Medicare A Connection

medicare.fcso.com

FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction N Providers

February 2015

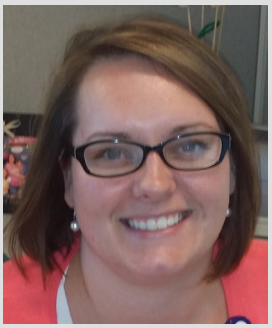
In this issue

Physician group feeling secure with SPOT love

You've got secure mail.

Since the release of the similarly titled 1998 movie starring Meg Ryan and Tom Hanks, technology has evolved dramatically. For the dozen Medicare billers handling claims for physicians at the University of Florida/Shands Hospital, *First Coast Service Options' secure provider portal, SPOT*, is delivering much more love and happiness than the sappy Hollywood story.

> **"SPOT will increase your staff accuracy and productivity. It is also a lot easier to track what you have done with the email confirmations. And, wow, it's free. Why wouldn't you get SPOT."**
>
> — *Kristin Sierens, UF/Shands*



"We have a team of 12 billers. We handle everything Part B and use the SPOT for everything we can. It saves so much time," says Kristin Sierens, Supervisor for the Medicare/Tricare billing team at UF/Shands physician group practice.

The team handles about 11,000 claims each month for more than 120 physicians practicing under the UF/Shands umbrella. In addition to being the team supervisor, Kristin Sierens works claim rejections, follow-ups, and appeals. As the team leader she has seen productivity and efficiency increase greatly with their use of First Coast's SPOT portal.

"With SPOT, we put our information in. BAM, there it is. It's in the system. It's cut down by half the amount of time we were spending on each patient claim. We love SPOT," she said.

In December 2014, First Coast extended SPOT, adding

See **SPOT**, Page 3

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Contents

Try our E/M interactive worksheet

First Coast Service Options (First Coast) Inc. offers its exclusive E/M interactive worksheet, available at *http://medicare.fcso.com/EM/165590.asp* to assist providers with identifying the appropriate code to bill for evaluation and management (E/M) services performed during a specific patient visit.

This interactive resource is ideal for use as a checklist by physicians or as a quality assurance tool by auditors, billing specialists, and coders.

Click here to read how one innovative provider is using the E/M worksheet to improve communication in her office.

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

Publication staff:
Terri Drury
Kathleen Cruz Fuentes
Sofia Lennie
Martin Smith
Mark Willett
Robert Petty

Fax comments about this publication to:

Medicare Publications
904-361-0723

Articles included in the *Medicare A 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.

SPOT

From front page

the option for providers to submit correspondence for claim redeterminations and overpayments through the secure mail tool. For Sierens' team and UF/Shands, this has translated into less time spent going to the post office and tracking correspondence with First Coast.

"I spent 30-45 minutes a day logging appeals in a spreadsheet to track where we were in the process. We handle 20-30 appeals each day. This adds up to a lot of time for me and for my team handling appeals. When SPOT added secure mail to handle appeals too, it was like, wow this is so great. SPOT just keeps getting better."

In addition to saving time, the secure mail tool within SPOT also gives Sierens assurance her time spent isn't wasted.

"Being able to handle the appeals online is great. We started filing electronic appeals right away. Before SPOT offered secure messaging, we would call the customer service line to check on appeals status. Sometimes there was no record of First Coast receiving the paperwork for the appeal," Sierens said. "With secure messaging it is reassuring. We know when we get the email confirmation from SPOT, our appeals have been received by First Coast and they are in the system."

In addition to the secure mail tool, Sierens found love at first sight when First Coast added the ability to reopen claims. "Reopenings has drastically cut down the amount of time we spend on claims. My team was so happy when reopenings came out in SPOT We can go in and change an incorrect diagnosis code and cut the time in half in what it takes for us to handle that claim," Sierens said.

"We might have a charge go out with an incorrect modifier. With reopenings, we can make the correction online. With the IVR, we could do a reopening, but we would have to wait two weeks before we received a new EOB to find out if we keyed in the correct information."

For her peers in medical billing offices throughout Florida, Sierens says if the office doesn't have SPOT they should get it right away. "SPOT will increase your staff accuracy and productivity. It is also a lot easier to track what you have done with the email confirmations. And, wow, it's free. Why wouldn't you get SPOT."

Got a success story using First Coast Web tools?

With its *Tools Center*, First Coast Service Options offers medical providers an abundance of self-service tools to improve their Medicare billing practices.

Provider profiles - *Click here* to read about how providers are making innovative use of Web tools to grow their bottom line.

Success story? - If you have a success story you would like to share with First Coast, let us know by *clicking here*. Check the "Success Story" button on the form and let us know how First Coast's Tools Center is helping to improve your practice.

General Information

New timeframe for response to additional documentation requests

***Note**: This article was revised February 9, 2015, to reflect the revised change request (CR) 8583 issued February 4. In the article, the CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same. This information was previously published on the front page of the January 2015 Medicare A Connection.*

Provider types affected

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

What you need to know

This article is based on CR 8583, which instructs MACs and zone program integrity contractors (ZPICs) to produce pre-payment review additional documentation requests (ADRs) that state that providers and suppliers have 45 days to respond to an ADR issued by a MAC or a ZPIC. Failure to respond within 45 days of a pre-payment review ADR will result in denial of the claim(s) related to the ADR. Make sure your billing staffs are aware of these changes.

Background

In certain circumstances, CMS review contractors (MACs, ZPICs, recovery auditors, the comprehensive error rate testing contractor and the supplemental medical review contractor) may not be able to make a determination on a claim they have chosen for review based upon the information on the claim, its attachments or the billing history found in claims processing system (if applicable) or Medicare's common working file (CWF).

In those instances, the CMS review contractor will solicit documentation from the provider or supplier by issuing an ADR. The requirements for additional documentation are as follows:

- The Social Security Act, Section 1833(e) - Medicare contractors are authorized to collect medical documentation. The Act states that no payment shall be made to any provider or other person for services unless they have furnished such information as may be necessary in order to determine the amounts due to such provider or other person for the period with respect to which the amounts are being paid or for any prior period.
- According to the *Medicare Program Integrity Manual*, Chapter 3, Section 3.2.3.2,(Verifying Potential Errors and Tracking Corrective Actions), when requesting documentation for pre-payment review, the MAC and ZPIC shall notify providers that the requested documentation is to be submitted within 45 calendar days of the request. The reviewer should not grant extensions to the providers who need more time to comply with the request. Reviewers shall deny claims for which the requested documentation was not received by day 46.

Additional information

The official instruction, CR 8583, issued to your MAC regarding this change, is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R567PI.pdf.*

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

MLN Matters® Number: MM8583 *Revised*
Related Change Request (CR) #: CR 8583
Related CR Release Date: February 4, 2015
Effective Date: April 1, 2015
Related CR Transmittal #: R567PI
Implementation Date: April 6, 2015

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.

Extension of provider enrollment moratoria for home health agencies and Part B ambulance suppliers

***Note**: This article was revised January 30, 2015, to reflect an extension of the moratoria for another six months, as noted in the article. This information was previously published in the August 2014 Medicare A Connection, Pages 4-5.*

Provider types affected

This *MLN Matters*® article is intended for home health agencies (HHAs), HHA sub-units, and Part B ambulance suppliers in parts of Florida, Illinois, Michigan, Texas and New Jersey that provide services to Medicare, Medicaid and CHIP beneficiaries.

Provider action needed

Stop – impact to you

Effective January 29, 2015, the temporary moratoria on new HHAs, HHA sub-units, and Part B ambulance suppliers are being extended for an additional six months in certain geographic locations.

Caution – what you need to know

During the six-month temporary moratorium, initial provider enrollment applications and change of information applications to add additional practice locations, received from HHAs, HHA sub-units, and Part B ambulance suppliers in the listed counties will be denied. Application fees that are paid for applications that are denied due to this temporary moratorium will be refunded.

Go – what you need to do

Effective January 29, 2015, HHAs, HHA sub-units, and Part B ambulance suppliers should not submit initial enrollment applications or change of information applications to add additional practice locations until the six-month moratoria has expired. CMS will announce in the *Federal Register* when the moratorium has been lifted or if it will be extended.

Background

In accordance with 42 CFR §424.570(c), the Centers for Medicare & Medicaid Services (CMS) may impose a moratorium on the enrollment of new Medicare providers and suppliers of a specific type or the establishment of new practice locations in a particular geographic area.

On January 29, 2015, CMS announced, in a *Federal Register* notice (*https://s3.amazonaws.com/public-inspection.federalregister.gov/2015-01696.pdf*), the extension of temporary moratoria on the enrollment of new HHAs, HHA sub-units, and Part B ambulance suppliers in designated geographic locations.

The moratoria initially became effective January 30, 2014, and its implementation was announced in the *Federal Register*, which may be accessed at *https://www.federalregister.gov/articles/2014/02/04/2014-02166/medicare-medicaid-and-childrens-health-insurance-programs-announcement-of-new-and-extended-temporary#page-6475*.

Moratoria extension

Effective January 29, 2015, the temporary moratoria on new HHAs, HHA sub-units is being extended for an additional six months in the areas stated in Table 1.

Table 1: HHAs and HHA sub-units under temporary moratorium

City and state	Counties
Fort Lauderdale, FL	Broward
Miami, FL	Miami-Dade Monroe
Detroit, MI	Macomb Monroe Oakland Washtenaw Wayne
Dallas, TX	Collin Dallas Denton Ellis Kaufman Rockwall Tarrant
Houston, TX	Brazoria Chambers Fort Bend Galveston Harris Liberty Montgomery Waller
Chicago, IL	Cook DuPage Kane Lake McHenry Will

See **EXTENSION**, next page

EXTENSION

From previous page

In addition, the temporary moratorium on new Part B ambulance suppliers is being extended for an additional six months in the areas stated in Table 2.

