Medicare B CONNECTION

FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction 9 Providers August 2013

In this issue

A nation united with a shared goal

All MACs join forces

Part A/B Medicare administrative contractors (MACs) share a common goal to reduce the Medicare national payment error rate as measured by the Comprehensive Error Rate Testing (CERT) program. Recently, the MACs joined forces to educate on issues of mutual concern regarding claim errors. The partnership led to creation of the CERT A/B Contractor Task Force with the full support of the Centers for Medicare & Medicaid Services (CMS). This new partnership affords providers the benefit of a collaborative, consistent voice to reduce costly claim denials as well as the CERT error rate.

The CERT A/B Contractor Task Force will serve to enhance, not replace, the ongoing educational activities by CMS, the *Medicare Learning Network* (*MLN*®), and the MACs within their jurisdictions. Providers can identify educational efforts of the CERT A/B Contractor Task Force by the clear identity of its logo, which represents the task force's united vision:

Educational strategy

The A/B CERT Contractor Task Force will select one to four national CERT "hot topics" each year. The topics may focus on multiple provider types, or focus on certain specialties or facility types. The group will then periodically publish scenario-driven articles with tips focused on avoiding specific errors. Each contractor will also highlight the scenarios in any of their individual educational activities.

Each contractor hosts a dedicated page on their website for the CERT A/B Contractor Task Force and its communications. Providers will be able to access all communications for the task force on this page. Providers with First Coast Service Options can access their page at: *http://medicare.fcso.com/Landing/203608.asp*.

Stay tuned

Over the next few months, the CERT A/B Contractor Task Force will conduct a campaign to inform hospitals, home health, hospice, physician billing and compliance staff, and practitioners within all jurisdictions on this new initiative.First Coast will provide more information as it becomes available.

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

Sincerely,

Cahaba Government Benefit Administrators, LLC/J10
CGS Administrators, LLC/J15
First Coast Service Options, Inc./J9
National Government Services, Inc./J6 & JK
NHIC, Corp/J14
Noridian Healthcare Solutions, LLC/JF
Novitas Solutions, Inc./JL & JH
Palmetto GBA/J1 & J11
Wisconsin Physicians Service Insurance Corporation/J5, J8, & T18

Contents

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

Publication staff:
Terri Drury
Martin Smith
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.

Register for the SPOT

First Coast Service Options Inc. (First Coast) developed its provider Internet portal – Secure Provider Online Tool (the SPOT), which offers faster access to claim information, benefit/eligibility data, payment history, and analytical data reports.

Register today!

About the *Medicare B Connection*

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

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

Who receives the Connection

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

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

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

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

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

Publication format

The Connection is arranged into distinct sections.

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

In addition to the above, other sections include:

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

The Medicare B Connection represents formal notice of coverage policies

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

Advance beneficiary notices

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

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

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

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

Patient liability notice

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

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

ABN modifiers

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

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

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

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

GA modifier and appeals

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

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

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

Mandatory reporting of an eight-digit clinical trial number on claims

Provider types affected

This *MLN Matters*® article is intended for physicians, providers, and suppliers submitting claims to Medicare contractors (fiscal intermediaries (FIs), carriers, durable medical equipment (DME) Medicare administrative contractors (MACs) and A/B MACs) for items and services provided in clinical trials to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 8401, which informs you that, effective January 1, 2014, it will be mandatory to report a clinical trial number on claims for items and services provided in clinical trials that are qualified for coverage as specified in the *Medicare National Coverage Determination (NCD) Manual*, Section 310.1.

The clinical trial number to be reported is the same number that has been reported voluntarily since the implementation of CR 5790, dated January 18, 2008. That is the number assigned by the National Library of Medicine (NLM) *http://clinicaltrials.gov/* website when a new study appears in the NLM clinical trials database.

Make sure that your billing staff is aware of this requirement.

Background

CR 5790, Transmittal 310, dated January 18, 2008, titled "Requirements for Including an 8-digit Clinical Trial Number on Claims" is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R310OTN.pdf*. The *MLN Matters*® article for CR 5790 is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM5790.pdf*.

This number is listed prominently on each specific study's page and is always preceded by the letters 'NCT'.

The Centers for Medicare & Medicaid Services (CMS) uses this number to identify all items and services provided to beneficiaries during their participation in a clinical trial, clinical study, or registry. Furthermore, this identifier permits CMS to better track Medicare payments, ensure that the information gained from the research is used to inform coverage decisions, and make certain that the research focuses on issues of importance to the Medicare population.

Suppliers may verify the validity of a trial/study/registry by consulting CMS's clinical trials/registry website at *http://www.cms.gov/Medicare/Medicare-General-Information/MedicareApprovedFacilitie/index.html*.

For institutional paper or direct data entry (DDE) claims, the eight-digit clinical trial number is to be placed in the value amount for paper only value code D4/DDE claim UB-04 (for locators 39-41) when a clinical trial claim includes:

- Condition code 30,
- ICD-9 code of V70.7/ICD-10 code Z00.6 (in either the primary or secondary positions), and
- Modifier Q0 and/or Q1, as appropriate (outpatient claims only).

For institutional claims that are submitted on the electronic claim 837I, the eight-digit number should be placed in Loop 2300 REF02 (REF01=P4) when a clinical trial claim includes:

- Condition code 30,
- ICD-9 code of V70.7/ ICD-10 code Z00.6 (in either the primary or secondary positions), and
- Modifier Q0 and/or Q1, as appropriate (outpatient claims only).

For professional claims, the eight-digit clinical trial number preceded by the two alpha characters of CT must be placed in field 19 of the paper claim Form CMS-1500 (e.g., CT12345678) or the electronic equivalent 837P in loop 2300 REF02(REF01=P4) when a clinical trial claim includes:

- ICD-9 code of V70.7/ICD-10 code Z00.6 (in either the primary or secondary positions), and
- Modifier Q0 and/or Q1, as appropriate (outpatient claims only).

Medicare Part B clinical trial/registry/study claims with dates of service on and after January 1, 2014, not containing an eight-digit clinical trial number will be returned as unprocessable to the provider for inclusion of the trial number using the messages listed below.

- **Claim adjustment reason code (CARC) 16**: "Claim/service lacks information which is needed for adjudication. At least one remark code must be provided (may be comprised of either National Council for Prescription Drug Programs (NCPDP) Reject Reason Code, or Remittance Advice Remark Code (RARC) that is not an ALERT.)"

(continued on next page)

Mandatory *(continued)*

- **RARC MA50**: "Missing/incomplete/invalid Investigational Device Exemption number for FDA-approved clinical trial services."
- **RARC MA130**: "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** – contractual obligation (CO).

Note: This is a reminder/clarification that clinical trials that are also investigational device exemption (IDE) trials must continue to report the associated IDE number on the claim form as well.

Additional information

The official instruction, CR 8401, issued to your Medicare contractor regarding this change, may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2758CP.pdf*.

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

MLN Matters® Number: MM8401
Related Change Request (CR) #: CR 8401
Related CR Release Date: August 9, 2013
Effective Date: January 1, 2014
Related CR Transmittal #: R2758CP
Implementation Date: January 6, 2014

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

Don't miss the chance to evaluate your Medicare administrative contractor

The Centers for Medicare & Medicaid Services (CMS) is committed to ensuring a quality experience for health care providers who participate in the Medicare program. We can't do this without input from you.

If you are a Medicare fee-for-service (FFS) provider, practice manager or work on behalf of a Medicare FFS provider (such as a billing agency), please *register now* for an opportunity to tell CMS about the level of services that your MAC provides.

You'll need your national provider identifier (NPI) and provider transaction access number (PTAN) to sign up. If you work for a medical practice, you can list a group NPI and PTAN. MAC services to be rated include, but are not limited to, claim processing, Medicare enrollment, and responsiveness to inquiries.

It's quick and easy. Those selected to participate will be emailed a link to an online survey. All information collected will be kept confidential and used solely for this survey. Yes, I'd like to *sign up*.

Source: CMS PERL 201308-05

Find out first: Subscribe to First Coast *eNews*

Subscribe to First Coast Service Options *eNews*, to learn the latest Medicare news and critical program changes affecting the provider community. Join as many lists as you wish, in English or Spanish, and customize your subscription to fit your specific needs, line of business, specialty, or topics of interest. So, *subscribe to eNews, and stay informed.*

Diagnostic Services

Coding changes to ultrasound diagnostic procedures for transesophageal Doppler monitoring

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8330, which directs Medicare contractors to recognize and accept Healthcare Common Procedure Coding System (HCPCS) code G9157 when billed for esophageal Doppler monitoring, effective for claims with dates of service (DOS) on or after January 1, 2013. Make sure that your billing staff is aware of this code change.

Background

On May 17, 2007, CR 5608/ TR76 Ultrasound Diagnostic Procedures, was released by the Centers for Medicare & Medicaid Services (CMS). (See the related article at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM5608.pdf*. CR 5608 explained that, effective for claims with DOS on and after May 22, 2007, CMS determined that esophageal Doppler monitoring of cardiac output for ventilated patients in the intensive care unit (ICU) and operative patients with a need for intra-operative fluid optimization was reasonable and necessary.

Therefore, the *Medicare National Coverage Determination (NCD) Manual* was amended at Section 220.5 by adding "Monitoring of cardiac output (Esophageal Doppler)" for ventilated patients in the ICU and operative patients with a need for intra-operative fluid optimization to Category I (covered procedures), and deleting "Monitoring of cardiac output (Esophageal Doppler)" from Category II (non-covered procedures). This manual is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part4.pdf*.

CR 8330 announces that the new HCPCS code G9157 for esophageal Doppler monitoring will be used in place of unlisted code *76999* (Unlisted ultrasound procedure (e.g., diagnostic, interventional)) effective for claims with DOS on or after January 1, 2013.

The code G9157 is a diagnostic procedure indicated for ventilated patients in the intensive care unit (ICU) and operative patients with a need for intra-operative fluid optimization and is only covered when furnished in an inpatient hospital place of service (POS) 21. The services under code G9157 include the insertion, placement, and repositioning of the esophageal Doppler probe in addition to the assessment(s) with report, image acquisition(s), and interpretation(s) per course of treatment.

Code G9157 will have a procedure status indicator of A on the Medicare physician fee schedule (MPFS). This indicator denotes that the professional services are separately payable for a maximum of once per course of treatment. The code reflects physician work involved in probe placement, image acquisition, and interpretation per course of treatment for monitoring purposes.

Please refer to CR 5608, ultrasound diagnostic procedures for any further information. Please note that no changes are being made to the current policy for esophageal Doppler monitoring. This service is only covered in a hospital setting, and is part of the existing inpatient prospective payment system (IPPS) payment. The *MLN Matters*® related to CR 5608 is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM5608.pdf*.

Claims with DOS on or before December 31, 2012, will continue to process with unlisted code *76999*. But, claims submitted with *76999* for esophageal Doppler monitoring services with DOS on or after January 1, 2013, will be denied with the following messages:

- **Claim adjustment reason code (CARC) 189:** "'Not otherwise classified' or 'unlisted' procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/ service."
- **Remittance advice remark code M20:** "Missing/ incomplete/invalid HCPCS."

(continued on next page)

Doppler *(continued)*

Also, Medicare will deny G9157 when billed in any POS other than 21 with a CARC message 58, "Treatment was deemed by the payer to have been rendered in an inappropriate place of service.

Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present." and a group code of CO.

Additional information

The official instruction, CR 8330, issued to your Medicare contractor regarding this change, may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2743CP.pdf*.

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

MLN Matters® Number: MM8330
Related Change Request (CR) #: CR 8330
Related CR Release Date: July 25, 2013
Effective Date: January 1, 2013
Related CR Transmittal #: R2743CP
Implementation Date: August 26, 2013

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

Drugs and Biologicals

Annual clotting factor furnishing fee update

Provider types affected

This *MLN Matters*® article is intended for physicians and other providers billing Medicare carriers, fiscal intermediaries (FIs), Part A/B Medicare administrative contractors (MACs), or regional home health intermediaries (RHHIs) for services related to the administration of clotting factors to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 8423, which announces that for calendar year 2014, the clotting factor furnishing fee of $0.192 per unit is included in the published payment limit for clotting factors. For dates of service of January 1, 2014, through December 31, 2014, the clotting factor furnishing fee of $0.192 per unit is added to the payment when no payment limit for the clotting factor is included in the average sales price (ASP) or not otherwise classified (NOC) drug pricing files. Please be sure your billing staffs are aware of this fee update.

Background

Section 1842(o)(5)(C) of the Social Security Act (added by the Medicare Modernization Act Section 303(e)(1)) requires, beginning January 1, 2005, that a clotting factor furnishing fee be paid separately if you furnish clotting factor; unless the costs associated with furnishing the clotting factor are paid through another payment system.

The Centers for Medicare & Medicaid Services (CMS) includes the clotting factor furnishing fee in the published national payment limits for clotting factor billing codes. When the national payment limit for a clotting factor is not included on the ASP Medicare Part B drug pricing file, or the NOC pricing file; your carrier, FI, RHHI, or A/B MAC must make payment for the clotting factor as well as make payment for the furnishing fee.

The clotting factor furnishing fees applicable for dates of service in each calendar year are listed below:

Calendar year	Clotting factor furnishing fee
2005	$0.140 per unit
2006	$0.146 per unit
2007	$0.152 per unit
2008	$0.158 per unit
2009	$0.164 per unit
2010	$0.170 per unit

(continued on next page)

Clotting *(continued)*

Calendar year	Clotting factor furnishing fee
2011	$0.176 per unit
2012	$0.181 per unit
2013	$0.188 per unit
2014	$0.192 per unit

Additional information

The official instruction, CR 8423, issued to your Medicare contractor regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2760CP.pdf*.

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

MLN Matters® Number: MM8423
Related Change Request (CR) #: CR 8423
Related CR Release Date: August 9, 2013
Effective Date: January 1, 2014
Related CR Transmittal #: R2760CP
Implementation Date: January 6, 2014

Converting dose to units billed for rituximab and bevacizumab

Note: This article was revised August 1, 2013, to add the section *Supplemental Information on Reporting Drugs*. This information was previously published in the July 2013 *Medicare B Connection*, Pages 7-8.

Provider types affected

This *MLN Matters*® special edition article is intended for physicians and nonphysician practitioners who bill Medicare for rituximab (Rituxan®) and bevacizumab (Avastin®). The purpose of the article is to remind providers how to properly compute the units of rituximab and bevacizumab that should be billed to Medicare.

What you need to know

This article informs you that the recovery auditors conducted complex reviews of claims billed for rituximab and bevacizumab. According to the Healthcare Common Procedure Coding System (HCPCS), rituximab is coded as J9310 and bevacizumab is coded as C9257 or J9035. Recovery auditors reviewed medical records to verify the exact number of milligrams (mg) administered and identify the correct number of units that should have been billed to Medicare.

Please remember to verify the milligrams given to the patient and then convert to the proper units for billing. When the recovery auditors reviewed medical records, the common billing error was forgetting to convert milligrams to units.

To accurately bill for rituximab and bevacizumab, it is very important that providers instruct their billing staff to verify the milligrams given, convert to the proper units for billing, and ensure the quantity administered is consistent with the units billed. Providers should differentiate between unit billing versus milligram billing on these high cost drugs.

The following are key points to remember when billing Medicare for rituximab (J9310):

- J9310 is defined in the HCPCS manual as: Injection, rituximab, 100 mg
- One (1) unit represents 100 mg of rituximab ordered/administered per patient
- Rituximab should be billed based on units, not the total number of milligrams
  - For example, if the quantity administered is 200 mg and the description of the drug code is 100 mg, the units billed should be two (2).

The following are key points to remember when billing Medicare for bevacizumab (J9035 or C9257):

- C9257 is defined in the HCPCS manual as: Injection, bevacizumab, 0.25 mg
- J9035 is defined in the HCPCS manual as: Injection, bevacizumab, 10 mg
- One (1) unit represents 10 mg of (J9035) or 0.25 mg (C9257) of bevacizumab ordered/administered per patient
- Bevacizumab should be billed based on units, not the total number of milligrams
  - For example, if the quantity administered is 300 mg and the description of the drug code is 10 mg, the units billed should be thirty (30).

