payment policy does not allow ASCs to bill for separate payment for a blepharoplasty procedure (CPT® codes 15822, 15823) in addition to a blepharoptosis procedure (CPT® codes 67901-67908) on the ipsilateral upper eyelid. Any removal of upper eyelid skin in the context of an upper eyelid blepharoptosis surgery is considered a part of the blepharoptosis surgery and is already be included in the payment rate. Also ASCs cannot bill a blepharoplasty to Medicare and the beneficiary cannot be separately charged for a cosmetic surgery regardless of the amount of upper eyelid skin that is removed on a patient receiving a blepharoptosis repair because removal of (any amount) of upper eyelid skin is part of the blepharoptosis repair. In addition, the following are not permitted:

- Operating on the left and right eyes on different days when the standard of care is bilateral eyelid surgery
- Charging the beneficiary an additional amount for a cosmetic blepharoplasty when a blepharoptosis repair is performed
- Charging the beneficiary an additional amount for removing orbital fat when a blepharoplasty or a blepharoptosis repair is performed
- Performing a blepharoplasty on a different date of service than the blepharoptosis procedure for the purpose of unbundling the blepharoplasty or charging the beneficiary for a cosmetic surgery
- Performing blepharoplasty as a staged procedure, either by one or more surgeons (note that under certain circumstances a blepharoptosis procedure could be a staged procedure)
- Billing for two procedures when two surgeons divide the work of a blepharoplasty performed with a blepharoptosis repair
- Using modifier 59 to unbundle the blepharoplasty from the ptosis repair on the claim form; this applies to both physicians and facilities
- Treating medically necessary surgery as cosmetic for the purpose of charging the beneficiary for a cosmetic surgery
- Using an advance beneficiary notice of noncoverage for a service that would be bundled into another service if billed to Medicare.

3. Category III CPT® codes effective July 1, 2016

The American Medical Association (AMA) releases Category III CPT® codes twice per year: in January, for implementation beginning the following July, and in July, for implementation beginning the following January.

For the July 2016 update, CMS is implementing in the ASC payment system five Category III CPT® codes that the AMA released in January 2016 for implementation on July 1, 2016. The long and short descriptors, and ASC payment indicators (PIs) for these codes are shown in Table 1 (see page 7).

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Payment rates for these services are in Addendum AA of the July 2016 ASC Update that is posted at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html*. HCPCS code C9743 will be deleted June 30, 2016, since it will be replaced with Category III CPT® 0438T effective July 1, 2016.

4. Drugs, biologicals, and radiopharmaceuticals

a. Drugs and biologicals with payments based on average sales price (ASP) effective July 1, 2016

For 2016, payment for nonpass-through drugs, biologicals and therapeutic radiopharmaceuticals is made at a single rate of ASP + 6 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In 2016, a single payment of ASP + 6 percent for pass-through drugs, biologicals and radiopharmaceuticals is made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items. Payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. Updated payment rates effective July 1, 2016 are in the July 2016 ASC Addendum BB at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html*.

b. Drugs and biologicals based on ASP methodology with restated payment rates

Some drugs and biologicals based on ASP methodology may have payment rates that are corrected retroactively. These retroactive corrections typically occur on a quarterly basis. The list of drugs and biologicals with corrected payments rates will be accessible at *https://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/index.html* on the first date of the quarter. Suppliers who think they may have received an incorrect payment for drugs and biologicals impacted by these corrections may request MAC adjustment of the previously processed claims.

c. New 2016 HCPCS codes and dosage descriptors for certain drugs, biologicals, and radiopharmaceuticals

Seven new HCPCS codes have been created for reporting drugs and biologicals in the ASC setting. These new codes, their descriptors, PIs, and their effective dates are listed in Table 2 (see page 7).

d. Biosimilar biological product payment and required modifiers

ASC claims for separately paid biosimilar biological products are now required to include a modifier that identifies the manufacturer of the specific product. The modifier does not affect payment determination, but is used to distinguish between biosimilar products that appear in the same HCPCS code but are made by different manufacturers.

- **Q5101**: This is a reminder that for claims with dates of service January 1, 2016 and later, Q5101 must be submitted with a modifier to identify the manufacturer of the biosimilar product. Currently, the ZA modifier is the only manufacturer/modifier that may be submitted with Q5101. Claims submitted without the modifier cannot be processed.
- **Q5102**: Effective April 5, 2016, Q5102 (Inj., infliximab biosimilar) is payable in the ASC setting, where there has not previously been a specific code available. Q5102 must be submitted with a modifier to identify the manufacturer of the biosimilar product. Currently, the ZB modifier is the only manufacturer/modifier that may be submitted with this HCPCS. Claims submitted without the modifier will be returned as unprocessable.

When these claims are returned, MACs will use the following messages when returning these claims:

- **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) MA-130**- Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
- **Group code**: CO (contractual obligation)

The biosimilar HCPCS codes and required modifiers are listed in Table 3 (see page 8).

e. Other changes to 2016 HCPCS codes for certain drugs, biologicals, and radiopharmaceuticals

Effective July 1, 2016, HCPCS code Q9982, flutemetamol f18 diagnostic, will replace HCPCS code C9459, Flutemetamol f18. The ASC payment indicator will remain K2, “Pass-Through Drugs and Biologicals.”

Effective July 1, 2016, HCPCS code Q9983, florbetaben f18 diagnostic, will replace HCPCS code C9458, Florbetaben f18. The ASC payment will remain K2, “Pass-Through Drugs and Biologicals.”

Both C9458 and C9459 have a termination date of 6/30/2016. Other Changes to 2016 HCPCS codes for certain drugs, biologicals, and radiopharmaceuticals effective July 1, 2016, are listed in Table 4 (see page 8).

5. Coverage determinations

The fact that a drug, device, procedure or service is assigned a HCPCS code and a payment rate under the ASC payment system does not imply coverage

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by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the program. MACs) determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, MACs determine that it is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment.

Additional information

The official instruction, CR 9668, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3531CP.pdf*.

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

MLN Matters® Number: MM9668
Related Change Request (CR) #: CR 9668
Related CR Release Date: May 27, 2016
Effective Date: July 1, 2016
Related CR Transmittal #: R3531CP
Implementation Date: July 5, 2016

Table 1 – Category III CPT® codes effective July 1, 2016

CPT® code	Long descriptor	Short descriptor	ASC PI
0438T	Transperineal placement of biodegradable material, peri-prostatic (via needle), single or multiple, includes image guidance	Tprnl plmt biodegrdabl matrl	G2
0440T	Ablation, percutaneous, cryoablation, includes imaging guidance; upper extremity distal/peripheral nerve	Abltj perc uxtr/perph nrv	G2
0441T	Ablation, percutaneous, cryoablation, includes imaging guidance; lower extremity distal/peripheral nerve	Abltj perc lxtr/perph nrv	G2
0442T	Ablation, percutaneous, cryoablation, includes imaging guidance; nerve plexus or other truncal nerve (eg, brachial plexus, pudendal nerve)	Abltj perc plex/trncl nrv	G2
0443T	Real time spectral analysis of prostate tissue by fluorescence spectroscopy	R-t spctrl alys prst8 tiss	G2

Table 2 – New 2016 HCPCS codes and dosage descriptors for certain drugs, biologicals, and radiopharmaceuticals

HCPCS code	Long descriptor	Short descriptor	ASC PI	Effective date
C9476	Injection, daratumumab, 10 mg	Injection, daratumumab	K2	7/1/2016
C9477	Injection, elotuzumab, 1 mg	Injection, elotuzumab	K2	7/1/2016
C9478	Injection, sebelipase alfa, 1 mg	Injection, sebelipase alfa	K2	7/1/2016
C9479*	Instillation, ciprofloxacin otic suspension, 6 mg	Instill, ciprofloxacin otic	K2	7/1/2016
C9480	Injection, trabectedin, 0.1 mg	Injection, trabectedin	K2	7/1/2016
Q9981	Rolapitant, oral, 1 mg	Rolapitant, oral, 1mg	K2	7/1/2016
Q5102**	Injection, infliximab, biosimilar, 10 mg	Inj., infliximab biosimilar	K2	4/5/2016

***Note on reporting C9479**: Each vial of C9479 contains 60 mg, or 10 doses. If one single use vial is used for both patient's ears with the remainder of the drug in the vial unused, then two units of C9479 should be reported as administered to the patient; any discarded amount should be reported with the JW modifier according to the *Medicare Claims Processing Manual*, Chapter 17 - Drugs and Biologicals, Section 40 - Discarded Drugs and Biologicals.

****Note on Q5102**: the effective date of Q5102 is 4/5/2016.

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Chiropractic Services

Educational resources to assist chiropractors with Medicare billing

***Note**: This article was revised June 21, 2016, to add a reference and link to an educational video on Improving the Documentation of Chiropractic Services that gives a thorough presentation on medical necessity and proper documentation. All other information is unchanged. This information was previously published in the March 2016 Medicare B Connection, pages 12-13.*

Provider types affected

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

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

Provider action needed

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

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

Background

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

Enrollment information

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

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Table 3 – Biosimilar biological product payment and required modifiers

HCPCS code	Short descriptor	ASC PI	FDA approval date	Modifier	Modifier	Effective Date
Q5101	Inj filgrastim g-csf biosim	K2	03/06/2015	ZA	Novartis/Sandoz	01/01/2016
Q5102	Inj., infliximab biosimilar	K2	04/05/2016	ZB	Pfizer/Hospira	04/05/2016

Table 4 – Other changes to 2016 HCPCS codes for certain drugs, biologicals, and radiopharmaceuticals effective July 1, 2016

HCPCS code	Short descriptor	Long descriptor	ASC PI	Add date	Term date
C9459	Flutemetamol f18	Flutemetamol f18, diagnostic, per study dose, up to 5 millicuries	K2	01/01/2016	06/30/2016
Q9982	flutemetamol f18 diagnostic	Flutemetamol F18, diagnostic, per study dose, up to 5 millicuries	K2	07/01/2016	
C9458	Florbetaben f18	Florbetaben f18, diagnostic, per study dose, up to 8.1 millicuries	K2	01/01/2016	06/30/2016
Q9983	florbetaben f18 diagnostic	Florbetaben f18, diagnostic, per study dose, up to 8.1 millicuries	K2	07/01/2016	
C9743	Bulking/spacer material impl	Injection/implantation of bulking or spacer material (any type) with or without image guidance (not to be used if a more specific code applies)	G2		06/30/2016

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

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

Coverage, documentation, and billing

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

MLN Matters® article *MM3449*, discusses "Revised requirements for chiropractic billing of active/corrective treatment and maintenance therapy, full replacement of CR 3063".