Table 2: Part B ambulance suppliers under six-month temporary moratoria

City and state	Counties
Houston, TX	Harris Brazoria Chambers Fort Bend Galveston Liberty Montgomery Waller
Philadelphia, PA	Bucks (PA) Delaware (PA) Montgomery (PA) Philadelphia (PA) Burlington (NJ) Camden (NJ) Gloucester (NJ)

Initial provider enrollment applications and change of information applications to add additional practice locations received from HHAs, HHA sub-units, and Part B ambulance suppliers in the above listed counties will be denied in accordance with 42 CFR §424.570(c). Application fees that are paid for applications that are denied due to this temporary moratorium will be refunded.

Note: HHAs, HHA sub-units, and Part B ambulance suppliers are afforded appeal rights. However, the scope of review will be limited to whether the temporary moratorium applies to the provider or supplier appealing the denial. CMS' basis for imposing a temporary moratorium is not subject to review.

Additional information

For more information regarding CMS' use of temporary moratoriums, please review *MLN Matters*® article MM7350 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7350.pdf*.

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

MLN Matters® Number: SE1425 *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

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.

Medical record documentation requirements

A fact sheet was developed November 2014 by the *Medicare Learning Network*® (*MLN*), in conjunction with the comprehensive error rate testing (CERT) Part A and Part B (A/B) and durable medical equipment (DME) Medicare administrative contractor (MAC) Outreach & Education task forces, to provide nationally-consistent education on topics of interest to health care professionals. It is designed to help providers understand how to provide accurate and supportive medical record documentation.

This fact sheet discusses the following:

- Third-party additional documentation requests
- Insufficient documentation errors
1. Vertebral augmentation procedures
2. Physical therapy services
3. Evaluation and management services
4. DME
5. Computed tomography scans
6. Resources

First Coast Service Options Inc. (First Coast) encourages providers to review *MLN Matters® fact sheet MLN ICN 909160* to learn more about reducing medical documentation errors.

Continued use of modifier 59 after January 1, 2015

Provider types affected

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

What you need to know

The Centers for Medicare & Medicaid Services (CMS) implemented change request (CR) 8863 on January 5, 2015, effective January 1, 2015. This CR established four new HCPCS modifiers (XE, XP, XS, XU) to define specific subsets of the 59 modifier, a modifier used to define a "distinct procedural service". These modifiers are collectively referred to as –X {EPSU} modifiers. Please note that providers may continue to use the 59 modifier after January 1, 2015, in any instance in which it was correctly used prior to January 1, 2015. The initial CR establishing the modifiers was designed to inform system developers that healthcare systems would need to accommodate the new modifiers.

Additional guidance and education as to the appropriate use of the new –X {EPSU} modifiers will be forthcoming as CMS continues to introduce the modifiers in a gradual and controlled fashion. That guidance will include additional descriptive information about the new modifiers. CMS will identify situations in which a specific –X {EPSU} modifier will be required and will publish specific guidance before implementing edits or audits.

CR 8863 states that providers who wish to use the new modifiers may use them in accordance with their published definitions, and the X modifiers will function within CMS systems in the same manner as the 59 modifier, bypassing procedure-to-procedure (PTP) edits with a modifier indicator of "1," for example. A modifier indicator of "1" indicates that NCCI-associated modifiers may be used to bypass an edit under appropriate circumstances.

Additional information

CR 8863 is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1422OTN.pdf* and a related *MLN Matters*® article is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8863.pdf*.

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

Inquiries about CR 8863 (Specific Modifiers for Distinct Procedural Services) and any *MLN Matters*® article associated with the new X modifiers, should be sent to the following email address: *NCCIPTPMUE@cms.hhs.gov*.

MLN Matters® Number: SE1503
Related Change Request (CR) #: CR 8863
Related CR Release Date: N/A
Effective Date: January 1, 2015
Related CR Transmittal #: N/A
Implementation Date: January 5, 2015

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.

Widespread probe notification for modifier 24

First Coast Service Options Inc. (First Coast) conducted a widespread probe (WSP) in response to an aberrant billing pattern identified for *Current Procedural Terminology* (*CPT*®) codes *99223* (Initial hospital care); *99233* (Subsequent hospital care) and *99291* (Critical care, evaluation and management) in 2012. The results of the WSP probe yielded a 66.95 percent error rate.

First Coast plans to complete an additional WSP of hospital evaluation and management services for dates of service June 1, 2014, to November 30, 2014, to determine the effectiveness of provider outreach and education activities.

The widespread probe will include *CPT*® codes *99223, 99233* and *99291*.

General Coverage

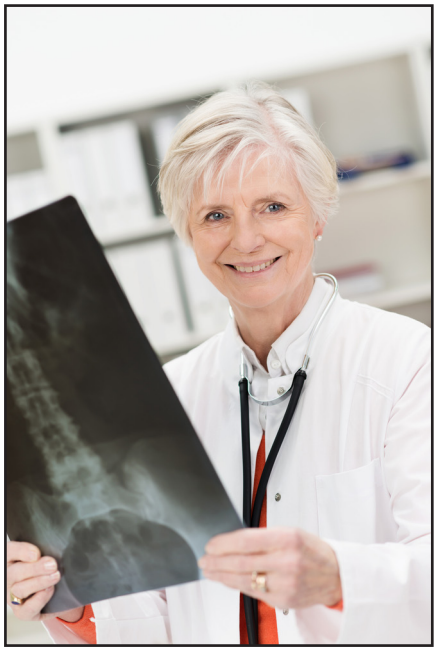
Percutaneous image-guided lumbar decompression

Provider types affected

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

What you need to know

Change request (CR) 8954 is a follow-up to change request (CR) 8757, Transmittal 2959 and Transmittal 167 (Percutaneous Image-guided Lumbar Decompression (PILD) for Lumbar Spinal Stenosis (LSS)). CR 8757 was effective January 9, 2014, and provided for percutaneous image-guided decompression (PILD) when provided in a clinical study through coverage with evidence development (CED) for beneficiaries with LSS.



Background

CR 8954 provides additional direction specifically for PILD, procedure code G0276, when performed in a randomized, blinded clinical trial ONLY, for claims with dates of service on or after January 1, 2015.

Healthcare Common Procedure Coding System (HCPCS) G0276 - Blinded procedure for lumbar stenosis, percutaneous image-guided lumbar decompression (PILD), or placebo control, performed in an approved coverage with evidence development (CED) clinical trial, is to be used only when the CED PILD trial is blinded, randomized, and controlled and contains a placebo procedure control arm. It appears in the January 2015 updates of the Medicare physician fee schedule database and the integrated outpatient code editor (IOCE).

Payment for HCPCS G0276 under the hospital outpatient prospective payment system (OPPS) is available in the latest OPPS Addendum B at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html*.

All PILD for LSS claims with dates of service December 31, 2014, and earlier, should be processed with procedure code *0275T* **only** and are not subject to reprocessing regardless of the type of trial in which the services were rendered.

Note: Beginning with PILD for LSS claims with dates of service on and after January 1, 2015, there are two distinct procedure codes that are to be used: G0276 for clinical trials that are blinded, randomized, and controlled, and contain a placebo procedure control arm (use this CR 8954 for claim processing instructions), and *0275T* for all other clinical trials (use CR 8757 for claim processing instructions).

CR 8954 does not replace but rather is in addition to CR 8757. The *MLN Matters*® article related to CR 8757 is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8757.pdf*.

Billing requirements

Medicare will accept HCPCS code G0276 for PILD for LSS claims received with dates of service on and after January 1, 2015, when those services are provided in a blinded, randomized, controlled trial with a placebo procedure control arm under CED only.

Claims for PILD for LSS with dates of service on and after January 1, 2015, will be accepted when billed in a place of service (POS) 22 (outpatient) or 24 (ambulatory surgical center), using HCPCS G0276, along with:

- ICD-9 diagnosis range 724.01-724.03, or,
- ICD-10 diagnosis range M48.05-M48.07 (when ICD-10 is implemented)

Only when billed with:

- Diagnosis code ICD-9 V70.7 (ICD-10 Z00.6) (once ICD-10 is implemented) either in the primary/secondary positions;
- Modifier -Q0; and
- An eight-digit clinical trial identifier number listed on the CMS CED website.

Medicare will return claims for PILD for LSS claims, HCPCS G0276, as unprocessable when billed with a diagnosis code other than 724.01-724.03 (ICD-9), or, M48.05-M48.07 (ICD-10) (when ICD-10 is implemented) using:

- **Claim adjustment reason code (CARC) B22** – "This

See **IMAGE**, next page

IMAGE

From previous page

payment is adjusted based on the diagnosis."

- **Remittance advice remark code (RARC) N704** – "Alert: You may not appeal this decision but can resubmit this claim/service with corrected information if warranted."
- **Group code** – contractual obligation (CO).

Medicare will return PILD for LSS claims, HCPCS G0276, as unprocessable when billed in a POS other than 22 or 24 using:

- **CARC 58** – "Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service."
- **RARC N704** – "Alert: You may not appeal this decision but can resubmit this claim/service with corrected information if warranted."
- **Group code** – CO.

Medicare will return PILD for LSS claims, HCPCS G0276, as unprocessable if they do not contain the required clinical trial diagnosis code V70.7 (ICD-9) or Z00.6 (ICD-10) (once ICD-10 is implemented) in either the primary/secondary positions with the following:

- **CARC B22** – "This payment is adjusted based on the diagnosis."
- **RARC M76** – "Missing/incomplete/invalid diagnosis or condition"
- **RARC N704** – "Alert: You may not appeal this decision but can resubmit this claim/service with corrected information if warranted."
- **Group code** – CO

Medicare will return PILD for LSS claims, HCPCS G0276, as unprocessable when billed without a -Q0 modifier with the following:

- **CARC 4** – "The procedure code is inconsistent with the modifier used or a required modifier is missing."
- **RARC N657** – "This should be billed with the appropriate code for these services."
- **RARC N704** – "Alert: You may not appeal this decision but can resubmit this claim/service with corrected information if warranted."
- **Group code** – CO

Also, remember that you must submit the numeric, eight-digit clinical trial identifier number in the electronic 837P in Loop 2300 REF02 (REF01=P4) or preceded by "CT" when placed in Field 19 of paper claim form CMS-1500.

