# Medicare B CONNECTION

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FIRST COAST SERVICE OPTIONS, INC.

*A Newsletter for MAC Jurisdiction N Providers*

December 2014


## In this issue



# Web tools hit the SPOT for veteran Medicare billing team

Kim Gonzales and her team of 12 medical claim billers see more than most. On an average day, Gonzales and the Medicare billing team at the Watson Clinic will work some aspect of the 10,400 active claims for medical services provided at the Lakeland, FL, clinic.

A veteran Medicare biller for more than 15 years, Gonzales says the addition of *First Coast Service Options' secure provider portal, SPOT*, has greatly enhanced the clinic's billing processes, making it easier to get claims paid.

"With my team, if they have a problematic claim, I will ask them if they checked it on SPOT," Gonzales said. "I know we can save 20-30 minutes working it through SPOT, rather than checking the status over the phone."

Accessing claims status information online is one of several features that became available to providers when First Coast launched the SPOT in August 2013. SPOT gives providers faster access to Medicare benefits and eligibility data, payment history, and analytical data reports.

At the Watson Clinic, Medicare beneficiaries represent 54 percent of the claims handled by the billing team. These are comprised of services provided by more than 200 physicians and physician extenders from 40 different medical and surgical specialties. The Watson Clinic has 17 offices located in three counties across Central Florida. Given this volume, the Medicare billing team is a critical

**"I've seen the First Coast website grow and change. SPOT has been a really great addition. If you stay informed and use all of the tools, you will have clean claims and know exactly what to do should a claim get denied."**

***-Kimberly Gonzales, Watson Clinic***


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# Contents




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

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

# About the 'Medicare B Connection'

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

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

## Who receives the *Connection*

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

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

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

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

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

## Publication format

The *Connection* is arranged into distinct sections.

- The **Claims** section provides claim submission requirements and tips.
- The **Coverage/Reimbursement** section discusses specific *CPT*® and HCPCS procedure codes. It is arranged by categories (not specialties). For example,

"Mental Health" would present coverage information of interest to psychiatrists, clinical psychologists and clinical social workers, rather than listing articles separately under individual provider specialties. Also presented in this section are changes to the Medicare physician fee schedule, and other pricing issues.

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

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

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

# Medicare Part B advance beneficiary notices

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

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

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

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

## Patient liability notice

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

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

## ABN modifiers

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

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

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

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

## GA modifier and appeals

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

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

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

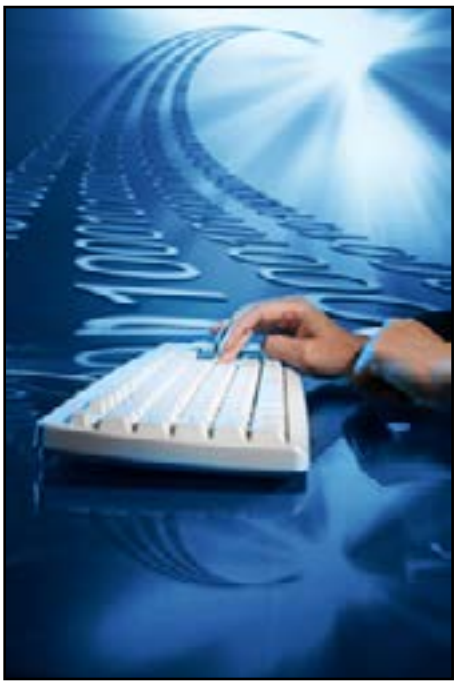
# April update to the correct coding initiative edits

## Provider types affected

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

## Provider action needed

Change request (CR) 8908 informs MACs about the release of the latest package of correct coding initiative (CCI) edits, version 21.1, which will be effective April 1, 2015. Make sure that your billing staffs are aware of these changes.



## Background

The Centers for Medicare & Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment in Part B claims. The coding policies developed are based on coding conventions defined in the American Medical Association's Current Procedural Terminology manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practice, and review of current coding practice.

The latest package of NCCI edits, version 21.1, effective April 1, 2015, will be available to the MACs via the CMS data center on or about January 31, 2015, and a final file will be available to them on or about February 14, 2015.

Version 21.1 will include all previous versions and updates from January 1, 1996, to the present. In the past, NCCI was organized in two tables: column one/column two correct coding edits and mutually exclusive code (MEC) edits. In order to simplify the use of NCCI edit files (two tables), on April 1, 2012, CMS consolidated these two edit files into the column one/column two correct coding edit file. Separate consolidations have occurred for the two practitioner NCCI edit files and the two NCCI edit files used for the outpatient code editor (OCE). It will only be necessary to search the column one/column two correct coding edit file for active or previously deleted edits. CMS no longer publishes a mutually exclusive edit file on its website for either practitioner or outpatient hospital services, since all active and deleted edits will appear in the single column one/column two correct coding edit file on each website. The edits previously contained in the mutually exclusive edit file are NOT being deleted but are being moved to the column one/column two correct coding edit file. Refer to the CMS NCCI Web page for additional information at *http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html*.

## Additional information

The official instruction, CR 8908 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3132CP.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.

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Implementation Date: April 6, 2015

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### Try our E/M interactive worksheet

First Coast Service Options (First Coast) Inc. is proud of its exclusive E/M interactive worksheet, available at *http://medicare.fcso.com/EM/165590.asp*. This resource was developed 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. After you've tried the E/M interactive worksheet, send us your thoughts of this resource through our website feedback form, available at *http://medicare.fcso.com/Feedback/160958.asp*.

## Ambulance

# Clarification of specialty care ambulance transport

Specialty care transport (SCT) under the fee schedule for ambulance services is defined in 42 *Code of Federal Regulations* (CFR) §414.605 as an interfacility transportation of a critically injured or ill beneficiary by a ground ambulance vehicle, including medically necessary supplies and services, at a level of service beyond the scope of the emergency medical technician (EMT) – paramedic. SCT is necessary when a beneficiary's condition requires ongoing care that must be furnished by one or more health professionals in an appropriate specialty area, for example, nursing, emergency medicine, respiratory care, cardiovascular care, or a paramedic with additional training.

In the December 1, 2006, final rule (71 FR 69716), the Centers for Medicare & Medicaid Services (CMS) expanded the definition of "interfacility" to include both hospitals and skilled nursing facilities (SNFs). CMS considers a "facility" to include only a SNF or a hospital that participates in the Medicare program, or a hospital-based facility that meets our requirements for provider-based status as specified at 42 CFR §413.65. Medicare hospitals include, but are not limited to, rehabilitation hospitals, cancer hospitals, children's hospitals, psychiatric hospitals, critical access hospitals (CAHs), inpatient acute care hospitals, and sole community hospitals (SCHs).

## SPOT

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component to successful business operations.

According to Gonzales, the biggest challenge for her team is working denied claims. "We spend a good amount of time working on denials and checking to see what is necessary to get the claim reprocessed. We started doing re-openings the first day it was offered by First Coast. Now with online re-openings, we are trying to push everything to SPOT," Gonzales said.

First Coast added the online claim reopening feature to SPOT in September 2014. Providers may submit Part B clerical reopening requests and correct their claims on the SPOT, adjusting such claim elements as date(s) of service, procedure code, modifier, diagnosis code, or units billed.

SPOT represents a huge leap in helping the Watson Clinic and its Medicare billing. "I've seen the First Coast website grow and change. SPOT has been a really great addition," Gonzales said. "If it's something like a missed modifier, we can correct it right there in SPOT. If we can resolve it there, we'll determine if the claim is eligible for the next level of appeal."

### Your Feedback Matters

To ensure that our website meets the needs of our provider community, we carefully analyze your feedback and implement changes to better meet your needs. Discover the results of your feedback on our "*Website enhancements*" page. You'll find the latest enhancements to our provider websites and find out how you can share your thoughts and ideas with First Coast's Web team.

Durable Medical Equipment

# 2015 update for DMEPOS fee schedule

## Provider types affected

This *MLN Matters*® article is intended for providers and suppliers submitting claims to Medicare administrative contractors (MACs) for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) items or services paid under the DMEPOS fee schedule.

## Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 8999 to advise providers of the 2015 annual update for the Medicare DMEPOS fee schedule. The instructions include information on the data files, update factors, and other information related to the update of the fee schedule. Make sure your staffs are aware of these updates.

## Background

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

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

## Key points

### Fee schedule files

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

### HCPCS codes added/deleted

The following new codes are effective January 1, 2015:

- A4602 in the inexpensive/routinely purchased (IN) payment category.
- The following new codes are in the prosthetics and orthotics (PO) payment category: A7048, L3981, L6026, L7259, and L8696. (Fee schedule amounts for these codes will be added to the DMEPOS fee schedule, effective January 1, 2015.)
- Also, code A4459 is added.

The base fee for code A4602 will be submitted to CMS by CMS contractors by April 3, 2015, for inclusion in the July 2015 DMEPOS fee schedule update.

The following codes are deleted from the DMEPOS fee schedule files effective January 1, 2015: A7042, A7043, L6025, L7260, and L7261.

For gap-filling purposes, the 2014 deflation factors by payment category are as follows:

| Factor | Category |
|---|---|
| 0.459 | Oxygen |
| 0.462 | Capped rental |
| 0.464 | Prosthetics and orthotics |
| 0.588 | Surgical dressings |
| 0.640 | Parenteral and enteral nutrition |
| 0.963 | Intraocular lenses |
| 0.980 | Splints and casts |

### Specific coding and pricing issues

CMS is also adjusting the fee schedule amounts for shoe modification codes A5503 through A5507 in order to reflect more current allowed service data. Section 1833(o)(2)(C) of the Act required that the payment amounts for shoe modification codes A5503 through A5507 be established in a manner that prevented a net increase in expenditures when substituting these items for therapeutic shoe insert codes (A5512 or A5513). To establish the fee schedule amounts for the shoe modification codes, the base fees for codes A5512 and A5513 were weighted based on the approximated total allowed services for each code for items furnished during the second quarter of 2004.

For 2015, CMS is updating the weighted average insert fees used to establish the fee schedule amounts for the shoe modification codes with more current allowed service data for each insert code. The base fees for A5512 and A5513 will be weighted based on the approximated total allowed services for each code for items furnished during 2013.

The fee schedule amounts for shoe modification codes A5503 through A5507 are being revised to reflect this change, effective January 1, 2015.

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# DMEPOS

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### Diabetic testing supplies (DTS)

The fee schedule amounts for non-mail order diabetic testing supplies (DTS) (without KL modifier) for codes A4233, A4234, A4235, A4236, A4253, A4256, A4258, A4259 are not updated by the covered item update for CY 2014. In accordance with Section 636(a) of the American Taxpayer Relief Act of 2012, the fee schedule amounts for these codes were adjusted in 2013 so that they are equal to the single payment amounts for mail order DTS established in implementing the national mail order competitive bidding program (CBP) under Section 1847 of the Act.

The non-mail order payment amounts on the fee schedule file will be updated each time the single payment amounts are updated which can happen no less often than every three years as CBP contracts are re-competed. The national competitive bidding program for mail order diabetic supplies is effective July 1, 2013, to June 30, 2016.