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

- 30.5: Chiropractor's services;
- 220.1.3: Certification and recertification of need for treatment and therapy plans of care;
- 240: Chiropractic services – general; This section establishes that payment for chiropractic services is based on the Medicare physician fee schedule (MPFS) and that payment is made to the beneficiary or, on assignment, to the chiropractor.
- 240.1.1: Manual manipulation;
- 240.1.2: Subluxation may be demonstrated by X-ray or physician's exam;
- 240.1.3: Necessity for treatment;
- 240.1.4: Location of subluxation; and
- 240.1.5: Treatment parameters.

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

- National Government Services (LCD L33613);
- First Coast Options, Inc (LCD L33840);
- CGS Administrators, LLC (LCD L33982);
- Noridian Healthcare Solutions, LLC (Jurisdiction F) (LCD L34009);
- Noridian Healthcare Solutions, LLC (Jurisdiction E) (LCD 34242);
- Wisconsin Physicians Service Insurance Corporation (LCD L34585); and
- Novitas Solutions, Inc (LCD L35424).

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

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

The *MLN Matters*® article – SE1305 Revised *Full implementation of edits on the ordering/referring providers in Medicare Part B, DME, and Part A home health agency (HHA) claims (change requests 6417, 6421, 6696, and 6856)* explains that chiropractors are not eligible to order or refer supplies or services.

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

- 30.3.12: Carrier annual participation program;
- 30.3.12.1: Annual open participation enrollment process;
- 30.3.12.1.2: Annual Medicare physician fee schedule file information; and
- 80.3.2.1.3: A/B MAC (B) Specific requirements for certain specialties/services.

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

The *Medicare Claims Processing Manual*, Chapter 26 "Completing and processing form CMS-1500 data set," includes *Section 10.4*, "Items 14-33 – Provider of service or supplier information." This section includes specific instructions for chiropractic services for items 14, 17, and 19.

The *NCCI Policy Manual for Medicare Services* under the "Downloads" section. Chapter XI, "Medicine, evaluation and management services (CPT® codes 90000-99999)," includes information on chiropractic manipulative treatment.

More resources: A chiropractor is eligible to receive incentive payments under the Physician Quality Reporting System (PQRS), Electronic Prescribing (eRx) Incentive

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Program, and Electronic Health Record (EHR) Incentive Program. Information on reporting these measures is available in the Physician and Other Enrolled Health Care Professionals pathway.

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

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

Advance beneficiary notice (ABN) information

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

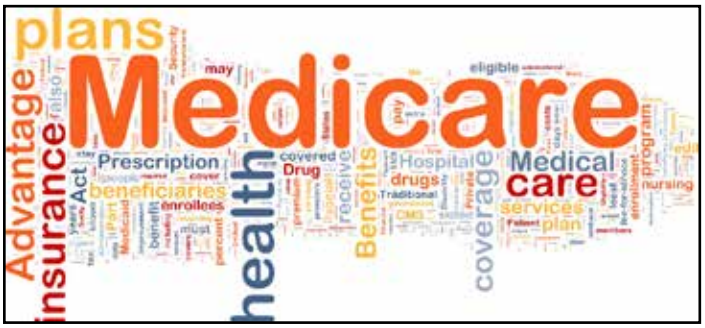
The *Medicare Claims Processing Manual*" Chapter 23 "Fee Schedule Administration and Coding Requirements," includes *Section 20.9.1.1*, "Instructions for Codes With Modifiers (Carriers Only)." This section outlines the modifiers that may be used when a chiropractor notifies a beneficiary the item or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

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

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

Additional Information

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



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

Document history

Date of change	Description
June 21, 2016	The article was revised to add a reference and link to an educational video on Improving the Documentation of Chiropractic Services that gives a thorough presentation on medical necessity and proper documentation.
March 16, 2016	Initial article post

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

Dialysis Services

2016 ESRD prospective payment system

Provider types affected

This *MLN Matters*® article is intended for end-stage renal disease (ESRD) facilities that submit claims to Medicare administrative contractors (MACs) for ESRD services provided to Medicare beneficiaries.

What you need to know

Change request (CR) 9541 updates Chapter 11 of the *Medicare Benefit Policy Manual* to reflect the provisions in the 2016 ESRD prospective payment system (PPS) final rule. There are no new coverage policies, payment policies, or codes introduced in CR 9541. Specific policy changes and related business requirements were addressed in CR 9367, as discussed in *MLN Matters*® article *MM9367*.

Background

The ESRD PPS provides a single payment to ESRD facilities, that is, hospital-based and free-standing facilities, that cover all the resources used in providing an outpatient dialysis treatment. This includes supplies and equipment used to administer dialysis in the ESRD facility or at a patient's home, drugs, biologicals, laboratory tests, training, and support services.

The ESRD PPS base rate is adjusted for patient-level case mix and facility-level characteristics. For 2016, in accordance with the American Taxpayers Relief Act of 2012 (ATRA; Section 632(c)), The Centers for Medicare & Medicaid Services (CMS) analyzed the case-mix payment adjustments using more recent data.

CMS revised the adjustments by changing the adjustment payment amounts based on an updated regression analysis using 2012 and 2013 ESRD claims and cost report data. CMS also removed two comorbidity payment adjustments (bacterial pneumonia and monoclonal gammopathy). Because the updated regression analysis conducted enabled CMS to analyze and revise the case-mix payment adjustments, CMS also revised the low-volume payment adjustment and implemented a payment adjustment for rural ESRD facilities.

For 2016, in accordance with the Protecting Access to Medicare Act of 2014 (PAMA) (Section 217(c)), CMS finalized a drug designation process for:

1. Determining when a product would no longer be considered an oral-only drug; and
2. Including new injectable and intravenous products into the bundled payment under the ESRD PPS.

Updates to the 'Medicare Benefit Policy Manual'

The key clarifications/updates to the *Medicare Benefit Policy Manual* are as follows:

Section 20.2

To the extent a laboratory test is performed to monitor the levels or effects of any of the drugs that were specifically excluded from the ESRD PPS, these tests would be separately billable. The following table lists the drug categories that were excluded from the ESRD PPS and the rationale for their exclusion. Laboratory services furnished to monitor the medication levels or effects of drugs and biologicals that fall in those categories would not be considered to be furnished for the treatment of ESRD.

Drug categories excluded from the ESRD PPS base rate for the purpose of reporting labs

Drug category	Rationale for exclusion
Anticoagulant	Drugs labeled for non-renal dialysis conditions and not for vascular access.
Antidiuretic	Used to prevent fluid loss.
Antiepileptic	Used to prevent seizures.
Anti-inflammatory	May be used to treat kidney disease (glomerulonephritis) and other inflammatory conditions.
Antipsychotic	Used to treat psychosis.
Antiviral	Used to treat viral conditions such as shingles.
Cancer management	Includes oral, parenteral and infusions. Cancer drugs are covered under a separate benefit category.
Cardiac management	Drugs that manage blood pressure and cardiac conditions.
Cartilage	Used to replace synovial fluid in a joint space.
Coagulants	Drugs that cause blood to clot after anti-coagulant overdose or factor VII deficiency
Cytoprotective agents	Used after chemotherapy treatment
Endocrine/ metabolic management	Used for endocrine/metabolic disorders such as thyroid or endocrine deficiency, hypoglycemia, and hyperglycemia
Erectile dysfunction management	Androgens were used prior to the development of ESAs for anemia management and currently are not recommended practice. Also used for hypogonadism and erectile dysfunction.
Gastrointestinal management	Used to treat gastrointestinal conditions such as ulcers and gallbladder disease

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Drug category	Rationale for exclusion
Immune system management	Anti-rejection drugs covered under a separate benefit category.
Migraine management	Used to treat migraine headaches and symptoms
	Used to treat muscular disorders such as prevent muscle spasms, relax muscles, improve muscle tone as in myasthenia gravis, relax muscles for intubation and induce uterine contractions
Pharmacy handling for oral anti-cancer, anti-emetics and	Not a function performed by an ESRD facility
Pulmonary system management	Used for respiratory/lung conditions such as opening airways and newborn apnea
	Includes contrasts and procedure preparation
Unclassified drugs	Should only be used for drugs that do not have a HCPCS code and therefore cannot be identified
Vaccines	Covered under a separate benefit category

Also, effective January 1, 2016, the lipid panel is no longer considered to be a renal dialysis service. However, if the panel is furnished for the treatment of ESRD it is the responsibility of the ESRD facility and should be reported on the facility's claim.

Section 20.3

The ESRD PPS functional category is a distinct grouping of drugs and biologicals, as determined by CMS, whose end action effect is the treatment or management of a condition or conditions associated with ESRD. The drug designation process is dependent on the functional categories, as discussed in Section 20.3.1., below in this article.

Drugs and biologicals always considered to be renal dialysis services are those used for access management, anemia management, bone and mineral metabolism management, and cellular management. ESRD facilities are responsible for furnishing these drugs directly or under arrangement. This includes any drug or biological that is furnished in the ESRD facility or taken by the patient outside of the ESRD facility.

Erythropoiesis stimulating agents (ESAs), such as epoetin alfa (EPOGEN®) and darbepoetin alfa (ARANESP®) when furnished to Medicare ESRD patients are always considered to be renal dialysis services and included in the ESRD PPS. Monthly dosages of these ESAs are subject to Medicare's ESA claims monitoring policy. See the *Medicare Claims Processing Manual*, Chapter 8, Section 60.4.1 for more information on the ESA monitoring policy.