This requirement is further discussed in *MLN Matters*® article MM8401 available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8401.pdf*.

For hospital outpatient procedures on type of bill (TOB) 13x or 85x, on or after January 1, 2015, Medicare will allow payment for PILD for LSS, HCPCS G0276, along with:

- ICD-9 diagnosis range 724.01-724.03; or,
- ICD-10 diagnosis range M48.05-M48.07 (once ICD-10 is implemented)

Only when billed with:

- Diagnosis code ICD-9 V70.7 (ICD-10 Z00.6) (once ICD-10 is implemented) and condition code 30 either in the primary/secondary positions;
- Modifier -Q0; and
- An eight-digit clinical trial identifier number listed on the CMS CED website.

For hospital outpatient procedures on TOB 13x or 85x, on or after January 1, 2015, MACs will line-level deny claims for PILD for LSS, HCPCS G0276, along with:

- ICD-9 diagnosis range 724.01-724.03; or,
- ICD-10 diagnosis range M48.05-M48.07 (once ICD-10 is implemented);

When billed without diagnosis code ICD-9 V70.7 (ICD-10 Z00.6) (once ICD-10 is implemented) and condition code 30 either in the primary/secondary positions, Modifier -Q0, or an eight-digit clinical trial identifier number listed on the CMS CED website, with the following:

- **CARC: 50** – These are non-covered services because this is not deemed a "medical necessity" by the payer.
- **RARC N386** – This decision was based on a National Coverage Determination (NCD). An NCD provides a

See **IMAGE**, next page

Payment for HCPCS code Q0091 as an RHC or FQHC billable visit under the AIR system

The Centers for Medicare & Medicare Services (CMS) determined that a screening Papanicolaou smear, Healthcare Common Procedure Coding System (HCPCS) code Q0091, is a billable visit when furnished by a rural health clinic (RHC) or federally qualified health center (FQHC) practitioner to a RHC or FQHC patient. If other billable visits are furnished on the same day as HCPCS code Q0091, only one visit shall be paid.

To avoid payment delays, RHCs and FQHCS that bill under the all-inclusive rate (AIR) system should follow the guidance in the Preventive Services Chart on the RHC (*http://go.cms.gov/1pow3WT)* or FQHC (*http://go.cms.gov/1k5EWW3*) center pages on the CMS website. Submit adjustments for any claims with Q0091, rejected on or after January 1, 2014, to your Medicare administrative contractor (MAC), using this billing guidance.

For RHCs and FQHCs billing under the AIR system that do not follow this billing guidance, your MAC will hold any claim submitted with Q0091 as a stand-alone service until the system change is implemented April 6, 2015.

Background fingerprints – check status online

The fingerprint-based background requirement was implemented August 6, 2014; details released in *special edition article SE1427*.

Accurate Biometrics is the Centers for Medicare & Medicaid Services (CMS) contractor responsible for processing fingerprints for CMS.

Providers can find all of the information necessary to complete the provider fingerprinting requirement, which now includes the ability to authenticate and check the status of fingerprint submission online.

If at any time during this process you have a question, please call 1-866-361-9944 for assistance.

IMAGE

From previous page

coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *http://www.cms.hhs.gov/mcd/search.asp*. If you do not have web access, you may contact the contractor to request a copy of the NCD.

- **Group code** – CO

Additional information

You can review the list of approved clinical studies related to PILD for LSS at *http://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/PILD.html*.

The official instruction, CR 8954 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3175CP.pdf*.

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

MLN Matters® Number: MM8954
Related Change Request (CR) #: CR 8954
Related CR Release Date: January 30, 2015
Effective Date: January 1, 2015
Related CR Transmittal #: R3175CP
Implementation Date: March 2, for local system edits; July 6, 2015, for Medicare shared system edits

Local Coverage Determinations

This section of *Medicare A 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 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.

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

Advance beneficiary notice

- **Modifier GZ** must be used when providers, 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 providers, 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 (LCD) must append the billed service with **modifier GA or GZ.**

First Coast Service Options Inc provides current and draft local coverage determinations (LCDs), when they exist, for Medicare-covered procedure codes.

Not every procedure code is covered by an LCD. *Click here* **to look up current LCDs**

Bortezomib (Velcade®) – revision to the Part A LCD

LCD ID number: L28787 (Florida)
LCD ID number: L28789 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for Bortezomib (Velcade®) was most recently revised April 10, 2014.

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 indications of Waldenström's Macroglobulinemia/Lymphoplasmacytic Lymphoma, Non-Hodgkin's lymphoma (NHL) - Adult T-Cell Leukemia/Lymphoma, NHL - Peripheral T-Cell Lymphoma, and NHL - Primary Cutaneous CD30+ T-Cell Lymphoproliferative Disorders.

Also, under the "ICD-9 Codes that Support Medical Necessity" section of the LCD, diagnosis codes 200.60-200.68, 200.80-200.88, 204.80, 204.82, 273.3, and V10.79 and descriptors were added. In addition, the "Sources of Information and Basis for Decision" section of the LCD was updated.

Effective date

This LCD revision is effective for **services rendered on or after February 11, 2015**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Implantable miniature telescope – revision to Part A LCD

LCD ID number: L32824 (Florida, Puerto Rico, U.S. Virgin Islands)

The local coverage determination (LCD) for implantable miniature telescope (IMT) was revised to decrease the age of eligibility from 75 and older to 65 and older based on the Food and Drug Administration's (FDA's) approval (PMA P050034 S013).

The "Indications and Limitations of Coverage and /or Medical Necessity" section of the LCD was revised to change the age of eligibility. In addition, the "Sources of Information and Basis of Decision" section of the LCD was updated.

Effective date

The LCD revision is effective for **claims processed on or after February 24, 2015**, for **services rendered on or after October 8, 2014**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Update on Injectafer® claims that may have been denied

Claims submitted for HCPCS code J1439 (Injection, ferric carboxymaltose) between January 1, 2015, and February 6, 2015, may have been denied incorrectly with the following denial message: "Service is not medically necessary based on Medicare guidelines."

This error was corrected on February 6, 2015.

Claims processed on or after February 7, 2015, were adjudicated correctly.

No action required by providers.

Providers whose claims were incorrectly denied due to this error do not need to take any action.

First Coast Service Options Inc. will perform adjustments to correct the error on all the affected claims.

Take the time to 'chat' with the website team

You now have the opportunity to save your valuable time by asking your website-related questions online – with First Coast's Live Chat service.

Live chat is available Monday-Friday, from 10 a.m.-2 p.m. ET.

Noncovered services – revision to the Part A LCD

LCD ID number: L28991 (Florida)
LCD ID number: L29023 (Puerto Rico/U.S. Virgin Islands)

The Medical Policy & Procedures Department evaluated the following services and determined that they are not considered medically reasonable and necessary at this time based on current available published evidence (e.g., peer-reviewed medical literature, and published studies).

Therefore, the following procedure codes have been added to the Noncovered Services local coverage determination (LCD). After a draft LCD becomes effective/active, any stakeholder may request a revision to the LCD, by following the reconsideration process as outlined on our website.

C2624 – Implantable wireless pulmonary artery pressure sensor with delivery catheter, including all system components

C9741 - Right heart catheterization with implantation of wireless pressure sensor in the pulmonary artery, including any type of measurement, angiography, imaging supervision, interpretation, and report

0008M - Oncology (breast), mRNA analysis of 58 genes using hybrid capture, on formalin-fixed paraffin-embedded (FFPE) tissue, prognostic algorithm reported as a risk score.

0347T- Placement of interstitial device(s) in bone for radiostereometric analysis (RSA)

0348T – 0350T- Radiologic examination, radiostereometric analysis (RSA)

0351T - 0352T- Optical coherence tomography of breast or axillary lymph node, excised tissue, each specimen

0353T – 0354T - Optical coherence tomography of breast, surgical cavity

0355T- Gastrointestinal tract imaging, intraluminal (eg,capsule endoscopy), colon, with interpretation and report

0356T- Insertion of drug-eluting implant (including punctual dilation and implant removal when performed) into lacrimal canaliculus, each

0358T- Bioelectrical impedance analysis whole body composition assessment, supine position, with interpretation and report

0359T-Behavior identification assessment, by the physician or other qualified health care professional, face-to-face with patient and caregiver(s), includes administration of standardized and non-standardized tests, detailed behavioral history, patient observation and caregiver interview, interpretation of test results, discussion of findings and recommendations with the primary guardian(s)/caregiver(s), and preparation of report

0360T - Observational behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by one technician; first 30 minutes of technician time, face-to-face with the patient

0361T - Observational behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by one technician; each additional 30 minutes of technician time, face-to-face with the patient (List separately in addition to code for primary service)

0362T - Exposure behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by physician or other qualified health care professional with the assistance of one or more technicians; first 30 minutes of technician(s) time, face-to-face with the patient

0363T - Exposure behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by physician or other qualified health care professional with the assistance of one or more technicians; each additional 30 minutes of technician(s) time, face-to-face with the patient (List separately in addition to code for primary procedure)

0364T - 0365T- Adaptive behavior treatment by protocol, administered by technician, face-to-face with one patient

0366T – 0367T - Group adaptive behavior treatment by protocol, administered by technician, face-to-face with two or more patients

0368T – 0369T - Adaptive behavior treatment with protocol modification administered by physician or other qualified health care professional with one patient

0370T - Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present)

0371T - Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present)

0372T - Adaptive behavior treatment social skills group, administered by physician or other qualified health care professional face-to-face with multiple patients

0373T – 0374T - Exposure adaptive behavior treatment with protocol modification requiring two or more technicians for severe maladaptive behavior(s)

In determining if a service or procedure reaches the threshold for coverage, this contractor addresses the quality of the evidence per the *Program Integrity*

See **NONCOVERED**, next page

Adjustment of gastric band outside the 90-day global period of laparoscopic gastric band placement

This article was developed to address recent inquires related to the adjustment of gastric lap band outside of the 90-day global period.