The program instructions reviewing the changes are in Transmittal 2661, CR 8204, dated February 22, 2013. The *MLN Matters*® article related to CR 8204 is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-NetworkMLN/MLNMattersArticles/downloads/MM8204.pdf*.

Although for payment purposes the single payment amounts replace the fee schedule amounts for mail order DTS (KL modifier), the fee schedule amounts remain on the DMEPOS fee schedule file as reference data such as for establishing bid limits for future rounds of competitive bidding programs. The mail order DTS fee schedule amounts shall be updated annually by the covered item update, adjusted for multi-factor productivity (MFP), which results in update of 1.5 percent for 2015. The single payment amount public use file for the national mail order competitive bidding program is available at *http://www.dmecompetitivebid.com/palmetto/cbicrd2.nsf/DocsCat/Single%20Payment%20Amounts* .

### 2015 fee schedule update factor of 1.5 percent

For 2015, the update factor of 1.5 percent is applied to the applicable 2014 DMEPOS fee schedule amounts. In accordance with the statutory Sections 1834(a)(14) and 1886(b)(3)(B)(xi)(II) of the Act, the DMEPOS fee schedule amounts are to be updated for 2015 by the percentage increase in the consumer price index for all urban consumers (United States city average) or CPI-U for the 12-month period ending with June of 2014, adjusted by the change in the economy-wide productivity equal to the 10-year moving average of changes in annual economy-wide private non-farm business multi-factor productivity (MFP). The MFP adjustment is 0.6 percent and the CPI-U percentage increase is 2.1 percent. Thus, the 2.1 percentage increase in the CPI-U is reduced by the 0.6 percentage increase in the MFP resulting in a net increase of 1.5 percent for the update factor.

### 2015 update to the labor payment rates

The following table contains the 2015 allowed payment

amounts for HCPCS labor payment codes K0739, L4205 and L7520. Since the percentage increase in the CPI-U for the 12-month period ending with June 30, 2014, is 2.1 percent this change is applied to the 2014 labor payment amounts to update the rates for 2015.

The 2015 labor payment amounts in the following table are effective for claims submitted using HCPCS codes K0739, L4205 and L7520 with dates of service from January 1, 2015, through December 31, 2015.

| State | K0739 | L4205 | L7520 |
|---|---|---|---|
| AK | $27.98 | $31.88 | $37.50 |
| AL | $14.86 | $22.14 | $30.05 |
| AR | $14.86 | $22.14 | $30.05 |
| AZ | $18.37 | $22.11 | $36.97 |
| CA | $22.79 | $36.34 | $42.35 |
| CO | $14.86 | $22.14 | $30.05 |
| CT | $24.81 | $22.63 | $30.05 |
| DC | $14.86 | $22.11 | $30.05 |
| NC | $14.86 | $22.14 | $30.05 |
| ND | $18.51 | $31.81 | $37.50 |
| NE | $14.86 | $22.11 | $41.90 |
| NH | $15.95 | $22.11 | $30.05 |
| NJ | $20.04 | $22.11 | $30.05 |
| NM | $14.86 | $22.14 | $30.05 |
| NV | $23.67 | $22.11 | $40.96 |
| NY | $27.35 | $22.14 | $30.05 |
| DE | $27.35 | $22.11 | $30.05 |
| FL | $14.86 | $22.14 | $30.05 |
| GA | $14.86 | $22.14 | $30.05 |
| HI | $18.37 | $31.88 | $37.50 |
| IA | $14.86 | $22.11 | $35.97 |
| ID | $14.86 | $22.11 | $30.05 |
| IL | $14.86 | $22.11 | $30.05 |
| IN | $14.86 | $22.11 | $30.05 |
| KS | $14.86 | $22.11 | $37.50 |

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| State | K0739 | L4205 | L7520 |
|---|---|---|---|
| KY | $14.86 | $28.34 | $38.43 |
| LA | $14.86 | $22.14 | $30.05 |
| MA | $24.81 | $22.11 | $30.05 |
| MD | $14.86 | $22.11 | $30.05 |
| ME | $24.81 | $22.11 | $30.05 |
| MI | $14.86 | $22.11 | $30.05 |
| MN | $14.86 | $22.11 | $30.05 |
| MO | $14.86 | $22.11 | $30.05 |
| MS | $14.86 | $22.14 | $30.05 |
| MT | $14.86 | $22.11 | $37.50 |
| OH | $14.86 | $22.11 | $30.05 |
| OK | $14.86 | $22.14 | $30.05 |
| OR | $14.86 | $22.11 | $43.21 |
| PA | $15.95 | $22.77 | $30.05 |
| PR | $14.86 | $22.14 | $30.05 |
| RI | $17.70 | $22.79 | $30.05 |
| SC | $14.86 | $22.14 | $30.05 |
| SD | $16.60 | $22.11 | $40.18 |
| TN | $14.86 | $22.14 | $30.05 |
| TX | $14.86 | $22.14 | $30.05 |
| UT | $14.90 | $22.11 | $46.79 |
| VA | $14.86 | $22.11 | $30.05 |
| VI | $14.86 | $22.14 | $30.05 |
| VT | $15.95 | $22.11 | $30.05 |
| WA | $23.67 | $32.44 | $38.53 |
| WI | $14.86 | $22.11 | $30.05 |
| WV | $14.86 | $22.11 | $30.05 |
| WY | $20.71 | $29.50 | $41.90 |
| WY | $20.71 | $29.50 | $41.90 |

### 2015 national monthly payment amounts for stationary oxygen equipment

As part of CR 8999, CMS is implementing the 2015 national monthly payment amount for stationary oxygen equipment (HCPCS codes E0424, E0439, E1390 and E1391), effective for claims with dates of service on or after January 1, 2015. Included is the updated national 2015 monthly payment amount of $180.92 for stationary oxygen equipment codes in the DMEPOS fee schedule. As required by statute, the payment amount must be adjusted on an annual basis, as necessary, to ensure budget neutrality of the new payment class for oxygen generating portable equipment (OGPE). Also, the updated 2015 monthly payment amount of $180.92 includes the 1.5 percent update factor for the 2015 DMEPOS fee schedule. Thus, the 2014 rate changed from $178.24 to the 2015 rate of $180.92.

When updating the stationary oxygen equipment fees,

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

### 2015 maintenance and servicing payment amount for certain oxygen equipment

Also updated for 2015 is the payment amount for maintenance and servicing for certain oxygen equipment. Payment instructions for claims for maintenance and servicing of oxygen equipment are in Transmittal 635, CR 6792, dated February 5, 2010, (see the article at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-NetworkMLN/MLNMattersArticles/downloads/MM6792.pdf*) and Transmittal 717, CR 6990, dated June 8, 2010, (see the related article at *http://www.cms.gov/Outreach-andEducation/Medicare-Learning-NetworkMLN/MLNMattersArticles/downloads/MM6990.pdf*).

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

Per 42 CFR Section 414.210(5)(iii), the 2010 maintenance and servicing fee for certain oxygen equipment was based on 10 percent of the average price of an oxygen concentrator. For 2011 and subsequent years, the maintenance and servicing fee is adjusted by the covered item update for DME as set forth in Section 1834(a)(14) of the Act. Thus, the 2014 maintenance and servicing fee is adjusted by the 1.5 percent MFP-adjusted covered item update factor to yield a 2015 maintenance and servicing fee of $69.76 for oxygen concentrators and transfilling equipment.

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### Update to change request (CR) 8566

Effective April 1, 2014, payment on a purchase basis was established for capped rental wheelchair accessory codes furnished for use with complex rehabilitative power wheelchairs. Such accessories are considered as part of the complex rehabilitative power wheelchair and associated lump sum purchase option set forth at 42 CFR Section 414.229(a)(5). These changes were implemented in Transmittal 1332, CR 8566, dated January 2, 2014. Code E2378 is added to the list of codes eligible for payment on a purchase basis when furnished for use with a complex rehabilitative power wheelchair.

## Additional information

The official instruction for CR 8999 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-andGuidance/Guidance/Transmittals/Downloads/R3129CP.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-LearningNetwork-MLN/MLNMattersArticles/index.html* under - How Does It Work?

*MLN Matters*® Number: MM8999
Related Change Request (CR) #: CR 8999
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## Laboratory/Pathology

# Clinical laboratory new waived tests

## Provider types affected

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

## Provider action needed

Change request (CR) 8951 informs MACs about the new Clinical Laboratory Improvement Amendments of 1998 (CLIA) waived tests approved by the Food and Drug Administration (FDA). Since these tests are marketed immediately after approval, the Centers for Medicare & Medicaid Services (CMS) must notify its MACs of the new tests so that they can accurately process claims. There are four newly added waived complexity tests.

CLIA requires that for each test it performs, a laboratory facility must be appropriately certified. The *Current Procedural Terminology* (*CPT*®) codes that the CMS considers to be laboratory tests under CLIA (and thus requiring certification) change each year. If you do not have a valid, current, CLIA certificate and submit a claim to your MAC for a *CPT*® code that is considered to be a laboratory test requiring a CLIA certificate, your Medicare payment may be impacted. Make sure that your billing staffs are aware of these changes.

## Background

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

Listed below are the latest tests approved by the FDA as waived tests under CLIA. *CPT*® codes for the following new tests must have the modifier QW to be recognized as a waived test. Tests with *CPT*® codes shown on the first page of the attachment to CR 8951 (*81002, 81025, 82270, 82272, 82962, 83026, 84830, 85013*, and *85651*) do not require a QW modifier to be recognized as a waived test.

The *CPT*® code, effective date, and description for the latest tests approved by the FDA as waived tests under CLIA are listed in the following table.

| *CPT*® code | Effective date | Description |
|---|---|---|
| *87807QW* | March 18, 2014 | BD Veritor System for Rapid Detection of RSV (For use with nasopharyngeal specimens){Includes a reader} |
| G0434QW | May 12, 2014 | Native Diagnostics International, DrugSmart Dip Single/Multi-Panel Drug Screen Dip Card Tests |
| *87807QW* | May 30, 2014 | Sofia RSV |
| G0434QW | June 9, 2014 | Healgen THC One Step Marijuana Test Strip |
| G0434QW | June 9, 2014 | Healgen THC One Step Marijuana Test Cassette |

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| *CPT*® code | Effective date | Description |
|---|---|---|
| G0434QW | June 9, 2014 | Healgen THC One Step Marijuana Test Cup |
| G0434QW | June 9, 2014 | Healgen THC One Step Marijuana Test Dip Card |
| G0434QW | June 9, 2014 | Healgen mAMP One Step Methamphetamine Test Strip |
| G0434QW | June 9, 2014 | Healgen mAMP One Step Methamphetamine Test Cassette |
| G0434QW | June 9, 2014 | Healgen mAMP One Step Methamphetamine Test Cup |
| G0434QW | June 9, 2014 | Healgen mAMP One Step Methamphetamine Test Dip Card |
| *87880QW* | June 11, 2014 | Poly stat Strep A Strip Test {Specimen type (Throat Swab)} |
| *87880QW* | June 25, 2014 | StrepAim {Specimen type (Throat Swab)} |
| G0434QW | June 27, 2014 | Wal-Mart Stores, Inc. ReliOn Home Drug Urine Cup Test |
| *86308QW* | July 7, 2014 | Jant Pharmacal Corp. Accutest Rapid Mono Test {Whole Blood} |
| *87880QW* | July 9, 2014 | Cardinal Health Strep A Dipstick – Rapid Test (Throat Swab Specimen) |
| G0434QW | July 18, 2014 | Healgen COC One Step Cocaine Test Strip |
| G0434QW | July 18, 2014 | Healgen COC One Step Cocaine Test Cassette |
| G0434QW | July 18, 2014 | Healgen COC One Step Cocaine Test Cup |
| G0434QW | July 18, 2014 | Healgen COC One Step Cocaine Test Dip Card |


| *CPT*® code | Effective date | Description |
|---|---|---|
| G0434QW | July 18, 2014 | Healgen MOP One Step Morphine Test Strip |
| G0434QW | July 18, 2014 | Healgen MOP One Step Morphine Test Cassette |
| G0434QW | July 18, 2014 | Healgen MOP One Step Morphine Test Cup |
| G0434QW | July 18, 2014 | Healgen MOP One Step Morphine Test Dip Card |
| *81003QW* | August 8, 2014 | Medline 120 Urine Analyzer |

MACs will not search their files to either retract payment or retroactively pay claims processed prior to implementation of CR 8951; however, they should adjust claims if you bring such claims to your MAC's attention.