Note: ESA dose edits are applied prior to pricing so that ESAs are not overvalued in determining eligibility for outlier payments.

Drugs and biologicals included in the ESRD PPS base rate that may be used for both the treatment of ESRD and for reasons other than the treatment of ESRD are those used as antiemetics, anti-infectives, antipruritics, anxiolytics, excess fluid management, fluid and electrolyte management including volume expanders, and pain management. ESRD facilities are responsible for furnishing these drugs directly or under arrangement when they are prescribed for the treatment of ESRD. This includes any drug or biological that is furnished in the ESRD facility or taken by the patient outside of the ESRD facility.

ESRD facilities are responsible for furnishing antibiotics for access site infections directly or under arrangement. When antibiotics are used at home by a patient to treat an infection of the catheter site or peritonitis associated with peritoneal dialysis, the antibiotics are included in the ESRD PPS and may not be paid separately. This includes antibiotics that may be added to a patient's dialysate solution for the purposes of vascular access-related and peritonitis infections.

Any other drugs (other than those categories described above and below) when used for the treatment of ESRD are also included in the ESRD PPS. For example,

- Patient A experiences nausea or pain during a hemodialysis dialysis treatment and requires medications. Any medication furnished during the dialysis treatment or after the treatment is considered a renal dialysis service and may not be billed separately.
- Patient B experiences anxiety with dialysis treatments and is prescribed anti-anxiety medication during and between the dialysis treatments. Any medications furnished in preparation for the dialysis treatment, during the dialysis treatment or after the dialysis treatment, is considered a renal dialysis service and may not be billed separately.
- Any drug or biological added to patient dialysate solutions.

Functional categories included in the ESRD base rate but may be used for dialysis and non-dialysis purposes

Category	Rationale for association
Antiemetic	Used to prevent or treat nausea and vomiting related to dialysis. Excludes antiemetics used for purposes unrelated to dialysis, such as those used in conjunction with chemotherapy as these are covered under a separate benefit category.

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Category	Rationale for association
Anti-infectives	Used to treat vascular access-related and peritonitis infections. May include antibacterial and antifungal drugs.
Antipruritic	Drugs in this classification have multiple clinical indications. Use within an ESRD functional category includes treatment for itching related to dialysis.d
Anxiolytic	Drugs in this classification have multiple actions. Use within an ESRD functional category includes treatment of restless leg syndrome related to dialysis.
Excess fluid	Drug/fluids used to treat fluid excess/ overload.
Fluid and electrolyte	Intravenous drugs/fluids used to treat fluid and electrolyte needs.
Pain	Drugs used to treat vascular access site pain and to treat pain medication overdose, when the overdose is related to medication provided to treat vascular access site pain.

Oral-only forms of renal dialysis drugs and biologicals that have no other form of administration will be included in the ESRD PPS as a Part B renal dialysis service. Implementation of renal dialysis oral-only drugs has been delayed until January 1, 2025.

Section 20.3.1 – Drug designation process

A. Definition of a new injectable or intravenous product

A new injectable or intravenous product is an injectable or intravenous product that is approved by the Food and Drug Administration (FDA) under Section 505 of the Federal Food, Drug, and Cosmetic Act or Section 351 of the Public Health Service Act, commercially available, assigned a Healthcare Common Procedure Coding System (HCPCS) code, and designated by CMS as a renal dialysis service.

B. Determination

To make the determination as to whether a product is a new injectable or intravenous drug or biological; whether the new injectable or intravenous drug or biological is a renal dialysis service; and whether the new injectable or intravenous drug or biological fits into an existing functional category CMS will:

1. Review the new product's FDA labeling data and information;
2. Review the new product's information presented for obtaining a HCPCS code; and
3. Conduct an internal medical review following the announcement of the new product's FDA and HCPCS decision.

If a new injectable or intravenous drug is used to treat or manage a condition for which there is an ESRD PPS functional category, the new drug would be considered included in the ESRD PPS bundled payment and no separate payment is available. If the new injectable or intravenous drug is used to treat or manage a condition for which there is not an ESRD PPS functional category, the following steps occur:

1. The new injectable or intravenous drug or biological would be paid for using a transitional drug add-on payment adjustment;
2. At the next rulemaking opportunity, CMS would add a new functional category applicable to the new injectable or intravenous drug or biological being used in the treatment of ESRD;
3. The new injectable or intravenous product would be added to the ESRD PPS bundled payment following payment of the transitional drug add-on payment adjustment.

C. Transitional drug add-on payment adjustment

If the new injectable or intravenous drug or biological is used to treat or manage a condition for which there is not an ESRD PPS functional category, CMS will pay for the drug or biological using a transitional drug add-on payment adjustment. The transitional drug add-on payment is based on payment methodologies under Section 1847A and would continue for a period of two years. During the time that injectable or intravenous drugs and biologicals are paid the transitional drug add-on payment adjustment, the drug or biological is not considered an outlier service.

D. Determination of when an oral-only renal dialysis service drug or biological is no longer oral-only

An oral-only renal dialysis service drug or biological is a drug or biological with no injectable equivalent or other form of administration other than an oral form. An oral-only renal dialysis service drug or biological is no longer considered oral-only when a non-oral version of the oral-only drug or biological is approved by the FDA.

Section 60

Based on the refinement of the ESRD PPS, effective January 1, 2016, adult case-mix payment adjustments are made for four comorbidity categories (two acute and two chronic) as discussed in detail in the revised Section 60, which also includes detailed examples. The revised Section 60 is included as part of CR 9541 and the web address for accessing the CR is in the *Additional information* section of this article.

In addition, the revised Section 60 shows that beginning January 1, 2016, the ESRD PPS provides a 1.008 percent payment adjustment for ESRD facilities located in a rural core-based statistical area.

Additional information

The official instruction, CR 9541, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R224BP.pdf*.

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Drugs and Biologicals

Updated information on the intravenous immune globulin demonstration

Provider types affected

This *MLN Matters*® article is intended for suppliers submitting claims to durable medical equipment Medicare administrative contractors (DME MACs) for intravenous immune globulin (IVIG) drugs and services for Medicare beneficiaries.

As mentioned in *MLN Matters*® article SE1424, suppliers do not need to apply to participate in the demonstration as long as they meet all Medicare as well as other national, state, and local standards and regulations applicable to the provision of demonstration covered services.

Provider action needed

In this article, the Centers for Medicare & Medicaid Services (CMS) informs providers that a new Medicare contractor, Noridian Healthcare Solutions, LLC, will replace NHIC as the implementation support contractor for the IVIG demonstration as of July 1, 2016. This article also reminds suppliers of the 2016 payment rate for demonstration service code Q2052. The 2016 payment rate is $336.05. As of June 2016, Medicare is continuing to accept applications from beneficiaries on a rolling basis. This will continue as long as the funding or enrollment limitations are not reached or until the demonstration ends, whichever occurs sooner. As of June 24th, applications should no longer be submitted to NHIC. The last date to submit an application for coverage prior to September 30, 2017 (when the demonstration is scheduled to end) is August 15, 2017.

Make sure your staff is aware of this information.

Background

In *MLN Matters*® article *SE1424*, CMS provides a complete overview of the IVIG demonstration. Part of the overview includes a discussion of how beneficiaries need to submit an application in order to participate in the demonstration. As of June 24, 2016, such applications must be submitted to Noridian Healthcare Solutions, LLC.

The enrollment application and the application completion guide will be available at *https://med.noridianmedicare.com/web/ivig* or through the IVIG call center at (844)-625-6284. You can also sign up to receive IVIG demonstration listserve updates from the new implementation support contractor.

As of June 24, 2016, completed applications may be submitted by fax or mail to Noridian.

Applications may be mailed to:

Noridian Healthcare Solutions, LLC
IVIG Demo
PO Box 6788
Fargo ND 58108-6788

For overnight mailings:

Noridian Healthcare Solutions, LLC
IVIG Demo
900 42nd Street South
Fargo ND 58103

Applications may be faxed to: 701-277-2428

Additional information

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

MLN Matters® article SE1424 has more details and is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1424.pdf*.

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

Related *MLN Matters*® article MM9367 is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9367.pdf*.

Chapter 8, Section 60.4.1 of the *Medicare Claims Processing Manual* is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c08.pdf*.

MLN Matters® Number: MM9541
Related Change Request (CR) #: CR 9541
Related CR Release Date: June 3, 2016
Effective Date: January 1, 2016
Related CR Transmittal #: R224BP
Implementation Date: September 6, 2016

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

***Note**: This article was revised on June 10, 2016, to reflect the revised CR 9603 issued on June 9. The CR was revised to change the effective and implementation dates. The article is revised accordingly. In the article, the CR release date, transmittal number and link to the CR were also changed. All other information remains the same. This information was previously published in the* May 2016 Medicare A Connection, page 1.

Provider types affected

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

Provider action needed

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

Effective January 1, 2017, providers are required to:

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

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

Background

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

Be aware in order to more effectively identify and monitor billing and payment for discarded drugs and biologicals, CMS is revising this policy to require the uniform use of the JW modifier for all claims with discarded Part B drugs and biologicals.

Additional information

The official instruction, CR 9603, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3538CP.pdf*.

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

Document history

Document history	Description
June 10, 2016	The article was revised to reflect a revised CR 9603. The CR revision changed the effective and implementation dates. In the article, the CR release date, transmittal number and link to the CR were also changed. All other information remains the same.
May 25, 2016	The article was revised to reflect an updated CR. That CR updated the X-ref requirement number in the CR's supporting information section. In the article, the CR release date, transmittal number and link to the CR was changed. All other information remains the same.

MLN Matters® Number: MM9603 *Revised*
Related Change Request (CR) #: CR 9603
Related CR Release Date: June 9, 2016
Effective Date: January 1, 2017
Related CR Transmittal #: R3538CP
Implementation Date: January 3, 2017

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MLN Matters® Number: SE1610
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

Implementation of intravenous immune globulin demonstration

***Note**: This article was revised June 2, 2016, to make suppliers aware that a new contractor is administering this demonstration. See article SE1610 at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1610.pdf for more information. This information was previously published in the September 2014 Medicare B Connection, pages 13-16.*

Provider types affected

This *MLN Matters*® article is intended for suppliers submitting claims to durable medical equipment Medicare administrative contractors (DME MACs) for intravenous immune globulin (IVIG) drugs and services to Medicare beneficiaries.