Examples of findings

Rituximab (Rituxan®)

1. For date of service 10/27/2009, the provider billed J9310 for 71 units. Since J9310 has 1 unit equal to 100 mg, this would mean that the patient received 7,100 mg of rituximab for that date of service. This seemed abnormal and, therefore, a chart was requested. The medical record showed that the patient only received 710 mg and the provider billed an incorrect number

(continued on next page)

Converting *(continued)*

of units. The correct units should be 7.1 units; however, this would be rounded up to 8 units for billing purposes.

2. For date of service 04/29/2010, the provider billed J9310 for 100 units. Since J9310 has 1 unit equal to 100 mg, this would mean that the patient received 10,000 mg of rituximab for that date of service. This seemed abnormal and, therefore, a chart was requested. The medical record showed that the patient only received 1,000 mg and the provider billed an incorrect number of units. The units were adjusted down to 10 units to reflect the proper dosage amount given.

Bevacizumab (Avastin®)

1. A provider billed code J9035 for 1,300 units. Since J9035 has 1 unit equal to 10 mg, this would mean that the patient received 13,000 mg of bevacizumab for that date of service. It is unlikely a patient would receive 13,000 mg of bevacizumab in one day. The medical record showed that the patient only received 1,300 mg and the provider billed an incorrect number of units. Therefore, the correct number of units that should have been billed is 130 units.
2. For date of service 10/6/2010, the provider billed code J9035 for 1,600 units. Since J9035 has 1 unit equal to 10 mg, this would mean that the patient received 16,000 mg of bevacizumab for that date of service. It is unlikely a patient would receive 16,000 mg of bevacizumab in one day. The medical record showed that the patient only received 1,600 mg and the provider billed an incorrect number of units. Therefore, the correct number of units that should have been billed is 160 units.

Supplemental information related to reporting drugs

The following serves to clarify billing guidelines and provide examples of proper billing with a single-dose vial and discarded drug billing:

- Providers and hospitals are reminded to ensure that amounts of drugs administered to patients are accurately reported in terms of the dosage specified in the long descriptors for the applicable HCPCS codes. This is because the short descriptors are limited to 28 characters so they do not always capture the complete description of the drug.
- When submitting Medicare claims, units should be reported in multiples of the dosage included in the long HCPCS descriptor. If the dosage given is not a multiple of the number provided in the HCPCS code description, the provider shall round up to the nearest whole number in order to express the number as a multiple.
- If the provider must discard the remainder of a single-use vial or other package after administering the prescribed dosage of any given drug, Medicare may cover the amount of the drug discarded along with the amount administered. The following elements must be followed in order for the discarded amount to be covered.
    1. The vial must be a single-use vial. Multi-use vials are not subject to payment for any discarded amounts of the drug.
    2. The units billed must correspond with the smallest dose (vial) available for purchase from the manufacturer(s) that could provide the appropriate dose for the patient.
    3. The left-over amount must actually be discarded and may not be used for another patient regardless of whether or not that other patient has Medicare.
- Please clearly document in the patient's medical record the actual dose administered in addition to the exact amount wasted and the total amount the vial is labeled to contain. This kind of detailed documentation helps benefit your practice by justifying your billing in the event a medical review should occur.
- If your Medicare contractor requires discarded drugs to be reported with the JW modifier on a separate line, the total number of discarded units reported should not include amounts of the drug also included on the administered line due to the rounding up of units (see "Hypothetical examples").
- Please remember to verify the milligrams given to the patient and then convert to the proper units for billing.

Hypothetical examples

Rituximab (Rituxan®)

- Rituxan® is supplied as 100 mg/10 mL and 500 mg/50 mL solution in single-use vials.
- The physician administers 80 mg of rituximab to a patient. The smallest-sized vial available for this dose is 100 mg. The physician uses the 100 mg vial to administer 80 mg. The physician discards the remaining 20 mg in the vial.
- Since the J9310 long descriptor for rituximab (Rituxan®) shows that 1 billing unit represents 100 mg ordered/administered per patient, the correct calculation of units would be 0.8 units (80/100). However, for billing purposes, this would be rounded up to 1 unit.
- In this example, billing for 100 units would be an error. Since J9310 is defined as 1 unit being equal to 100 mg, this would mean that the patient

(continued on next page)

Converting *(continued)*

received an unlikely dosage of 10,000 mg of rituximab for that date of service.

- Due to the single-use vial type, the provider may bill for the amount administered as well as the amount appropriately discarded. The discarded amount is reported with the JW modifier. The JW modifier is only applied to the amount of drug or biological that is discarded. A situation in which the JW modifier is not permitted is when the actual dose of the drug or biological administered is less than the billing unit. (See the *Medicare Claims Processing Manual*, Chapter 17, Section 40 at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c17.pdf*.) For example, one billing unit for a drug is equal to 10mg of the drug in a single use vial. A 7mg dose is administered to a patient while 3mg of the remaining drug is discarded. The 7mg dose is billed using one billing unit that represents 10mg on a single line item. The single line item of 1 unit would be processed for payment of the total 10mg of drug administered and discarded. Billing another unit on a separate line item with the JW modifier for the discarded 3 mg of drug is not permitted because it would result in overpayment. Therefore, when the billing unit is equal to or greater than the total actual dose and the amount discarded, the use of the JW modifier is not permitted.

Bevacizumab (Avastin®)

- Avastin® is supplied as 100 mg/4 mL and 400 mg/16 mL solution in single-use vials.
- The physician administers 395 mg of bevacizumab to a patient. The smallest-sized vial available for this dose is 400 mg. The physician uses the 400 mg vial to administer 395 mg. The physician discards the remaining 5 mg in the vial.
- Since the J9035 long descriptor for bevacizumab (Avastin®) shows that 1 billing unit represents 10 mg ordered/administered per patient, the correct calculation of units would be 39.5 units (395/10). However, for billing purposes, this would be rounded up to 40 units.
- In this example, billing for 395 units would be an error. Since J9035 is defined as 1 unit being equal to 10 mg, this would mean that the patient received 3,950 mg of bevacizumab for that date of service. This would be a billing error.
- Due to the single-use vial type, the provider may bill for the amount administered as well as the amount appropriately discarded.

Additional information

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

Links to additional resources

National coverage determination (NCD) for bevacizumab

- *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*
  - Document ID: 110.17

Supplementary *MLN Matters*® articles:

- *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM3419.pdf*
- *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM3742.pdf*

Alpha-numeric HCPCS codes

- *http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html*

JW HCPCS modifier information

- *http://www.wpsmedicare.com/part_b/resources/modifiers/modifier-jw.shtml*
- *http://www.palmettogba.com/palmetto/providers.nsf/vmasterdid/8eelbr2808*
- *http://www.cgsmedicare.com/parta/pubs/news/2012/1112/786.html*

Medicare manual references

- *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c17.pdf*
- *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf*

2013 Medicare Part B drug average sales price

- *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/2013ASPFiles.html*

MLN Matters® Number: SE1316 *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

Durable Medical Equipment

Prescribing specific brands under the DMEPOS competitive bidding program

Do you order or refer Medicare beneficiaries for items included in the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program? If so, this is a reminder to you that the requirement for suppliers to furnish items in accordance with the prescription continues to apply under the program. In addition, the program includes a special beneficiary safeguard to ensure that beneficiaries have access to specific brands or modes of delivery of competitively bid items when needed to avoid an adverse medical outcome. This safeguard, which is sometimes called the physician authorization process, allows a physician (including a podiatric physician) or treating practitioner (i.e., a physician assistant, clinical nurse specialist, or nurse practitioner) to prescribe a specific brand or mode of delivery to avoid an adverse medical outcome. The physician or treating practitioner must document in the beneficiary's medical record the reason why the specific brand or mode of delivery is necessary to avoid an adverse medical outcome.

If a physician or treating practitioner prescribes a particular brand or mode of delivery for a beneficiary to avoid an adverse medical outcome, the contract supplier must, as a term of its contract, ensure that the beneficiary receives the needed item. If the contract supplier does not ordinarily furnish the specific brand or mode of delivery and cannot obtain a revised prescription or locate another contract supplier that will furnish the needed item, the contract supplier must furnish the item as prescribed. Medicare will pay the single payment amount for covered competitively bid items furnished through the physician authorization process.

For more information about the physician authorization process, please see the *Referral Agents Fact Sheet* on the CMS website.

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

July quarterly update for 2013 DMEPOS fee schedule

Note: This article was revised August 1, 2013, to add additional language to address questions raised about the implementation of the non-mail order fee schedule changes required by the American Taxpayer Relief Act. This information was previously published in the June 2013 *Medicare B Connection*, Pages 12-13.

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8325 and alerts providers and suppliers that the Centers for Medicare & Medicaid Services (CMS) issued instructions updating the DMEPOS fee schedule payment amounts. Be sure your billing staff is aware of these changes.

Background

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

Key points of CR 8325

- CR 8325 updates fees for Healthcare Common Procedure Coding System (HCPCS) codes E2378, L5859, and L7902. These HCPCS codes were added to the HCPCS file effective January 1, 2013. Previously these items were paid on a local fee schedule. If claims for these codes with dates of service on or after January 1, 2013, have already been processed, they will be adjusted to reflect the new fees if you bring the claims to your contractor's attention.
- As part of this update fee schedule amounts are also established for HCPCS code K0009 (Other manual wheelchair/base). Payment on a fee schedule basis is mandated for all DME by Section 1834(a) of the Social Security Act (the Act), other than items that meet the definition of customized DME at 42 CFR Section 414.224 of the regulations. Effective July 1, 2013, payment

(continued on next page)

July *(continued)*

for claims for manual wheelchairs, that receive a HCPCS code verification of K0009 by the pricing data analysis and coding (PDAC) contractor, will be made on a capped rental basis with the fee schedule amounts established in accordance with Section 1834 (a)(8) of the Act using data for all manual wheelchair codes effective in 1986.

Diabetic testing supplies

Effective for dates of service on or after July 1, 2013, in accordance with Section 636(a) of the American Taxpayer Relief Act (ATRA), the fee schedule amounts for non-mail order diabetic supplies are adjusted so that they are equal to the single payment amounts for mail order diabetic supplies established in implementing the national mail order competitive bidding program under Section 1847 of the Act. The national competitive bidding program for mail order diabetic supplies takes effect July 1, 2013. This provision of the ATRA achieves competitive non-mail order prices for the same diabetic testing supplies furnished through the national mail order program without requiring local pharmacies to compete and be awarded contracts while still providing Medicare beneficiaries a choice in where they obtain supplies.

Diabetic testing supplies are the supplies necessary for the effective use of a blood glucose monitor as described by the HCPCS codes below:

- A4233 Replacement battery, alkaline (other than J cell), for use with medically necessary home blood glucose monitor owned by patient, each
- A4234 Replacement battery, alkaline, J cell, for use with medically necessary home blood glucose monitor owned by patient, each
- A4235 Replacement battery, lithium, for use with medically necessary home blood glucose monitor owned by patient, each
- A4236 Replacement battery, silver oxide, for use with medically necessary home blood glucose monitor owned by patient, each
- A4253 Blood glucose test or reagent strips for home glucose monitor, per 50 strips.
- A4256 Normal, low and high calibration solution/ chips
- A4258 Spring-powered device for lancet, each
- A4259 Lancets, per box of 100

Effective for dates of service on or after July 1, 2013, the non-mail order fee schedule amounts for the diabetic testing supplies listed above will be adjusted so that they are equal to the single payment amounts for mail order diabetic supplies established under the national mail order competition for diabetic testing supplies.

The annual covered item update will not be applied to the new national fee schedule amounts for non-mail order diabetic testing supplies. Rather, the non-mail order fee schedule amounts on the fee schedule file will be updated each time the single payment amounts are updated, which can happen no less often than every three years as contracts are recompeted. The rules related to assignment of claims for non-mail order diabetic testing supplies are not affected by this new law. Since claim assignment is not mandatory for diabetic testing supplies furnished on a non-mail order basis, beneficiaries should ask the pharmacy or supplier storefront for the supplier's charge and whether they will accept assignment of the claim before purchase.

The definitions of mail order item and non-mail order item set forth in 42 CFR 414.402 are:

- **Mail order item (KL modifier)** – any item shipped or delivered to the beneficiary's home, regardless of the method of delivery; and
- **Non-mail order item (KL modifier not applicable)** – any item that a beneficiary or caregiver picks up in person at a local pharmacy or supplier storefront.

Effective July 1, 2013, only national mail order contract suppliers will be paid by Medicare for diabetic testing supplies other than those that a beneficiary or caregiver picks up in person at a local pharmacy or supplier storefront. The single payment amount public use file for the national mail order competitive bidding program is available at *http://www.dmecompetitivebid.com/palmetto/cbicrd2.nsf/DocsCat/Single%20Payment%20Amounts*. Although for payment purposes the single payment amounts replace the fee schedule amounts for mail order diabetic testing supplies, the mail order fee schedule amounts (KL modifier) for these codes will remain on the DMEPOS fee schedule file as reference data. The mail order diabetic testing supply fee schedule amounts will be maintained and

(continued on next page)

July *(continued)*

updated annually by the covered item update for use in establishing bid limits for future competitive bidding competitions.

Additional information

The official instruction, CR 8325 issued to Medicare contractor regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2709CP.pdf*.

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

MLN Matters® Number: MM8325 *Revised*
Related Change Request (CR) #: CR 8325
Related CR Release Date: May 17, 2013
Effective Date: January 1, 2013 - for implementation of fee schedule amounts for codes in effect January 1, 2013; July 1, 2013 for all other changes
Related CR Transmittal #: R2709CP
Implementation Date: July 1, 2013

Evaluation and Management

E/M services billed with allergen immunotherapy services *CPT*® codes *95115-95199* require modifier 25

First Coast Service Options Inc. (First Coast) recently conducted a data analysis to evaluated allergen immunotherapy services *Current Procedural Terminology* (*CPT*® codes *95115-95199*) and found that evaluation and management (E/M) services were billed without appending modifier 25 to indicate the E/M service was a significant and separately identifiable service performed on the same patient same date as the allergen immunotherapy services by the same provider.

According the American Medical Association (AMA) *CPT*® code book, "Codes for Allergen Immunotherapy *CPT*® codes *95115-95199* includes the professional services necessary for allergen immunotherapy. Office visit codes may be used in addition to allergen immunotherapy if other identifiable services are provided at that time".

Modifier 25

According to the guidelines for the correct use of modifier 25 for global procedures found in the Center Medicare & Medicaid services(CMS) *Publication 100-04 Medicare Claims Processing Manual Chapter 12*, Section 30.6.6 B, and 40.2.8 which indicates that the 25 modifier is used only with claims for E/M services and only when the services are provided by the same physician or by a qualified healthcare practitioner to the same patient on the same day of a procedure with a global fee period if the physician indicates that the service is for a significant, separately identifiable and the E/M service was above and beyond the usual pre- and post- operative work of the procedure.

The modifier 25 is used to denote a significant, separately identifiable E/M services performed by the same physician on the same day that he or she performed another procedure or service. The following guidelines apply:

- The modifier 25 should only be used with E/M services (*CPT*® code range *99201-99499*) and not with surgery/global codes
- Different diagnoses are not required for reporting E/M service
- Adequate documentation is required to indicate the medical necessity E/M service and the procedure must be appropriately and sufficiently documented in the medical records
- Medicare administrative contractor (MAC) will pay for E/M serves with modifier 25 in addition to the global fee without any other requirements for documentation, however, carriers may conduct a specific medical review on a case-by-case bases when high statistics regarding the use of the modifier 25 by an individual or group is significant
- The modifier 25 is only used to notify the payer that the E/M service needs to be paid separately from the reimbursement for the procedure indicating the E/M service was significant and separately identifiable.

Billing requirements for global surgeries

The billing requirements for global surgeries can be found in the CMS Publication 100-04 *Medicare Claims Processing Manual* Chapter 12, Section 40.20 to ensure that the proper identification of services for both included and excluded services from the global package the following procedures apply:

(continued on next page)

E/M *(continued)*

The use of modifiers apply to major procedures with a global period of 90-day postoperative period and minor procedures with a 10-day postoperative period and or zero day postoperative period in the case of modifiers 22 and 25.