## Additional information

The official instruction, CR 8951 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3149CP.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.

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Related Change Request (CR) #: CR 8951
Related CR Release Date: December 12, 2014
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Related CR Transmittal #: R3149CP
Implementation Date: January 5, 2015

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Preventive Services

# Update – IBT for obesity, screening digital tomosynthesis mammography, and anesthesia associated with screening colonoscopy

## Provider types affected

This *MLN Matters*® article is intended for Medicare practitioners providing preventive and screening services to Medicare beneficiaries and billing Medicare administrative contractors (MACs) for those services.

## Provider action needed

Change request (CR) 8874 is an update from the Centers for Medicare & Medicaid Services (CMS) to ensure accurate program payment for three screening services. The coinsurance and deductible for these services are currently waived, but due to coding changes and additions, the payments for 2015 would not be accurate without updated CR 8874 for intensive behavioral group therapy for obesity, digital breast tomosynthesis, and anesthesia associated with screening colonoscopy. Make sure billing staffs are aware of these updates.

## Background

The following outlines the CMS updates:

### Intensive behavioral therapy for obesity

Intensive behavioral therapy for obesity became a covered preventive service under Medicare, effective November 29, 2011. It is reported with HCPCS code G0447 (Face-to-face behavioral counseling for obesity, 15 minutes). Coverage requirements are in the *Medicare National Coverage Determinations (NCDs) Manual*, Chapter 1, Section 210.

To improve payment accuracy, in 2015 physician fee schedule (PFS) proposed rule, CMS created a new HCPCS code for the reporting and payment of behavioral group counseling for obesity – HCPCS codes G0473 (Face-to-face behavioral counseling for obesity, group (2-10), 30 minutes).

For coverage requirements of intensive behavioral therapy for obesity, see the NCD for intensive behavioral therapy for obesity.

The same claims editing that applies to G0447 applies to G0473. Therefore, effective for claims with dates of service on or after January 1, 2015, MACs will recognize HCPCS code G0473, but only when billed with one of the ICD-9 codes for body mass index (BMI) 30.0 and over (V85.30,-V85.39, V85.41-V85.45). (Once ICD-10 is effective, the related ICD-10 codes are Z68.30-Z68.39 and Z68.41-Z68.45.) When claims for G0473 are submitted without a required diagnosis code, they will be denied using the following remittance codes:

- **Claim adjustment reason code (CARC) 167**: This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- **Remittance advice remarks code (RARC) N386**: This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.mcd.search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.

Effective for claims with dates of service on or after January 1, 2015, beneficiary coinsurance and deductible do not apply to claim lines with HCPCS code G0473.

Note that Medicare pays claims with code G0473 only when submitted by the following provider specialty types as found on the provider's Medicare enrollment record:

- 01 – General practice
- 08 – Family practice
- 11 – Internal medicine
- 16 – Obstetrics/gynecology
- 37 – Pediatric medicine
- 38 – Geriatric medicine
- 50 – Nurse practitioner
- 89 – Certified clinical nurse specialist
- 97 – Physician assistant

Claim lines submitted with G0473, but without an appropriate provider specialty will be denied with the following remittance codes:

- **CARC 8**: The procedure code is inconsistent with the provider type/specialty (taxonomy). **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- **RARC N95**: This provider type/provider specialty may not bill this service.
- **Group code CO** (if GZ modifier present) or PR (if modifier GA is present).

Further, effective for dates of service on or after January 1, 2015, claim lines with G0473 are only payable for the following places of service (POS) codes:

- 11 – Physician's office
- 22 – Outpatient hospital
- 49 – Independent clinic

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- 71 – State or local public health clinic

Claim lines for G0473 will be denied without an appropriate POS code using the following remittance codes:

- **CARC 5**: The procedure code/bill type is inconsistent with the place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- **RARC M77**: Missing/incomplete/invalid place of service.
- **Group code CO** (if GZ modifier present) or PR (if modifier GA is present).

Remember that Medicare will deny claim lines billed for HCPCS codes G0447 and G0473 if billed more than 22 times in a 12-month period using the following codes:


- **CARC 119**: Benefit maximum for this time period or occurrence has been reached.
- **RARC N362**: The number of days or units of service exceeds our acceptable maximum.
- **Group code CO** (if GZ modifier present) or PR (if modifier GA is present).

**Note**: MACs will display the next eligible date for obesity counseling on all MAC provider inquiry screens.

MACs will allow both a claim for the professional service and a claim for a facility fee for G0473 when that code is billed on type of bill (TOB) 13x or on TOB 85x when revenue code 096x, 097x, or 098x is on the TOB 85x. Payment on such claims is based on the following:

- TOB 13x paid based on the OPPS:
- TOB 85x in critical access hospitals based on reasonable cost; except
- TOB 85x Method II hospitals based on 115 percent of the lesser of the fee schedule amount or the submitted charge.

Institutional claims submitted on other than TOB 13x or 85x will be denied using:

- **CARC 171**: Payment is denied when performed by this type of provider on this type of facility. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- **RARC N428**: Not covered when performed in this place of service.
- **Group code CO** (if GZ modifier present) or PR (if modifier GA is present).

### Digital breast tomosynthesis

In the 2015 PFS final rule with comment period, CMS established a payment rate for the newly created *CPT*® code *77063* for screening digital breast tomosynthesis mammography. The same policies that are applicable to other screening mammography codes are applicable to *CPT*® code *77063*. In addition, since this is an add-on code it should only be paid when furnished in conjunction with a 2D digital mammography.

Effective January 1, 2015, *CPT*® code *77063* (*Screening digital breast tomosynthesis, bilateral (list separately in addition to code for primary procedure*)), must be billed in conjunction with the screening mammography HCPCS code G0202 (Screening mammography, producing direct digital image, bilateral, all views, 2D imaging only. Effective January 1, 2015, beneficiary coinsurance and deductible does not apply to claim lines with *77063* (*Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary procedure*).

Payment for *77063* is made only when billed with an ICD-9 code of V76.11 or V76.12 (and when ICD-10 is effective with ICD-10 code Z12.31). When denying claim lines for *77063* that are submitted without the appropriate diagnosis code, the claim lines are denied using the following messages:

- **CARC 167**: This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- **RARC N386**: This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *www.cms.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** (if GZ modifier present) or PR (if modifier GA is present).

**On institutional claims:**

- MACs will pay for tomosynthesis, HCPCS code *77063*, on TOBs 12x, 13x, 22x, 23x based on MPFS, and TOB 85x with revenue code other than 096x, 097x, or 098x based on reasonable cost. TOB 85x claims with revenue code 096x, 097x, or 098x are paid based on MPFS (115 percent of the lesser of the fee schedule amount and submitted charge).
- MACs will pay for tomosynthesis, HCPCS code *77063* with revenue codes 096x, 097x, or 098x when billed on TOB 85x Method II based on 115 percent of the lesser of the fee schedule amount or submitted charge.
- MACs will return to the provider any claim submitted with tomosynthesis, HCPCS code *77063* when the TOB is not 12x, 13x, 22x, 23x, or 85x.

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- MACs will pay for tomosynthesis, HCPCS code *77063*, on institutional claims TOBs 12x, 13x, 22x, 23x, and 85x when submitted with revenue code 0403 and on professional claims TOB 85x when submitted with revenue code 096x, 097x, or 098x.
- Effective for claims with dates of service on or after January 1, 2015, MACs will RTP claims for HCPCS code *77063* that are not submitted with revenue code 0403, 096x, 097x, or 098x.

### Anesthesia furnished in conjunction with colonoscopy

Section 4104 of the Affordable Care Act defined the term "preventive services" to include "colorectal cancer screening tests" and as a result it waives any coinsurance that would otherwise apply under Section 1833(a)(1) of the Act for screening colonoscopies. In addition, the Affordable Care Act amended Section 1833(b)(1) of the Act to waive the Part B deductible for screening colonoscopies. These provisions are effective for services furnished on or after January 1, 2011.

In the 2015 PFS proposed rule, CMS proposed to revise the definition of "colorectal cancer screening tests" to include anesthesia separately furnished in conjunction with screening colonoscopies; and in the 2015 PFS final rule with comment period, CMS finalized this proposal. The definition of "colorectal cancer screening tests" includes anesthesia separately furnished in conjunction with screening colonoscopies in the Medicare regulations at Section 410.37(a)(1)(iii). As a result, beneficiary coinsurance and deductible does not apply to anesthesia services associated with screening colonoscopies.

As a result, effective for claims with dates of service on or after January 1, 2015, anesthesia professionals who furnish a separately payable anesthesia service in conjunction with a screening colonoscopy (HCPCS code 00810 performed in conjunction with G0105 and G0121) shall include the following on the claim for the services that qualify for the waiver of coinsurance and deductible:

- **Modifier 33 – Preventive services:** when the primary purpose of the service is the delivery of an evidence based service in accordance with a USPSTF A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory), the service may be identified by adding 33 to the procedure. For separately reported services specifically identified as preventive, the modifier should not be used.


## Additional information

The official instruction, CR 8874 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3146CP.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.

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## Correct your claims on the 'SPOT'

The SPOT offers registered users the time-saving advantage of not only viewing claim data online but also the option of correcting clerical errors on their eligible Part B claims quickly, easily, and securely – online.

# Screening for hepatitis C virus (HCV) in adults

***Note**: This article was revised November 26, 2014, in order to (1) make editorial changes, (2) add TOBs 71x & 77x and clarify payment methodology, (3) add POS 50, 72 & 81, (4) clarify MAC claim processing prior to January 1, 2015, (5) clarify remittance codes, and (6) revise implementation information. All other information remains the same. This information was previously published in the September 2014 Medicare B Connection, Pages 19-21.*

## Provider types affected

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

## What you need to know

Change request (CR) 8871 states, effective June 2, 2014, the Centers for Medicare & Medicaid Services (CMS) will cover screening for HCV consistent with the grade B recommendations by the United States Preventive Services Task Force (USPSTF) for the prevention or early detection of an illness or disability and is appropriate for individuals entitled to benefits under Medicare Part A or enrolled under Part B. Make sure your billing staffs are aware of these changes.