Suppliers do not need to apply to participate in the demonstration as long as they meet all Medicare as well as other national, state, and local standards and regulations applicable to the provision of demonstration covered services.

Provider action needed

In this article, the Centers for Medicare & Medicaid Services (CMS) alerts providers to a three year demonstration to evaluate the benefits of providing payment for items and services needed for the in-home administration of IVIG for the treatment of primary immune deficiency disease (PIDD). CMS has designed the IVIG demonstration to pay a bundled payment for items and services needed for the in-home administration of intravenous immune globulin for the treatment of PIDD. The demonstration will begin paying for services as of October 1, 2014, and will continue for three years, as long as funding remains available.

Background

Depending on the circumstances, traditional fee-for-service (FFS) Medicare covers some, or all, components of home infusion services. By special statutory provision, Medicare Part B covers IVIG for persons with PIDD who wish to receive the drug at home. Medicare does not separately pay for any services or supplies to administer the drug if the person is not homebound, and is otherwise receiving services under a Medicare home health episode of care. As a result, many beneficiaries have chosen to receive the drug at their doctor's office, in an outpatient hospital setting, or to self-administer the drug subcutaneously. Beneficiaries may also alternate between settings or drug formulations, if necessary, to accommodate travel or other personal situations.

IVIG demonstration

The "Medicare IVIG Access and Strengthening Medicare and Repaying Taxpayers Act of 2012" authorized the demonstration under Part B of Title XVIII of the Social Security Act. The demonstration is limited to no more than 4,000 beneficiaries, and the $45 million budget covers benefit costs, as well as administrative expenses for implementation and evaluation. Participation is voluntary and may be terminated by the beneficiary at any time.

Under this demonstration, Medicare will issue under Part B a bundled payment for all items and services that are necessary to administer IVIG in the home to enrolled beneficiaries who are not otherwise homebound and receiving home health care benefits. In processing all services and supplies needed for the administration of IVIG, CMS is not making any changes to existing coverage determinations to receive the IVIG drug in the home or for services and supplies that are otherwise not covered under the traditional FFS Medicare Part B benefit.

The demonstration only applies to situations where the beneficiary requires IVIG for the treatment of PIDD, or is currently receiving subcutaneous immune globulin to treat PIDD and wishes to switch to IVIG. This demonstration does not apply if the immune globulin is intended to be administered subcutaneously. Only those beneficiaries with PIDD who are eligible to receive IVIG under the current Medicare benefit (have Part B, and have traditional FFS Medicare) will be eligible to enroll in the demonstration and have the services paid under the new demonstration.

This demonstration will not change how subcutaneous administration of immune globulin (SCIG) is covered and paid for under the traditional Medicare fee-for-service (FFS) program. Also, nothing in this demonstration will impact how IVIG is paid by Medicare for beneficiaries who are covered under a home health episode of care.

Beneficiaries participating in the demonstration shall not be restricted in any way from receiving Medicare covered IVIG, and non-demonstration Medicare covered related services from different providers at different times should they so choose. For example, a beneficiary receiving services under the demonstration at home may choose to switch and receive them at a doctor's office or outpatient department at any time. The beneficiary may switch back to receiving services under the demonstration as long as they are otherwise still eligible, and funding remains available.

Beneficiaries under hospice shall not be excluded from this demonstration, and their demonstration claims shall be processed in the same manner as other Medicare (non-demonstration) claims for hospice patients.

Beneficiaries covered under a home health episode of care may apply to participate in the demonstration but will not be eligible to have services paid for under the demonstration until after the home health episode of care has ended. Similarly, beneficiaries who are participating in the demonstration and subsequently become eligible to receive services under a home health episode of care will not be eligible to have services paid for under the demonstration for the period of time they are covered under such episodes.

Providers/suppliers billing for the services and supplies

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covered under the demonstration must meet all Medicare as well as other national, state, and local standards and regulations applicable to the provision of services related to home infusion of IVIG.

Beneficiary eligibility

In order to pay for the new demonstration covered services, the following requirements must be met:

1. The beneficiary must be enrolled in the demonstration on the eligibility file provided by NHIC, Corp., the implementation support contractor (as of July 1, 2016, Noridian Healthcare Solutions, LLC is the support contractor);
2. The beneficiary must be eligible to have the IVIG drug paid for at home (has a diagnosis of PIDD) under the traditional Medicare benefit;
3. The beneficiary must be enrolled in Medicare Part B and not be enrolled in a Medicare Advantage plan (i.e. have traditional FFS Medicare coverage);
4. The beneficiary must not be covered on the date of service in a home health episode (In such circumstances, the services are covered under the home health episode payment.)
5. The place of service must be the beneficiary's home or a setting that is "home like".

Billing details

A new "Q" code has been established for services, supplies, and accessories used in the home under the Medicare IVIG demonstration:

Q2052: (long description) – Services, supplies, and accessories used in the home under Medicare intravenous immune globulin (IVIG) demonstration.

Q2052: (short description) – IVIG demo, services/supplies.

The code is for use with the IVIG demo only and the jurisdiction for this code is DME MAC.

The new demonstration service code (Q2052) must be billed as a separate claim line on the same claim for the IVIG drug itself.

Specialty pharmacies will bill for the IVIG drug itself when intended for home administration by beneficiaries who are not homebound and not covered under a home health benefit episode. For those beneficiaries participating in the demonstration, specialty pharmacies shall bill for the demonstration covered services on the same claim as the drug itself. Claims for the demonstration bundled service (Q2052) billed in the absence of the "J" code for the IVIG drug will not be payable. The new demonstration covered services will be paid as a bundle and will be subject to coinsurance and deductible in the same manner as other Part B services.

For 2014, the nationwide Medicare allowable for Q2052

will be $300 each time the IVIG is administered. (The 2016 payment rate for Q2052 is $336.05.) While this is expected to be approximately monthly, it can be more or less frequent depending upon a patient's medical need.

As with all DMEPOS claims, specialty pharmacies will bill these claims to the appropriate DME MAC jurisdiction based on the beneficiary's state.

The following "J" codes (as updated by CR 8724) represent immune globulin drugs that are administered intravenously and payable in 2014 under Medicare Part B for services rendered in the home (or home-like setting) for beneficiaries with PIDD: Privigen, (J1459), Bivigam (J1556), Gammaplex (J1557), Gamunex (J1561), Immune Globulin Not Otherwise Specified (J1566 and J1599), Octagam (J1568), Gammagard liquid (J1569), and Flebogamma (J1572). Immune globulin drugs covered under Medicare Part B for administration in the home for patients with PIDD are subject to change; coverage of any drugs under the demonstration shall not differ from drugs that are eligible for payment under Part B for beneficiaries not enrolled in the demonstration.

Note: If the claim for IVIG is not otherwise payable under Medicare Part B, the Q2052 claim line is not payable under the demonstration. The claim for Q2052 must have the same place of service code on the claim line as the IVIG (J code) for which it is applicable.

In cases where the drug is mailed or delivered to the patient prior to administration, the date of service for the administration of the drug (the "Q2052" claim line) may be no more than 30 calendar days after the date of service on the drug claim line.

If multiple administrations of IVIG are submitted on a single claim, each date of service for the administration of the drug (Q2052) must be on a separate claim line. If these requirements are not met, the claim will not be processed and Medicare will return a group code of CO (contractual obligation), a remittance advice remarks code (RARC) of M51 (Missing/incomplete/invalid procedure code(s)) and a claim adjustment remarks code (CARC) of B15 (This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other

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service/procedure has not been received/adjudicated).

If a claim is submitted with the HCPCS Q2052 code and the beneficiary is not enrolled in the demonstration on the date of service, the claim will be denied with a RARC of M138 (Patient identified as a demonstration participant but the patient was not enrolled in the demonstration at the time services were rendered. Coverage is limited to demonstration participants.), a CARC of 96 (non-covered charge(s)), and a group code of CO.

Coverage of demonstration services shall be subject to the usual coordination of benefit process and the usual Medicare secondary payer process as well.

Questions and answers relating to supplier eligibility

Question: Is the DMEPOS (durable medical equipment, prosthetics, orthotics, and supplies) Supplier required to be certified to bill the A/B MACs in order to provide the nursing component of the Q2052 - services, supplies, and accessories used in the home under the Medicare IVIG demonstration?

Answer: No. The DMEPOS supplier must currently be able to bill the DME MACs (enrolled and current with the national supplier clearinghouse) and meet all regulatory and statutory requirements. If a state requires licensure to furnish certain items or services, a DMEPOS supplier: Must be licensed to provide the item or service; and may contract with a licensed individual or other entity to provide the licensed services unless expressly prohibited by state law. A supplier may not contract with any entity that is currently excluded from the Medicare program, any state health care programs or from any other federal procurement or non-procurement programs.

Question: Can the supplier/pharmacy contract or subcontract nursing services for the administration of the IVIG to bill the Q2052 - services, supplies, and accessories used in the home under the Medicare IVIG demonstration?

Answer: Yes. If a state requires licensure to furnish certain items or services, a supplier/pharmacy: Must be licensed to provide the item or service; and may contract with a licensed individual or other entity to provide the licensed services unless expressly prohibited by state law.

A supplier may not contract with any entity that is currently excluded from the Medicare program, any state health care programs, or from any other federal procurement or non-procurement programs.

How beneficiaries can apply for the IVIG demonstration

To participate in this demonstration the beneficiary must complete and submit an application form. All applications must be signed by the beneficiary as well as his or her physician. Submission of an application does not guarantee that a beneficiary will be accepted to participate in the demonstration.

CMS has contracted with NHIC, Corp., DME MAC Jurisdiction A, (NHIC is being replaced by Noridian as of July 1, 2016) to help administer the demonstration. NHIC (Noridian, effective July 1, 2016) will review all applications for eligibility and will create and upload an enrollment file to be used by CMS' claim processing systems.