Laparoscopic placement of an adjustable gastric band (LAGB) (*CPT*® code *43770*) is a covered procedure for surgical treatment of morbid obesity, when appropriate, based on the criteria outlined in the Medicare National Coverage Determination (NCD) for Bariatric Surgery for Treatment of Morbid Obesity (NCD 100.1) and local coverage determination (LCD) for Surgical Management of Morbid Obesity (L33019).

Adjustment of the gastric band after LAGB consists of an injection or withdrawal of saline. Adjustments to the LAGB should not be billed during the 90-day global period of the laparoscopic placement of an adjustable gastric band, as it is included in the primary procedure and is not separately payable during the global period.

Currently, adjustment of a LAGB does not have a unique *CPT*® code. After the 90-day global period, it should be billed using *CPT*® code *43659* (Unlisted laparoscopy procedure, stomach) with the statement "adjustment of gastric band" in Item 19 of the CMS-1500 or its electronic equivalent. An evaluation and management (E&M) code and adjustment of LAGB will only be allowed on the same date of service if a significant separately identifiable and medically necessary service is provided. Modifier 25 should be appended to the E&M code only if it does not apply to the evaluation and adjustment of the LAGB.

NONCOVERED

From previous page

Manual. When addressing the articles and related information in the public domain, the jurisdiction N (JN) Medicare administrative contractor (MAC) reached the determination that available evidence was of moderate to low quality, consisting of small case series, retrospective studies, and review articles reporting limited safety and efficacy data for these procedures. Due to the unavailability of high quality evidence, the JN MAC reiterates that there is insufficient scientific evidence to support these procedures, and therefore they are not considered reasonable and necessary under section 1862(a)(1)(a) of the Social Security Act.

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

An interested stakeholder can request a reconsideration of an LCD after the notice period has ended and the draft becomes active. In the case of the noncovered services LCD, the stakeholder may request the list of the articles and related information in the public domain that were considered by the Medical Policy department in making the noncoverage decision. If the stakeholder has new information based on the evaluation of the list of articles and related information, an LCD reconsideration can be initiated.

It is the responsibility of the interested stakeholder to request the evidentiary list from the contractor and to submit the additional articles, data, and related information in support of their request for coverage. The request must meet the LCD reconsideration requirements outlined on the web site.

Also, any interested party could request the Centers for Medicare & Medicaid Services (CMS) to consider developing a national coverage determination (NCD). Of note, if the evidence is not adequate for coverage under section 1862(a)(1)(A), an item or service may be considered for coverage under the CMS Coverage with Evidence Development (CED) policy in which "reasonable and necessary" is established under 1862(a)(1)(E) of the Act.

Under the authority of section 1862(a)(1)(E), the NCD process may result in coverage if the item or service is covered only when provided within a setting in which there is a pre-specified process for gathering additional data, and in which that process provides additional protections and safety measures for beneficiaries, such as those present in certain clinical trials.

Effective date

The LCD revision is effective for **services rendered on or after February 7, 2015**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Parenteral iron supplementation for patients receiving ESA therapy – Part A LCD retired

LCD ID number: L28840 (Florida)
LCD ID number: L28873 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for parenteral iron supplementation for patients receiving erythropoiesis stimulating agents (ESA) therapy for anemia of chronic kidney disease or iron deficiency anemia is retired effective February 24, 2015. The LCD is outdated given the varying approved indications for the drugs in the class. Please refer to LCD L32094 (label and off-label coverage of outpatient drugs and biologicals) for guidance on drug coverage.

Based on national coverage determination (NCD) 110.10 (intravenous iron therapy), the following dual diagnosis requirement must be met when sodium ferric gluconate complex or iron sucrose injections are administered intravenously to patients undergoing chronic hemodialysis who are receiving supplemental erythropoietin therapy:

One of the following chronic kidney disease, ICD-9-CM diagnosis codes 585.4, 585.5, or 585.6 and one of the secondary ICD-9-CM diagnosis codes for iron deficiency anemia 280.0, 280.1, 280.8 or 280.9).

Generally, off label use (non Food and Drug Administration (FDA) approved indication) is not a covered service for drugs used in a non- cancer episode of care. For the FDA approved use in patients with iron deficiency anemia who have intolerance to oral iron or have had unsatisfactory response to oral iron, the medical record documentation must support the need for the IV drug by addressing the specific issues with intolerance to oral iron and the details of previous oral iron use leading up to the decision that there is unsatisfactory response to oral iron.

Use of these drugs in the outpatient hospital setting or incident to in the physician's office may be subject to pre or post payment medical review.

Should the contractor request documentation to support the billing of these drugs, providers should submit a relevant history and physical, physician progress notes, any results of pertinent diagnostic tests or procedures, a physician's order, the name of the drug, the route of administration, the dosage (e.g., mgs, mcgs, ccs or IUs), the duration of administration and any wastage of the drug.

Effective date

This LCD retirement is effective for services rendered on or after February 24, 2015. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Get ready for ICD-10

On October 1, 2015, the health care industry will transition from ICD-9 to ICD-10 codes for diagnoses and inpatient procedures.

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

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

Online ICD-10 guide

ICD-10 basics for large medical practices

Electronic Data Interchange

Medicare shared systems modifications necessary to capture various HIPAA compliant fields

***Note**: This article was revised January 15, 2015, to reflect a revised change request (CR) January 14, 2015. That CR removed bill types 81x and 82x from Business Requirement 8384.2.4 (ZIP code mapping). The transmittal number, CR date, and the link to the CR also changed. All other information remains the same. This article was previously published in the November 2014 edition of Medicare A Connection, Page 17.*

Provider types affected

This *MLN Matters*® article is intended for hospitals, other providers, and suppliers submitting institutional claims to Medicare administrative contractors (MACs) for services paid under the Medicare physician fee schedule (MPFS).

Provider action needed

This article is based on CR 8384 which informs MACs that the Centers for Medicare & Medicaid Services (CMS) needs to expand institutional claim processing fields and to update items on the version 5010 837I flat files. Specifically, CMS is:

- Updating the direct data entry (DDE) screens to allow entry of three patient reason for visit codes;
- Updating the DDE screens to allow entry of a nine-digit ZIP code for the service facility; and
- Editing to ensure that when a patient reason for visit code is received that the 5010 requirements for claims are enforced (that is to say that the services billed involve unscheduled outpatient visits type of bill (TOB) 013x or 085x together with priority of visit/type of admission codes 1,2 or 5 and revenue codes 045x, 0516, or 0762). Claims failing this edit will return to the provider (RTP).

Medicare outpatient service providers report the nine-digit ZIP code of the service facility location in the 2310E loop of the 837 institutional claim transaction. direct data entry submitters also are required to report the nine-digit ZIP code of the service facility location for off-site or multiple satellite office outpatient facilities. DDE submitters should key the 9 digit service facility's ZIP code in the "FAC.ZIP" field found on MAP 1711. Paper submitters shall report this information in form locator (FL) 01 on the paper claim form.

Medicare systems use this service facility ZIP code to determine the applicable payment locality whenever it is present. Make sure that your billing staffs are aware of these changes.

Background

Services that are paid subject to the MPFS are adjusted based on the applicable payment locality. Medicare

systems determine which locality applies using ZIP codes. In cases where the provider has only one service location, the payment locality used to calculate the fee amount is determined using the ZIP code of the master address contained in the Medicare contractors' provider file.

Increasingly, hospitals operate off-site outpatient facilities and other institutional outpatient service providers operate multiple satellite offices. In some cases, these additional locations are in a different payment locality than the parent provider. In order for MPFS payments to be accurate, the nine-digit ZIP code of the satellite facility is used to determine the locality in these cases.

Additional information

The official instruction, CR 8384 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3164CP.pdf.*

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

MLN Matters® Number: MM8384
Related Change Request (CR) #: CR 8384
Related CR Release Date: January 14, 2015
Effective Date: April 1, 2015
Related CR Transmittal #: R3164CP
Implementation Date: April 6, 2015

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.

ICD-10 limited end-to-end testing with submitters for 2015

Provider types affected

This *MLN Matters*® article is intended for providers and clearinghouses wishing to submit test claims with International Classification of Diseases, Tenth Revision (ICD-10) codes to Medicare administrative contractors (MACs).

What you need to know

Change request (CR) 8867 directs MACs to test with a limited number of providers and clearinghouses to ensure claims with ICD-10 codes can be processed from submission to remittance. This additional testing effort will help ensure a successful transition to International Classification of Disease, Tenth Revision, (ICD-10).

The Centers for Medicare & Medicaid Services (CMS) defines successful end-to-end testing as being able to demonstrate that:

- Testing entities are able to successfully submit ICD-10 claims to the shared systems,
- Software changes made to support ICD-10 result in appropriately adjudicated claims based on the pricing data employed for testing purposes; and
- Remittance advices are produced.

Make sure your billing staffs are aware of this update.

Background

The ICD-10 must be implemented by October 1, 2015. While system changes to implement this project have been completed and tested in previous releases, the industry has requested the opportunity to test with CMS.

CR 8867 will allow a small subset of submitters to test with MACs and the common electronic data interchanges (CEDIs) in three testing periods to demonstrate to the industry that CMS systems are ready for the ICD-10 implementation. MACs and CEDI shall conduct three limited End-to-End testing weeks with a small subset of submitters.