## Background

HCV is an infection that attacks the liver and is a major cause of chronic liver disease. Inflammation over long periods of time (usually decades) can cause scarring, called cirrhosis. A cirrhotic liver fails to perform the normal functions of the liver which leads to liver failure. Cirrhotic livers are more prone to become cancerous and liver failure leads to serious complications, even death. HCV is reported to be the leading cause of chronic hepatitis, cirrhosis, and liver cancer, and a primary indication for liver transplant in the Western World.

Prior to June 2, 2014, CMS did not cover screening for HCV in adults. Pursuant to §1861(ddd) of the Social Security Act, CMS may add coverage of "additional preventive services" through the national coverage determination (NCD) process.

Effective June 2, 2014, CMS will cover screening for HCV with the appropriate U.S. Food and Drug Administration (FDA) approved/cleared laboratory tests (used consistently with FDA-approved labeling and in compliance with the Clinical Laboratory Improvement Act (CLIA) regulations) and point-of-care tests (such as rapid anti-body tests that are performed in outpatient clinics and physician offices) when ordered by the beneficiary's primary care physician or practitioner within the context of a primary care setting, and performed by an eligible Medicare provider for these services, for beneficiaries who meet either of the following conditions:

1. Adults at high risk for HCV infection. "High risk" is defined as persons with a current or past history of illicit injection drug use, and persons who have a history of receiving a blood transfusion prior to 1992. Repeat screening for high risk persons is covered annually only for persons who have had continued illicit injection drug use since the prior negative screening test.
2. Adults who do not meet the high risk definition as defined above, but who were born from 1945 through 1965. A single, once-in-a-lifetime screening test is covered for these individuals.

The determination of "high risk for HCV" is identified by the primary care physician or practitioner who assesses the patient's history, which is part of any complete medical history, typically part of an annual wellness visit and considered in the development of a comprehensive prevention plan. The medical record should be a reflection of the service provided.

### General claim processing requirements for claims with dates of service on and after June 2, 2014

1. New HCPCS G0472, short descriptor -Hep C screen high risk/other and long descriptor-Hepatitis C antibody screening for individual at high risk and other covered indication(s), will be used. HCPCS G0472 will appear in the January 2015 recurring updates of the Medicare physician fee schedule database (MPFSDB) and the integrated outpatient code editor (IOCE) with a June 2, 2014 effective date. Contractors shall apply contractor pricing to claims with dates of service June 2, 2014, through December 31, 2014 that contain HCPCS G0472.
2. Beneficiary coinsurance and deductibles do not apply to HCPCS G0472.
3. For services provided to beneficiaries born between the years 1945 and 1965 who are not considered high risk, HCV screening is limited to once per lifetime, claims shall be submitted with:
   - HCPCS G0472
4. For those determined to be high-risk initially, claims must be submitted with:
   - HCPCS G0472; and
   - ICD-9 diagnosis code V69.8, other problems related to life style/ICD-10 diagnosis code Z72.89, other problems related to lifestyle (once ICD-10 is implemented)
5. Screening may occur on an annual basis if appropriate, as defined in the policy. Claims for adults at high risk who have had continued illicit injection drug use since the prior negative screening shall be submitted with:
   - HCPCS G0472;
   - ICD diagnosis code V69.8/Z72.89; and

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- ICD diagnosis code 304.91, unspecified drug dependence, continuous/F19.20, other psychoactive substance abuse, uncomplicated (once ICD-10 is implemented).

**Note**: Annual is defined as 11 full months must pass following the month of the last negative HCV screening.

### Institutional billing requirements

Effective for claims with dates of service on and after June 2, 2014, institutional providers may use types of bill (TOB) 13x, 71x, 77x, and 85x when submitting claims for HCV screening, HCPCS G0472. Medicare will deny G0472 service line-items on other TOBs using the following messages:

- **Claim adjustment reason code (CARC) 170** – Payment denied when performed/billed by this type of provider. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- **Remittance advice remarks code (RARC) N95** – This provider type/provider specialty may not bill this service.
- **Group code CO** (contractual obligation) – If claim received without a GZ modifier.

The service is paid on the following basis:

- **Outpatient hospitals** – TOB 13x – based on Medicare physician fee schedule (MPFS).
- **Rural health clinics (RHCs)** – TOB 71x – and federally qualified health centers (FQHCs) - 77x -technical component paid based on the MPFS. For RHCs and FQHCs that are authorized to bill under the reasonable cost system, payment for the professional component is included in the RHC/FQHC all-inclusive rate (AIR). HCV screening is not a stand-alone payable visit for RHCs and FQHCs.
- **Critical access hospitals (CAHs)** – TOB 85x – based on reasonable cost; and
- **CAH Method II** – TOB 85x – based on 115 percent of the lesser of the MPFS amount or actual charge as applicable with revenue codes 096x, 097x, or 098x.

**Note**: Separate guidance shall be issued for FQHCs that are authorized to bill under the prospective payment system.

### Professional billing requirements

For professional claims with dates of service on or after June 2, 2014, CMS will allow coverage for HCPCS G0472, only when services are submitted by the following provider specialties found on the provider's enrollment record:

01 – General practice

08 – Family practice

11 – Internal medicine

16 – Obstetrics/gynecology

37 – Pediatric medicine

38 – Geriatric medicine

42 – Certified nurse midwife

50 – Nurse practitioner

89 – Certified clinical nurse specialist

97 – Physician assistant

Medicare will deny claims submitted for these services by providers other than the specialty types noted above. When denying such claims, Medicare will use the following messages:

- **CARC 184** – The prescribing/ordering provider is not eligible to prescribe/order the service. **NOTE**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- **RARC N574** – Our records indicate the ordering/ referring provider is of a type/specialty that cannot order/refer. Please verify that the claim ordering/ referring information is accurate or contact the ordering/referring provider.
- **Group code CO** if claim received without GZ modifier.

For professional claims with dates of service on or after June 2, 2014, CMS will allow coverage for HCV screening, HCPCS G0472, only when submitted with one of the following place of service (POS) codes:

11 – Physician's office

22 – OutpatienthHospital

49 – Independent clinic

50 – FQHC

71 – State or local public health clinic

72 – RHC

81 – Independent laboratory

Medicare will deny claims submitted without one of the POS codes noted above with the following messages:

- **CARC 171** – Payment denied when performed by this type of provider in this type of facility. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- **RARC N428** – Not covered when performed in this place of service.
- **Group code CO** if claim received without GZ modifier.

### Other billing information for both professional and institutional claims

On both institutional and professional claims, Medicare will deny claims line-items for HCPCS G0472 with dates of

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service on or after June 2, 2014, where it is reported more than once-in-a-lifetime for beneficiaries born from 1945 through 1965 and who are not high risks. Medicare will also line-item deny when more than one HCV screening is billed for the same high-risk beneficiary prior to their annual eligibility criteria being met. In denying these claims, Medicare will use:

- **CARC 119** – Benefit maximum for this time period or occurrence has been reached.
- **RARC N386** – This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *www.cms.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** if claim received without GZ modifier.

When applying the annual frequency limitation, MACs will allow both a claim for a professional service and a claim for a facility fee.

In addition, remember that the initial HCV screening for beneficiaries at high risk must also contain ICD-9 diagnosis code V69.8 (ICD-10 code Z72.89 once ICD-10 is implemented). Then, for the subsequent annual screenings for high risk beneficiaries, you must include ICD-9 code V69.8 and 304.91 (ICD-10 of Z72.89 and F19.20 once ICD-10 is implemented). Failure to include the diagnosis code(s) for high risk beneficiaries will result in denial of the line item. In denying these payments, Medicare will use the following:

- **CARC 119** – Benefit maximum for this time period or occurrence has been reached. (for initial high risk screening), or,
- **CARC 167** – This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. (for subsequent annual high risk screening)
- **RARC N386** – This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *www.cms.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** if claim received without GZ modifier.

## Additional information

The official instruction, CR 8871, was issued to your MAC regarding this change via two transmittals. The first transmittal updates the *Medicare Claims Processing Manual* and it is available at *http://www.cms.gov/Regulations-andGuidance/Guidance/Transmittals/Downloads/R3127CP.pdf*. The second transmittal updates the NCD Manual and it is available at *http://www.cms.gov/Regulations-andGuidance/Guidance/Transmittals/Downloads/R177NCD.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.

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Related Change Request (CR) #: CR 8871
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Related CR Transmittal #: R3127CP and R177NCD
Implementation Date: January 5, 2015, for non-shared MAC edits and CWF analysis; April 6, 2015, for remaining shared system edits

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# Deductible, coinsurance, and premium rates for 2015

## Provider types affected

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

## Provider action needed

Change request (CR) 8982 informs the MACs about the changes needed to update the claims processing system with the new 2015 Medicare deductible, coinsurance, and premium rates. Make sure that your billing staff are aware of these changes.

## Background

Beneficiaries who use covered Part A services may be subject to deductible and coinsurance requirements. A beneficiary is responsible for an inpatient hospital deductible amount, which is deducted from the amount payable by the Medicare program to the hospital, for inpatient hospital services furnished in a spell of illness. When a beneficiary receives such services for more than 60 days during a spell of illness, he or she is responsible for a coinsurance amount equal to one-fourth of the inpatient hospital deductible per-day for the 61st-90th day spent in the hospital. An individual has 60 lifetime reserve days of coverage, which they may elect to use after the 90th day in a spell of illness. The coinsurance amount for these days is equal to one-half of the inpatient hospital deductible. A beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible per day for the 21st through the 100th day of skilled nursing facility (SNF) services furnished during a spell of illness.

Most individuals age 65 and older, and many disabled individuals under age 65, are insured for health insurance (HI) benefits without a premium payment. The Social Security Act provides that certain aged and disabled persons who are not insured may voluntarily enroll, but are subject to the payment of a monthly premium. Since 1994, voluntary enrollees may qualify for a reduced premium if they have 30-39 quarters of covered employment. When voluntary enrollment takes place more than 12 months after a person's initial enrollment period, a 10 percent penalty is assessed for two years for every year they could have enrolled and failed to enroll in Part A.

Under Part B of the supplementary medical insurance (SMI) program, all enrollees are subject to a monthly premium. Most SMI services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay), which are set by statute. When Part B enrollment takes place more than 12 months after a person's initial enrollment period, there is a permanent 10 percent increase in the premium for each year the beneficiary could have enrolled and failed to enroll. The 2015 rates are as follows:

### 2015 Part A – Hospital insurance (HI)

- **Deductible**: $1,260.00
- **Coinsurance**
  - $315.00 a day for 61st-90th day :
  - $630.00 a day for 91st-150th day (lifetime reserve days)
  - $157.50 a day for 21st-100th day (Skilled nursing facility coinsurance)
- **Base premium (BP)**: $407.00 a month
- BP with 10 percent surcharge: $447.70 a month
- BP with 45 percent reduction: $224.00 a month (for those who have 30-39 quarters of coverage)
- BP with 45 percent reduction and 10 percent surcharge: $246.40 a month

### 2015 Part B – Supplementary medical insurance (SMI)

- ***Standard premium***: $104.90 a month
- **Deductible**: $147.00 a year
- **Pro rata data amount**
  - $114.99 1st month :
  - $32.01 2nd month
- **Coinsurance**: 20 percent

## Additional information

The official instruction, CR 8982, issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R89GI.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?