CMS conducted an initial enrollment period from 8/8/14-9/12/14. Since the number of beneficiaries and funds available to implement this demonstration are limited, not all beneficiaries who are eligible may be accepted if more eligible beneficiaries apply than can be served with the funds available. If the number of eligible beneficiaries that apply during the initial enrollment period is below the statutory limits, then additional applications will continue to be accepted after the 9/12/14 deadline on a rolling basis until enrollment and/or funding limits are reached. As of June 2016, Medicare is continuing to accept applications from beneficiaries on a rolling basis. This will continue as long as the funding or enrollment limitations are not reached or until the demonstration ends, whichever occurs sooner. The last date to submit an application for coverage prior to September 30, 2017 (when the demonstration is scheduled to end) is August 15, 2017.

Until June 24, 2016, the enrollment application and the application completion guide are available at: *https://www.medicarenhic.com* or through the IVIG Demo Hot Line at: (844)-625-6284.

As of June 24, 2016, the enrollment application and the application completion guide will be available at *http://med.noridianmedicare.com/web/ivig*.

Until June 23, 2016, completed applications may be submitted by fax or mail to NHIC, Corp. at the following address:

Applications may be mailed to:

NHIC, Corp.
IVIG Demo
P.O. Box 9140
Hingham, MA. 02043-9140

For overnight mailings:

NHIC, Corp
IVIG Demo
75 William Terry Dr.
Hingham, MA. 02043

Applications may be faxed to: 781-741-3533

As of June 24, 2016, completed applications may be submitted by fax or mail to Noridian.

Applications may be mailed to:

Noridian Healthcare Solutions, LLC
IVIG Demo
PO Box 6788
Fargo ND 58108-6788

See **DEMO**, next page

DEMO

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For overnight mailings:

Noridian Healthcare Solutions, LLC
IVIG Demo
900 42nd Street South
Fargo ND 58103

Applications may be faxed to: 701-277-2428

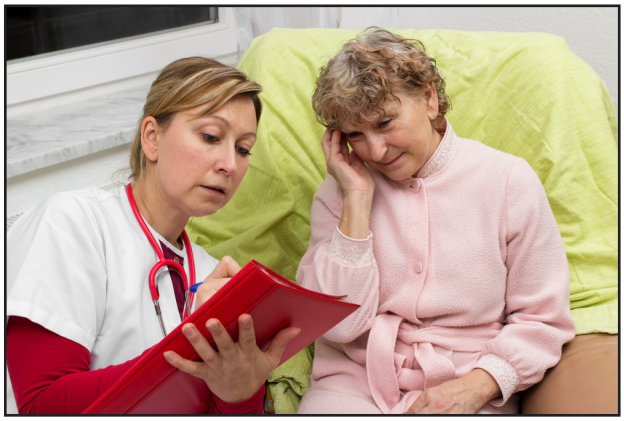
Additional Information

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

MLN Matters® article SE1610 at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1610.pdf* contains details on submitting applications to Noridian, the new support contractor, as of July 1, 2016.

Document history

- **July 31, 2014** – Initial issuance.
- **August 28, 2014** – revised to amend some of the billing instructions, particularly with regard to date of service on the Q2052 claim line. Also, some questions and answers related to supplier eligibility are added to the article.



- **June 2, 2016** – Revised to add a link to SE1610, which announces a new contractor administering the demonstration, and to update the article to reflect the new contractor's information.

MLN Matters® Number: SE1424 *Revised*
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal N/A
Implementation: N/A

Laboratory/Pathology

Potential assignment violations by clinical laboratories in U.S. Virgin Islands

It has come to the attention of First Coast Service Options by the State Health Insurance Assistance Program (SHIP) in the U.S. Virgin Islands that some laboratories are charging patients upfront to perform services. This would not be appropriate as, typically, beneficiaries are not held financially responsible for lab services.

As a reminder, providers of laboratory services should be aware of the following Medicare regulations:

- By law, a provider must submit Part B claims for all Medicare beneficiaries.
- Additionally, a provider must accept assignment for laboratory tests paid on the laboratory fee schedule. Otherwise, a Part B Medicare administrative contractor (MAC) cannot make payment for laboratory tests. Furthermore, no payment may be made for clinical diagnostic laboratory tests furnished by a physician or medical group **unless** the physician or medical group accepts assignment or claims payment under the indirect payment procedure for the laboratory services.
- For all clinical laboratory tests, specimen collection fees or travel allowance related to laboratory tests performed by a physician, laboratory, or other entity paid on assigned basis, **neither the annual deductible nor the 20 percent coinsurance apply**; the MAC will pay the lesser of the actual charge or 100 percent of the clinical laboratory fee schedule.
  - By law, the basic allowable charges for a beneficiary are the remaining deductible and 20 percent of the customary (or reasonable) charges in excess of the deductible. If the provider collects any monies from the beneficiary, the provider must inform the MAC of any amounts collected from them or from other persons on his or her behalf by completing Item 29 of the CMS-1500 claim form (or electronic equivalent).
  - **Note**: Please review "*When not to show patient paid amounts on claims*" article before collecting payments from patients.

See **USVI**, next page

Medicare Physician Fee Schedule Database

July update to the 2016 MPFSDB

Provider types affected

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

Provider action needed

Change request (CR) 9633 amends payment files that were issued to your MAC based upon the 2016 Medicare physician fee schedule database (MPFSDB) final rule published in the *Federal Register* November 16, 2015. These payment files are to be effective for services furnished between January 1, 2016, and December 31, 2016. Make sure your billing staff is aware of these changes.

Background

Section 1848(c)(4) of the Social Security Act authorizes the Secretary to establish ancillary policies necessary to implement relative values for physicians' services.

Key changes in CR 9633

Unless otherwise stated, the changes included in the July update to the 2016 MPFSDB are effective for dates of service on and after January 1, 2016.

The key changes for the July update, effective as of January 1, 2016, are as follows:

Code	Action
G0296	Multiple surgery = 0; Diagnostic imaging family indicator = 99
G9678	Procedure status = C (Effective for services on or after 7-1-16.)
10036	Multiple surgery indicator = 0
37188	Multiple surgery indicator = 0
45346	Endo base code = 45330
61651	Multiple surgery indicator = 0
65855	Bilateral indicator = 1
69209	PC/TC indicator = 3

The following new codes in CR 9636 have also been added to the MPFSDB:

Code	Short descriptor	Code status	RVU	Effect date
Q5102	Inj., infliximab biosimilar	E	No RVUs	4/5/16
Q9981	rolapitant, oral, 1mg	E	No RVUs	7-1-16
Q9982	flutemetamol f18 diagnostic	E	No RVUs	7/1/16
Q9983	florbetaben f18 diagnostic	E	No RVUs	7/1/16

For more information on the codes in CR 9636, you may want to review the related *MLN Matters*® article MM9636 at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9636.pdf*.

CPT® codes effective on or after July 1, 2016

The new CPT® Category III codes listed below have been added to the MPFSDB effective for dates of service on and after July 1, 2016.

There are no RVUs for these codes, and the following payment policy indicators are the same for each code: Procedure status = C, multiple surgery = 0, bilateral surgery = 0, assistant at surgery = 0, co-surgeons = 0, team surgeons = 0, PC/TC = 0, physician supervision of diagnostic procedures = 09, and diagnostic imaging family = 99. The global surgery days for 0437T, 0439T, and 0443T = ZZZ; the rest are YYY.

See **MPFSDB**, next page

USVI

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Potential penalties for assignment violations

Providers that knowingly and willfully bill patients on an unassigned basis may be subject to sanctions, civil money penalties (up to $2,000 per violation), and/or exclusion from the Medicare program for a period of up to five years imposed.

Beneficiaries are encouraged to report possible assignment violations to **1-800-MEDICARE**.

Source: The Centers for Medicare & Medicaid Services (CMS) Internet-only manual (IOM) *Pub. 100-04, Chapter 1, Section 30.3.6 and 30.3.9*; Pub. 100-04, Chapter 16, Section 30.1 and 30.2; Social Security Act (SSA) Act, Section 1848(g)(4); *Medicare Learning Network (MLN®) Matters® special edition (SE) article SE0908 Mandatory Claims Submission and its Enforcement*; *Code of Federal Regulations (CFR)* Title 42, *Section 489.30(b)*; and *489.35*

MPFSDB

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Code	Short descriptor	Long descriptor
0437T	Impltj synth rnfcmt abdl wal	Implantation of non-biologic or synthetic implant (eg, polypropylene) for fascial reinforcement of the abdominal wall (List separately in addition to code for primary procedure)
0438T	Tprnl plmt biodegrdabl matrl	Transperineal placement of biodegradable material, peri-prostatic (via needle), single or multiple, includes image guidance
0439T	Myocrd contrast prfuj echo	Myocardial contrast perfusion echocardiography; at rest or with stress, for assessment of myocardial ischemia or viability (List separately in addition to code for primary procedure)
0440T	Abltj perc uxtr/ perph nrv	Ablation, percutaneous, cryoablation, includes imaging guidance; upper extremity distal/peripheral nerve
0441T	Abltj perc lxtr/ perph nrv	Ablation, percutaneous, cryoablation, includes imaging guidance; lower extremity distal/peripheral nerve
0442T	Abltj perc plex/ trncl nrv	Ablation, percutaneous, cryoablation, includes imaging guidance; nerve plexus or other truncal nerve (eg, brachial plexus, pudendal nerve)
0443T	R-t spctrl alys prst8 tiss	Real time spectral analysis of prostate tissue by fluorescence spectroscopy
0444T	1st plmt drug elut oc ins	Initial placement of a drug-eluting ocular insert under one or more eyelids, including fitting, training, and insertion, unilateral or bilateral
0445T	Sbsqt plmt drug elut oc ins	Subsequent placement of a drug-eluting ocular insert under one or more eyelids, including re-training, and removal of existing insert, unilateral or bilateral

Note: MACs will not search their files to either retract payment for claims already paid or to retroactively pay claims. However, they will adjust claims brought to their attention.