The documentation must clearly reflect that the E/M services was above and beyond the usual care provided on the same day of the procedure and the services provided were not a normal part of the procedure. The documentation must reflect the following:

An independent evaluation and management service due to a complaint, symptom, condition, problem, or circumstance that may or may not be related to the procedure or service being provided and should include important, notable and distinct correlation with the signs and symptoms for a distinct problem.

Educational resources

First Coast local coverage determination (LCD) for allergen immunotherapy (10/01/2011 revision). The LCD numbers are L29056 for Florida and L29074 for Puerto Rico and the U.S. Virgin Islands.

The following Web-based training courses are available at *http://www.fcsouniversity.com/* to help providers learn more about the proper billing of the modifier 25 as well as the documentation requirements to support the necessity or validity of its use:

- **Introduction to Global Surgery** *https://gm1.geolearning.com/geonext/fcso/coursesummary.CourseCatalog.geo?id=22506181968*
- **Modifier 25** *https://gm1.geolearning.com/geonext/fcso/coursesummary.CourseCatalog.geo?id=22506266653*
- **Medical Documentation Request** *https://gm1.geolearning.com/geonext/fcso/coursesummary.CourseCatalog.geo?id=22506172567*

Laboratory/Pathology

Revision to editing for technical component of pathology services rendered same day as outpatient hospital visit

Provider types affected

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

What you need to know

This article is based on change request (CR) 8399, which informs Medicare contractors about the changes to the claim processing systems to allow the technical component (TC) of a pathology claim when there is a claim in history from the ordering/referring physician for the same date of service (DOS) as the TC of the pathology claim and when the place of service on the ordering/referring physician's claim for physician services is a non-hospital place of service, i.e., it is not 21 or 22. The TC of physician pathology services provided to a Medicare beneficiary who is not a hospital inpatient or hospital outpatient (at the time of the ordering/referring physician's service) is paid on the Medicare physician fee schedule (MPFS).

While contractors are not required to identify and adjust claims previously denied by edit 729F, they may reprocess claims that meet the exception criteria described below that are brought to their attention by suppliers.

Note: It is imperative that physicians and suppliers who submit claims for TC of physician pathology services ensure they are reporting the correct NPI for the ordering/referring physician on their claims.

Background

CR 5347 (Transmittal 1221, issued April 18, 2007) implemented a process to prevent payments for the TC of radiology and pathology services furnished to an inpatient or outpatient of a hospital by any entity other than the admitting hospital. At the request of the industry to allow independent laboratories and hospitals sufficient time to negotiate arrangements, provisions established under Section 542 of the Benefits Improvement and Protection Act of 2000 (BIPA), administrative extensions of these provisions, and provisions established under subsequent legislative extensions, delayed the implementation of the policy change until July 1, 2012. Therefore, for dates of service from January 1, 2007, through June 30, 2012, Medicare continued to pay independent laboratories (IL) and pathologists for the TC of physician pathology services when furnished to an inpatient or outpatient of a covered hospital. (Covered hospital refers to a hospital that had an arrangement with an independent laboratory that was in effect as of July 22, 1999, under which a laboratory furnished the TC of physician pathology services to fee-for-service Medicare beneficiaries who were patients of a hospital and submitted claims for payment for the TC to a carrier.)

(continued on next page)

Pathology *(continued)*

As a result of CR 5347, common working file (CWF) edit 729F was created to prevent payment of the TC of pathology services when an outpatient hospital service occurs on the same date of service (DOS). This edit (among others) was activated for dates of service beginning July 1, 2012, due to the expiration of all legislative extensions of the moratorium on implementation of the regulation at 42 CFR 415.130 (d), which provides that the TC of physician pathology services provided to a hospital inpatient or outpatient may be paid only to the hospital.

Since the activation of edit 729F, Medicare contractors have experienced an increased volume of appeals from physicians and suppliers who have received denials for the TC of pathology services when they occurred on the same DOS as an outpatient hospital service. While most denials have been upheld, some denials have been overturned based on supporting documentation which demonstrates that the outpatient hospital service, although occurring on the same day, did not include services for which the hospital would have already been paid for the TC of a pathology service. CR 8399 implements refinements to edit 729F (which denies TC of pathology claims when an outpatient hospital service occurs on the same DOS) in an effort to help reduce the number of claims inappropriately denied by the aforementioned edit during initial determination. Therefore, effective for the TC of pathology claims processed on and after January 1, 2014, the CWF shall incorporate additional bypass criteria to edit 729F to allow the TC of a pathology claim when there is a claim in history from the ordering/referring physician for the same DOS as the TC of the pathology claim and the ordering/referring physician's claim has a non-hospital place of service.

Additional information

The official instruction, CR 8399 issued to your Medicare contractor regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1276OTN.pdf*.

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

MLN Matters® Number: MM8399
Related Change Request (CR) #: CR 8399
Related CR Release Date: August 9, 2013
Effective Date: January 1, 2014
Related CR Transmittal #: R1276OTN
Implementation Date: January 6, 2014

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

Learn the secrets to billing Medicare correctly

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

Medicare Physician Fee Schedule Database

October update to the 2013 Medicare physician fee schedule database

Provider types affected

This *MLN Matters*® article is intended for physicians and other providers submitting claims to Medicare contractors (carriers, fiscal intermediaries (FIs), A/B Medicare administrative contractors (A/B MACs), and/or regional home health intermediaries (RHHIs)) for services that are paid under the Medicare physician fee schedule database (MPFSDB).

What you need to know

This article is based on change request (CR) 8386 and instructs Medicare contractors to download and implement a new MPFSDB, effective October 1, 2013.

Background

Section 1848(c)(4) of the Social Security Act (see *http://www.ssa.gov/OP_Home/ssact/title18/1848.htm*) authorizes the U.S. Secretary of Health and Human Services (HHS) to establish ancillary policies necessary to implement relative values for physicians' services.

CR 8386, from which this article is taken, announces that the MPFSDB has been updated effective October 1, 2013; and new payment files were issued to your contractor(s) based upon the 2013 Medicare physician fee schedule (MPFS) final rule (published in the *Federal Register* on November 16, 2012); as modified by the American Taxpayer Relief Act of 2012 (applicable January 1, 2013, see *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html*), and the October 1, 2013, updated payment files.

Key changes for the October update are as follows:

- Medicare contractors add HCPCS code G9187 (BPCI home visit) to their systems with an effective date of October 1, 2013.
- The effective date of HCPCS code G0460 (Autologous platelet-rich plasma (PRP) for chronic non-healing wounds) is adjusted to be August 2, 2012.

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

CMS will notify your contractors when the new files are available for retrieval, and CR 8386 instructs them to provide you 30 days' notice before implementing the changes. Further, while they do not have to search their files to either retract payment for claims already paid, or to retroactively pay claims; they will adjust claims that you bring to their attention.

Additional information

The official instruction, CR 8386, issued to your Medicare contractor regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2754CP.pdf*.

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

MLN Matters® Number: MM8386
Related Change Request (CR) #: CR 8386
Related CR Release Date: August 2, 2013
Effective Date: October 1, 2013
Related CR Transmittal #: R2754CP
Implementation Date: October 7, 2013

Radiology

Positron emission tomography

Provider types affected

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

Provider action needed

Stop – impact to you

This article is based on change request (CR) 8381 which announces that July 11, 2012, the Centers for Medicare & Medicaid Services (CMS) opened a reconsideration of the *Medicare National Coverage Determinations (NCD) Manual* (Publication (Pub) 100-03, Section 220.6 (Positron Emission Tomography (PET) Scans -Effective April 6, 2009)), to review coverage of PET for oncologic imaging. The new policy appears below.

Caution – what you need to know

CMS has determined that (unless there is a specific NCD to the contrary) local MACs may determine coverage or noncoverage for PET (within their respective jurisdictions) using new, proprietary radiopharmaceuticals for their Food and Drug Administration (FDA)-approved labeled indications for oncologic imaging only. This is effective for dates of service on or after March 7, 2013, and includes those radiopharmaceuticals that may be approved by the FDA in the future.

This decision does not change coverage for any uses of PET using the following four radiopharmaceuticals: FDG (2-deoxy-2-[F-18] fluoro-D-Glucose (fluorodeoxyglucose)); NaF-18 (fluorine-18 labeled sodium fluoride); ammonia N-13; or rubidium-82 (Rb-82)). In addition, this decision does not prevent CMS from determining national coverage for any uses of any radiopharmaceuticals in the future, and if such determinations are made, future determination would supersede local MAC determination(s).

Go – what you need to do

See the *Background* and *Additional information* sections of this article for further details, and make sure that your billing staff is aware of these changes.

Background

PET is a minimally-invasive diagnostic imaging procedure used to evaluate normal tissue as well as in diseased tissues in conditions such as cancer, ischemic heart disease, and some neurologic disorders.

On July 11, 2012, CMS opened a reconsideration of the *NCD Manual* Pub 100-03, Section 220.6 PET Scans, to review coverage of PET for oncologic conditions. See *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part4.pdf*.

The *NCD Manual*, Section 220.6 currently identifies the following radiopharmaceuticals as the only nationally covered radiopharmaceuticals (also known as radioisotopes or tracers) for certain defined uses in PET:

1. FDG (2-deoxy-2-[F-18] fluoro-D-Glucose (fluorodeoxyglucose)),
2. NaF-18 (fluorine-18 labeled sodium fluoride),
3. Ammonia N-13, and,
4. Rubidium-82 (Rb-82)

All remaining uses of PET are nationally non-covered.

Effective March 7, 2013, CMS subsequently decided that (unless there is a specific NCD to the contrary) local MACs may determine coverage or non-coverage for PET (within their respective jurisdictions) using new, proprietary radiopharmaceuticals for their FDA-approved labeled indications for oncologic imaging only, and includes those radiopharmaceuticals that may be approved by the FDA in the future.

This decision does not:

1. Change coverage for any uses of PET using the four radiopharmaceuticals listed above (i.e., FDG (2-deoxy-2-[F-18] fluoro-D-Glucose (fluorodeoxyglucose)), NaF-18 (fluorine-18 labeled sodium fluoride), Ammonia N-13, or Rubidium-82 (Rb-82)); or
2. Prevent CMS from determining national coverage for any uses of any radiopharmaceuticals in the future, and if such determinations are made, a future determination would supersede local contractor determination.

For claims with dates of service on or after March 7, 2013, Medicare contractors will not search their files, but contractors will adjust claims brought to their attention.

CR 8381 revised the *Medicare NCD Manual*, Pub 100-03, Section 220.6 (Positron Emission Tomography (PET) Scans (Effective April 6, 2009)) as follows:

(continued on next page)

PET *(continued)*

The following points are emphasized:

1. Changing the 'restrictive' language of prior PET decisions will not by itself suffice to expand Medicare coverage to new PET radiopharmaceuticals.
2. The scope of this change extends only to FDA-approved indications for oncologic uses of PET tracers.

3. This change does not include screening uses of PET scanning.

CR 8381 also revises the *Medicare Claims Processing Manual*, Chapter 13, Radiology Services and Other Diagnostic Procedures, and adds Section 60.19 (Local Local Coverage Determination for PET Using New, Proprietary Radiopharmaceuticals for their FDA-Approved Labeled Indications for Oncologic Imaging Only) as follows:

- Effective for dates of service on or after March 7, 2013, MACs may determine coverage within their respective jurisdictions for PET using radiopharmaceuticals for their FDA- approved labeled indications for oncologic imaging. When the local MAC determines that a claim is non-covered, the following messages apply:
    1. Claim adjustment reason code (CARC) 167: This (these) diagnosis(es) is(are) not covered. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
    2. If an advance beneficiary notice (ABN) is provided with a GA modifier indicating there is a signed ABN on file, the liability falls to the beneficiary. However, if an ABN is provided with a GZ modifier indicating no ABN was provided, the liability falls to the provider.

Additional information

The official instruction, CR 8381, issued to your Medicare contractor regarding contained two transmittals. The first updates the *Medicare Claims Processing Manual* and is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2750CP.pdf*. The second updates the *NCD Manual* and is at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R156NCD.pdf*.

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

MLN Matters® Number: MM8381
Related Change Request (CR) #: CR 8381
Related CR Release Date: August 2, 2013
Effective Date: March 7, 2013
Related CR Transmittal #: R2750CP and R156NCD
Implementation Date: September 3, 2013

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

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

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

Therapy Services

Outpatient therapy functional reporting requirements

Provider types affected

This *MLN Matters*® special edition article is intended for physicians and providers submitting claims to Medicare contractors (fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), carriers, and A/B Medicare administrative contractors (MACs)) for Part B outpatient therapy services provided to Medicare beneficiaries.

Functional reporting applies to all claims for therapy services furnished under the Medicare Part B outpatient therapy benefit and to physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP) services furnished under the comprehensive outpatient rehabilitation facility (CORF) benefit. Specifically, functional reporting is required of the following:

- Hospitals, including beneficiaries in outpatient and emergency departments, and inpatients paid under Medicare Part B
- Critical access hospitals
- Skilled nursing facilities
- Comprehensive outpatient rehabilitation facilities
- Rehabilitation agencies
- Home health agencies (for beneficiaries who are not under a home health plan of care, are not homebound, and whose therapy or other services are not paid under the home health prospective payment system)
- Therapists in private practice: physical therapists, occupational therapists, and speech-language pathologists
- Physicians: medical doctors, doctors of osteopathy, doctors of podiatric medicine, and doctors of optometry
- Nonphysician practitioners: nurse practitioners, clinical nurse specialists, and physician assistants.

Provider action needed

This article describes the reporting requirements for functional reporting using 42 G-codes and seven severity/complexity modifiers.

The functional reporting data collection system is effective for therapy services with a date of service (DOS) on or after January 1, 2013. However, a testing period was in effect from January 1, 2013, through June 30, 2013, to allow providers to use the new coding requirements without penalty while they assured that their systems worked. During this period, claims were processed with or without the required G-codes and modifiers.

Background and purpose

The Middle Class Tax Relief and Jobs Creation Act (MCTRJCA) of 2012 required the Centers for Medicare & Medicaid Services (CMS) to implement a claims-based data collection strategy for outpatient therapy services. CMS developed this collection strategy known as “functional reporting” in the 2013 physician fee schedule final rule (77 Federal Regulation (FR) 68958). Functional reporting collects data on patient function during the therapy episode of care to understand beneficiary functional limitations and outcomes. Effective January 1, 2013, claims for outpatient therapy services are required to include non-payable G-codes and modifiers, which describe a beneficiary’s functional limitation and severity level, at specified intervals during the therapy episode of care.

Functional reporting requirements

Definitions

A **reporting episode** is similar to the therapy episode of care. A reporting episode is defined as the period of time, based upon DOS, from the first reporting of functional codes for the functional limitation being treated by one therapy discipline (PT, OT, or SLP) until the date of discharge (if one occurs) from the therapy episode. Within a reporting episode, there can be multiple reporting periods as defined in this article.

(continued on next page)

Therapy *(continued)*

A **reporting period** covers the same period as progress reporting. A clinician (therapist, physician, or NPP) is required to report once every 10 treatment days. A reporting period is defined as the period from the first reporting of functional codes until reporting at the 10th treatment day. For subsequent reporting periods, the first visit is the treatment date following the 10th treatment date. Clinicians are permitted to report functional information prior to the 10th treatment day. Please note that a submission of G-codes and modifiers restarts the 10 day count towards the progress reporting period.

Note: A reporting episode links a beneficiary to a specific therapy billing provider NPI. For the purpose of tracking beneficiary's functional limitations, functional reporting data is reported **per beneficiary, per therapy discipline, and per billing provider NPI** on specified therapy claims for certain DOS.

Required reporting of functional codes

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

- At the outset of a therapy episode of care, i.e., on the DOS for the initial therapy service;
- At every progress reporting period, which occurs at least once every 10 treatment days;
- At the DOS that an evaluative or re-evaluative procedure code is submitted on the claim; and
- At the time of discharge from the therapy episode of care, unless discharge data is unavailable, e.g., when the beneficiary discontinues therapy unexpectedly.