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# Provider enrollment requirements for writing prescriptions for Medicare Part D drugs

## Provider types affected

This *MLN Matters*® special edition is intended for physicians and other eligible professionals who write prescriptions for Medicare beneficiaries for Medicare Part D drugs. The article is also directed to Medicare Part D plan sponsors.

## Provider action needed

The Centers for Medicare & Medicaid Services (CMS) finalized CMS-4159-F "Medicare Program; Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs" May 23, 2014. This rule requires physicians and, when applicable, other eligible professionals who write prescriptions for Part D drugs to be enrolled in an approved status or to have a valid opt-out affidavit on file for their prescriptions to be covered under Part D. The final regulation stated that the effective date for this requirement would be June 1, 2015. However, CMS is announcing that it will delay enforcement of the requirements in 42 CFR 423.120(c)(6) until December 1, 2015. Nevertheless, prescribers of Part D drugs must submit their Medicare enrollment applications or opt-out affidavits to their Part B Medicare administrative contractors (MACs) by June 1, 2015, or earlier, to ensure that MACs have sufficient time to process the applications or opt out affidavits and avoid their patients' prescription drug claims from being denied by their Part D plans, beginning December 1, 2015. Note that enrollment functions for physicians and other prescribers are handled by Part B MACs.


## Background

If you write prescriptions for covered Part D drugs and you are not enrolled in Medicare in an approved status or have a valid record of opting out, you need to submit an enrollment application or an opt out affidavit to your Medicare administrative contractor (MAC) by June 1, 2015, or earlier. You may submit your enrollment application electronically using the Internet-based Provider Enrollment, Chain, and Ownership System (PECOS) located at *https://pecos.cms.hhs.gov/pecos/login.do* or by completing the paper CMS-855I or CMS-855O application, which is available at *http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-List.html*. Note that an application fee is not required as part of your application submission.

If you wish to enroll to be reimbursed for the covered services furnished to Medicare beneficiaries, you must complete the CMS-855I application. The CMS-855O, which is a shorter, abbreviated form, should only be completed if you are seeking to enroll solely to order and refer and/or prescribe Part D drugs. (While the CMS-855O form states it is for physicians and non-physician practitioners who want to order and refer, it is appropriate for use by prescribers, who also want to enroll to prescribe Part D drugs.) If you do not see your specialty listed on either of the applications, select the "Undefined Physician/Non-Physician" type option and identify your specialty in the space provided.

If you are a physician or eligible professional who wants to opt out of Medicare, you must submit an opt-out affidavit to the MAC within your specific jurisdiction. Your opt-out information must be current (an affidavit must be completed every two years, and a national provider identifier (NPI) is required to be submitted on the affidavit). For more information on the opt-out process, refer to *MLN Matters*® article SE1311, titled "Opting out of Medicare and/or Electing to Order and Refer Services," which is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1311.pdf*.

In an effort to prepare the prescribers and Part D sponsors for the December 1, 2015, enforcement date, CMS is making available an enrollment file that identifies physician and eligible professional who are enrolled in Medicare in an approved or opt out status. The first iteration of the enrollment file is now available at *https://data.cms.gov/dataset/Medicare-Individual-Provider-List/u8u9-2upx*. The file contains production data but is considered a test file since the Part D prescriber enrollment requirement is not yet applicable. An updated enrollment file will be generated every two weeks and continue through the December 1, 2015 enforcement date.

The file displays physician and eligible professional eligibility as of and after November 1, 2014, (i.e., currently enrolled, new approvals, or changes from opt-out to enrolled as of November 1, 2014). Any periods, prior to November 1, 2014, for which a physician or eligible professional was not enrolled in an approved or opt-out status will not be displayed on the enrollment file. However, any periods after November 1, 2014, for which a physician or eligible professional was not enrolled in an approved or opt-out status will be on the file with its respective end dates for that given provider. For opted out providers, the opt-out flag will display a Y/N (Yes/No) value to indicate the periods the provider was opted out of Medicare. The file will include the provider's:

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# DRUGS

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- (NPI);
- First and last names;
- Effective and end dates; and
- Opt-out flag

**Example 1**

| NPI | First name | Last name | Effective date | End date | Opt-out flag |
|---|---|---|---|---|---|
| 123456789 | John | Smith | 11/01/2014 | 12/15/2014 | N |

**Example 1**– Dr. John Smith's effective date of enrollment is January 1, 2014. Since he was enrolled prior to the generation of the test file, his effective date will display as November 1, 2014. Dr. Smith submits an enrollment application to voluntarily withdraw from Medicare effective December 15, 2014. Dr. Smith will appear on the applicable file as:

**Example 2** - Dr. Mary Jones submits an affidavit to opt out of Medicare, effective December 1, 2014. Since she has opted out after the generation of the test file, her effective date will display as December 1, 2014. After the two year opt out period expires, Dr. Jones decides she wants to enroll in Medicare to bill, order, and refer, or to write prescriptions. The enrollment application is received on January 31, 2017, and the effective date issued is January 1, 2017. Dr. Jones will display on the applicable file as:

**Example 2**

| NPI | First name | Last name | Effective date | End date | Opt-out flag |
|---|---|---|---|---|---|
| 987654321 | Mary | Jones | 12/01/2014 | 12/01/2016 | Y |
| 987654321 | Mary | Jones | 01/01/2017 | | N |

After the enforcement date of December 1, 2015, the applicable effective dates on the file will be adjusted to December 1, 2015, and it will no longer be considered a test file. All inactive periods prior to December 1, 2015, will be removed from the file and it will only contain active and inactive enrollment or opt out periods as of December 1, 2015, and after. The file will continue to be generated every two weeks, with a purposeful goal toward more frequent updates on a set schedule. Part D sponsors may utilize the file to determine a prescriber's Medicare enrollment or opt out status when processing Part D pharmacy claims. The file will not validate the provider's ability to prescribe under applicable laws. Please submit questions or issues encountered in accessing the file to *providerenrollment@cms.hhs.gov*.

## Additional information

For more information on the enrollment requirements, visit *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Part-D-Enrollment-Information.html*. If you have questions and need to speak with the Part B contractor that handles your enrollment, you may find their toll-free number at *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/contact_list.pdf*. To identify your Medicare contractor, locate the state in which you provide services and refer to the contractor listed on the "Part B Contractor" line.

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# Revisions to Chapter 15 of the 'Program Integrity Manual'

## Provider types affected

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

## What you need to know

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 8810 to make several clarifications to Chapter 15 of the *Medicare Program Integrity Manual*. Most of these changes were editorial in nature to clarify other Medicare manuals being referenced in Chapter 15. The revised Chapter 15 is attached to CR 8810.

## Additional information

The official instruction, CR 8810, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R556PI.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.

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# Quarterly provider update

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

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

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

# Medicare ICD-10 testing approach

***Note**: This article was revised December 8, 2014, to include the dates and some additional details for the three end-to-end testing periods. This information was previously published in the August 2014 Medicare B Connection, Pages 23-25.*

## Provider types affected

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

## Provider action needed

For dates of service on and after October 1, 2015, entities covered under the Health Insurance Portability and Accountability Act (HIPAA) are required to use the ICD-10 code sets in standard transactions adopted under HIPAA. The HIPAA standard health care claim transactions are among those for which International Classification of Diseases, 10th Edition (ICD-10) codes must be used for dates of service on and after October 1, 2015. Be sure you are ready. This *MLN Matters*® special edition article is intended to convey the testing approach that the Centers for Medicare & Medicaid Services (CMS) is taking for ICD-10 implementation.

## Background

The implementation of ICD-10 represents a significant code set change that impacts the entire health care community. As the ICD-10 implementation date of October 1, 2015, approaches, CMS is taking a comprehensive four-pronged approach to preparedness and testing for ICD-10 to ensure that CMS as well as the FFS provider community is ready.

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

The four-pronged approach includes:

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

Each approach is discussed in more detail below.

### CMS internal testing of its claim processing systems

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

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

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

### Provider-initiated beta testing tools

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

- NCDs and LCDs converted from International Classification of Diseases, 9th Edition (ICD-9) to ICD-10 located at *http://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html*.
- The ICD-10 Medicare Severity-Diagnosis Related Groups (MS-DRGs) conversion project (along with payment logic and software replicating the current MS-DRGs), which used the General Equivalence Mappings to convert ICD-9 codes to International Classification of Diseases, 10th Edition, Clinical Modification (ICD-10-CM) codes, located at *http://cms.hhs.gov/Medicare/Coding/ICD10/ICD-10-MS-DRG-Conversion-Project.html*. On this Web page, you can also find current versions of the ICD-10-CM MS-DRG grouper, Medicare code editor (available from National Technical Information Service), and *MS-DRG Definitions Manual* that will allow you to analyze any payment impact from the conversion of the MS-DRGs from ICD-9-CM to ICD-10-CM codes and to compare the same version in both ICD-9-CM and ICD-10-CM; and
- A pilot version of the October 2013 integrated outpatient code editor (IOCE) that utilizes ICD-10-CM located at *http://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/Downloads/ICD-10-IOCE-Code-Lists.pdf*. The final version of the IOCE that utilizes ICD-10-CM is scheduled for release in the near future.

### Acknowledgement testing

Providers, suppliers, billing companies, and clearinghouses are welcome to submit acknowledgement test claims anytime up to the October 1, 2015, implementation date. In addition, CMS will be highlighting this testing by offering three separate weeks of ICD-10 acknowledgement testing. These special acknowledgement testing weeks give submitters access to real-time help desk support and allows CMS to analyze testing data. Registration is not required for these virtual events.

All MACs and the DME MAC common electronic data interchange (CEDI) contractor will promote this ICD-

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10 acknowledgement testing with trading partners. This testing allows all providers, billing companies, and clearinghouses the opportunity to determine whether CMS will be able to accept their claims with ICD-10 codes. While test claims will not be adjudicated, the MACs will return an acknowledgment to the submitter (a 277A or a 999) that confirms whether the submitted test claims were accepted or rejected.

MACs and CEDI will be appropriately staffed to handle increased call volume on their electronic data interchange (EDI) help desk numbers, especially during the hours of 9:00 a.m. to 4:00 p.m. local MAC time, during these testing weeks. The testing weeks will occur in November 2014, March 2015, and June 2015. For more information about acknowledgement testing, refer to the information on your MAC's website.