Additional information

The official instruction, CR 9633, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3528CP.pdf*.

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

MLN Matters® Number: MM9633
Related Change Request (CR) #: CR 9633
Related CR Release Date: May 20, 2016
Effective Date: January 1, 2016
Related CR Transmittal #: R3528CP
Implementation Date: July 5, 2016

General Coverage

Coding revisions to national coverage determinations

***Note**: This article was revised June 6, 2016, to reflect the revised change request (CR) 9631 issued June 3, 2016. In the article, the CR release date, transmittal number, and the web address for accessing the CR are revised. All other information remains the same. This information was previously published in the May 2016 Medicare B Connection, pages 20-21.*

Provider types affected

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

Provider action needed

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

Background

The translations from ICD-9 to ICD-10 are not consistent one-to-one matches, nor are all ICD-10 codes appearing in a complete general equivalence mappings (GEMS) guide or other mapping guides appropriate when reviewed against individual NCD policies. In addition, for those policies that expressly allow MAC discretion, there may be changes to those NCDs based on current review of those NCDs against ICD-10 coding. For these reasons, there may be certain ICD-9 codes that were once considered appropriate prior to ICD-10 implementation that are no longer considered acceptable.

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

Edits to ICD-10 and other coding updates specific to NCDs will be included in subsequent, quarterly releases as needed. No policy-related changes are included with these updates. Any policy-related changes to NCDs continue to be implemented via the current, long-standing NCD process.

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

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

Additional information

The official instruction, CR 9631, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1672OTN.pdf*.

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

MLN Matters® Number: MM9631
Related Change Request (CR) #: CR 9631
Effective Date: October 1, 2016 - unless noted differently in CR 9631
Related CR Release Date: June 3, 2016
Related CR Transmittal #: R1672OTN
Implementation Date: October 3, 2016

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) for services provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 9550 informs MACs about the changes to claim status category codes and claim status codes. Make sure that your billing staffs are aware of these changes.

Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all covered entities to use only claim status category codes and claim status codes approved by the National Code Maintenance Committee in the ASC X12 276/277 health care claim status request and response transaction standards adopted under HIPAA for electronically submitting health care claims status requests and responses. These codes explain the status of submitted claim(s). Proprietary codes may not be used in the ASC X12 276/277 transactions to report claim status.

The National Code Maintenance Committee meets at the beginning of each ASC X12 trimester meeting (January/February, June, and September/October) and makes decisions about additions of new codes, as well as modifications and retirement of existing codes. The committee has decided to allow the industry six months for implementation of newly added or changed codes.

The codes sets are available at *https://www.wpc-edi.com/reference/codelists/healthcare/claim-status-category-codes/* and *https://www.wpc-edi.com/reference/codelists/healthcare/claim-status-codes/*.

Included in the code lists are specific details, including the date when a code was added, changed, or deleted.

All code changes approved during the June 2016 committee meeting will be posted on the above mentioned websites on or about July 1, 2016.

The Centers for Medicare & Medicaid Services (CMS) will issue future CRs regarding the need for future updates to these codes. These code changes are to be used in

editing of all ASC X12 276 transactions processed on or after the date of implementation and to be reflected in the ASC X12 277 transactions issued on and after the date of implementation of CR 9550.

Additional information

The official instruction, CR 9550 issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3527CP.pdf*.

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

MLN Matters® Number: MM9550
Related Change Request (CR) #: CR 9550
Related CR Release Date: May 20, 2016
Effective Date: October 1, 2016
Related CR Transmittal #: R3527CP
Implementation Date: October 3, 2016

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Take action to combat the flu

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

General Information

Recovering overpayments from providers who share tax identification numbers

Provider types affected

This *MLN Matters*® article is intended for providers of services and suppliers who share the same tax identification number (TIN) even though they may have different national provider identifiers or other billing numbers used to bill Medicare.

What you need to know

Section 1866j(6) of the Social Security Act authorizes the Secretary to make any necessary adjustments to the payments of a provider of services or supplier who shares a TIN with a provider of services or supplier that has an outstanding Medicare overpayment. The Secretary of Health and Human Services is authorized to adjust the payments of such a provider of services or supplier regardless of whether it has been assigned a different billing number or NPI from that of the provider of services or supplier with the outstanding Medicare overpayment.

In January 2016, the Centers for Medicare & Medicaid Services (CMS) enhanced its financial accounting system to include a function that allows CMS to recover payments made to a provider of services or supplier that shares the same TIN with a provider of services or supplier that has an outstanding Medicare overpayment across multiple states within a Medicare administrative contractor (MAC) jurisdiction.

Additional information

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

You may review Section 1866j(6) at *https://www.ssa.gov/OP_Home/ssact/title18/1866.htm*.

MLN Matters® Number: SE1612
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

SNF

From front page

The updated lists for institutional and professional billing are available at *https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html*.

Section 1888 of the Social Security Act codifies SNF PPS and CB. The new coding identified in each update describes the same services that are subject to SNF PPS payment by law. No additional services will be added by these routine updates; that is, new updates are required by changes to the coding system, not because the services subject to SNF CB are being redefined. Other regulatory changes beyond code list updates will be noted when and if they occur.

Your MAC will re-open and re-process claims which you bring to their attention, for claims with dates of service on or after January 1, 2016, that have previously been denied/rejected incorrectly prior to the implementation of CR 9688.

Additional information

The official instruction, CR 9688, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3546CP.pdf*.

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

MLN Matters® Number: MM9688
Related Change Request (CR) #: CR 9688
Related CR Release Date: June 17, 2016
Effective Date: October 1, 2016
Related CR Transmittal #: R3546CP
Implementation Date: October 3, 2016

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

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

Effective and notice dates

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

Electronic notification

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

More information

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

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

Looking for LCDs?

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

Advance beneficiary notice

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

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

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

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

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

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

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

Revisions to LCDs

Botulinum toxins – revision to the Part A and Part B LCD

LCD ID number: L33274 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for botulinum toxins was revised to add ICD-10-CM code range G81.11-G81.14 under the "ICD-10 Codes that Support Medical Necessity" section of the LCD for procedure code J0588. These codes were inadvertently missed when the FDA approved indication, upper limb spasticity in adult patient, was added to the LCD for incobotulinumtoxina (Xeomin®).

In addition, the LCD was revised based on LCD reconsideration requests to include additional ICD-10-CM diagnosis codes for the FDA approved indication, upper limb spasticity in adult patient, for abobotulinumtoxina (Dysport™) and incobotulinumtoxina (Xeomin®). ICD-10-CM codes G80.0, G80.1, G80.2, G82.53, G82.54, G83.0*, and ICD-10-CM code ranges G83.21-G83.24*, I69.031-I69.034, I69.051-I69.054, I69.131-I69.134, I69.151-I69.154, I69.231-I69.234, I69.251-I69.254, I69.331-I69.334, I69.351-I69.354, I69.831-I69.834, and I69.851-I69.854 were added under the "ICD-10 Codes that Support Medical Necessity" section of the LCD for procedure codes J0586 and J0588. Language clarifying the asterisked diagnoses was also added to this section.

Additionally, "spasticity of the arm in patients following a stroke" was removed from the "Off-label Indications" section for Dysport™.

Effective date

This LCD revision to add code range G81.11-G81.14 for procedure code J0588 is effective for claims processed **on or after June 09, 2016**, for services rendered **on or after December 22, 2015**. The LCD revision to include additional diagnosis codes for upper limb spacticity for procedure codes J0586 and J0588 is effective for services rendered **on or after June 09, 2016**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

External ocular photography – revision to the Part B LCD

LCD ID number: L33819 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for external ocular photography was revised based on a reconsideration request to include ICD-10-CM diagnosis code D49.2 (Neoplasm of unspecified behavior of bone, soft tissue, and skin) under the "ICD-10 Codes that Support Medical Necessity" section of the LCD for CPT® code 92285 (External ocular photography with interpretation and report for documentation of medical progress). In addition, the "Sources of Information and Basis for Decisions" section of the LCD was updated.

Effective date

This LCD revision is effective for claims processed **on or after June 23, 2016**, for services rendered **on or after October 1, 2015**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Your feedback matters

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

G-CSF (Neupogen®, Granix™, Zarxio™) – revision to the Part A and Part B LCD

LCD ID number: L34002 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for G-CSF (Neupogen®, Granix™, Zarxio™) was revised based on the Centers for Medicare & Medicaid Services (CMS) change request (CR) 9658 (July 2016 Update of the Hospital Outpatient Prospective Payment System [OPPS]). Modifier, "ZA" was added to the "CPT/HCPCS Codes" section of the LCD, to indicate that the biosimilar manufacturer is Novartis/Sandoz.

Effective date

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

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

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

Infliximab (Remicade™) – revision to the Part A and Part B LCD

LCD ID number: L33704 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for infliximab (Remicade™) has been revised within the "Limitations" and "Documentation Requirements" sections of the LCD to clarify requirements for the indication of aortic arch syndrome (Takayasu). In addition, based on change request (CR) 9633 (Quarterly update to the MPFSDB – July 2016), CR 9636 (Quarterly HCPCS drug/biological code changes), CR 9658 (July 2016 update to the hospital OPPS), CR 9661 (July 2016 I/OCE specifications), and CR 9668 (July 2016 update of the ASC payment system), the "CPT®/HCPCS codes" section of the LCD was revised to add HCPCS code Q5102 and modifier ZB.

Effective date

The LCD revision related to aortic arch syndrome (Takayasu) is effective for claims processed **on or after July 14, 2016**. The LCD revision related to the addition of HCPCS code Q5102 and modifier ZB is effective for claims processed **on or after July 5, 2016**, for services rendered **on or after April 5, 2016**, for HCPCS code Q5102, and **on**

or after April 1, 2016, for modifier ZB.

First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Noncovered services – revision to the LCD

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

The local coverage determination (LCD) for noncovered services was revised to remove CPT® code 27279 (arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device) from the "CPT®/HCPCS Codes" section of the LCD under the subtitle " Procedures for Part A and Part B."