Note: Once one functional limitation is discharged and further therapy is medically necessary, reporting of the subsequent functional limitation begins on the next treatment DOS.

Discharge reporting

Discharge reporting is required at the end of the reporting episode or to end reporting on one functional limitation prior to reporting on another medically necessary functional limitation. The exception is in cases where the beneficiary discontinues therapy expectantly. When the beneficiary discontinues therapy expectantly, we encourage clinicians to include discharge reporting whenever possible on the claim for the final services of the therapy episode.

When a beneficiary discontinues therapy without notice, and returns less than 60 calendar days from the last recorded DOS to receive treatment for one of the following:

- **the same functional limitation**, the clinician must resume reporting following the reporting requirements outlined in the "Required reporting of functional codes" subsection.
- **a different functional limitation**, the clinician must discharge the functional limitation that was previously reported and begin reporting on a different functional limitation at the next treatment DOS.

Note: A reporting episode will automatically be discharged when it has been 60 or more calendar days since the last recorded DOS.

Functional reporting example

In the example below, the self-care G-code set (G8987-G8989) is used to illustrate the required reporting of functional G-codes and severity modifiers at specified reporting intervals. See the "Functional reporting codes" section for a complete list of G-codes and modifiers used in functional reporting.

	At the outset of the therapy episode of care	At the end of each progress reporting period	At the time of discharge from the therapy episode of care
Self-care G-code set (G8987-G8989)			
G8987 Current status + corresponding modifier	X	X	
G8988 Goal status + corresponding modifier	X	X	X
G8989 Discharge status + corresponding modifier			X

If further therapy is medically necessary once reporting for the self-care functional limitation has ended, the clinician may begin reporting on a subsequent functional limitation using the appropriate G- code set on the next treatment DOS.

(continued on next page)

Therapy *(continued)*

Unique functional reporting scenarios

When functional reporting is required at specified intervals for a treatment DOS, generally two G-codes are required. The following exceptions exist:

1. **One-time therapy visit**. When a beneficiary is seen for a one-time visit and future therapy services are either not medically indicated or are going to be furnished by a different provider, the clinician reports as a one-time visit. The clinician reports on the claim for the DOS of the visit, all three G-codes in the appropriate code set (current status, goal status and discharge status), along with corresponding severity modifiers.
2. **Reporting evaluative procedures for multiple POCs for the same therapy discipline**. The clinician should report the evaluative procedure furnished under a separate/different POC for a functional limitation that is not subject to reporting as a one-time visit by reporting all three G-codes and corresponding severity modifiers for the functional limitation that most closely matches the evaluative procedure that was furnished.
3. **Therapy services from more than one therapy discipline**. Claims will contain more than two non- payable functional G-codes in cases where a beneficiary receives therapy services on the same treatment DOS from more than one therapy discipline (PT, OT, and/or SLP) from the same therapy provider.

Note: In unique scenario two, the DOS that functional codes are reported as a one-time visit alongside separately payable procedure code(s), including evaluative/re-evaluative services, does not count as a treatment day for the progress reporting period of the functional limitation subject to reporting.

Claims Requirements

Claims containing any of these functional G-codes must also contain:

- another separately payable (non-bundled) service;
- functional severity modifier in the range CH-CN;
- therapy modifier indicating the discipline of the plan of care (POC) – GP, GO or GN for PT, OT, and SLP services, respectively;
- date of the corresponding payable service;
- nominal charge, e.g., a penny;
- completion of the units field with “1” unit of service; and
- all other currently required claims data elements as described in the claims processing manuals.

Out of sequence claims

An out of sequence therapy claim has a DOS earlier than the last DOS recorded by the claims processing system. To avoid claims being returned or rejected, we encourage clinicians to submit claims in order by treatment DOS. An out of sequence claim that does not meet the functional reporting requirements outlined above may be returned or rejected and providers will need to resubmit the out of sequence claim, and possibly other claims, to correct the information.

Other requirements

Evaluative procedures

As described in the “Required reporting of functional codes” subsection, functional reporting is always required when a HCPCS/*CPT*® evaluation or re-evaluation code is reported on a DOS. These HCPCS/*CPT*® codes are listed below:

Evaluation/Re-evaluation codes

92506 92597 92607 92608 92610

92611 92612 92614 92616 96105

96125 97001 97002 97003 97004

Note: Clinicians are not required to furnish an evaluative or re-evaluative procedure every time G-codes and modifiers are reported. An evaluation or re-evaluation should be furnished when it is medically necessary and not solely for reporting at the required intervals.

Tracking and documentation

The clinician furnishing the therapy services must report the functional information on the therapy claim, and must also track and document the G-codes and modifiers in the beneficiary’s medical record of therapy services.

Transitioning from the testing period

For beneficiaries whose therapy episode of care and functional reporting began prior to July 1, 2013, clinicians do not need to restart functional reporting on the first DOS on or after July 1, 2013. Simply, report at the next required reporting interval that occurs on or after July 1, 2013.

For beneficiaries whose therapy episode of care began prior to July 1, 2013, but for whom functional reporting information has not been submitted prior to July 1, 2013, clinicians must report on the first claim with a treatment DOS on or after July 1, 2013, and document the beneficiary’s functional status for that DOS in a progress report.

Functional reporting codes

G-codes are used to report a beneficiary’s functional limitation being treated and note whether the report is on the beneficiary’s current status, projected goal status, or discharge status. Modifiers are used to indicate the severity/complexity level of the functional

(continued on next page)

Therapy *(continued)*

limitation being reported. By reporting G-codes and modifiers on a periodic basis, a beneficiary's functional limitation is tracked throughout the therapy episode of care.

The functional reporting G-codes:

- have a status code indicator of Q =therapy functional information code, used for required reporting purposes only
- have no payment amounts or relative value units, and
- are "always therapy" codes, which requires the use of a therapy modifier (GP, GO, or GN). A separate article (see *MLN Matters*® article MM8126 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8126.pdf*) was issued to alert providers/suppliers and contractors that these non-payable functional G-codes are "always therapy" codes on the therapy code list.

Functional reporting G-codes – short descriptors

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

Mobility G-code set

- G8978 Mobility status
- G8979 Mobility goal status
- G8980 Mobility D/C status

Changing & maintaining body position G-code set

- G8981 Body pos current status
- G8982 Body pos goal status
- G8983 Body pos D/C status

Carrying, moving & handling objects G-code set

- G8984 Carry current status
- G8985 Carry goal status
- G8986 Carry D/C status

Self-care G-code set

- G8987 Self care current status
- G8988 Self care goal status
- G8989 Self care D/C status

Other PT/OT primary G-code set

- G8990 Other PT/OT current status
- G8991 Other PT/OT goal status
- G8992 Other PT/OT D/C status

Other PT/OT subsequent G-code set

- G8993 Sub PT/OT current status
- G8994 Sub PT/OT goal status
- G8995 Sub PT/OT D/C status

Swallowing G-code set

- G8996 Swallow current status
- G8997 Swallow goal status
- G8998 Swallow D/C status

Motor speech G-code set (Note: Codes in this set are not sequentially numbered)

- G8999 Motor speech current status
- G9186 Motor speech goal status
- G9158 Motor speech D/C status

Spoken language comprehension G-code set

- G9159 Lang comp current status
- G9160 Lang comp goal status
- G9161 Lang comp D/C status

Spoken language expressive G-code set

- G9162 Lang express current status
- G9163 Lang express goal status
- G9164 Lang express D/C status

Attention G-code set

- G9165 Atten current status
- G9166 Atten goal status
- G9167 Atten D/C status

Memory G-code set

- G9168 Memory current status
- G9169 Memory goal status
- G9170 Memory D/C status

Voice G-code set

- G9171 Voice current status
- G9172 Voice goal status
- G9173 Voice D/C status

Other speech-language pathology G-code set

- G9174 Speech lang current status
- G9175 Speech lang goal status
- G9176 Speech lang D/C status

Severity/complexity modifiers

For each non-payable G-code, a modifier must be used to report the severity level for that functional limitation. The severity modifiers reflect the beneficiary's percentage of functional impairment as determined by the clinician furnishing the therapy

(continued on next page)

Therapy *(continued)*

services. Therefore, the beneficiary's current status, projected goal status, and discharge status are reported via the appropriate severity modifiers. The following table includes the seven modifier's definitions.

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

Other information

Remittance advice messages

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

Additional resources

There are related *MLN Matters*® articles that you may want to review:

- MM8126: "2013 Annual Update to the Therapy Code List," discusses the 42 "always therapy" codes, which are non-payable and for use only in functional reporting, and is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8126.pdf*.
- MM8166: "Outpatient Therapy Functional Reporting Non-Compliance Alerts" inform providers of alert messaging that conveys supplemental information regarding your claims for outpatient therapy during the six-month functional reporting testing period of January 1, 2013, to June 30, 2013, to allow you to use the new G-codes to assure that your systems work. It is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8166.pdf*.

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

You are encouraged to go to the *Therapy Services* page at *http://www.cms.gov/Medicare/Billing/TherapyServices/index.html* for more information and links related to this article.

MLN Matters® Number: SE1307
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: July 1, 2013
Related CR Transmittal #: N/A
Implementation Date: July 2, 2013

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

Quarterly provider update

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

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

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

General Coverage

The Affordable Care Act and Model 4 Bundled Payments for Care Improvement

Provider types affected

This *MLN Matters*® article is intended for hospitals, physicians, and non-physician providers participating in model 4 of the Bundled Payments for Care Improvement (BPCI) initiative and submitting claims to Medicare contractors (fiscal intermediaries (FIs) and A/B Medicare administrative contractors (MACs)) for services to Medicare beneficiaries.

What you need to know

This article provides an overview of Medicare's implementation of model 4 of the BCPI. General program information is provided along with separate sections containing information of special interest to hospitals and physicians and non-physician providers. It addresses issues related to readmissions, claims crossover, remittance advice, and claims submission, among others. This pilot program is being conducted under the Centers for Medicare & Medicaid Services (CMS) Innovation Center's model testing authority. The program is slated to be implemented in October 2013.

Background

The Affordable Care Act provides a number of new tools and resources to help improve health care and lower costs for all Americans. Bundling payment for services that patients receive during a single episode of care, such as heart bypass surgery or a hip replacement, is one way to encourage doctors, hospitals, and other health care providers to work together to better coordinate care for patients, both when they are in the hospital and after they are discharged. Such initiatives can help improve health, improve quality of care, and lower costs.

CMS is working in partnership with providers to develop models of bundling payments through the BPCI. On August 23, 2011, CMS invited providers to apply to help test and develop four different models for bundling payments. Model 4, one of these four models, is discussed in this article. In model 4, the episode of care is defined as the acute care hospital stay and includes inpatient hospital services, Part B services furnished during the hospitalization, and hospital and Part B services for related readmissions.

Information in this article is based on the change requests implemented for model 4 of the BCPI, including change requests (CRs) 7887, 8070, and 8196.

General BPCI model 4 information

Beneficiary eligibility

In order to be eligible for model 4, the beneficiary must meet the following requirements:

- Beneficiary is eligible for Part A and enrolled in Part B
- At the time of admission, beneficiary either (a) has at least one day of utilization left and that day is also a day of entitlement or (b) has at least one lifetime reserve day remaining
- Beneficiary does not have end-stage renal disease
- Beneficiary is not enrolled in any managed care plans
- Beneficiary must not be covered under the United Mine Workers
- Medicare must be the primary payer

If the beneficiary does not meet all of these requirements, the following codes will be assigned to rejected or cancelled NOAs:

- **Claims adjustment reason code (CARC) B5**: Coverage/program guidelines were not met or were exceeded.
- **Remittance advice remarks code (RARC) N564**: This patient did not meet the inclusion criteria for the demonstration project or pilot program.

Model 4 bundled payment provision

Hospitals that participate in model 4 of the BPCI will receive a prospectively established bundled payment for agreed upon Medicare severity diagnosis related groups (MS-DRGs).

- This will not apply to claims that are paid on a transfer per-diem basis.

(continued on next page)

Bundled *(continued)*

- This payment will include both the DRG payment for the hospital and a fixed amount for the Part B services anticipated to be rendered during the admission. Separate payment for providers' professional services rendered during the inpatient hospital stay will not be made.
- Participating model 4 hospitals receiving a model 4 payment will be responsible for paying providers who would otherwise be paid separately for professional services under the physician fee schedule (PFS).
- Claims from physicians will be processed as no-pay claims if they occur between the inpatient hospital admission and discharge date in order to prevent duplicate payment of physicians under the bundled payment.

Co-payments, co-insurance, and deductibles

- The regular Part A deductible, including the Part A blood deductible, and daily coinsurance amounts (when applicable) will continue to be applied to the claim.
- The fixed Part B portion of the negotiated bundled payment will first be applied to the Part B deductible, if applicable.
- A fixed Part B copayment will be applied to the claim. This will be the responsibility of the beneficiary and will be calculated as an approximation of what the Part B coinsurance would have been in the absence of model 4.
- Both the copayment and the deductible to be paid by the beneficiary for the Part B services will appear on the MSN along with the Part A deductible and any applicable coinsurance.

Appeals

Payments made under model 4 have no rights of appeal, except in the case of calculation errors.

- **RARC N83**: No appeal rights. Adjudicative decision based on the provisions of a demonstration project.

Information for hospitals

Notification of admission (NOA)

Hospitals participating in this initiative should submit a notice of admission (NOA) when a beneficiary expected to be included in the model is admitted. Timely filing of the NOA allows subsequent Part B claims submitted before the hospital claim to be properly processed as "no-pay" claims, which indicates that payment for these claims are to be included in hospital payments under model 4. By extension, these Part B claims will then be included timely on weekly Part B reports provided to the hospital to be used in calculating payments for Part B providers.

Hospitals will be paid a $500 payment upon submission of the NOA and will receive the balance of the prospectively established bundled payment when the hospital claim is processed.

- **RARC N568**: Initial payment based on the Notice of Admission (NOA) under the Bundled Payment Model IV initiative.
- If the patient ultimately does not qualify for a model 4 prospective payment based on the MS-DRG ultimately assigned to their inpatient stay, or if the NOA is cancelled, the $500 NOA payment will be recouped.
- Medicare systems will initiate a "look back" into the claims history records upon receipt of a canceled NOA to identify model 4 BPCI claims- i.e., Part B physician or other professional claims – which were processed as "no pay" as a result of the NOA being opened. If such claims were processed, the Medicare contractor will adjust the claims automatically and remit payment for services rendered based on regular Medicare fee-for-service claims processing rules.
- Hospitals must submit the final claim within 60 days of the beneficiary's hospital admission or submit an interim claim during that time period to demonstrate that the beneficiary is still an inpatient. Otherwise, the beneficiary will be considered not subject to episode payment and the $500 will be recouped.
  - The following codes will be assigned when a Model 4 claim matches an NOA for admission date and beneficiary, but not provider.
    - **CARC 208**: National Provider Identifier - Not matched
    - **RARC N562**: The provider number of your incoming claim does not match the processed Notice of Admission (NOA) for this bundled payment
  - The following codes shall be assigned when an NOA is cancelled because a matching claim is not received within 60 days. A match consists of beneficiary, admit date, and provider.
    - **CARC 226**: Information requested from the Billing/Rendering Provider was not provided or not provided timely or was insufficient/incomplete
    - **RARC N560**: This pilot program requires an interim or final claim within 60 days of the Notice of Admission. A claim was not received

Readmissions

Model 4 hospitals will not be paid for readmissions that

(continued on next page)

Bundled *(continued)*

occur to the same hospital (i.e., another admission with a date of admission within 30 days of discharge of the model 4 stay) under this model unless the MS-DRG assigned to that readmission is expressly excluded as unrelated to the MS-DRG assigned to the original admission.