### End-to-end testing

During 2015, CMS plans to offer three separate end-to-end testing opportunities. Each opportunity will be open to a limited number of providers that volunteer for this testing. As planned, approximately 2,550 volunteer submitters will have the opportunity to participate over the course of the three testing periods. End-to-end testing includes the submission of test claims to Medicare with ICD-10 codes and the provider's receipt of a remittance advice (RA) that explains the adjudication of the claims. The goal of this testing is to demonstrate that:

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

The sample will be selected from providers, suppliers, and other submitters who volunteer to participate. To facilitate this testing, CMS 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 to represent a broad cross-section of provider types, claims types, and submitter types. At least five, but not more than fifteen, of the testers will be a clearinghouse.
- MACs and CEDI will post a volunteer form to their website during the enrollment periods to collect volunteer information with which to select volunteers. Those interested in testing should review the minimum testing requirements on the form to ensure they qualify before volunteering.

Additional details about the end-to-end testing process will be disseminated at a later date in a separate *MLN Matters*® article.

### Claims submission alternatives

If you will not be able to complete the necessary systems changes to submit claims with ICD-10 codes by October 1, 2015, you should investigate downloading the free billing software that CMS offers via their MAC websites. The software has been updated to support ICD-10 codes and requires an Internet connection. This billing software only works for submitting FFS claims to Medicare. It is intended to provide submitters with an ICD-10 compliant claims submission format; it does not provide coding assistance. Alternatively, all MACs offer provider Internet portals, and a subset of these MAC portals offer claims submission; providers submitting to this subset of MACs may choose to use the portal for submission of ICD-10 compliant claims. Register in the portals that offer claims submission to ensure that you have the flexibility to submit professional claims this way as a contingency. More information may be found on your MAC's website.

## Additional information

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. In addition to showing the toll-free numbers, you will find your MAC's website address at this site in the event you want more information on the free billing software or the MAC's provider Internet portals mentioned above.

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# FAQs – ICD-10 end-to-end testing

## Provider types affected

This *MLN Matters*® special edition article is intended for all physicians, providers, suppliers, clearinghouses, and billing agencies selected to participate in Medicare ICD-10 end-to-end testing.

## Provider action needed

Physicians, providers, suppliers, clearinghouses, and billing agencies selected to participate in Medicare ICD-10 end-to-end testing should review the following questions and answers before preparing claims for ICD-10 end-to-end testing to gain an understanding of the guidelines and requirements for successful testing.

## What to know prior to testing

**1. How is ICD-10 end-to-end testing different from acknowledgement testing?**

The goal of acknowledgement testing is for testers to submit claims with ICD-10 codes to the Medicare fee-for-service claims systems and receive acknowledgements to confirm that their claims were accepted or rejected.

End-to-end testing takes that a step further, processing claims through all Medicare system edits to produce and return an accurate electronic remittance advice (ERA). While acknowledgement testing is open to all electronic submitters, end-to-end testing is limited to a smaller sample of submitters who volunteer and are selected for testing.

**2. What constitutes a testing slot for this testing?**

A testing slot is the ability to submit 50 claims to a particular Medicare administrative contractor (MAC) who selected you for testing.

**3. What data must I provide to the MAC before testing?**

For each testing slot, you must provide the MAC: up to two submitter identifiers (IDs), up to five national provider identifiers (NPIs)/provider transaction access numbers (PTANs), and up to 10 health insurance claim numbers (HICNs). You may use these in any combination on the 50 claims. You will need to use the same HICN on multiple claims. Therefore, you will need to consider this when designing a test plan, since claims will be subject to standard utilization edits.

If you were selected to test with only one submitter ID but would like to choose a second one, you must contact the MAC to add the second submitter ID. If the MAC is not aware of your preference to use a second submitter ID, claims submitted with that ID may not be processed.

**4. What should I consider when choosing HICNs for testing?**

The MAC will copy production information into the test region for the HICNs that you provide. This includes eligibility information, claims history, and other documentation such as certificates of medical necessity (CMNs). The HICNs you provide must be real beneficiaries and may not have a date of death on file. If you previously submitted HICNs for beneficiaries who are deceased, contact the MAC as soon as possible with replacement HICNs.

**5. If I was selected for the January 2015 end-to-end testing, do I need to reapply for later testing rounds?**

No, once you are selected for testing, you are automatically registered for the later rounds of testing.

**6. Does this mean that no new submitters will be accepted for the April and July 2015 end-to-end testing periods or will a new group of 850 testers be selected for both April and July?**

A new group will be selected for each of the April and July 2015 testing periods, and these groups will be able to test in addition to the already chosen testers. Therefore, the total number of potential testers will be 1,700 for April 2015 and 2,550 for July 2015.

**7. Do you have information on who has been selected for the January 2015 end-to-end testing?**

We will release this information as part of the public release of our January test results.

**8. When do you expect to publically release results of the first round of end-to-end testing?**

We expect to publically release results of the first round of end-to-end testing around the end of February 2015.

**9. Can I submit additional NPIs, PTANs, and HICNs for the later rounds of testing?**

Yes, while you do not need to re-apply for the later rounds of testing, you may choose to submit up to two additional submitter IDs, up to five additional NPIs/PTANs, and up to 10 additional HICNs. You may also still use the information you submitted for the previous testing round. The MAC will provide the form you must use to submit this new information, and the information must be received by the due date on the form to be considered for the next round of testing.

## What to know during testing

**1. Is it safe to submit test claims with protected health information (PHI)?**

The test claims you submit are accepted into the system using the same secure method used for production claims on a daily basis. They will be processed by the same MACs who process production claims, and all the same security protocols will be followed. Therefore, using real data for this test does not cause any additional risk of release of PHI.

**2. What dates of service can be used on test claims?**

**Professional claims** with an ICD-10 code must have a date of service on or after October 1, 2015.

**Inpatient claims** with an ICD-10 code must have a discharge date on or after October 1, 2015.

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# FAQ

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**Supplier claims** with an ICD-10 code must have a date of service between October 1, 2015, and October 15, 2015.

For **professional and institutional claims**, you may use dates up to December 31, 2015. You cannot use dates in 2016 or beyond.


**3. Can both ICD-9 and ICD-10 codes be submitted on the same claim?**

ICD-9 and ICD-10 codes cannot be submitted on the same claim. For additional information on how to submit claims that span the ICD-10 implementation date (when ICD-9 codes are effective for that portion of the services rendered on September 30, 2015, and earlier, and when ICD-10 codes are effective for that portion of the services rendered on October 1, 2015, and later), please refer to *MLN Matters*® article SE1325, "Institutional Services Split Claims Billing Instructions for Medicare Fee-For-Service (FFS) Claims that span the ICD-10 Implementation Date" located at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1325.pdf*.

**4. Do returned to provider (RTP) claims count toward the 50 claims submitted? Can RTP'd claims be re-submitted for testing?**

Institutional claims that fail return to provider (RTP) editing count toward the 50 claim submission limit. Claims that are RTP'd will not appear on the electronic remittance advice, and will not be available through DDE. If claims accepted by the front end edits do not appear on the remittance advice, please contact the Medicare administrative contractor (MAC) for further information.

Claims that are rejected by front end editing do not count toward the 50 claim submission limit; therefore, they should be corrected and resubmitted.

**5. If a certificate of medical necessity (CMN) or DME information form (DIF) is required for a supplier claim, do I need to submit a CMN during testing?**

If the beneficiary has a **valid CMN or DIF** on file for that equipment/supply covered by the dates of service on your test claim (after 10/1/2015), you do not need to submit a new CMN/DIF.

If the beneficiary's **CMN/DIF has expired** for the dates of service on your test claim (after 10/1/2015), you must submit a revised CMN/DIF to extend the end date for that CMN/DIF.

If the beneficiary **does not have a CMN or DIF** for that equipment/supply, you must submit a new CMN/DIF.

**6. For home health claims, how should I submit the request for anticipated payment (RAP) and final claim for testing?**

Submit the RAP and final claim in the same file and the system will allow them to process. The final claim will be held and recycle (as in normal processing) until the RAP finalizes. It will then be released to the common working file (CWF). The RAP processing time will be short since the test beneficiaries are set up in advance.

To get your results more quickly, you may also want to consider billing low utilization payment adjustment claims with four visits or less that do not require a RAP.

**7. For hospice claims, should I submit the notice of election (NOE) prior to testing?**

You will not need to provide NOEs to the MAC prior to the start of testing. The MACs will set up NOEs for any hospice claims received during testing.

**8. For an inpatient rehabilitation facility (IRF) or skilled nursing facility (SNF) stay, can the case-mix group (CMG) or resource utilization group (RUG) code be submitted on the claim even though the date of service is in the future?**

Yes, you can send the IRF claim with a valid CMG code on the claim and a SNF claim with a valid RUG code on the claim, even though the date is in the future. For testing purposes, only a claim with a valid health insurance prospective payment system (HIPPS) code will be required. You do not need to submit the supporting data sheets.

## Additional information

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.

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# Discover the benefits of electronic remittance advice

## Do you receive standard paper remittance (SPR) advices?

The majority of the providers in the First Coast Service Options Inc. (First Coast) jurisdiction submit their claims electronically. However, First Coast's records also show that for October 2014, 11 percent of all the Part A remittance advices and 12 percent of all the Part B remittance advices were sent to providers as paper instead of an easy-to-use electronic format.

## Why not "go electronic"?

**Here are a few benefits to receiving electronic remittance advice (ERA):**

- Receive your remittances the day the claim finalizes
- Reduce costs associated with:
  - Storage and maintenance of SPRs
  - Staff time to review and file SPRs

The Centers for Medicare & Medicaid Services (CMS) provides free software for you so that you can download, view, and print duplicate copies of Part A or B electronic remittances whenever you wish. If you currently submit your claims electronically and are not set up for electronic remittance, please complete the *Electronic Data Interchange (EDI) Enrollment form* prior to downloading the free software.

**How do you get this free software?**

- For Part A providers, download *PC-Print Software*.
- For Part B providers, download *MREP software*.

Your time and money are valuable. Save both by downloading the software for ERA.

# Claim status category and claim status codes update

## Provider types affected

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

## Provider action needed

Change request (CR) 8994 informs MACs about the changes to claim status category codes and claim status codes. Make sure that your billing staff are aware of these changes.

## Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all health care payers to use only claim status category codes and claim status codes approved by the National Code Maintenance Committee in the Accredited Standards Committee (ASC) x12 276/277 Health Care Claim Status Request and Response format adopted as the standard for National use under HIPAA. These codes explain the status of submitted claim(s). Proprietary codes may not be used in the ASC x12 276/277 to report claim status. The National Code Maintenance Committee meets at the beginning of each ASC x12 trimester meeting (January, June, and October) and makes decisions about additions of new codes, as well as modifications and retirement of existing codes. The codes sets are available at *http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-category-codes/* and *http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-codes/*.

These pages have previously been referenced at *http://www.wpc-edi.com/codes*. Included in the code lists are specific details, including the date when a code was added, changed, or deleted.

All code changes approved during the January 2015 committee meeting shall be posted on the previously mentioned websites on or about February 1, 2015. MACs must complete entry of all applicable code text changes and new codes, and terminate use of deactivated codes by the implementation date of CR 8994.

These code changes are to be used in the editing of all ASC x12 276 transactions processed on or after the date of implementation and are to be reflected in ASC x12 277 transactions issued on and after the date of implementation of CR 8994.