Effective date

This LCD revision is effective for services rendered **on or after June 16, 2016**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Please refer to a separate article titled "Medical review article for percutaneous minimally invasive fusion/ stabilization of the sacroiliac joint" that addresses this episode of care.

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

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

The following services were evaluated and determined that they are not considered medically reasonable and necessary at this time based on current available published evidence (e.g., peer-reviewed medical literature, and published studies). Therefore, the following procedure codes have been added to the noncovered services local coverage determination (LCD).

- 96931-96936 – Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin
- 0396T – Intra-operative use of kinetic balance sensor for implant stability during knee replacement arthroplasty (List separately in addition to code for primary procedure)
- 0397T – Endoscopic retrograde cholangiopancreatography (ERCP), with optical endomicroscopy (List separately in addition to code for primary procedure)
- 0399T – Myocardial strain imaging (quantitative assessment of myocardial mechanics using image-based analysis of local myocardial dynamics) (List separately in addition to code for primary procedure)
- 0400T-0401T – Multi-spectral digital skin lesion analysis of clinically atypical cutaneous pigmented lesions
- 0402T – Collagen cross-linking of cornea (including removal of the corneal epithelium and intraoperative pachymetry when performed)
- 0403T – Preventive behavior change, intensive program of prevention of diabetes using a standardized diabetes prevention program curriculum, provided to individuals in a group setting, minimum 60 minutes, per day
- 0404T – Transcervical uterine fibroid(s) ablation with ultrasound guidance, radiofrequency
- 0405T – Oversight of the care of an extracorporeal liver assist system patient requiring review of status, review of laboratories and other studies, and revision of orders and lever assist care plan (as appropriate), within a calendar month, 30 minutes or more of non-face-to-face time
- 0406T-0407T – Nasal endoscopy, surgical, ethmoid sinus, placement of drug eluting implant
- 0408T-0411T – Insertion or replacement of permanent cardiac contractility modulation system
- 0412T-0413T – Removal of permanent cardiac contractility modulation system
- 0414T – Removal and replacement of permanent cardiac contractility modulation system; pulse generator only
- 0415T – Repositioning of previously implanted cardiac contractility modulation transvenous electrode, (atrial or ventricular lead)
- 0416T – Relocation of skin pocket for implanted cardiac contractility modulation pulse generator
- 0417T – Programming device evaluation (in person) with interative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, including review and report, implantable cardiac contractility modulation system
- 0418T – Interrogation device evaluation (in person) with analysis review and report, includes connection, recording and disconnection per patient encounter; implantable cardiac contractility modulation system
- 0419T-0420T – Destruction neurofibromata, extensive, (cutaneous, dermal extending into subcutaneous)
- 0421T – Transurethral waterjet ablation of prostate, including control of post-operative bleeding, including ultrasound guidance, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included when performed)
- 0422T – Tactile breast imaging by computer-aided tactile sensors, unilateral or bilateral
- 0423T – Secretory type II phospholipase A2 (sPLA2-IIA)
- 0424T-0427T – Insertion or replacement of neurostimulator system for treatment of central sleep apnea
- 0428T-0430T – Removal of neurostimulator system for treatment of central sleep apnea
- 0431T – Removal and replacement of neurostimulator system for treatment of central sleep apnea, pulse generator only
- 0432T-0433T – Repositioning of neurostimulator system for treatment of central sleep apnea
- 0434T – Interrogation device evaluation implanted of neurostimulator pulse generator system for central sleep apnea
- 0435T-0436T – Programming device evaluation of implanted neurostimulator pulse generator system for central sleep apnea

Additionally, CPT® code 88375 (Optical endomicroscopic image[s], interpretation and report, real-time or referred, each endoscopic session) has been removed based on a prior revision removing associated services (CPT® codes 43206 and 43252). Also, the formatting of the LCD was revised to remove duplicity of coding.

In determining if a service or procedure reaches the threshold for coverage, this contractor addresses the

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quality of the evidence per the *Program Integrity Manual* when addressing the articles and related information in the public domain, the jurisdiction N (JN) Medicare administrative contractor (MAC) reached the determination that 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 these procedures. Due to the unavailability of high quality evidence, the JN MAC concluded that there is insufficient scientific evidence to support these procedures, and therefore they are not considered reasonable and necessary under Section 1862(a)(1)(a) of the Social Security Act.

Any denied claim would have Medicare 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 draft is finalized, the notice period has ended, and the draft becomes active. In the case of the noncovered 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 request 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.

Effective date

The LCD revision for the addition of CPT® codes 96931-96936, 0396T, 0397T, and 0399T-0436T is effective for services rendered **on or after July 25, 2016**.

The LCD revision for the removal of CPT® code 88375 is effective for claims processed **on or after April 13, 2016**, for services rendered **on or after December 21, 2015**.

The LCD revision for reformatting the LCD is based on process date.

First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Additional Information

Medical review article for percutaneous minimally invasive fusion/stabilization of the sacroiliac joint

Noncovered services local coverage determination (LCD) (L33777) identifies services that **do not meet** the medically reasonable and necessary threshold for coverage as defined in the *Program Integrity Manual* (standard of care, meets but does not exceed the medical need, etc.) after review of the **quality of evidence** and strength of recommendation as published in the peer reviewed literature.

Certain procedures may be removed from the LCD for noncovered services when the medical policy development process identifies access to care situations for beneficiaries with certain conditions who may benefit from a procedure that is still under investigation by the community given lack of long term outcomes, difficulty in establishing adequate controls in clinical studies, inadequate data on the more complex Medicare age population, etc. As stated in the noncovered services LCD, when a procedure is removed from the LCD without an alternative LCD implemented at the same time, the **contractor is silent in terms of coverage policy**, and the reasonable and necessary (R&N) threshold of coverage applies as with any procedure that does not have applicable national or local policy in play.

Percutaneous minimally invasive fusion/stabilization of the sacroiliac joint (SIJ fusion) for the treatment of back pain is a problematic procedure in terms of establishing proven effectiveness and therefore its medical necessity (given that the underlying mechanisms of chronic back pain are not remedied by fusion procedures alone, absent obvious acute/subacute trauma). Low back pain is a complex and common problem in the Medicare population.

The MAC JN has no current LCD given there is a paucity of evidence to establish medical necessity for the general Medicare population. However, due to the common nature of this problem, the contractor will be providing access to coverage for CPT® code 27279 (Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device). It will be considered for coverage on a case-by-case basis for the treatment of chronic back pain for certain patients, assuming all other applicable program requirements are met.

According to the *Internet-Only Manual Publication 100-08, Chapter 13, Section 13.3*, "When making individual claim determinations, the contractor shall determine whether the item or service in question is covered based on an LCD or the clinical judgment of the medical reviewer."

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The following patient criteria will be considered by First Coast Service Options Inc. (First Coast) medical reviewers in making clinical judgements if a prepayment or post payment audit is implemented:

1. Patient's report of non-radiating, unilateral pain that is caudal to the lumbar spine (L5 vertebrae), localized over the posterior SIJ, and consistent with SIJ pain;
2. Patient has undergone and failed a minimum six months of intensive non-operative treatment that must include medication optimization, activity modification, and active physical therapy;
3. Localized tenderness with palpation of the posterior SIJ in the absence of tenderness of similar severity elsewhere (e.g., greater trochanter, lumbar spine, coccyx) and other obvious sources for pain do not exist;
4. Positive response to the thigh thrust test OR compression test AND two of the following additional provocative tests: Gaenslen's test, distraction test, Patrick's sign;
5. Absence of generalized pain behavior (e.g., somatoform disorder) or generalized pain disorders (e.g., fibromyalgia);
6. Diagnostic imaging studies that include all of the following:
   - Imaging (plain radiographs and a computed tomography (CT) or magnetic resonance imaging (MRI)) of the SI joint that excludes the presence of destructive lesions (e.g., tumor, infection) or inflammatory arthropathy that would not be properly addressed by percutaneous SIJ fusion;
   - Imaging of the ipsilateral hip (plain radiographs) to rule out osteoarthritis;
   - Imaging of the lumbar spine (CT or MRI) to rule out neural compression or other degenerative condition that can be causing low back or buttock pain;
7. At least 75 percent reduction of pain for the expected duration of the anesthetic used **following an image-guided, contrast-enhanced SIJ injection** on **two separate occasions**.

After reviewing the available published scientific literature, it is the clinical judgement of the JN MAC that percutaneous SIJ fusion for SIJ pain is not indicated in the presence of:

- systemic arthropathy such as ankylosing spondylitis or rheumatoid arthritis;
- generalized pain behavior (e.g., somatoform disorder) or generalized pain disorder (e.g., fibromyalgia);
- infection, tumor, or fracture;
- acute, traumatic instability of the SIJ;
- neural compression as seen on an MRI or CT that correlates with the patient's symptoms or other more likely source for pain.

The procedure code that describes this service is CPT® code 27279 (arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device). The JN MAC expects that both of the following ICD-10 codes will be reported for the treatment of chronic low back pain due to sacroiliac joint syndrome: M46.1 (sacroiliitis, not elsewhere classified) and M54.5 (low back pain).

Viscosupplementation therapy for knee – arthrography to provide guidance for injections is non-covered

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

The local coverage determination (LCD) for viscosupplementation therapy for knee (L33767) contains the following language related to the non-coverage of arthrography to provide guidance for injections (e.g., 27370 and 73580).

Arthrography to provide guidance for injections will not be covered. Therefore, the billing of Current Procedural Terminology (CPT®) code 73580 (Radiologic examination, knee, arthrography, radiological supervision and interpretation) and 27370 (Injection of contrast for knee arthrography) or similar services will not be covered when billed with HCPCS codes C9471, J7321, J7323, J7324, J7325, J7326, J7327, J7328, or Q9980 (Hyaluronan or derivative, for intra-articular injection).

Therefore, these services will be denied. Please note that services associated with non-covered services are also not covered (e.g. contrast injection for knee arthrography).