- Unrelated readmissions have been defined by CMS, and a list of DRGs defining unrelated readmissions has been provided for each included MS-DRG to every model 4 participating hospital. This list can also be found on the bundled payments collaboration site, accessible to model 4 awardees.
- Related readmissions to a hospital other than the original treating hospital, as well as payments for physicians' services during related readmissions to hospitals other than the original treating hospital, will be reconciled retrospectively by a BPCI payment reconciliation contractor and payment will be recouped, as applicable, by the model 4 awardee.
- If claims for a model 4 anchor admission and a readmission are submitted out of order, the readmission claim will be canceled and must be resubmitted to receive payment. The following codes will be used in this situation:
  - **CARC 249**: This claim has been identified as a readmission.
  - **RARC N561**: The bundled payment for the episode of care includes payment for related readmissions. You may resubmit your claim to receive a corrected payment.

Payment rate updates and adjustors

Payment rates may be updated as often as quarterly to allow for ongoing updates to Medicare payment rates, including regular recurring changes made to the physicians fee schedule (PFS) and inpatient prospective payment system (IPPS), indirect medical education (IME) and disproportionate share hospital (DSH) payments, as well as outlier payments and hospital capital payments to model 4 hospitals will be calculated based on the non-discounted base DRG payment that would have been made in the absence of the model. This is true for both anchor admissions and related readmissions to the model 4 hospital. In the case of readmissions, these payments will be denoted by the following:

- **CARC 249**: This claim has been identified as a readmission.
- **RARC N524**: Based on policy this payment constitutes payment in full.

Other applicable payment adjustors will also be calculated based on the base DRG that would otherwise have applied to the case, as opposed to the prospectively established amount paid through this initiative, which will be higher as it includes payment for Part B services in addition to the base DRG payment.

Information for physicians and non-physician providers

Claim submission and processing

Physicians and non-physician practitioners shall submit claims for dates of service during an episode of care included in model 4 BPCI as usual.

Physicians and non-physician practitioners shall be required to accept assignment for all claims covered under the model 4 BPCI payment.

For those Part B services rendered during a model 4 admission or a related readmission to that model 4 hospital, Medicare will process claims as no-pay. In processing no-pay professional claims, Medicare will assign the following:

- **CARC 234**: This procedure is not paid separately.
- **RARC N67**: Professional provider services not paid separately. Included in facility payment under a demonstration project. Apply to that facility for payment, or resubmit your claim if: the facility notifies you the patient was excluded from this demonstration; or, if you furnished these services in another location on the date of admission or discharge from a demonstration hospital. If services furnished in a facility not involved in the demonstration on the same date the patient was discharged from or admitted to a demonstration facility, you must report the provider ID number for the non-demonstration facility on the new claim.

Physicians submitting claims should take care not to include on the same claim services that are both within the dates (admission and discharge) of a model 4 BPCI episode and outside the dates of the episode. If such claims with both model 4 and non-model 4 services are received, Medicare contractors will reject the claims and advise the physician to separate the services and rebill. The following remittance messages will be used in this situation:

- **CARC 239**: Claim spans eligible and ineligible periods of coverage. Rebill separate claims.
- **RARC N61**: Rebill services on separate claims.

Incentive payments

Bonus or incentive payments calculated by CMS, such as HPSA bonus payments, will not be affected by physician or non-physician practitioner participation in the bundled payments initiative.

Participation declination

Physicians have the right to decline participation in this program. Declination will be indicated by including a HCPCS modifier on each claim. Further details will be provided at a future date.

(continued on next page)

Bundled *(continued)*

Readmissions

Part B services provided during a related readmission to the original treating hospital will not be paid separately. If Part B claims were processed prior to receipt of the hospital's readmission claim, Medicare will take steps to recover payments to the physician.

- **CARC A1**: Claim/Service denied; and
- **RARC N68**: Prior payment being cancelled as we were subsequently notified this patient was covered by a demonstration project in this site of service. Professional services were included in the payment to the facility. You must contact the facility for payment. Prior payment made to you by the patient or another insurer for this claim must be returned within 30 days.

Claims crossover

In association with this initiative, CMS will make changes to allow for the reporting of two new claim adjustment reason codes (CARCs) within the 2320 claim adjustment segment (CAS), so that supplemental payers can more easily determine these amounts when adjudicating Medicare Health Insurance Portability and Accountability Act (HIPAA) 837 institutional coordination of benefits (COB)/ crossover claims.

- CARC 247 will be defined as "Part B deductible on a Part A claim."
- CARC 248 will be defined as "Part B coinsurance on a Part A claim."
- An adjusted RARC M137 will be defined as "Part B coinsurance under a demonstration project or pilot program.

This initiative will also result in the reporting of a new value code within the 2300 Health Care Information Codes (HI) value information (qualifier BE) portion of outbound HIPAA 837 institutional COB/crossover claims.

Additional information

The official instruction, CR 8070, issued to your Medicare contractor regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1251OTN.pdf*. In addition, CR 8196 is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1189OTN.pdf* and CR 7887 is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1240OTN.pdf*.

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

MLN Matters® Number: MM8070
Related Change Request (CR) #: 8070
Related CR Release Date: June 27, 2013
Effective Date: July 1, 2013
Related CR Transmittal #: R1251OTN
Implementation Date: July 1, 2013

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

Update on processing issue with Medicare secondary payer claims

This is an update on the processing issue related to Medicare secondary payer (MSP) claims rejecting with reason code 39071, 39072, or 39073. First Coast Service Options Inc. (First Coast) has successfully released the majority of held claims. However, there is still a small amount of claims that are not processing through to completion. First Coast is working closely with the Centers for Medicare & Medicaid Services and system maintainers to resolve this issue. A system fix is being worked and scheduled for October 7.

Source: Change request 7605

How can the PDS help my practice?

The Provider Data Summary (PDS) can help you quickly identify potential billing issues through detailed analysis of personal billing patterns in comparison with those of similar providers. Additional information, including a quick-start guide to help you easily get started right away, is available at *http://medicare.fcso.com/PDS/index.asp.*

October 2013 healthcare provider taxonomy codes update

Provider types affected

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

What you need to know

Change request (CR) 8417, from which this article is taken, instructs Medicare contractors to obtain the most recent healthcare provider taxonomy codes (HPTC) set and use it to update their internal HPTC tables and/or reference files.

Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that covered entities use the standards adopted under this law when electronically transmitting certain health care transactions. These standards contain implementation guides that dictate when and how data must be sent, and specify the code sets that must be used.

Both the current ASC x12 837 institutional and professional claims require that the National Uniform Claim Committee (NUCC) HPTC set be used to identify provider specialty information on a health care claim. However, the standards do not mandate that a HPTC be on every claim, nor for every provider to be identified by specialty there.

They state that this information is:

- "Required when the payer's adjudication is known to be impacted by the provider taxonomy code" and
- "If not required by this implementation guide, do not send."

In addition, please note that Medicare does not use HPTCs to adjudicate its claims, and would not expect to see these codes on a Medicare claim. However, it does currently validate any HPTC that a provider happens to supply against the NUCC HPTC code set.

As the HPTC code set maintainer, the NUCC updates the code set twice a year (effective April 1 and October 1), and CR 8417 implements the NUCC HPTC code set that is effective on October 1, 2013. CR 8417 instructs Medicare contractors and maintainers to obtain the October 2013 HPTC set, and to update the current HPTC tables with this updated list. It further instructs the contractors and maintainers that: 1) Have the capability to implement the updated October 2013 HPTC set, to update the HPTC table so that claims received on and after October 1, 2013, can be validated against this updated set; or 2) Lack this

capability, to implement the October 2013 HPTC update as soon as they can after October 1, 2013, but not beyond January 6, 2014.

The HPTC set is available for view or for download at *http://www.wpc-edi.com/reference/* on the Washington Publishing Company (WPC) website. When reviewing the HPTC set online, revisions made since the last release can be identified by the color code: new items are green, modified items are orange, and inactive items are red.

Additional information

The official instruction, CR 8417, issued to your Medicare contractor regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2762CP.pdf*.

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

MLN Matters® Number: MM8417
Related Change Request (CR) #: CR 8417
Related CR Release Date: August 9, 2013
Effective Date: October 1, 2013
Related CR Transmittal #: R2762
Implementation Date: January 6, 2014

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

Manual updates related to extended repayment schedules

Provider types affected

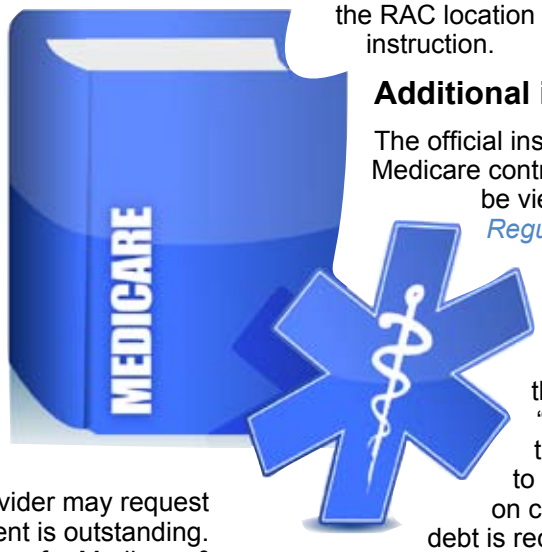
This *MLN Matters*® article is intended for all physicians, providers, and suppliers who bill Medicare contractors (carriers, fiscal intermediaries (FIs), post hospital home health (HHH), regional home health intermediaries (RHHIs), Medicare administrative contractors (A/B MACs), and durable medical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

Provider action needed

Change request (CR) 8347 is a policy change that streamlines the extended repayment schedules (ERS) process by updating the policy language and standard practices. See the *Key points* section of this article for specifics.

Background

Overpayments are Medicare payments to a provider that are in excess of amounts due and payable under the statute and regulations. When an overpayment is determined, a demand letter is sent requesting repayment. A provider is expected to repay any overpayment promptly. If repaying an overpayment within 30 days would constitute a "hardship" for the provider, the provider may request an ERS at any time the overpayment is outstanding. Medicare Contractors and/or Centers for Medicare & Medicaid Services (CMS) staff will review the request to determine if extending a repayment schedule is justified.



Key points

The following points are based on the revised manual, *Medicare Financial Management*," Chapter 4 – Debt Collection.

- Medicare contractors are charged with establishing an ERS formerly called an extended repayment plan (ERP). Contractors must process ERS requests within 30 days of receipt and make certain providers complete all instructions. Contractors are required to post information and instructions on their websites and supply paper copies if requested.
- Your Medicare contractor will approve/disapprove an ERS request from six months up to 36 months and the CMS for an ERS up to 60 months – again within 30 days of receipt.
- Your Medicare contractor will not refund monies recouped during the review process. The recouped amounts will be applied to the overpayment.
- Contractors will notify a provider of approval or no approval within five days of decision.
- Contractors will recoup ERS payments from a provider's future Medicare payment, unless the contractor determines there is a valid reason to send in a check.
- Chapter 4, Section 100.6.4 details the ERS process that occurs if a request is received by the recovery audit contractor (RAC) from a provider. The point of contact information for the ERS at the RAC location will be provided in a separate instruction.

Additional information

The official instruction, CR 8347, issued to your Medicare contractor regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R224FM.pdf*.

You may review CR 7688 for an explanation of the policy that implements a standard "immediate recoupment" process that gives providers the option to avoid interest from accruing on claims overpayments when the debt is recouped in full prior to or by day 30 after the initial demand letter date at: *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7688.pdf*.

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

MLN Matters® Number: MM8347
Related Change Request (CR) #: CR 8347
Related CR Release Date: August 2, 2013
Effective Date: September 3, 2013
Related CR Transmittal #: R224FM
Implementation Date: September 3, 2013

New claim adjustment reason code to identify a reduction in federal spending due to sequestration

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8378 which informs Medicare contractors about a new claim adjustment reason code (CARC) reported when payments are reduced due to sequestration. Make sure that your billing staff is aware of these changes.

Background

As required by law, President Obama issued a sequestration order on March 1, 2013. As a result, Medicare fee-for-service claims, with dates of service or dates of discharge on or after April 1, 2013, incur a two percent reduction in Medicare payment. The Centers for Medicare & Medicaid Services (CMS) previously assigned CARC 223 (adjustment code for mandated federal, state or local law/regulation that is not already covered by another code and is mandated before a new code can be created) to explain the adjustment in payment.

Effective June 3, 2013, a new CARC was created and will replace CARC 223 on all applicable claims. The new CARC is as follows:

- 253 - Sequestration - Reduction in Federal Spending

Also, Medicare contractors will not take any action on claims processed prior to implementation of CR 8378.

Additional information

The official instruction, CR 8378, issued to your Medicare contractor regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2739CP.pdf*.

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

MLN Matters® Number: MM8378
Related Change Request (CR) #: CR 8378
Related CR Release Date: July 25, 2013
Effective Date: June 3, 2013
Related CR Transmittal #: R2739CP
Implementation Date: January 6, 2014

When to collect the deductible from the beneficiary

When assignment is accepted, Medicare Part B **recommends**:

- Since it is difficult to predict when deductible/coinsurance amounts will be applicable - and over-collection is considered program abuse - **do not collect these amounts until you receive Medicare Part B payment**.
- If you believe you can accurately predict the coinsurance amount and wish to collect it before Medicare Part B payment is received, note the amount collected for coinsurance on your claim form. (We do not recommend that you collect the deductible prior to receiving payment from Medicare Part B because, as noted above, **over-collection is considered program abuse** and can cause a portion of the provider's check to be issued to beneficiaries on assigned claims.)
- Do not show any amounts collected from patients if the service is never covered by Medicare Part B or you believe, in a particular case, the service will be denied payment. Where patient paid amounts are shown for services that are denied payment, a portion of the provider's check may go to the beneficiary.

CMS issues update on incarcerated beneficiary claims

The Centers for Medicare & Medicaid Services (CMS) has posted frequently asked questions (FAQs) about incarcerated beneficiary claims denials on CMS' "All-Fee-For-Service-Providers" page at http://www.cms.gov/Center/Provider-Type/All-Fee-For-Service-Providers-Center.html.

Source: CMS PERL 201308-01

Mobile apps for the Open Payments program (Physician Payments Sunshine Act)

Provider types affected

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

What you need to know

The Centers for Medicare & Medicaid Services (CMS) announced July 17, 2013, the availability of two new mobile applications (mobile apps) for the Open Payments program (Physician Payments Sunshine Act), which are designed to assist in helping physicians, applicable manufacturers, and applicable group purchasing organizations (GPOs) track much of the data necessary for successful program reporting. Both apps are compatible with the iOS (Apple™) and Android platforms; they are available free through the iOS Apple™ Store and Google Play™ Store.

The two new mobile apps track contact information of physicians and industry, share information between the physician and industry apps using mobile technology, and track payments and other transfers of value in real-time.

One app is targeted specifically to physicians (Open Payments Mobile for Physicians) and the other is for industry, including applicable manufacturers and applicable GPOs (Open Payments Mobile for Industry). A picture of the app icons is shown below.

Physician

Industry

Ultimately, the goal of these apps is to make tracking payment information easier and more convenient, and to improve the accuracy of payment information by tracking payments as they occur throughout the year.

You and your staff should read more information about the apps in the *Background* section.

Additional information

For more information about the Open Payments program, read the *MLN Matters*® special edition article SE1303, "Information on the National Physician Payment Transparency Program: Open Payments," available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1303.pdf*.

More information about Open Payments is available at *http://www.cms.gov/Regulations-and-Guidance/Legislation/National-Physician-Payment-Transparency-Program/index.html*.

Background

Why are these apps needed?

The new Open Payments mobile applications will assist physicians and the industry in tracking financial relationships. The two free mobile apps will help physicians and health care industry users to track their payments and other financial transfers that the industry will report under the Open Payments program (Physician Payments Sunshine Act). Created by a provision of the Affordable Care Act, Open Payments creates greater public transparency about the financial transactions between doctors, teaching hospitals, drug and device manufacturers, and other health care businesses.

CMS has made these apps available to facilitate accurate reporting of required information, which will be available to the public and will be published annually on the Open Payments website. CMS's goal is about providing user-friendly tools for doctors, manufacturers, and others in the health care industry to use in working with CMS to implement the law in a smart way. These two apps are innovative options for doctors and the industry to accurately and securely track their financial ties and other transfers of values as required under this important transparency program.