To facilitate this testing, CR 8867 requires MACs to do the following:

- Conduct limited end-to-end testing with submitters in three testing periods; January 2015, April 2015 and July 2015. Test claims will be submitted January 26-30, 2015, April 27-May 1, 2015, and July 20-24, 2015.
- Each MAC (and CEDI with assistance from DME MACs) will select 50 submitters for each MAC jurisdiction supported to participate in the end-to-end testing. The Railroad Retirement Board (RRB) contractor will also select 50 submitters. Testers will be selected randomly from a list of volunteers. At least five, but not more than fifteen of the testers will be a clearinghouse, and submitters should be a mix of provider types.
- MACs and CEDIs will post a volunteer form to their website to collect volunteer information with which to select volunteers.
    - Form verifies testers are ready to test, meet the requirements to test, and collect data about the tester. (How they submit claims, what types of claims they will submit, and so forth.)
    - MACs and CEDIs will post the form to its website by March 13, 2015, for the July 2015 testing.
    - Volunteers must submit completed forms to the MACs and CEDIs by April 17, 2015, for the July 2015 testing.
- By May 8, 2015, for the July 2015 testing, the MACs and CEDIs (for the DME MACs) will notify the volunteers that they have been selected to test and provide them with the information needed for the testing, such as:
    - How to submit test claims (for example, what test indicators should be set);
    - What dates of service may be used for testing;
    - How many claims may be submitted for testing (Test claims volume is limited to a total of 50 claims for the entire testing week, submitted in no more than three files);
    - Request for national provider identifiers (NPIs) and health insurance claim numbers (HICNs) that will be used in testing (no more than five NPIs and 10 HICNs per submitter);
    - Notice that if more than 50 claims are submitted, they may not be processed;
    - Notice that claims submitted with NPIs or HICNs not previously submitted for testing, likely will not be completed; and
    - Notice of potential protected health information (PHI) on test remittances not submitted (and instructions to report PHI found to the MAC).
- MACs and CEDIs (for the DME MACs) will collect information from the testers after they have been notified of their selection, using a form provided by CMS. This form will specifically request the HICNs, provider transaction access number (PTANs), and NPIs the tester will use during testing. Testers shall submit these forms back to the MAC/CEDI by

See **ICD-10**, next page

ICD-10

From previous page

February 20, 2015, for the April 2015 testing, and by May 29, 2015, for the July 2015 testing. Notification will warn testers that if forms are not received timely, they may lose their opportunity to test.

- Testers selected in the January 2015 testing may participate in the April 2015 testing, and may submit an additional 50 test claims using the same HICNs and NPIs provided previously. MACs shall send a reminder to the January 2015 testers of this option 30 days prior to the start of the April 2015 testing, using language provided by CMS.
- Testers selected in the January 2015 and April 2015 Testing may participate in the July 2015 testing, and may submit an additional 50 test claims using the same HICNs and NPIs provided previously. MACs shall send a reminder to the January 2015 and April 2015 testers of this option 30 days prior to the start of the July 2015 testing, using language provided by CMS.
- MACs and CEDI will work with the testers selected to ensure they are prepared to test, and understand the requirements for testing.
- MACs and CEDI will instruct the testers to submit up to a total of 50 test claims during the testing period. This may be submitted in one to three files, but the total number of test claims cannot exceed 50.
- CEDI will instruct suppliers to submit claims with ICD-10 code with dates of service October 1, 2015, through October 15, 2015. They may also submit claims with ICD-9 codes with dates of service before October 1, 2015.
    - MACs will instruct testers to submit test claims with ICD-10 code with dates of service on or after October 1, 2015. They may also submit test claims with ICD-9 codes with dates of service before October 1, 2015.
    - MACs and CEDIs will be prepared to support increased call volume from testers during the testing window, and up to 2 weeks following the receipt of the ERAs from testing.
    - MACs and CEDIs will provide information to the testers on who to contact for testing questions. This may be separate contacts for front end questions and remittance questions.
    - MACs and CEDIs will post an announcement about the testing to its websites. The announcement will be provided by CMS.

Additional information

The official instruction, CR 8867, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1451OTN.pdf*.

You may also want to review *MLN Matters*® article SE1409, which discusses ICD-10 testing. That article is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1409.pdf*.

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

MLN Matters® Number: MM8867
Related Change Request (CR) #: CR 8867
Related CR Release Date: January 20, 2015
Related CR Transmittal #: R1451OTN
Effective dates: September 12, 2014 - for MACs and CEDI (non-systems change requirements)

(**Note**: This is the due date of the first MAC and CEDI requirement); January 26, 2015, for FISS and CEDI coding for January testing week; April 27, 2015, for FISS and CEDI coding for April testing week; July 20, 2015, for FISS and CEDI coding for July testing week.

Implementation dates: January 5, 2015, for FISS and CEDI coding for January testing week; February 16, 2015, for MAC requirements for the January 15 testing. This is the due date of the last MAC deliverable. April 6, 2015, for FISS and CEDI coding for April testing week; May 18, 2015, for MAC requirements for the April 15 testing. This is the due date of the last MAC deliverable.; July 6, 2015, for FISS and CEDI coding for July testing week; August 10, 2015, for MAC requirements for the July 15 testing. This is the due date of the last MAC deliverable.

New condition code for device placement in clinical trials

Provider types affected

This *MLN Matters*® article is for hospitals submitting outpatient claims to Medicare administrative contractors (MAC) for services provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 8961 implements condition code "53" (Initial placement of a medical device provided as part of a clinical trial or a free sample) for reporting on the outpatient hospital claim. Make sure your billing staffs are aware of the new condition code of 53.

Background

Current system edits require a condition code to be billed for outpatient claims when the provider bills value code "FD" (Credit Received from the Manufacturer for a Replaced Medical Device), indicating that they have received a credit on the device.

A new Medicare outpatient payment policy was implemented on January 1, 2014, requiring reporting of value code FD for medical devices furnished without cost to the hospital or when the hospital receives a full or partial credit for the device. (See the *Federal Register* December 10, 2013, pages 75005-75008, IV. OPPS Payment for Devices, B. Adjustment to OPPS Payment for No Cost/Full Credit and Partial Credit Devices at *https://www.federalregister.gov/articles/2013/12/10/2013-28737/medicare-and-medicaid-programshospital-outpatient-prospective-payment-and-ambulatory-surgical.)*

Under this policy, outpatient hospitals are required to report the amount of the credit in the amount portion for value code "FD" (Credit Received from the Manufacturer for a Medical Device) when the hospital receives a credit for a device listed in Table 31 of *Federal Register* December 10, 2013 that is 50 percent or greater than the cost of the device.

Currently, hospitals must use either condition code 49 (Product Replacement within Product Lifecycle) or 50 (Product Replacement for Known Recall of a Product) along with value code FD. These two condition codes describe only replacement devices. They do not describe a reduced cost for initially implanted (non-replacement) devices, which are commonly supplied to Medicare beneficiaries, especially in the context of medical device clinical trials. Therefore, a new condition code is needed to describe initially implanted medical devices that are not replacement devices.

Effective January 1, 2014 (and for claims received on or after July 1, 2015), an additional new condition code "53" was created for institutional provider use. This new code is used to identify and track medical devices that are provided by a manufacturer at no cost or with full credit to the hospital due a clinical trial or a free sample.

Please note that you are no longer required to append the "FB" or "FC" modifier when receiving a device at no cost or with a full or partial credit. Additionally, the Centers for Medicare & Medicaid Services (CMS) limits the outpatient prospective payment system (OPPS) payment deduction for device-intensive average production costs (APCs) to the total amount of the device offset when the "FD" value code appears on a claim.

When a hospital furnishes a device for which it incurs no cost, (these cases include, but are not limited to, devices replaced under warranty, due to recall, or due to defect in a previous device; devices provided in a clinical trial; or devices provided as a sample) the hospital charge for a device furnished to the hospital at no cost should equal $0.00. However, some hospital billing systems require a charge be reported for separately billable codes in order for the claim to be submitted for payment, even items for which the hospital incurs no cost.

Hospitals paid under the OPPS that implant a device furnished at no cost to the hospital shall report a charge of zero for the device, or, if the hospital's billing system requires that a charge be entered, the hospital shall submit a token charge (e.g. $1.00) on the line with the device code. CMS recognizes that showing a charge for a device that has been furnished without cost is not optimal, but showing a token charge in this circumstance will allow claims for reasonable and necessary services to be adjudicated.

Additional information

The official instruction, CR 8961 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3181CP.pdf.*

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

MLN Matters® Number: MM8961
Related Change Request (CR) #: CR 8961
Related CR Release Date: January 30, 2015
Effective Date: For claims received on or after July 1, 2015
Related CR Transmittal #: R3181CP
Implementation Date: July 6, 2015

Validation of payment group codes for prospective payment systems based on patient assessments

Provider types affected

This *MLN Matters*® article is intended for skilled nursing facilities (SNFs), home health agencies (HHAs) and inpatient rehabilitation facilities (IRFs) submitting claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

What you need to know

Change request (CR) 9016 informs MACs about the changes needed to implement the fiscal intermediary standard system (FISS) changes required to refine the interface between FISS and the quality improvement and evaluation service. These changes include new fields to house an assessment identification number (AIN) for each health insurance prospective payment system (HIPPS) revenue code line on submitted claims. Make sure your billing staffs are aware of these changes.

Background

The PPS case-mix groups used to determine payments under Home Health (HH) PPS, SNF PPS, and the IRF PPS are based on clinical assessments of the beneficiary.

In all three payment systems, the assessments are entered into software at the provider site that encodes the data from the individual assessments into a standard transmission format and transmits the assessments to the state survey agency or a national repository.

In addition, the software runs the data from the individual assessments through grouping software that generates a case-mix group to be used on Medicare PPS claims via a health insurance PPS (HIPPS) code. Although the Centers for Medicare & Medicaid Services (CMS) provides grouping software, many providers create their own software due to their need to integrate these data entry and grouping functions with their own administrative systems.

Currently, the transmission of assessment data and transmission of HIPPS codes on claims to MACs are entirely separate processes. The FISS has limited matching access to the assessment databases. Based on current business needs in order to more accurately match assessments, this process needs further refinement. Providers sending the AIN will provide more accurate matching.

Providers may report the AIN for each HIPPS revenue code line in various manners based on the type of claim submission that individual providers use. When providers choose to submit assessment identification using the 837I claims submission, they are to report the AIN for each HIPPS revenue code line as follows:

NTE*UPI*123456789012345~

The AIN submitted in the NTE02 segment must be right-justified and zero-filled. Repeat this segment for each HIPPS Revenue code Line (that is, a SNF claim with multiple revenue code lines [0022] with a HIPPS code that has a different assessment indicator (positions 4 and 5 of the HIPPS code) as necessary, as follow:.