## Additional information

The official instruction, CR 8994 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3143CP.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: MM8994
Related Change Request (CR) #: CR 8994
Related CR Release Date: December 5, 2014
Effective Date: April 1, 2015
Related CR Transmittal #: R3143CP
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.*

# Implementation of phase III CORE 360 CARCs and RARCs rule – update

## Provider types affected

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

## Provider action needed

Change request (CR) 8983 deals with the regular update in Council for Affordable Quality Healthcare (CAQH) Committee on operating rules for information exchange (CORE) defined code combinations per operating rule 360 - uniform use of CARCs and RARCs (835) rule. CAQH CORE will publish the next version of the code combination List on or about February 1, 2015, and CR 8983 instructs the MACs to use that list as of April 1, 2015. This update is based on November 1, 2014, CARC and RARC updates as posted at the Washington Publishing Company (WPC) website.

Visit *http://www.wpc-edi.com/reference* for CARC and RARC updates and *http://www.caqh.org/CORECodeCombinations.php* for CAQH CORE defined code combination updates.

## Background

The Department of Health and Human Services (HHS) adopted the phase III CAQH CORE electronic funds transfer (EFT) and electronic remittance advice (ERA) operating rule set that must be implemented by January 1, 2014, under the Affordable Care Act. The Health Insurance Portability and Accountability Act (HIPAA) amended the Social Security Act by adding Part C – administrative simplification – to Title XI of the Act, requiring the Secretary of the Department of HHS (the Secretary) to adopt standards for certain transactions to enable health information to be exchanged more efficiently and to achieve greater uniformity in the transmission of health information.

Through the Affordable Care Act, Congress sought to promote implementation of electronic transactions and achieve cost reduction and efficiency improvements by creating more uniformity in the implementation of standard transactions. This was done by mandating the adoption of a set of operating rules for each of the HIPAA transactions. The Affordable Care Act defines operating rules and specifies the role of operating rules in relation to the standards.

**Note**: Per Affordable Care Act mandate, all health plans, including Medicare, must comply with CORE 360 uniform use of CARCs and RARCs (835) rule or CORE developed maximum set of CARC/RARC/group code for a minimum set of four business scenarios. Medicare can use any code combination if the business scenario is not one of the four CORE defined business scenarios but for the four CORE defined business scenarios, Medicare must use the code combinations from the lists published by CAQH CORE.

## Additional information

The official instruction for CR 8983 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3135CP.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: MM8983
Related Change Request (CR) #: CR 8983
Related CR Release Date: November 26, 2014
Effective Date: April 1, 2015
Related CR Transmittal #: R3135CP
Implementation Date: April 6, 2015

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

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

### Effective and notice dates

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

### Electronic notification

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

### More information

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

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


## Looking for LCDs?

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

## Advance beneficiary notice

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

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

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

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

**Find out first: Subscribe to First Coast eNews**

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

## Retired LCDs

# Alemtuzumab (Campath®) – retired Part B LCD

### LCD ID number: L29055 (Florida)
### LCD ID number: L29073 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for Alemtuzumab (Campath®) is being retired based on the Campath® Distribution Program development to ensure continued access to Campath® (alemtuzumab) for appropriate patients. Effective September 4, 2012 Campath® will no longer be available commercially, but will be provided through the Campath® Distribution Program free of charge.

### Effective date

This LCD retirement is effective for services rendered on or after January 1, 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 "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page.

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

# Hepatitis C antibody in the ESRD and non-ESRD setting – retired Part B LCD

### LCD ID number: L29190 (Florida)
### LCD ID number: L29436 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for Hepatitis C antibody in the ESRD and non-ESRD setting is being retired based on data analysis.

### Effective date

This LCD retirement is effective for services rendered **on or after December 16, 2014**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. Coding guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page.

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

## New LCD

# Spinal cord stimulation for chronic pain – new LCD

### LCD ID number: L35648 (Florida/Puerto Rico/ U.S. Virgin Islands)

Data analysis identified an increase in utilization of spinal cord stimulation services, *CPT*® codes *63650* and *63655*. The Medicare Part B Extraction Summary System (BESS) statistical medical data obtained for dates of service July 1, 2013, through December 31, 2013, indicated a carrier to nation ratio for Florida at *1.52 for procedure code *63650* (between 50-100 percent above the national average), and *2.02 (100-150 percent above the national average) for *CPT*® code *63655*. (**Note**: Data for Puerto Rico and the U.S. Virgin Islands was below the national average for the applicable codes).

Due to the risk for a high dollar claim payment error, the LCD for Spinal Cord Stimulation for Chronic Pain has been created to address the limited indications for these services and to further clarify National Coverage Determination (NCD) 160.7, Electrical Nerve Stimulators, as well as align with other Medicare administrative contractors. This LCD supplements but does not replace, modify or supersede existing Medicare applicable NCDs or payment policy rules and regulations for Spinal Cord Stimulation (Dorsal Column Stimulation).

This LCD has been created to outline indications and limitations of coverage and/or medical necessity, *CPT*® codes, ICD-9-CM diagnosis codes, documentation guidelines, and utilization guidelines for Spinal Cord Stimulation for Chronic Pain. In addition, Coding Guidelines were created and attached to the LCD to provide instructions on coding and billing for all the codes in the policy.

### Effective date

This 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 "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page.

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

## Revised LCDs

# Mohs micrographic surgery – revision to the Part B LCD

**LCD ID number: L29230 (Florida)**
**LCD ID number: L29366 (Puerto Rico/U.S. Virgin Islands)**

The local coverage determination (LCD) for Mohs micrographic surgery (MMS) was revised to update the following sections: "Coverage Indications, Limitations, and/or Medical Necessity," "Indications," "Limitations," and "Documentation Requirements." Language in these sections was revised to make the intent of the LCD clearer: coverage is based on characteristics of the lesion, qualifications of the performing physician, and documentation of medical need in the medical record. Medical need entails that the beneficiary was informed of his/her treatment options and explained the risk/benefits of the MMS technique and associated repair.

The qualifications of the performing physician must be verifiable if requested by the contractor, and examples of verification were expanded based on the varying input by the different physician specialties and their societies that have an interest in the MMS technique.

### Effective date

This LCD revision is effective for services rendered **on or after January 1, 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 "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page.

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

# Noncovered services – revision to the Part B LCD

**LCD ID number: L29288 (Florida)**
**LCD ID number: L29398 (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.

- *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)*

See **NONCOVERED**, next page

## NONCOVERED

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- *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 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 noncovered procedures.

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 website.

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 "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page.

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

# Ophthalmological diagnostic services – revision to the Part B LCD

**LCD ID number: L29241 (Florida)**
**LCD ID number: L29457 (Puerto Rico/U.S. Virgin Islands)**

The local coverage determination (LCD) for ophthalmological diagnostic services has been revised based on a reconsideration request. Under the "ICD-9 Codes that Support Medical Necessity" section of the LCD and sub-section for "Dark Adaptation Examination (*CPT*® code *92284*)", ICD-9-CM codes 362.70, 362.75, 362.76, 368.61, 368.63, and 368.69 with 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 December 15, 2014**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. Coding guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page.

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

# Psychiatric diagnostic evaluation and psychotherapy services – revision to the Part B LCD

**LCD ID number: L33128 (Florida/Puerto Rico/ U.S. Virgin Islands)**

The local coverage determination (LCD) for psychiatric diagnostic evaluation and psychotherapy services was revised based on data analysis and medical review for psychiatric and psychotherapy services. Issues were identified related to the frequent use of psychotherapy services on an on-going basis, specifically in a nursing facility. Revisions were made to the "Utilization Guidelines" section of the LCD to outline the reasonable and necessary parameters that would address the issues identified in medical review.

**Effective date**

This 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 "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page.

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

## Additional Information

# 2015 HCPCS local coverage determination changes

First Coast Service Options Inc. has revised local coverage determinations (LCDs) impacted by the 2015 Healthcare Common Procedure Coding System (HCPCS) annual update. Procedure codes have been added, revised, replaced and deleted accordingly:

| LCD title | Changes |
|---|---|
| Allergy Testing | **Descriptor change** for *CPT*® code *84600*<br>**Deleted** HCPCS codes G0461 and G0462<br>**Added** *CPT*® codes *88341*, *88342*, and *88344* |
| Arthrocentesis | **Descriptor changes** for *CPT*® codes *20600*, *20605*, and *20610*<br>**Added** code *CPT*® codes *20604*, *20606*, and *20611*<br>**Developed** LCD "Coding Guidelines" attachment |

| LCD title | Changes |
|---|---|
| Biventricular Pacing/Cardiac Resynchronization Therapy | **Descriptor changes** for *CPT*® codes *33217, 33224, 33225, 33230, 33231, 33240*, and *33249* |
| Bone Mineral Density Studies | **Deleted** *CPT*® code *77082*<br>**Added** *CPT*® codes *77085* and *77086* |
| Cardiovascular Nuclear Imaging Studies | **Deleted** HCPCS code J0151<br>**Added** HCPCS code J0153 |

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# HCPCS

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| LCD title | Changes |
|---|---|
| Colorectal Cancer Screening | **Added** HCPCS code G0464<br><br>**Added** language pertaining to *CPT®* code *00810* and modifier *33* (Related to change request (CR) 8874)<br><br>**Revised** LCD to re-state the utilization parameters and ordering requirements (Related to CR 8881) |
| Diagnostic and Therapeutic Esophogastro-duodenoscopy | **Descriptor change** for *CPT®* codes *43247* and *43250* |
| Diagnostic Colonoscopy | **Descriptor change** for *CPT®* codes *44388, 44390, 44391, 44392, 45378, 45379, 45380, 45381, 45382, 45384, 45385, 45386, 45391, and 45392*<br><br>**Deleted** *CPT®* codes *44393, 44397, 45355, 45383*, and *45387*<br><br>**Added** HCPCS codes G6019, G6020, G6021, G6024, and G6025 |
| Erythropoiesis Stimulating Agents | **Removed** HCPCS code J0890 based on the nationwide recall and revisions in language were made throughout the LCD for clarification<br><br>**Added** HCPCS codes J0887 and J0888 |
| Ferrlecit® and Venofer® | **Added** HCPCS code J1439<br><br>**Changed** LCD Title to Parenteral Iron Supplementation for Patients Receiving ESA Therapy for Anemia of Chronic Kidney Disease or Iron Deficiency Anemia |
| Gene Expression Profiling Panel for use in the Management of Breast Cancer Treatment | **Removed** unlisted *CPT®* code *84999* and replaced with CPT® code *81519* |
| Genetic Testing for Lynch Syndrome | **Deleted** HCPCS code G0461 and G0462<br><br>**Added** *CPT®* codes *81288, 88341, 88342*, and *88344* |
| Hemophilia Clotting Factors | **Descriptor** change for HCPCS code J7195<br><br>**Deleted** HCPCS codes C9133 and C9135<br><br>**Removed** unlisted HCPCS code C9399 and replaced with HCPCS code C9136<br><br>**Added** HCPCS codes J7182, J7200 and J7201 |
| Hyperbaric Oxygen Therapy (HBO Therapy) | **Added** HCPCS code G0277 |
| Implantable Infusion Pump for the Treatment of Chronic Intractable Pain (Coding Guidelines only) | **Deleted** HCPCS code J2275<br><br>**Added** HCPCS code J2274 |
| Independent Diagnostic Testing Facility (IDTF) (Coding Guidelines only) | **Deleted** *CPT®* codes *74291, 76645*, and *77082*<br><br>**Added** *CPT®* codes *76641, 76642, 77063, 77085, 77086, 93260, 93261*, and HCPCS code G0279 |
| Intensity Modulated Radiation Therapy (IMRT) | **Deleted** *CPT®* codes *0073T, 76950, 77305, 77310 ,77315, 77326, 77327, 77328, 77402, 77403, 77404, 77406, 77407, 77408, 77409, 77411, 77412, 77413, 77414, 77416, 77418* , and *77421*<br><br>**Added** HCPCS codes G6001, G6002, G6003, G6004, G6005, G6006, G6007, G6008, G6009, G6010, G6011, G6012, G6013, G6014, G6015, G6016 and *CPT®* codes *77306, 77307, 77316, 77317*, and *77318* |
| Mohs Micrographic Surgery (MMS) | **Deleted** HCPCS codes G0461 and G0462<br><br>**Added** *CPT®* codes *88341, 88342*, and *88344* |