To support the "Open Payments" program, CMS designed the mobile applications (one each for physicians and health care industry users), merging this proven and efficient format with real-time 24-hour tracking technology. The apps offer on-the-go convenience for users to track financial data. Both apps are compatible with the iOS (Apple™) and Android platforms; they are available free through the iOS Apple™ Store and Google Play™ Store.

What are the reporting requirements of Open Payments?

August 2013 marked the beginning of pharmaceutical and device manufacturers and group purchasing

(continued on next page)

Mobile *(continued)*

organizations (GPOs) collecting and preparing to report payments and other transfers of value made to physicians and teaching hospitals, as well as certain ownership and investment interests, as required by the Open Payments program.

Physicians are not required to report any information to CMS, though they may wish to use this app to help validate reports submitted by manufacturers to CMS about payments they have received. (Reporting requirements do not apply to physician claims payments.)

Financial information entered into the apps will help health care industry entities meet the timely reporting requirements of the Open Payments program. Financial data loaded into the apps does not interact with CMS systems and cannot be used for direct data reporting to CMS or its contractors. In addition, CMS will not validate the accuracy of data stored in the apps, nor will it be responsible for protecting data stored in the apps.

For physician users, the Open Payments Mobile for Physicians mobile app will help them assure that industry information reported about them is accurate by:

- Tracking payments and other transfers of value received from their health care industry affiliations in real-time, as they occur;
- Transferring user profile and high level information associated with the event or situation in which the "transfer of value" occurred between physicians and industry; and
- Storing personal contact information.

Industry app users hold the responsibility for accuracy and completeness of their official reports. For industry users, the Open Payments Mobile for Industry mobile app will facilitate their reporting by:

- Tracking their payments and other transfers of value assigned to physicians and teaching hospitals, in real-time;
- Transferring user profile and high level information associated with the event or situation in which the "transfer of value" occurred between physicians and industry;
- Helping to ensure greater accuracy of information about financial relationships with physicians; and
- Collecting physician user profile information.

What is a mobile app?

A mobile application (or mobile app) is a software application designed to run on smartphones and other mobile devices.

Is use of the apps completely voluntary?

The use of the apps is voluntary. The apps are available for the user's own information collection and to serve as a personal storage depository only.

How can I obtain the mobile apps?

You can download the mobile apps directly from your app store (e.g., iOS Apple™ or GooglePlay™); search for either Open Payments Mobile for Physicians or Open Payments Mobile for Industry, depending on which app you are downloading and follow your normal downloading instructions.

What if I have questions about the functions and uses of the apps?

For more information on functionality and usage of the apps, visit the "Frequently Asked Questions for Open Payments Mobile for Physicians & Open Payments Mobile for Industry" document, available at *http://www.cms.gov/Regulations-and-Guidance/Legislation/National-Physician-Payment-Transparency-Program/Downloads/Mobile-App-Public-FAQs.pdf*.

A demonstration of the app was provided during a national provider call August 8, 2013. Check for other upcoming calls at *https://www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events.html*.

For help with the apps you can contact the Open Payments helpdesk at *openpayments@cms.hhs.gov*. Please also send any comments or suggestions regarding the apps' functionality to our help desk, as we are continuing to explore opportunities to leverage technology solutions that will help enable successful program implementation.

MLN Matters® Number: SE1329
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A

Redaction of health insurance claim numbers in Medicare redetermination notices

Provider types affected

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

What you need to know

This article is based on change request (CR) 8268, which instructs the MACs to redact HICNs on all MRNs. Make sure that your billing staff is aware of this change.

Background

Medicare contractors are required to issue a notice of Medicare redetermination after an appeal is requested in accordance with 42 CFR Section 405.956. One of the elements in the MRN is the beneficiary's HICN. To ensure that contractors protect personally identifiable information, the Centers for Medicare & Medicaid Services (CMS) is requesting that all contractors redact the HICNs in the MRNs. The HICNs will be redacted by replacing five or more values of the HICN with Xs or asterisks (*) with the last four or five digits of the HICN displayed. This applies to HICNs with both alpha and numeric digits.

Additional information

The official instruction, CR 8268, issued to your Medicare contractor regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1258OTN.pdf*.

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

MLN Matters® Number: MM8268
Related Change Request (CR) #: CR 8268
Related CR Release Date: July 25, 2013
Effective Date: January 1, 2014
Related CR Transmittal #: R1258OTN
Implementation Date: January 6, 2014

Requesting duplicate remittance advice

First Coast sometimes receives requests for duplicate Medicare remittance notices (MRNs), also known as Medicare summary notices (MSNs).

Trading partners who are directly submitting through the EDI Gateway using their own submitter number and receive electronic remittance advices (ERAs) may use the "Remittance reload request for X12 v5010," located at *http://medicare.fcso.com/gateway/rem.asp*.

Providers who are sending/receiving files through a clearinghouse should contact the clearinghouse for any reload requests. Providers may also download free software to retrieve ERAs.

How do I get the free software?

- For Part A providers, download "PC-Print Software" at *http://medicare.fcso.com/PC-print_software/*.
- For Part B providers, download "MREP software" at *http://medicare.fcso.com/MREP/*.

What if I receive paper remittance notices?

Medicare contractors do not routinely provide duplicate paper remits (standard paper remittance or SPR). Providers who receive SPR may contact customer service for duplicates **if the originals were never received or were lost due to natural disaster**. (**Note**: Customer service can only send the duplicates to the address printed on the SPR. In addition, Part A requests must be made within 30 days of the remit date; otherwise, there is a $25 fee for duplicates.)

We recommend using ERA. You may access answers to concerns you may have regarding ERA at *http://medicare.fcso.com/Remittance_advice/194782.asp*, or view ERA FAQs at *http://medicare.fcso.com/FAQs/205762.asp*.

Opting out of Medicare and/or electing to order and refer services

Provider types affected

This *MLN Matters*® special edition article is intended for physicians and non-physician practitioners who opt out of Medicare and/or elect to order and refer services to Medicare beneficiaries and who would otherwise submit claims to Medicare contractors (carriers and Medicare administrative contractors (A/B MACs) for services to Medicare beneficiaries.

What you need to know

This *MLN Matters*® special edition article informs physicians and non-physician practitioners who wish to opt-out of Medicare of the need to provide certain information in a written Affidavit to their Medicare contractor (Medicare carrier or Medicare administrative contractor (MAC)). Make sure that your billing staff is aware of this information.

Background

The following shows physicians and other practitioners who are permitted by statute to opt-out of the Medicare program:

Physicians who are:

- Doctors of medicine or osteopathy;
- Doctors of dental surgery or dental medicine;
- Doctors of podiatry; or
- Doctors of optometry; and
- Who are legally authorized to practice dentistry, podiatry, optometry, medicine, or surgery by the state in which such function or action is performed.

Practitioners who are:

- Physician assistants;
- Nurse practitioners;
- Clinical nurse specialists;
- Certified registered nurse anesthetists;
- Certified nurse midwives;
- Clinical psychologists;
- Clinical social workers; or
- Registered dietitians or nutrition professionals; and
- Who are legally authorized to practice by the state and otherwise meet Medicare requirements.

Filing an affidavit to opt-out

Physicians and non-physician practitioners who want to opt-out must file an affidavit with Medicare in which they agree to opt-out of Medicare for a period of two years and to meet certain other criteria.

- In general, the law requires that during that two-year period of time, physicians and non-physician practitioners who have filed affidavits opting out of Medicare must sign private contracts with all Medicare beneficiaries to whom they furnish services that would otherwise be covered by Medicare, except those who are in need of emergency or urgently needed care.
- They cannot sign such contracts with beneficiaries in need of emergency or urgent care services.
- Moreover, physicians and non-physician practitioners who opt-out cannot choose to opt-out of Medicare for some Medicare beneficiaries but not others; or for some services and not others.

The Centers for Medicare & Medicaid Services (CMS) does not have a standard affidavit form, so Medicare contractors must instruct those providers who wish to opt-out to provide the information mentioned in writing to the Medicare contractor within their service jurisdiction.

- The affidavit must be in writing and signed by the physician/non-physician practitioner.
- It must include various statements to which the physician/non-physician practitioner must agree; for example, the physician/non-physician practitioner must agree not to submit claims to Medicare for any services furnished during the opt-out period, except for emergency or urgent care services furnished to beneficiaries with whom the physician/non-physician practitioner has not previously entered into a private contract.
- It must identify the physician/non-physician practitioner sufficiently so that the Medicare contractor can ensure that no payment is made to the physician/non-physician practitioner during the opt-out period.
- It must be filed with all Medicare contractors who

(continued on next page)

Opting *(continued)*

have jurisdiction over the claims the physician/non-physician practitioner would have otherwise filed with Medicare and must be filed no later than 10 days after entering into the first private contract to which the affidavit applies.

The following specific information must be included in the affidavit:

- The physician/non-physician practitioner's legal name;
- Medicare specialty;
- Taxpayer identification number (TIN) (Social Security number (SSN)) (required if a national payer identifier (NPI) has not been assigned);
- Address (If the address in the affidavit is a P.O. Box, the Medicare contractor may request a different address);
- Telephone number;
- Medicare billing ID/provider transaction number (PTAN) (if the provider was previously enrolled and one had been assigned); and
- NPI (only if one has been assigned).

Physicians/non-physician practitioners who have never enrolled in Medicare are not required to enroll in Medicare before they can opt-out of Medicare.

A nonparticipating physician or practitioner may opt-out of Medicare at any time and the effective date of the affidavit record must comply with the following:

- The two-year opt-out period begins the date the affidavit is signed, provided the affidavit is filed within 10 days after he or she signs his or her first private contract with a Medicare beneficiary.
- Physicians or practitioners that opt out in multiple contractor jurisdictions are required to file a separate affidavit with each contractor. If the physician or practitioner does not timely file all required affidavits, the two-year opt-out period begins when the last such affidavit is filed. Any private contract entered into before the last required affidavit is filed becomes effective upon the filing of the last required affidavit. The furnishing of any items or services to a Medicare beneficiary under such contract before the last required affidavit is filed is subject to standard Medicare rules.

If the physician or non-physician practitioner had been enrolled in Medicare and had signed a Part B participation agreement and is now opting out, the participation agreement terminates at the same time the enrollment terminates. If an enrolled physician/non-physician practitioner is opting out, the existing enrollment record will be automatically end dated. The effective date of the opt-out affidavit shall comply with the following:

- A participating physician may properly opt-out of Medicare at the beginning of any calendar quarter, provided that the affidavit is submitted to the participating physician's Medicare contractor at least 30 days before the beginning of the selected calendar quarter.
- A private contract entered into before the beginning of the selected calendar quarter becomes effective at the beginning of the selected calendar quarter and the furnishing of any items or services to a Medicare beneficiary under such contract before the beginning of the selected calendar quarter is subject to standard Medicare rules.

Opt-out providers who may order and refer services

There are differences between providers who are permitted to opt-out and providers who opt-out and elect to order and refer services. The following physicians and non-physician practitioners are permitted to order and refer:

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

CMS emphasizes that generally Medicare will only reimburse for specific items or services when those items or services are ordered or referred by providers or suppliers authorized by Medicare statute and regulation to do so. The denial will be based on the fact that neither statute nor regulation allows coverage of certain services when ordered or referred by the identified supplier or provider specialty.

CMS would like to highlight the following limitations:

- Chiropractors are not eligible to order or refer supplies or services for Medicare beneficiaries. All services ordered or referred by a chiropractor will be denied.
- Home health agency (HHA) services may only be ordered or referred by a doctor of medicine (M.D.), doctor of osteopathy (D.O.), or doctor of podiatric medicine (DPM). Claims for HHA services ordered by any other practitioner specialty will be denied.

(continued on next page)

Opting *(continued)*

- Optometrists may only order and refer DMEPOS products/services, and laboratory and X-ray services payable under Medicare Part B.

If an opt-out provider elects to order and refer services, Medicare contractors must develop for the following information through an additional information request:

- An NPI (if one is not contained on the affidavit voluntarily)
- Confirmation if an Office of Inspector General (OIG) exclusion exists (if not contained on the affidavit);
- Date of birth
- Social Security number (if not contained on the affidavit)

If the above information is not obtained, the opt-out provider will not be able to order and refer services. If the opt-out provider refuses to report the information listed immediately above, then the opt-out provider cannot order and refer, but the failure to report this additional information does not affect the provider's right to opt out of Medicare.

The Medicare contractor must ask the opt-out physician or non-physician practitioner if he or she has been excluded by the OIG and may specifically ask for a copy of the private contract he or she uses in order to ascertain whether he or she has been excluded from the Medicare program.

Additional information

You may want to review *MLN Matters*® article MM8100, titled "Effect of Beneficiary Agreements Not to Use Medicare Coverage and When Payment May be Made to a Beneficiary for Service of an Opt-Out Physician/ Practitioner," which is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm8100.pdf*.

The official Medicare requirements for opting out are in the Chapter 15, Section 40, of the *Medicare Benefit Policy Manual* and that section is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf*.

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

MLN Matters® Number: SE1311
Related Change Request (CR) #: Not applicable
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A

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

Enrollment denials when overpayment exists

Note: This article has been rescinded due to the related change request (CR) being rescinded. The CR and article will be replaced at a later date. This information was previously published in the June 2013 *Medicare B Connection*, Pages 34-35.

Additional information

The official instruction, CR 8039, issued to your Medicare contractor regarding this change, may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R469PI.pdf*.

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

MLN Matters® Number: MM8039 *Revised*
Related Change Request (CR) #: CR 8039
Related CR Release Date: May 31, 2013
Effective Date: October 1, 2013
Related CR Transmittal #: R469PI
Implementation Date: October 7, 2013

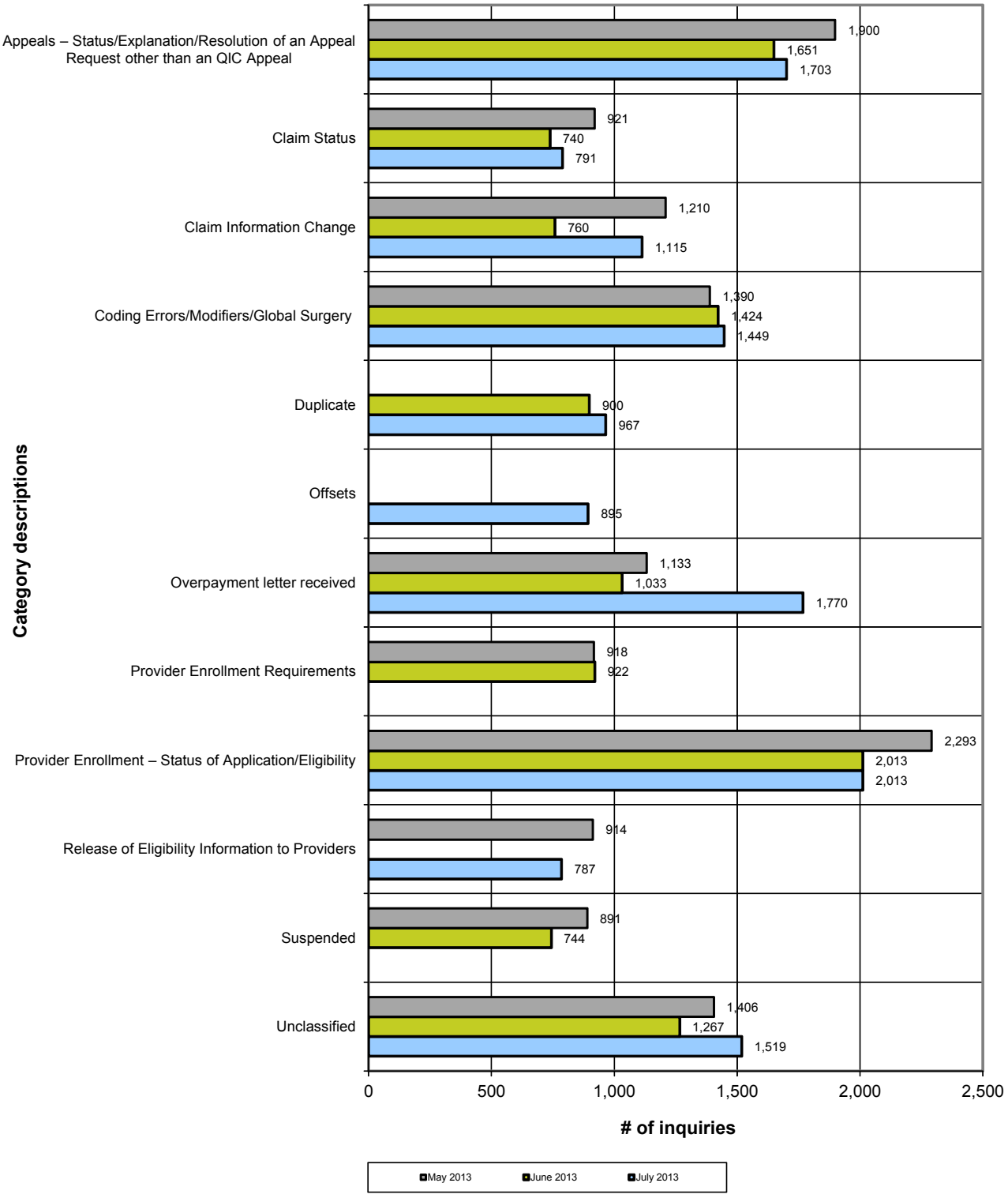
Disclaimer - This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended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

Top inquiries, denials, and return unprocessable claims

The following charts provide the most frequent inquiries, denials, and return unprocessable claims (RUC) submitted to First Coast Service Options Inc. (First Coast), by providers in Florida, Puerto Rico, and the U.S. Virgin Islands during May-July 2013.