The complete text of LCD L33767 is available at: *http://medicare.fcso.com/coverage_find_lcds_and_ncds/lcd_search.asp.*

Upcoming provider outreach and educational events

E/M coding: hospital codes

Date: Thursday, August 4
Time: 11:30 a.m.-1:00 p.m.
Type of Event: Webcast
http://medicare.fcso.com/Events/0345039.asp

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

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

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

Two easy ways to register

Online – Visit our provider training website at *http://www.fcsouniversity.com*, log on to your account and select the course you wish to register. Class materials are available under "My Courses" no later than one day before the event**.**

First-time User? Set up an account by completing *Request User Account Form* online. Providers who do not have yet a national provider identifier may enter "99999" in the NPI field. You will receive logon information within 72 hours of your request.

Fax – Providers without internet access may request a fax registration form through our Registration Hotline at 1-904-791-8103. Class materials will be faxed to you the day of the event.

Please Note:

- Pre-registration is required for all teleconferences, webcasts and in-person educational seminars.
- Dates and times are subject to change prior to opening of event registration.

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Provider Address: _____

City, State, ZIP Code: _____

Keep checking our website, *medicare.fcso.com*, for details and newly scheduled educational events (teleconferences, webcasts, etc.) or call the First Coast Provider Education Registration Hotline at 1-904-791-8103 to learn more about the about our newest training opportunities for providers.

Never miss a training opportunity

If you or your colleagues were unable to attend one of our past Medicare educational webcasts, you still have the opportunity to learn about the topics covered during the training session. Visit the First Coast Medicare training website, download the recording of the event, and listen to the webcast when you have the time.

Take advantage of 24-hour access to free online training

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

CMS MLN Connects® Provider eNews

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

MLN Connects® Provider eNews for May 26, 2016

MLN Connects® Provider eNews for May 26, 2016
View this edition as a PDF

In this edition:

MLN Connects® Events

- Physician Compare Initiative Call — Registration Now Open
- New Audio Recording and Transcript Available

Other CMS Events

- Comparative Billing Report on Podiatry: Nail Debridement and E/M Services Webinar

Medicare Learning Network® Publications and Multimedia

- PECOS for DMEPOS Suppliers Fact Sheet - Reminder
- New Educational Web Guides Fast Fact

Announcements

- New Quality Payment Program Webpages
- 2016 PQRS GPRO Registration Open through June 30
- Updates to IRIS Software

MLN Connects® Provider eNews for June 2, 2016

MLN Connects® Provider eNews for June 2, 2016
View this edition as a PDF

In this edition:

MLN Connects® Events

- Physician Compare Initiative Call — Register Now
- Quality Measures and the IMPACT Act Call — Registration Now Open
- New Audio Recording and Transcript Available

Other CMS Events

- SNF Quality Reporting Program Provider Training: Reserve Your Hotel Room by June 8

Medicare Learning Network® Publications and Multimedia

- CMS Provider Minute Videos for Part A and Part B Providers and DMEPOS Suppliers

Announcements

- Medicare's "Big Data" Tools Fight and Prevent Fraud to Yield Over $1.5 Billion in Savings
- Integrated Efforts to Improve Patient Safety and Reduce Hospital Readmissions
- DMEPOS Competitive Bidding Program Round 2 Recompete and National Mail-Order Recompete: List of Contract Suppliers Available
- ICD-10 Resources: Clinical Concepts Series
- June is National Safety Month

Claims, Pricers, and Codes

- July 2016 Average Sales Price Files Available

MLN Connects® Provider eNews for June 9, 2016

MLN Connects® Provider eNews for June 9, 2016

View this edition as a PDF

In this edition:

News & Announcements

- Medicare Makes Enhancements to the Shared Savings Program to Strengthen Incentives for Quality Care
- TEP on Refinement of NQF #0678: Nominations due June 10
- New PEPPER for Short-term Acute Care Hospitals and June 21 Webinar
- 2016 PQRS GPRO Registration Open through June 30
- Long-Term Care Facilities: Mandatory Submission of Staffing Data via PBJ Begins July 1
- Antipsychotic Drug use in Nursing Homes: Trend Update
- Home Health Quality of Patient Care Star Ratings TEP Summary Available

Claims, Pricers & Codes

- 2017 ICD-10-PCS Updates Available

Upcoming Events

- CMS Provider Minute Videos for Part A and Part B Providers and DMEPOS Suppliers

Announcements

- Physician Compare Initiative Call – June 16

- IRF Tier Comorbidity Updates: Soliciting Stakeholder Input Call – June 16
- Quality Measures and the IMPACT Act Call – July 7

Medicare Learning Network® Publications & Multimedia

- Updated Information on the IVIG Demonstration MLN Matters® Article – New
- June 2016 Catalog Available
- Medicaid Program Integrity: What Is a Prescriber's Role in Preventing the Diversion of Prescription Drugs? Fact Sheet – Revised
- Vaccine and Vaccine Administration Payments under Medicare Part D Fact Sheet – Revised
- Reading the Institutional Remittance Advice Booklet – Reminder
- Medicare Enrollment Guidelines for Ordering/Referring Providers Fact Sheet – Reminder

MLN Connects® Provider eNews for June 16, 2016

MLN Connects® Provider eNews for June 16, 2016
View this edition as a PDF

In this edition:

News & Announcements

- CMS Proposes Rule to Improve Health Equity and Care Quality in Hospitals
- Second Round of Support and Alignment Networks Announced for Transforming Clinical Practice Initiative
- EHR Incentive Program: Hardship Exception Applications Due July 1
- CMS to Release a CBR on Immunohistochemistry and Special Stains in July
- Track and Improve Your ICD-10 Progress
- Recognizing Men's Health Month and Men's Health Week

Upcoming Events

- MIPS: CPIA Performance Category Overview Webinar — June 22
- MIPS Scoring Overview Webinar — June 24
- Quality Measures and the IMPACT Act Call — July 7
- SNF Quality Reporting Program Call — July 12

Medicare Learning Network® Publications & Multimedia

- Hospital-Acquired Conditions and Present on Admission Reporting Provision Fact Sheet — Revised
- Mass Immunizers and Roster Billing Fact Sheet — Revised
- Reading a Professional Remittance Advice Booklet — Reminder

MLN Connects® Provider eNews for June 23, 2016

MLN Connects® Provider eNews for June 23, 2016
View this edition as a PDF

In this edition:

News & Announcements

- Medicare Will Use Private Payor Prices to Set Payment Rates for Clinical Diagnostic Laboratory Tests Starting in 2018
- HHS Announces Major Initiative to Help Small Practices Prepare for the Quality Payment Program
- Comment on the MACRA Proposed Rule by June 27
- 2016 PQRS GPRO Registration Open through June 30
- Hospice Quality Reporting: Annual Payment Update
- Quality Payment Program: What's Available Online

Claims, Pricers & Codes

- Chronic Care Management Payment Correction for RHCs and FQHCs

Upcoming Events

- Comparative Billing Report on Diabetic Testing Supplies Webinar — June 27
- Understanding the ESRD Measures Manual Webinar — June 28
- Clinical Diagnostic Laboratory Test Payment System Final Rule Call — July 6

- Quality Measures and the IMPACT Act Call — July 7
- SNF Quality Reporting Program Call — July 12

Medicare Learning Network® Publications & Multimedia

- Video Slideshow for QRUR Webcast — New
- DMEPOS Accreditation Fact Sheet — Revised
- MREP Software Fact Sheet — Revised
- Medicare Vision Services Fact Sheet — Revised
- New Educational Web Guides Fast Fact

Three files included in IRIS update

The Intern and Resident Information System (IRIS) software programs (IRISV3 and IRISEDV3) each have three updated files (medical school codes, residency type codes, and IRISV3 operating instructions) for collecting and reporting information on resident training in hospital and non-hospital settings.

They are categorized as follows:

October 2015 IRISV3 operating instructions and excerpts from IRISV3 operating instructions to use with IRISEDV3:

- CMS added sixteen new IRIS residency type codes to the IRIS residency type code table.
- CMS also added four new IRIS medical school codes to the IRIS medical school code table.

The IRIS programs are available for downloading via the *IRIS website*.

Check the status of claim redeterminations online

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

Phone numbers

Customer service

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

Education event registration hotline

904-791-8103 (NOT toll-free)

Electronic data interchange (EDI)

888-670-0940

Electronic funds transfers (EFT) (CMS-588)

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

Fax number (for general inquiries)

904-361-0696

Interactive voice response (IVR) system

877-847-4992

Provider enrollment

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

The SPOT help desk

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

Addresses

Claims

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

Redeterminations

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

Redetermination of overpayments

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

Reconsiderations

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

General inquiries

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

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

Provider enrollment

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

Medical policy

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

Medicare secondary payer

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

Electronic data interchange (EDI)

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

Overpayments

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

Medicare Education and Outreach

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

Fraud and abuse

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

Freedom of Information Act requests

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

Overnight mail and/or special courier service

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

Websites

Provider

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

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

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

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

Beneficiaries

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

Phone numbers

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

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

Electronic data interchange (EDI)
888-670-0940

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

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

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

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

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

Addresses

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Websites

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

http://medicare.fcso.com

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

Centers for Medicare & Medicaid Services

https://www.cms.gov

First Coast University

http://www.fcsouniversity.com/

Beneficiaries
Centers for Medicare & Medicaid Services

https://www.medicare.gov

Phone numbers

Customer service

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

Education event registration hotline

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

Electronic data interchange (EDI)

888-875-9779

Electronic funds transfers (EFT) (CMS-588)

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

General inquiries

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

Interactive voice response (IVR) system

877-847-4992

Provider enrollment

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

The SPOT help desk

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

Addresses

Claims

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

Redeterminations

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

Redetermination of overpayments

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

Reconsiderations

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

General inquiries

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

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

Provider enrollment

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

Medical policy

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

Medicare secondary payer

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

Electronic data interchange (EDI)

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

Overpayments

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

Medicare Education and Outreach

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

Fraud and abuse

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

Freedom of Information Act requests

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

Special courier service

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

Websites

Provider

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

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

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

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

Beneficiaries

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

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