NTE*UPI*123456789012345~NTE*UPI*123456789012345~NTE*UPI*12345678

9012345~NTE*UPI*123456789012345~

If there is more than one AIN for each HIPPS revenue code line (that is, IRF revenue code line [0024] Inactivation/Modification), when providers choose to submit, they must report multiple assessments up to two (2) per each HIPPS Revenue code line in the 837I claim submission as follows:

NTE*UPI*12345678901234522345678901234 5~

In this example, the first AIN will represent the most current original/modified assessment and the second AIN (which is in italics beginning with “223” represents a prior original inactivation/modified assessment.

For direct data entry (DDE) claims, providers using DDE should enter the AIN into these newly created fields on the DDE screens. Providers submitting paper claims should use form locator 43 to provide this information.

Additional information

The official instruction, CR 9016 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1459OTN.pdf.*

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

MLN Matters® Number: MM9016
Related Change Request (CR) #: CR 9016
Related CR Release Date: January 30, 2015
Effective Date: July 1, 2015
Related CR Transmittal #: R1459OTN
Implementation Date: July 6, 2015

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.

Reimbursement

Physician fee policies and telehealth originating site fees

Note: This article was revised January 18, 2015, to provide a link to a related *MLN Matters*® article MM9081 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9081.pdf*. This article announced an emergency update to payment files issued to contractors based on the 2015 MPFS final rule. The update amends those payment files, including an updated conversion factor of $35.7547 for services furnished between January 1, 2015, and March 31, 2015, consistent with the Protecting Access to Medicare Act of 2014 that provides for a zero percent update from 2014 rates. All other information is unchanged. This article was previously published in the *January 2015 Medicare A Connection, Pages 29-31*.

Provider types affected

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

Provider action needed

This article is based on change request (CR) 9034 which provides a summary of the policies in the 2015 MPFS final rule and announces the telehealth originating site facility fee payment amount. Make sure that your billing staff are aware of these updates for 2015.

Background

The Social Security Act (Section 1848(b)(1); (see *http://www.ssa.gov/OP_Home/ssact/title18/1848.htm*) requires the Centers for Medicare & Medicaid Services (CMS) to establish a fee schedule of payment amounts for physicians' services for the subsequent year. CMS issued a final rule with comment period October 13, 2014 (see *https://www.federalregister.gov/articles/2014/11/13*), that updates payment policies and Medicare payment rates for services furnished by physicians and non-physician practitioners (NPPs) that are paid under the MPFS in 2015.

The final rule also addresses public comments on Medicare payment policies that were described in the proposed rule earlier this year: "Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare & Medicaid Innovation Models & Other Revisions to Part B for CY 2015; Proposed Rule" was published in the *Federal Register* July 11, 2014. (See *http://www.gpo.gov/fdsys/pkg/FR-2014-07-11/pdf/2014-15948.pdf*).

The final rule also addresses interim final values established in the 2014 MPFS final rule with comment period. (See *http://www.gpo.gov/fdsys/pkg/FR-2013-12-10/pdf/2013-28737.pdf*). The final rule assigns interim final values for new, revised, and potentially misvalued codes for 2015 and requests comments on these values. CMS will accept comments on those items open to comment in the final rule with comment period until December 30, 2014.

Sustainable growth rate (SGR)

The Protecting Access to Medicare Act of 2014 (see *http://www.gpo.gov/fdsys/pkg/BILLS-113hr4302enr/pdf/BILLS-113hr4302enr.pdf*) provides for a zero percent update from the 2014 rates for services furnished between January 1, 2015, and March 31, 2015. Adjusting by .06 percent to achieve required budget neutrality, the conversion factor for this period is $35.8013.

Under current law, the conversion factor will be adjusted April 1, 2015. In the final rule CMS announced a conversion factor of $28.2239 for this period, resulting in an average reduction of 21.2 percent from the 2014 rates. In most prior years, Congress has taken action to avert large across-the-board reductions in PFS rates before they went into effect. The Administration supports legislation to permanently change SGR to provide more stability for Medicare beneficiaries and providers while promoting efficient, high quality care.

Screening and diagnostic digital mammography

To ensure that the higher resources needed for 3D mammography are recognized, Medicare will pay for 3D mammography using add-on codes that will be reported in addition to the 2D mammography codes when 3D mammography is furnished. See *MLN Matters*® article MM8874 (*http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8874.pdf*) for more information.

Primary care and chronic care management

Medicare continues to emphasize primary care by making payment for chronic care management (CCM) services – non-face-to-face services to Medicare beneficiaries who have two or more chronic conditions – beginning January 1, 2015. CCM services include regular development and revision of a plan of care, communication with other treating health professionals, and medication management. CCM can be billed once per month per qualified beneficiary, provided the minimum level of services is furnished.

See **TELEHEALTH**, next page

TELEHEALTH

From previous page

CMS is finalizing its proposal to allow greater flexibility in the supervision of clinical staff providing CCM services. The proposed application of the "incident to" supervision rules was widely supported by the commenters.

Payment for CCM is only one part of a multi-faceted CMS initiative to improve Medicare beneficiaries' access to primary care. Models being tested through the Innovation Center will continue to explore other primary care innovations.

Finally, CMS will require that in order to bill CCM, a practitioner must use a certified electronic health record (EHR) that meets the requirements for the EHR incentive program as of December 31 of the prior calendar year.

Application of beneficiary cost sharing to anesthesia related to screening colonoscopies

The Medicare statute waives the Part B deductible and coinsurance applicable to screening colonoscopy. In the 2015 final rule, CMS revised the definition of a "screening colonoscopy" to include separately provided anesthesia as part of the screening service so that the coinsurance and deductible do not apply to anesthesia for a screening colonoscopy, reducing beneficiaries' cost-sharing obligations under Part B. For more information, review *MLN Matters*® article MM8874 (*http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8874.pdf*).

Enhanced transparency in setting PFS rates

Since the beginning of the physician fee schedule in 1992, CMS adopted rates for new and revised codes for the following calendar year in the final rule on an interim basis subject to public comment. This policy was necessary because CMS did not receive the codes in time to include in the PFS proposed rule. Until recently, the only services that were affected by this policy were services with new and revised codes. In recent years, CMS began receiving new and revised codes and revaluing existing services under the misvalued codes initiative. Establishing payment in the final rule for misvalued codes often led to implementation of payment reductions before the public had the opportunity to comment. CMS finalized its proposal to change the process for valuing new, revised and potentially misvalued codes for 2016, so that payment for the vast majority of these codes goes through notice and comment rulemaking prior to being adopted. After a transition in 2016, the process will be fully implemented in 2017.

Potentially misvalued services

Consistent with amendments to the Affordable Care Act (see *http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf*), CMS has been engaged in a vigorous effort over the past several years to identify and review potentially misvalued codes, and to make adjustments where appropriate.

The following are major misvalued code decisions for 2015:

- **Radiation therapy and gastroenterology**: Consistent with the final rule policy and in response to public comments, CMS is not adopting the *CPT*® coding changes for 2015 for gastroenterology and radiation therapy services so that CMS can propose and obtain comments on the revised coding prior to using them for payment. As a result, CMS will not recognize some new *CPT*® codes, and created G-codes in place of changed and new *CPT*® codes.
- **Radiation treatment vault**: CMS proposed to refine the way it accounts for the infrastructure costs associated with radiation therapy equipment, specifically to remove the radiation treatment vault as a direct expense when valuing radiation therapy services. After considering public comments, CMS did not finalize this proposal.
- **Epidural pain injections**: CMS reduced payment for these services in 2014 under the misvalued code initiative. In response to concerns from pain physicians regarding the accuracy of the valuation, CMS proposed to raise the values in 2015 based on their prior resource inputs before adopting further changes after considering RUC recommendations. However, because the inputs for these services included those related to image guidance, CMS also proposed to prohibit separate billing for image guidance for 2015. CMS finalized the policy as proposed to avoid duplicate payment for image guidance. CMS has asked the RUC to further review this issue and make recommendations to us on how to value epidural pain injections.
- **Film to digital substitution**: CMS finalized its proposal to update the practice expense inputs for X-ray services to reflect that X-rays are currently done digitally rather than with analog film.

Global surgery

The U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG) has identified a number of surgical procedures that include more visits in the global period than are being furnished. CMS is also concerned that post-surgical visits are valued higher than visits that were furnished and billed separately by other physicians such as general internists or family physicians.

CMS finalized a proposal to transform all 10- day and 90-day globals to 0-day globals, beginning with 10-day global services in 2017 and following with the 90-day global

See **TELEHEALTH**, next page

TELEHEALTH

From previous page

services in 2018. As CMS revalues these services as zero-day global periods, CMS will actively assess whether there is a better construction of a bundled payment for surgical services that incentivizes care coordination and care redesign across an episode of care.

Access to telehealth services

CMS is adding the following services to the list of services that can be furnished to Medicare beneficiaries under the telehealth benefit:

- Annual wellness visits
- Psychoanalysis
- Psychotherapy
- Prolonged evaluation and management services

For the list of telehealth services, visit: *http://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index.html*.

Telehealth origination site facility fee payment amount

The Social Security Act (Section 1834(m)(2)(B) (see *http://www.ssa.gov/OP_Home/ssact/title18/1834.htm*) establishes the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001, through December 31 2002, at $20.

For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased by the percentage increase in the Medicare economic index (MEI) as defined in the Social Security Act (Section 1842(i)(3) (see *http://www.ssa.gov/OP_Home/ssact/title18/1842.htm*).

The MEI increase for 2015 is 0.8 percent. Therefore, for 2015, the payment amount for HCPCS code Q3014 (Telehealth originating site facility fee) is 80 percent of the lesser of the actual charge, or $24.83. (The beneficiary is responsible for any unmet deductible amount and Medicare coinsurance.)

Revisions to malpractice relative value units (RVUs)

As required by the Medicare law, CMS conducted a five-year review and updated the resource-based malpractice RVUs based on updated professional liability insurance premiums, largely paralleling the methodology used in the 2010 update. The final rule indicated that anesthesia RVUs will be updated in 2016.