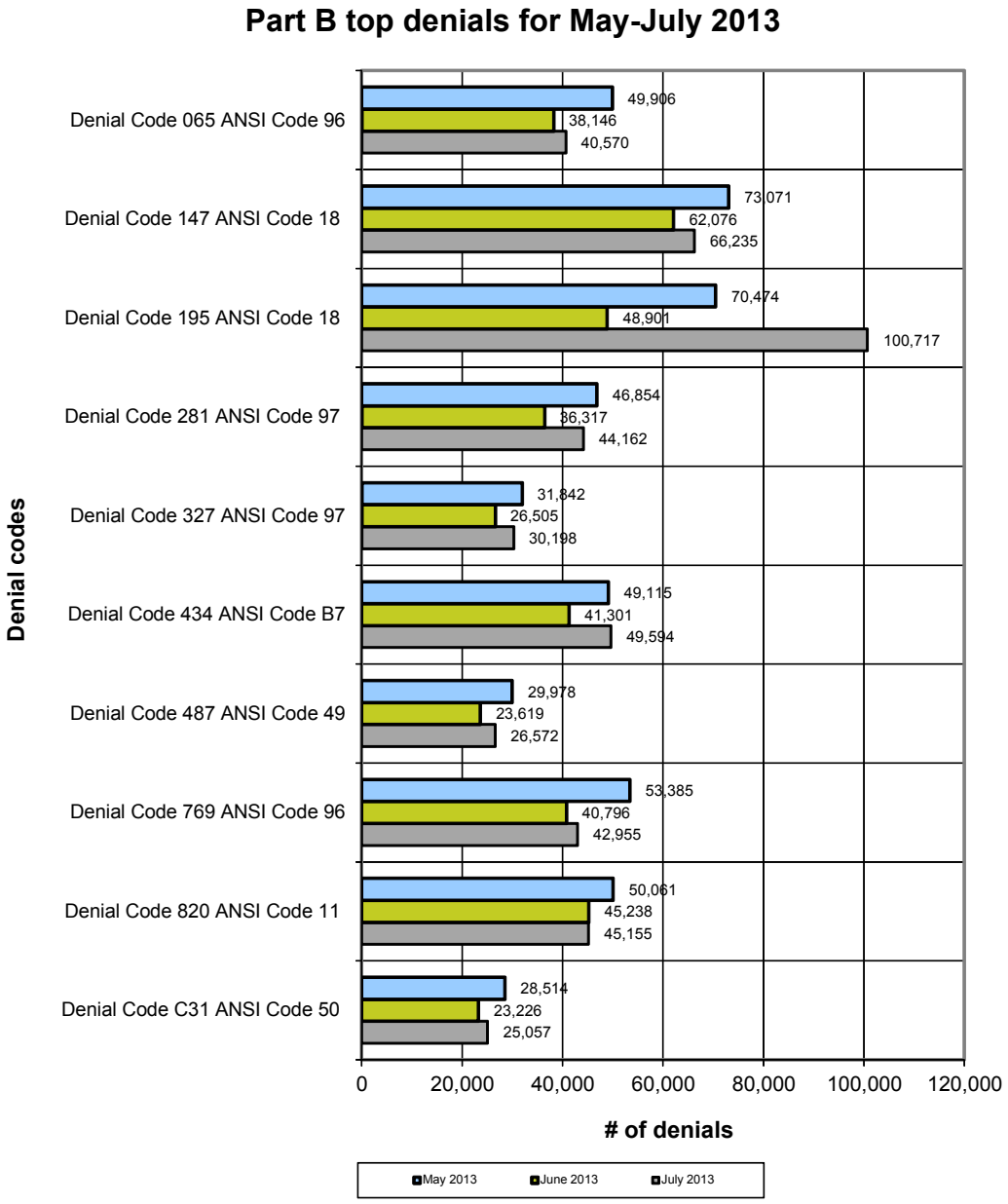
For tips and resources to help providers avoid or reduce the amount of time spent on many of these issues, refer to the Inquiries and Denials section of our website at *http://medicare.fcso.com/Inquiries_and_denials/index.asp*.

Part B top inquiries for May-July 2013



(continued on next page)

Top *(continued)*



What to do when your claim is denied

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

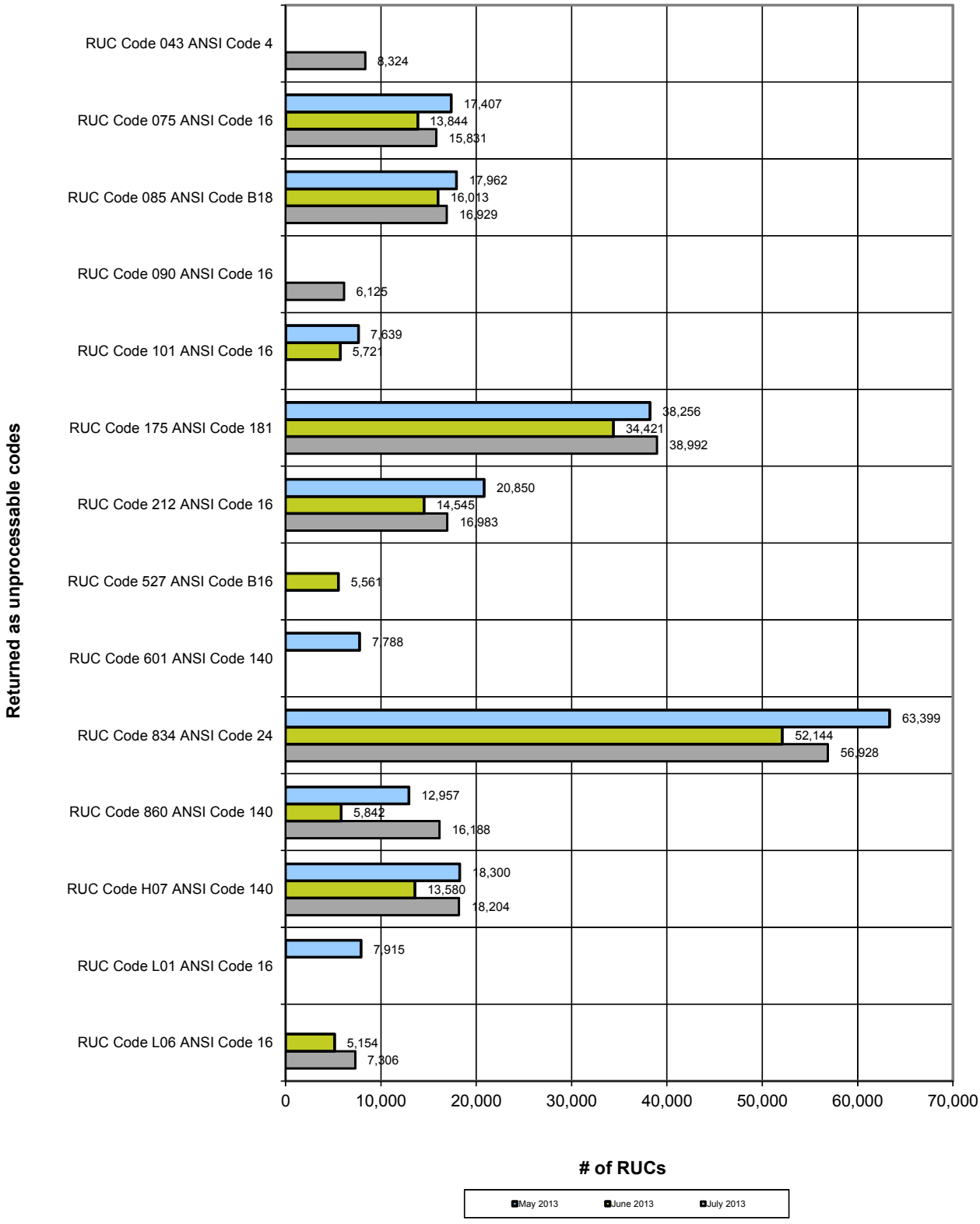
Ensure all information on a claim is correct before submitting to Medicare. Example: The date(s) of service (DOS) on the claim should correspond to the number of units/days being billed.

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

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

Top *(continued)*

Part B top return as unprocessable claims for May-July 2013



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

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

Effective and notice dates

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

Electronic notification

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

More information

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

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

Contents

Advance beneficiary notice

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

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

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

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

Looking for LCDs?

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

New LCDs

Molecular pathology procedures – new LCD

LCD ID number: L33703 (Florida/Puerto Rico/U.S. Virgin Islands)

Molecular pathology procedures are medical laboratory procedures involving the analyses of nucleic acid to detect variants in genes that may be indicative of germline (e.g., constitutional disorders) or somatic (e.g., neoplasia) conditions, or to test for histocompatibility antigens (e.g., HLA). Given the elimination of the stacking procedure codes (*83890-83914*) in the American Medical Association (AMA) 2013 *Current Procedural Terminology* (*CPT*®) manual and the array based evaluation procedure codes (*88384-88386*), molecular pathology codes now include all analytical services performed in the test (e.g., cell lysis, nucleic acid stabilization, extraction, digestion, amplification, and detection).

The molecular pathology procedure codes are categorized by two tiers. The Tier 1 molecular pathology codes (*81200-81383*) are applicable to specific biomarkers that represent gene-specific and genomic procedures. The Tier 2 molecular pathology codes (*81400-81408*) represent multiple biomarkers and are arranged by level of technical resources and interpretive work by the physician or other qualified healthcare professional. Tier 2 procedures are performed in lower volumes than Tier 1 procedures (e.g., the incidence of disease being tested is rare).

The focus of this local coverage determination (LCD) is to provide general guidance to the medically reasonable and necessary applications of the molecular pathology procedures described in *CPT*® code range *81200-81479* (with the exception of HLA testing *CPT*® code range *81370-81373* addressed in the LCD for Molecular Pathology for Human Leukocyte Antigen).

This new LCD has been developed to outline indications and limitations of coverage and/or medical necessity, documentation requirements, and utilization guidelines for molecular pathology procedures.

Effective date

This new LCD is effective for services rendered **on or after October 7, 2013**. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page.

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

Molecular pathology procedures for human leukocyte antigens (HLA) typing – new LCD

LCD ID number: L33732 (Florida/Puerto Rico/U.S. Virgin Islands)

Effective for services rendered on or after January 1, 2013, Medicare implemented the use of the *Current Procedural Terminology* (*CPT*®) molecular pathology codes. *CPT*® codes *83890-83914*, which were a component of the stacking method of coding molecular pathology testing, have been deleted for 2013.

The American Medical Association (AMA) in the 2012 and 2013 *CPT*® categorizes molecular pathology codes as either Tier one (*CPT*® codes *81200-81383*) or Tier two (*CPT*® codes *81400-81479*). Molecular diagnostic testing is a rapidly evolving science in which the significance of detecting specific mutations has yet to be clarified.

The focus of this local coverage determination (LCD) is Tier 1 *CPT*® codes (*81370-81383*) for molecular pathology procedures for human leukocyte antigen typing, also known as HLA, which are a group of proteins present on the surface of white blood cells and other nucleated cells. These proteins help the body's immune system to identify its own cells and to distinguish between "self" and "nonself".

(continued on next page)

HLA *(continued)*

This new LCD has been developed to include indications and limitation of coverage, documentation requirements, utilization guidelines, and procedure and diagnosis codes that support medical necessity.

For HLA-B*27 testing for the diagnosis of symptomatic patients with presumed ankylosing spondylitis (ICD-9-CM code 720.0), the contractor will request documentation supporting the medical necessity for the test from the physician in all cases where ankylosing spondylitis is indicated as the reason for the test.

Providers are required to code to specificity however, if *CPT®* code *81479* (*Unlisted molecular pathology procedure*) is used the documentation must clearly identify the unique molecular pathology procedure performed. When multiple procedure codes are submitted on a claim (unique and/or unlisted) the documentation supporting each code should be easily identifiable. If on review the contractor cannot link a billed code to the documentation, these service will be denied based on Title XVIII of the Social Security Act, §1833(e).

Effective date

This new LCD is effective for services rendered **on or after October 7, 2013**. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page.

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

Special EEG tests – new LCD

LCD ID number: L33699 (Florida/Puerto Rico/U.S. Virgin Islands)

This new local coverage determination (LCD) has been developed based on data analysis and claims review which resulted in the identification of aberrancies in Florida for the following *Current Procedural Terminology (CPT®)* codes: *95951* (*Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, combined electroencephalographic (EEG) and video recording and interpretation (e.g., for presurgical localization), each 24 hours*), *95953* (*Monitoring for localization of cerebral seizure focus by computerized portable 16 or more channel EEG, electroencephalographic (EEG) recording and interpretation, each 24 hours, unattended*), and *95957* (*Digital analysis of electroencephalogram (EEG) (e.g., for epileptic spike analysis)*. Data analysis also identified that ambulatory-EEGs were consistently billed by certain providers prior to a resting EEG as required by National Coverage Determination (NCD) 160.22-Ambulatory EEG Monitoring.

Additionally, it was determined that *CPT®* code *95957*-EEG digital spike analysis was consistently billed by certain providers as included in an initial package of care and 1-2 months later, this EEG test was repeated with a different package of care, and generally, a routine EEG was not billed prior to the billing of *CPT®* codes *95951*, *95953*, and *95957*.

This new LCD was developed to address the indications and limitations of coverage and/or medical necessity, procedure and diagnosis codes, documentation requirements, and utilization guidelines for ambulatory EEG tests.

Effective date

This new LCD is effective for services rendered **on or after October 7, 2013**. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page.

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

Transcranial magnetic stimulation (TMS) for major depressive disorder – new LCD

LCD ID number: L33676 (Florida/Puerto Rico/U.S. Virgin Islands)

Transcranial magnetic stimulation (TMS) is a non-invasive, non-systemic treatment modality that uses magnetic resonance imaging (MRI)-strength, pulsed and magnetic fields to induce an electric current in a localized region of the cerebral cortex.

This local coverage determination (LCD) has been developed to provide access to care of TMS as a treatment option for the management of major depressive disorder. Currently, the *Current Procedural Terminology* (*CPT*®) codes that describe TMS (*CPT*® codes *90867, 90868*, and *90869*) listed in this LCD are included in the Noncovered Services LCD, and will be removed upon finalization of this LCD.