Revisions to geographic practice cost indices (GPCIs)

As required by the Medicare law, CMS adjusts payments under the PFS to reflect local differences in the cost of operating a medical practice. For 2015, CMS is using territory-level wage data to calculate the work GPCI and employee wage component of the PE GPCI for the Virgin Islands.

The 2015 GPCIs also reflect the application of the statutorily mandated of 1.5 work GPCI floor in Alaska, and 1.0 work GPCI floor for all other physician fee schedule areas, and the 1.0 PE GPCI floor for frontier states (Montana, Nevada, North Dakota, South Dakota, and Wyoming).

However, given that the statutory 1.0 work GPCI floor is scheduled to expire under current law on March 31, 2015, the GPCIs reflect the elimination of the 1.0 work GPCI floor from April 1, 2015, through December 31, 2015.

Services in off-campus provider departments

CMS will collect data on services furnished in off-campus provider-based departments by requiring hospitals to report a modifier for those services furnished in an off-campus provider-based department of the hospital and by requiring physicians and other billing practitioners to report these services using a new place of service code on professional claims.

Data collection will be voluntary for hospitals in 2015 and required beginning January 1, 2016. The new place of service codes will be used for professional claims as soon as it is available, but not before January 1, 2016.

The official instruction, CR 9034, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3157CP.pdf*.

For more information about the EHR program, go to *http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html*.

The final rule, published on November 13, 2014, is available at *http://www.gpo.gov/fdsys/pkg/FR-2014-11-13/pdf/2014-26183.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Net work-MLN/MLNMattersArticles/index.html*.

MLN Matters® Number: MM9034
Related Change Request (CR) #: CR 9034
Related CR Release Date: December 24, 2014
Effective Date: January 1, 2015
Related CR Transmittal #: R3157CP
Implementation Date: January 5, 2015

Clinical laboratory fee schedule – Medicare travel allowance fees for collection of specimens

Provider types affected

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

Provider action needed

Change request (CR) 9066 informs MACs about the revisions to the payment of travel allowances when billed on a per mileage basis using Health Care Common Procedure Coding System (HCPCS) code P9603 and when billed on a flat rate basis using HCPCS code P9604 for 2015. These changes are also made to Chapter 16, Section 60.2 of the *Medicare Claims Processing Manual*. Make sure that your billing staffs are aware of these changes.

Background

CR 9066 revises the payment of travel allowances when billed on a per mileage basis using HCPCS code P9603 and when billed on a flat rate basis using HCPCS code P9604 for 2015. Medicare Part B, allows payment for a specimen collection fee and travel allowance, when medically necessary, for a laboratory technician to draw a specimen from either a nursing home patient or homebound patient under Section 1833(h)(3) of the Social Security Act. Payment for these services is made based on the clinical laboratory fee schedule.

Travel allowance

Payment of the travel allowance is made only if a specimen collection fee is also payable. The travel allowance is intended to cover the estimated travel costs of collecting a specimen including the laboratory technician's salary and travel expenses. MACs have the discretion to choose either a mileage basis or a flat rate, and how to set each type of allowance. Many MACs established local policy to pay based on a flat rate basis only.

Under either method, when one trip is made for multiple specimen collections (for example, at a nursing home), the travel payment component is prorated based on the number of specimens collected on that trip, for both Medicare and non-Medicare patients, either at the time the claim is submitted by the laboratory or when the flat rate is set by the MAC.

Per mile travel allowance (P9603)

The per mile travel allowance is to be used in situations where the average trip to the patients' homes is longer than 20 miles round trip, and is to be prorated in situations where specimens are drawn from non-Medicare patients in the same trip.

The allowance per mile was computed using the federal mileage rate of $0.575 per mile plus an additional $0.45 per mile to cover the technician's time and travel costs. MACs have the option of establishing a higher per mile rate in excess of the minimum $1.03 per mile if local conditions warrant it (actual total of $1.025 rounded up to reflect systems capabilities). Medicare reviews and updates the minimum mileage rate throughout the year, as well as in conjunction with the clinical laboratory fee schedule (CLFS), as needed. At no time may a laboratory bill for more miles than are reasonable, or for miles that are not actually traveled by the laboratory technician.

Per flat-rate trip basis travel allowance (P9604)

The per flat-rate trip basis travel allowance is $10.30.

Additional information

The Internal Revenue Service (IRS) determines the standard mileage rate for businesses based on periodic studies of the fixed and variable costs of operating an automobile.

The official instruction, CR 9066 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3189CP.pdf*.

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

MLN Matters® Number: MM9066
Related Change Request (CR) #: CR 9066
Related CR Release Date: February 5, 2015
Effective Date: January 1, 2015
Related CR Transmittal #: R3189CP
Implementation Date: As soon as possible, but not later than April 24, 2015

April 2015 quarterly ASP drug pricing files and revisions to prior quarterly pricing files

Provider types affected

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

Provider action needed

Change request (CR) 9084 informs Medicare MACs to download and implement the April 2015 average sales price (ASP) drug pricing files and, if released by the Centers for Medicare & Medicaid Services (CMS), the January 2015, October 2014, July 2014, and April 2014, ASP drug pricing files for Medicare Part B drugs.

Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after April 6, 2015, with dates of service April 1, 2015, through June 30, 2015. MACs will not search and adjust claims that have already been processed unless you bring such claims to their attention. Make sure that your billing staffs are aware of these changes.

Background

The Medicare Modernization Act of 2003 (MMA; Section 303(c)) revised the payment methodology for Part B covered drugs and biologicals that are not priced on a cost or prospective payment basis.

The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply Medicare contractors with the ASP and not otherwise classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the OPPS are incorporated into the outpatient code editor (OCE) through separate instructions that can be located in the *Medicare Claims Processing Manual* (Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)), Section 50 (Outpatient PRICER); see *http://www.cms.gov/manuals/downloads/clm104c04.pdf*) The following table shows how the quarterly payment files will be applied:

Files	Effective dates of service
April 2015 ASP and ASP NOC	April 1, 2015, through June 30, 2015
January 2015 ASP and ASP NOC	January 1, 2015, through March 31, 2015
October 2014 ASP and ASP NOC	October 1, 2014, through December 31, 2014
July 2014 ASP and ASP NOC	July 1, 2014, through September 30, 2014

Files	Effective dates of service
April 2014 ASP and ASP NOC	April 1, 2014, through June 30, 2014

Note: The absence or presence of a Healthcare Common Procedure Coding System (HCPCS) code and its associated payment limit does not indicate Medicare coverage of the drug or biological. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. The local MAC processing the claim shall make these determinations.

Additional information

The official instruction, CR 9084, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3180CP.pdf*.

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

MLN Matters® Number: MM9084
Related Change Request (CR) #: CR 9084
Related CR Release Date: January 30, 2015
Effective Date: April 1, 2015
Related CR Transmittal #: R3180CP
Implementation Date: April 6, 2015

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.

Renaming payment fields in the inpatient prospective payment system pricer output

Provider types affected

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

Provider action needed

Change request (CR) 9031 informs MACs about the changes to the PPS-FLX6-PAYMENT field in the inpatient prospective payment system (IPPS) pricer output record, created in CR 8546. The field will be renamed to identify the field as the hospital acquired condition (HAC) reduction amount. Make sure that your billing staffs are aware of these changes.

Background

Section 3008 of the Affordable Care Act established a program, beginning in fiscal year (FY) 2015, for IPPS hospitals to improve patient safety by imposing financial penalties on hospitals that perform poorly with regard to certain hospital acquired conditions (HACs).

HACs are conditions that patients did not have when they were admitted to the hospital, but which developed during the hospital stay. Under the HAC reduction program, hospitals that rank in the lowest-performing quartile of selected HAC measures will be subject to a reduction of what they would otherwise be paid under the IPPS.

The HAC payment reduction amount is currently displayed in the PPS-FLX6-PAYMENT field. The new name for this field will be HAC PAYMENT AMT.

Additional information

The official instruction, CR 9031 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1457OTN.pdf*.

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

MLN Matters® Number: MM9031
Related Change Request (CR) #: CR 9031
Related CR Release Date: January 30, 2015
Effective Date: July 1, 2015
Related CR Transmittal #: R1457OTN
Implementation Date: July 6, 2015

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.

Online Medicare refreshers

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

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

Click here to explore the wide away of training opportunities.

Educational Events

Provider outreach and educational events – Spring 2015

Medicare Part A – changes and regulations

When: Tuesday, March 17
Time: 10 a.m. - 11:30 a.m. ET – Delivery language: English
Type of Event: Webcast
Location: Jacksonville, Fl
http://medicare.fcso.com/Events/276916.asp

Medicare Speaks: Fort Lauderdale

When: May 19-20
Time: 7:30 a.m. -4:30 p.m. ET – Delivery language: English
Type of Event: Conference/Seminar
http://medicare.fcso.com/Medicare_Speaks/278353.pdf

Two easy ways to register

1. **Online** – Visit *www.fcsouniversity.com*, logon 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 a New Account" online. Providers with no national provider identifier may enter "99999" in the NPI field. You will receive logon information within 72 hours of your request.
2. **Fax** – Providers without Internet access may request a fax registration form through our Registration Hotline at 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 the *Education* section of 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 904-791-8103 to learn more about the about our newest training opportunities for providers.

Never miss a training opportunity

If you 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 *medicare.fcso.com*, download the recording of the event, and listen to the webcast when you have the time.

Take advantage of 24-hour access to free online training

In addition to our live training events, we also offer you the advantage of self-paced, free online courses that will allow you and your staff to train when and where it is most convenient for you. Our comprehensive course catalog allows you to find the Medicare training that fits your specific needs, and several of our online courses offer CEUs. Explore our catalog of online courses and learn more at *www.fcsouniversity.com*.

MLN Connects™

Medicare Learning Network®
Official Information Health Care Professionals Can Trust

CMS MLN Connects™ Provider eNews

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

MLN Connects™ Provider eNews for January 29, 2015

MLN Connects™ Provider eNews for January 29, 2015

View this edition as a PDF

In this edition:

MLN Connects™ National Provider Calls

- Payment of Chronic Care Management Services Under CY 2015 Medicare PFS – Registration Now Open
- ICD-10 Implementation and Medicare Testing – Registration Now Open
- New MLN Connects™ National Provider Call Audio Recording and Transcript

CMS Events

- Special Open Door Forum: Prior Authorization of Non-Emergent Hyperbaric Oxygen Therapy
- Special Open Door Forum: Understanding Dialysis Facility Compare-Driving Informed Decision Making
- Special Open Door Forum: Adding Star Ratings to the Home Health Compare Website

Announcements

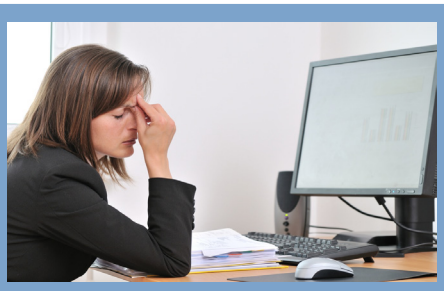
- Influenza Updates from CDC
- Pneumococcal Vaccinations Update from CMS
- CMS Launches Dialysis Facility Compare Star Ratings
- HHS Sets Clear Goals and Timeline for Shifting Medicare Reimbursements from Volume to Value
- EHR Incentive Program: Eligible Professional 2014 Attestation Deadline on February 28
- EHR Incentive Programs: New Stage 2 Summary of Care FAQ Provides Guidance on Measure #3
- Comparative Billing Report on Modifiers 24 & 25: Specialty Surgeons
- ICD-10 Resources

Claims, Pricers, and Codes

- Payment for HCPCS Code Q0091 as an RHC or FQHC Billable Visit under the All-Inclusive Rate System

Medicare Learning Network® Educational Products

- "Continued Use of Modifier 59 after January 1, 2015" *MLN Matters®* Article – Released
- "Telehealth Services" Fact Sheet – Revised
- "Medicare Part B Immunization Billing" Educational Tool – Revised
- New *Medicare Learning Network®* Provider Compliance Fast Fact
- *Medicare Learning Network®* Products Available In Electronic Publication Format



Puzzled about your enrollment status?

Put the pieces together using the enrollment status lookup. View all active applications, specific applications, and confirm if you have been sent a revalidation request at *http://medicare.fcso.com/Enrollment/PEStatus.asp*

MLN Connects™ Provider eNews for February 5, 2015

MLN Connects™ Provider eNews for February 5, 2015

View this edition as a PDF

In this edition:

MLN Connects™ National Provider Calls

- Payment of Chronic Care Management Services under CY 2015 Medicare PFS – Register Now
- ICD-10 Implementation and Medicare Testing – Register Now
- New MLN Connects™ National Provider Call Audio Recordings and Transcripts

CMS Events

- Special Open Door Forum: Home Health Clinical Templates

Announcements

- HHS Proposes Path to Improve Health Technology and Transform Care
- Extension of Temporary Moratoria on Enrollment of New HHAs, HHA Sub-units and Part B Ambulance Suppliers
- CLIA Individualized Quality Control Plan: Education and Transition Period Ends December 31, 2015
- 2015 PQRS Payment Adjustment and Providers who Rendered Services at RHCs/FQHCs
- Open Payments: Second Year of Data Submission
- CMS Intends to Engage in Rulemaking for EHR Incentive Program Changes for 2015
- Get Started with Hospice CAHPS
- Proposed Decision Memo: Screening for the HIV Infection

Claims, Pricers, and Codes

- Home Health Pricer will be Updated on April 1
- FY 2015 Inpatient PPS PC Pricer Update Available

Medicare Learning Network® Educational Products

- "Payment Codes on Home Health Claims Will Be Matched Against Patient Assessments" *MLN Matters*® Article – Released
- "Extension of Provider Enrollment Moratoria for Home Health Agencies and Part B Ambulance Suppliers" *MLN Matters*® Article – Revised
- "Internet-based PECOS Contact Information" Fact Sheet – Reminder
- *Medicare Learning Network*® Products Available In Electronic Publication Format
- Subscribe to the *MLN Matters*® Electronic Mailing List
- Helpful Tips on *Medicare Learning Network*® Products and Learning Management System – Subscribe Now

Learn the secrets to billing Medicare correctly

Who has the power to improve your billing accuracy and efficiency?

You do – visit the *Tools to 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).

MLN Connects™ Provider eNews for February 12, 2015

MLN Connects™ Provider eNews for February 12, 2015

View this edition as a PDF

In this edition:

MLN Connects™ National Provider Calls

- Payment of Chronic Care Management Services under CY 2015 Medicare PFS – Last Chance to Register
- ICD-10 Implementation and Medicare Testing – Register Now
- National Partnership to Improve Dementia Care in Nursing Homes and QAPI – Registration Now Open

CMS Events

- Physician Compare Benchmark Discussion Webinars

Announcements

- DMEPOS Competitive Bidding: Register by Tuesday in Order to Bid
- February is American Heart Month
- IRF Quality Reporting Program: Data Submission Deadline February 15
- LTCH Quality Reporting Program: Data Submission Deadline February 15
- EHR Incentive Program: 2014 Attestation Deadline for Eligible Professionals February 28
- EHR Incentive Programs: Public Health Objectives: Reporting Requirements in Stage 1 and 2
- NCD for Screening for Lung Cancer with Low Dose Computed Tomography
- Background Fingerprints: Check Your Status Online
- Antipsychotic Drug use in Nursing Homes: Trend Update
- CMS is Accepting Suggestions for Potential PQRS Measures

Claims, Pricers, and Codes

- CY 2015 HH PPS PC Pricer and PPS Main Frame Pricer Updates Available

Medicare Learning Network® Educational Products

- "Hospital Outpatient Prospective Payment System" Fact Sheet – *Revised*
- "DMEPOS Quality Standards" Booklet – Reminder
- "Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Information for Pharmacies" Fact Sheet -- Reminder
- "Screening, Brief Intervention, and Referral to Treatment (SBIRT) Services" Fact Sheet – Reminder

First Coast Service Options Phone Numbers

***(Note:** Specific geographic contact information is noted when phone numbers and addresses are different for providers in Florida, U.S. Virgin Islands or Puerto Rico.)*

Customer service
Monday to Friday
8:00 a.m. to 4:00 p.m
888-664-4112 (FL/USVI)
877-908-8433 (Puerto Rico)
877-660-1759 (TDD-FL/USVI)
888-216-8261 (TDD-Puerto Rico)

Electronic data interchange
888-670-0940 (FL/USVI)
888-875-9779 (Puerto Rico)

Interactive Voice Response
877-602-8816

Provider education/outreach
Event registration hotline
904-791-8103

Overpayments
904-791-6281

SPOT Help Desk
FCSOSPOTHelp@fcso.com
855-416-4199

Websites
medicare.fcso.com
medicareespanol.fcso.com

First Coast Service Options Addresses

Claims/correspondence
Florida/ U.S. Virgin Islands

Medicare Part A Customer Service
P. O. Box 2711
Jacksonville, FL 32231-0021

Puerto Rico

First Coast Service Options Inc.
P.O. Box 45003
Jacksonville, FL 32232-5003

Medicare EDI
Electronic claim filing
Direct Data Entry
P. O. Box 44071
Jacksonville, FL 32231-4071

Fraud and abuse
Complaint Processing Unit
P. O. Box 45087
Jacksonville, FL 32232-5087

FOIA requests
Provider audit/reimbursement
(relative to cost reports and audits)
Attn: FOIA PARD – 16T
P. O. Box 45268
Jacksonville, FL 32232-5268

General Inquiries

Online Form (Click here)

Email: *AskFloridaA@fcso.com*

Local coverage determinations
Medical Policy and Procedures – 19T
P.O. Box 2078
Jacksonville, FL 32231-0048

Medicare secondary payer (MSP)
Medicare Secondary Payer
P. O. Box 2711
Jacksonville, FL 32231-0021

Hospital audits
MSP – Hospital Review
P. O. Box 45267
Jacksonville, FL 32232-5267

MSPRC DPP debt recovery, auto accident settlements/lawsuits, liabilities
Auto/Liability – 17T
P. O. Box 44179
Jacksonville, FL 32231-4179

Overpayment collections and debt recovery
Repayment, cost reports, receipts and acceptances, tentative settlement determinations, provider statistical and reimbursement reports, cost report settlement, TEFRA target limit and SNF routine cost limit exceptions

Provider Audit and Reimbursement
P. O. Box 45268
Jacksonville, FL 32232-5268

Credit balance reports
First Coast Service Options Inc.
P.O. Box 45011
Jacksonville, FL 32232-5011

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

Provider enrollment
CMS-855 Applications
P. O. Box 44021
Jacksonville, FL 32231-4021

Redetermination
Florida:
Medicare Part A Redetermination/Appeals
P. O. Box 45053
Jacksonville, FL 32232-5053

Redetermination (cont'd)
U.S. Virgin Islands:
First Coast Service Options Inc
P. O. Box 45097
Jacksonville, FL 32232-5097

Puerto Rico

First Coast Service Options Inc.
P.O. Box 45028
Jacksonville, FL 32232-5028

Special delivery/courier services

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

Other Medicare carriers and intermediaries

DME regional carrier (DMERC)
DME, orthotic, prosthetic device, take-home supply, oral anti-cancer drug claims

CGS Administrators, LLC
P. O. Box 20010
Nashville, Tennessee 37202

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

Regional home health/hospice intermediary
Palmetto GBA
Medicare Part A
34650 US HWY 19N
Palm Harbor, FL 34684

Contact CMS

Centers for Medicare & Medicaid Services (CMS) (*www.cms.gov*)

Centers for Medicare & Medicaid Services, Division of Financial Management and Fee for Service Operations

ROATLFM@CMS.HHS.GOV

Office of Inspector General (OIG)
Medicare fraud hotline
800-HHS-TIPS (800-447-8477)

Medicare beneficiary customer service
1-800-MEDICARE
1-800-633-4227

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