This LCD has been developed to include indications and limitations of coverage and/or medical necessity, documentation requirements, utilization guidelines, procedure codes, and ICD-9-CM diagnosis codes that support medical necessity.

Effective date

This new LCD is effective for services rendered **on or after October 7, 2013**. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page.

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

Revisions to LCDs

Arthrocentesis – revision to the LCD

LCD ID number: L29061 (Florida)
LCD ID number: L29079 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for arthrocentesis was most recently revised October 1, 2009. Since that time, the LCD has been revised under the "Indications and Limitations of Coverage and/ or Medical Necessity" section of the LCD to add language indicating that arthrocentesis is a covered service when performed by a non-physician practitioner (NPP) in compliance with state laws, within their scope of practice/training and within the accepted standards of medical practice.

Effective date

This LCD revision is effective for claims processed **on or after August 19, 2013**. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page.

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

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

LCD ID number: L29195 (Florida)
LCD ID number: L29330 (Puerto Rico/U.S. Virgin Islands)

The "Coding Guidelines" attachment of the local coverage determination (LCD) for independent diagnostic testing facility (IDTF) was most recently revised March 19, 2013. An article was previously published in the June 2012 *Medicare B Connection* (Page 63) indicating the "Technician Qualification Requirements" have been revised for *Current Procedural Terminology* (*CPT*®) codes *95860*, *95861*, *95863*, *95864*, *95867*, *95868*, *95869*, *95870*, *95885*, *95886*, and *95887* to read: Must be performed by the qualified interpreting physician. Since that time, the "Credentialing Matrix" in the "Coding Guidelines" attachment has been revised.

Revisions include the following:

- Under the 'Supervising Physician and Interpreting Physician Qualification Requirements' column for *CPT*® codes *95860-95864*, *95867-95870*, *95872*, and *95885-95887*, a punctuation mark was added after Board Certified (ABMS) Neurologist and after "American Board of Neurophysiology" and "qualified electrophysiologic clinical specialist" was changed to "qualified clinical electrophysiology specialist".
- The "Technician Qualification Requirements" for *CPT*® codes *95860-95864*, *95867-95872*, and *95885-95887* were revised as follows: Procedure must be personally performed by a qualified physician who may or may not be the IDTF supervising physician. The qualified performing physician when assisted must provide personal supervision during the performance of electromyography (EMG) test(s) to the IDTF technician providing assistance*. In addition EMG procedures may be personally performed by a physical therapist (PT) with ABPTS certification and certification in this specific procedure.

*The following are considered appropriate credentials to assist a physician performing an EMG:

AAET: R. NCS.T, ABEM: CNCT or State Licensed Physical Therapist with ABPTS certification.

- The "Technician Qualification Requirements" for *CPT*® codes *95933* and *95937* were revised to read as follows: Credentialed by AAET: R. NCS.T, state licensed physical therapist with ABPTS certification or Qualified Physical Therapist or "ABEM: CNCT."

Effective date

This revision to the LCD "Coding Guidelines" attachment is effective for claims processed on or after July 9, 2013, for services rendered on or after May 29, 2012. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page.

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

Noncovered services – revision to the LCD

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

The local coverage determination (LCD) for noncovered services was most recently revised July 1, 2013. Since that time, the LCD has been revised to remove HCPCS codes G0456 (Negative pressure wound therapy, (e.g., vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds (s) surface area less than or equal to 50 square centimeters) and G0457 (Negative pressure wound therapy, (e.g., vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds (s) surface area greater than 50 square centimeters) under the heading "Devices" in the "*CPT*®/HCPCS Codes" section of the LCD.

For all claims submitted with HCPCS codes G0456 or G0457 medical record documentation will be requested and reviewed on an individual consideration basis. Of note, when an item or service is removed from the Noncovered Services LCD, it does not imply a positive coverage statement and coverage by Medicare. Therefore, claims billed for HCPCS codes G0456 and G0457 (assuming all other requirements of the program are met) would always need to meet the medically reasonable and necessary threshold for coverage in a prepayment or post payment audit of the official record.

When there is a question whether Medicare's medical reasonableness and necessity criteria would be met, we recommend the use of an advance beneficiary notice (ABN) and appending modifier GA to the billed HCPCS codes. For further details about the Centers for Medicare & Medicaid Services (CMS') Beneficiary Notices Initiative (BNI), please point your browser to this link: *http://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html*. Please note that services leading up to or associated with non-covered services are also not covered.

Effective date

This LCD revision is effective for services rendered **on or after August 5, 2013**. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page.

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

Vinorelbine tartrate (Navelbine®) – revision to the LCD

LCD ID number: L29306 (Florida)
LCD ID number: L29486 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for vinorelbine tartrate (Navelbine®) was most recently revised June 18, 2013. Since that time, a revision was made under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD to add the off-labeled indication of soft tissue sarcoma (retroperitoneal/intra-abdominal). Also, a revision was made under the "ICD-9 Codes that Support Medical Necessity" section of the LCD to add diagnosis codes 158.0, 171.5, and 171.9 and descriptors.

In addition, the "Sources of Information and Basis for Decision" section of the LCD was updated.

Effective date

This LCD revision is effective for services rendered **on or after August 26, 2013**. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page.

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

Additional Information

Billing and coding procedure code *76942*

Based upon further input, First Coast Service Options Inc. (First Coast), the Medicare administrative contractor (MAC) for jurisdiction 9 (J9) is retracting an article published in the June 2013 *Medicare B Connection* (Page 49) titled "Minimum criteria for reimbursement of diagnostic ultrasound tests."

In the 2014 proposed rule for "Revisions to Payment Policies under the Physician Fee Schedule," the Centers for Medicare & Medicaid Services (CMS) proposes a reduction in the relative value units (RVUs) based on equipment inputs and procedure time assumptions for *Current Procedural Terminology* (*CPT*®) code *76942* (*Ultrasound guidance for needle placement [eg, biopsy, aspiration, injection, localization device], imaging supervision and interpretation*). First Coast's prior guidance and recoding of procedure code *76942* to an unlisted procedure code has been rescinded and claim adjustments will be performed. However, services that were previously denied as not reasonable and necessary for an ultrasound guidance service will remain denied.

Based upon clinical literature and input from practicing physicians in several specialties, MAC J9 maintains that ultrasound guidance may not be reasonable and necessary and is not the established standard of care for all needle placement procedures. Therefore, billing and coding the ultrasound guidance procedure code *76942* with an associated procedure must be clearly supported in the medical record as meeting the reasonable and necessary threshold for coverage for the given beneficiary or it should not be coded and submitted with the claim. On audit, if the documentation does not support that the ultrasound guidance provided clinical value, the claim will be denied.

Providers should also be aware of MAC J9 local coverage determinations (LCDs) which specifically non-cover or limit coverage of ultrasound guidance for specific injection procedures. For example, LCD L29298 (Florida) and LCD L29403 (Puerto Rico and U.S. Virgin Islands) – Treatment of varicose veins of the lower extremity, specifically states under Limitations "Intraoperative ultrasound guidance is not separately reimbursable," and in the Coding Guidelines the LCD states "Procedure code *76942* represents a service that is not covered by Medicare for the purposes of this LCD." Another LCD providers should be aware of is L29307 (Florida)/L29408 (Puerto Rico and U.S. Virgin Islands) – Viscosupplementation therapy for knee. This LCD specifically states under Limitations that "Imaging procedures performed routinely for the purpose of visualization of the knee to provide guidance for needle placement will not be covered. Fluoroscopy may be medically necessary and allowed if documentation supports that the presentation of the patient's affected knee on the day of the procedure makes needle insertion problematic. No other imaging modality for the purpose of needle guidance and placement will be covered."

It is not expected that a non-physician practitioner (NPP) would perform procedures utilizing *76942* as they are not qualified to "interpret" diagnostic ultrasounds. Note that this code includes "imaging supervision and interpretation." An interpretation of the ultrasound guidance must be documented in the patient's medical record in order to separately bill this procedure code.

Of note, diagnostic musculoskeletal ultrasound has unique codes. *CPT*® codes *76881* (*Ultrasound, extremity, nonvascular, real-time with image documentation; complete*) and *76882* (*Ultrasound, extremity, nonvascular, real-time with image documentation; limited, anatomic specific*) describe an ultrasound imaging procedure for the evaluation of muscles, tendons, joints, and/or soft tissue structures generally after a standard radiograph does not determine the diagnosis and other imaging is not indicated (MRI, etc.). Use of these procedures codes with aspiration and/or injection procedures would not be expected unless a separate musculoskeletal diagnostic evaluation is indicated and documented as reasonable and necessary.

Educational Events

Upcoming provider outreach and educational events
September 2013

Join us on 'the SPOT' for Medicare data
When: September 10 & September 12
Time: 11:00 a.m.-12:30 p.m.

Medicare Part B changes and regulations
When: Wednesday, September 18
Time: 11:00 a.m.-1:00 p.m.

Medicare Part B changes and regulations
When: Wednesday, September 18
Time: 11:00 a.m.-1:00 p.m.

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

Two easy ways to register

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

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

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

Please Note:

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

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Provider Address: _____

City, State, ZIP Code: _____

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

Never miss a training opportunity

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

Take advantage of 24-hour access to free online training

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

Additional Resources

CMS MLN Connects™ Provider eNews

The Centers for Medicare & Medicaid Services (CMS) MLN Connects™ Provider eNews (previously "'CMS Medicare FFS Provider e-News") is an official *Medicare Learning Network®* (*MLN*)-branded product that contains a week's worth of news for Medicare fee-for-service (FFS) providers. CMS sends these messages weekly to national health industry provider associations, who then disseminates the eNews to their membership as appropriate. To improve consistency and to streamline operations in messaging to the FFS provider community across all Medicare information channels, CMS conducted a pilot that ended September 30, 2012; however, CMS has extended it until further notice. The following are links to the latest eNews:

- 'MLN Connects™ Provider eNews': July 25, 2013 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-07-25-Enews.pdf*
- ''MLN Connects™ Provider eNews': August 1, 2013 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-08-01-enews.pdf*
- 'MLN Connects™ Provider eNews': August 8, 2013 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-08-08-Enews.pdf*
- 'MLN Connects™ Provider eNews': August 15, 2013 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-08-15-Enews.pdf*

Source: CMS PERL 201307-06, 201307-07, 201308-03, 201308-06

Open Payments training modules for providers

Two continuing medical education activities are available

Continuing medical education (CME) activities are available for physicians to learn more about Open Payments (Physician Payments Sunshine Act). Two such activities are available and accessible via Medscape; both are accredited by the Accreditation Council for Continuing Medical Education:

1. **Are You Ready for the National Physician Payment Transparency Program?**: Physicians can receive a maximum of 1.00 AMA PRA Category 1 Credit™ by participating in the activity and receiving a minimum score of 70 percent on the post-test. Through the activity, participants will learn more about Open Payments, the steps involved in collecting and reporting physician data, key dates for implementation, and actions they can take to verify physician information in advance of website publication. *http://www.medscape.org/viewarticle/780900?src=cmsaca*
2. **The Physician Payment Transparency Program and Your Practice**: Physicians can receive a maximum of 0.25 AMA PRA Category 1 Credit™ by participating in the activity and receiving a minimum score of 70 percent on the post-test. Through this activity, participants will be able to identify opportunities for physicians to review transfers of value attributed to them and differentiate types of transfers of value that will or will not be reported under Open Payments. *http://www.medscape.org/viewarticle/807771*

Accredited by the Accreditation Council for Continuing Medical Education, physicians or health care professionals can earn one credit of continuing medical education for the first module and 0.25 credits for the second module. Medscape accounts are free and users do not have to be health care professionals to register. Registration can be found on the *Medscape* website.

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

Mail directory

Claims submissions

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

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

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

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

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

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

Communication

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

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

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

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

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

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

Durable medical equipment (DME)

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

Electronic media claims (EMC)

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

Additional development

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

Denied request for lack of response: Submit as a new claim, to:
Medicare Part B Claims
P. O. Box 2525
Jacksonville, FL 32231-0019

Miscellaneous

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

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

Provider education

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

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

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

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

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

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

Phone numbers

Providers

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

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

Email address: *AskFloridaB@fcso.com*

FAX: 1-904-361-0696

Beneficiary

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

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

Education event registration (not toll-free):

1-904-791-8103

Electronic data interchange (EDI)

1-888-670-0940

Option 1 -Transaction support

Option 2 - PC-ACE support

Option 4 - Enrollment support

Option 5 - 5010 testing

Option 6 - Automated response line

DME, orthotic or prosthetic claims

CGS Administrators, LLC
1-866-270-4909

Medicare Part A

Toll-Free:
1-888-664-4112

Medicare websites

Provider

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

Centers for Medicare & Medicaid Services
www.cms.gov

Beneficiaries

Centers for Medicare & Medicaid Services
www.medicare.gov

U.S. Virgin Islands Contact Information

Mail directory

Claims, additional development, general correspondence

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

Flu rosters

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

Electronic data interchange (EDI)

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

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

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

Provider enrollment

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

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

and

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

Durable medical equipment (DME)

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

Redeterminations

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

Redetermination overpayment

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

Freedom of Information Act requests (FOIA)

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

Congressional inquiries

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

Provider education

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

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

Medicare claims for railroad retirees

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

Fraud and abuse

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

Local coverage determinations

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

Post pay medical review

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

Overnight mail and/or other special courier services

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

Medicare websites

Provider

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

Centers for Medicare & Medicaid Services

www.cms.gov

Beneficiaries

Centers for Medicare & Medicaid Services
www.medicare.gov

Phone numbers

Provider customer service

1-866-454-9007

Interactive voice response (IVR)

1-877-847-4992

Email address:
AskFloridaB@fcso.com

FAX: 1-904-361-0696

Beneficiary customer service

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

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

Education event registration

1-904-791-8103

Electronic data interchange (EDI)

1-888-670-0940

Option 1 -Transaction support

Option 2 - PC-ACE support

Option 4 - Enrollment support

Option 5 - 5010 testing

Option 6 - Automated response line

DME, orthotic or prosthetic claims

CGS Administrators, LLC
1-866-270-4909

Medicare Part A

Toll-Free:
1-888-664-4112

Addresses

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

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

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

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

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

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

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

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

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

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

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

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

Other Medicare contractors and intermediaries

Durable Medical Equipment Regional Carrier (DMERC)
CGS Administrators, LLC
P. O. Box 20010
Nashville, Tennessee 37202

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

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

Phone numbers

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

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

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

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

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

Electronic Data Interchange
1-888-875-9779

Educational Events Enrollment
1-904-791-8103

Fax number
1-904-361-0407

Website for Medicare

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

Centers for Medicare & Medicaid Services
www.cms.gov

Beneficiary
Centers for Medicare & Medicaid Services
www.medicare.gov

Order form for Medicare Part B materials

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

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

Item	Acct Number	Cost per item	Quantity	Total cost
Part B subscription – The Medicare Part B jurisdiction 9 publications, in both Spanish and English, are available free of charge online at *http://medicare.fcso.com/Publications_B/index.asp* (English) or *http://medicareespanol.fcso.com/Publicaciones/* (Español). Nonprovider entities or providers who need additional copies may purchase an annual subscription. This subscription includes all issues published from October 2013 through September 2014.	40300260	$33		
2013 Fee Schedule – The Medicare Part B Physician and Nonphysician Practitioner Fee Schedules, effective for services rendered January 1 through December 31, 2013, are available free of charge online at *http://medicare.fcso.com/Data_files/* (English) or *http://medicareespanol.fcso.com/Fichero_de_datos/* (Español). Additional copies are available for purchase. The fee schedules contain payment rates for all localities. These items do not include the payment rates for injectable drugs, clinical lab services, mammography screening, or DMEPOS items. **Note:** Revisions to fees may occur; these revisions will be published in future editions of the Medicare Part B publication.	40300270	$12		
Language preference: **English** [ ] **Español** [ ]				
Please write legibly			Subtotal	$
			Tax (***add % for your area***)	$
			Total	$

Mail this form with payment to:

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

Contact Name: _____

Provider/Office Name: _____

Phone: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

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

Medicare B Connection

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

Attention Billing Manager