See **HCPCS**, next page

# HCPCS

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| LCD title | Changes |
|---|---|
| Molecular Pathology Procedures | **Descriptor change** for *CPT®* code *81245*<br><br>**Added** *CPT®* codes *81246, 81288*, and *81313* |
| Noncovered Services | **Descriptor change** for *CPT®* code *22856*<br><br>**Deleted** *CPT®* code *0059T* (*replaced* with *CPT®* codes *0357T* and *89337*), *CPT®* code *0092T* (replaced with *CPT®* code *0375T*), *CPT®* code *0181T* (replaced with *CPT®* code *92145*), *CPT®* code *0199T* (replaced with unlisted *CPT®* code *95999* – Tremor measurement with accelerometer(s) and/or gyroscope(s), *CPT®* code *0226T* (replaced with HCPCS code G6027), *CPT®* code *0227T* (replaced with HCPCS code G6028), *CPT®* code *0239T* (replaced with *CPT®* code *93702*), *CPT®* code *0334T* (replaced with *CPT®* code *27279*), unlisted *CPT®* codes *53899*/*55899* - Urethral lift (replaced with *CPT®* codes *52441*/*52442*), and *CPT®* codes *87620*/*87622* (replaced with *CPT®* codes *87623,87624*, and *87625*)<br><br>**Deleted** *CPT®* code *88349*<br><br>**Removed** HCPCS code P9019 from the "Coding Guidelines" attachment and replaced with HCPCS code P9020 (Not related to HCPCS update)<br><br>**Added** *CPT®* code *22858* |
| Paclitaxel (Taxol®) | **Deleted** HCPCS code J9265<br><br>**Added** HCPCS code J9267 |
| Psychiatric Diagnostic Evaluation and Psychotherapy Services | **Deleted** HCPCS code M0064 |
| Qualitative Drug Screen | **Deleted** *CPT®* code *80102*<br><br>**Added** HCPCS code G6058 |
| Qutenza® (capsaicin) 8% patch | **Deleted** HCPCS code J7335<br><br>**Added** HCPCS code J7336 |
| Radiation Therapy for T1 Basal Cell and Squamous Cell Carcinomas of the Skin | **Descriptor change** for *CPT®* code *77401*<br><br>**Deleted** *CPT®* codes *77402, 77403, 77404, 77406, 77407, 77408, 77409, 77411, 77412, 77413, 77414, 77416*, *77418*<br><br>**Added** HCPCS codes G6003, G6004, G6005, G6006, G6007, G6008, G6009, G6010, G6011, G6012, G6013, G6014, G6015 |
| Screening and Diagnostic Mammography | **Descriptor change** for HCPCS codes G0204 and G0206<br><br>**Added** *CPT®* code *77063* and HCPCS code G0279 |
| Skin Substitutes | **Added** HCPCS codes C9349, Q4150, Q4151, Q4152, Q4153, Q4154, Q4155, Q4156, Q4157, Q4158, Q4159, and Q4160 to "The following HCPCS codes are not separately payable and are considered not medically reasonable and necessary products" section of the LCD |
| Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiation Therapy (SBRT) (Coding Guidelines only) | **Deleted** HCPCS codes G0173 and G0251 |
| Transesophageal Echocardiogram | **Added** *CPT®* code *93355* |
| Vertebroplasty, Vertebral Augmentation; Percutaneous | **Deleted** *CPT®* code *22520, 22521, 22522, 22523, 22524, 22525, 72291*, and *72292*<br><br>**Added** *CPT®* codes *22510, 22511, 22512, 22513, 22514*, and *22515* |
| Viscosupplementation Therapy for Knee | **Descriptor change** for *CPT®* codes *20610* and *27370*<br><br>**Removed** unlisted HCPCS codes C9399/J3490 (Monovisc) and replaced with HCPCS code J7327 |

# Upcoming provider outreach and educational events

## Medicare Part B changes and regulations

**When:** Wednesday, March 18
**Time:** 11:30 a.m.-1:00 p.m. **Type of event:** Webcast

*http://medicare.fcso.com/Events/276321.asp*

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

## Two easy ways to register

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

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

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

**Please Note:**

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

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Provider Address: _____

City, State, ZIP Code: _____

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

## Never miss a training opportunity

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

## Take advantage of 24-hour access to free online training

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

### *Medicare Learning Network®*

The *Medicare Learning Network®* (*MLN*) is the home for education, information, and resources for the health care professional community. The *MLN* provides access to CMS Program information you need, when you need it, so you can focus more on providing care to your patients. Find out what the *MLN* has to offer you and your staff at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html*.

# MLN Connects™ Provider eNews for November 20, 2014

*MLN Connects™ Provider eNews for November 20, 2014*
*View this edition as a PDF*

### In this edition:

### MLN Connects™ National Provider Calls

- 2015 Physician Fee Schedule Final Rule: Changes to Physician Quality Reporting Programs – Register Now
- National Partnership to Improve Dementia Care in Nursing Homes – Register Now
- Certifying Patients for the Medicare Home Health Benefit – Register Now
- New MLN Connects™ National Provider Call Audio Recording and Transcript

### CMS Events

- "Home Health Change of Care Notice and Advance Beneficiary Notice of Noncoverage" Webinar – Registration Open

### Announcements

- National Home Care and Hospice Month
- Seasonal Influenza and Diabetes Awareness
- Affordable Care Act and Health Care Coverage: CME Articles on Medscape
- Prior Authorization Process for Repetitive, Scheduled, Non-Emergent Ambulance Transport
- 2013 QRURs Available
- PEPPER Still Available for SNFs, Hospices, CAHs, LTCHs, IPFs, IRFs and PHPs
- Distribution of 2012 PQRS Supplemental Incentive Payments
- EHR Incentive Program: How to Report Once in 2014 for Medicare Quality Reporting Programs
- EHR Incentive Programs: Summary of Care Meaningful Use Requirements in Stage 2

### *Medicare Learning Network*® Educational Products

- The *Medicare Learning Network*® Autumn 2014 Catalog – Released
- "Revised Centers for Medicare & Medicaid Services (CMS) 855R Application – Reassignment of Medicare Benefits" *MLN Matters*® Article – Released
- "Medicare Billing: 837I and Form CMS-1450" Fact Sheet – Revised
- "Medicare Billing: 837P and Form CMS-1500" Fact Sheet – Revised
- "Evaluation and Management Services Guide" Educational Tool – Revised
- New *Medicare Learning Network*® Provider Compliance Fast Fact
- *Medicare Learning Network*® Product Available in Electronic Publication Format

# MLN Connects™ Provider eNews for November 26, 2014

*MLN Connects™ Provider eNews for November 26, 2014*
*View this edition as a PDF*

### In this edition:

### MLN Connects™ National Provider Calls

- 2015 Physician Fee Schedule Final Rule: Changes to Physician Quality Reporting Programs – Last Chance to Register
- National Partnership to Improve Dementia Care in Nursing Homes – Register Now
- Certifying Patients for the Medicare Home Health Benefit – Register Now

### CMS Events

- "Home Health Change of Care Notice and Advance Beneficiary Notice of Noncoverage" Webinar – Reminder

### Announcements

- In Observance of World AIDS Day – Remember HIV Screenings
- CMS Creates New Chief Data Officer Post
- Get Ready for DMEPOS Competitive Bidding
- EHR Incentive Programs: Hardship Exception Applications due November 30
- New EHR Attestation Deadline for Eligible Hospitals: December 31

### Claims, Pricers, and Codes

- Hospice Notices Returned to Provider
- MA Claims Issue for FQHCs that Bill Under the AIR System

### *Medicare Learning Network*® Educational Products

- "Hospice Related Services – Part B" Podcast – Revised
- New *Medicare Learning Network*® Educational Web Guides Fast Fact
- Submit Your Feedback on the *Medicare Learning Network*® Learning Management System and Product Ordering System
- *Medicare Learning Network*® Product Available in Electronic Format

MLN Connects

# MLN Connects™ Provider eNews for December 4, 2014

*MLN Connects™ Provider eNews for December 4, 2014*

*View this edition as a PDF*

### In this edition:

### MLN Connects™ National Provider Calls

- National Partnership to Improve Dementia Care in Nursing Homes – Last Chance to Register
- Certifying Patients for the Medicare Home Health Benefit – Register Now

### MLN Connects™ Videos

- Monthly Spotlight: Physician Feedback Program/ Value-based Payment Modifier

### CMS Events

- Webinar for Comparative Billing Report on Modifier 25: Family Practice

### Announcements

- National Influenza Vaccination Week – December 7-13
- CMS Releases New Proposal to Improve Accountable Care Organizations
- Efforts to Improve Patient Safety Result in 1.3 Million Fewer Patient Harms, 50,000 Lives Saved and $12 Billion in Health Spending Avoided
- Provider Enrollment Application Fee Amount for CY 2015
- CMS is Accepting Suggestions for Potential PQRS Measures

### Claims, Pricers, and Codes

- ICD-10 MS-DRGs v32 Software Now Available
- Inpatient PPS FY 2014.8 PC Pricer Updated
- Clarification of Specialty Care Transport Payment Policy for Ambulance Transportation Services


### Medicare Learning Network® Educational Products

- "Affordable Care Act Provider Compliance Programs: Getting Started" Web-Based Training Course – Released
- "Complying With Medical Record Documentation Requirements" Fact Sheet – Released
- "Hospital Reclassifications" Fact Sheet – Revised
- *Medicare Learning Network*® Product Available In Electronic Publication Format

# MLN Connects™ Provider eNews for December 11, 2014

*MLN Connects™ Provider eNews for December 11, 2014*

*View this edition as a PDF*

### In this edition:

### MLN Connects™ National Provider Calls

- Certifying Patients for the Medicare Home Health Benefit – Last Chance to Register
- ESRD QIP Payment Years 2017 and 2018 Final Rule – Registration Opening Soon

### MLN Connects™ Videos

- Coding for ICD-10-CM: More of the Basics

### CMS Events

- Volunteer for ICD-10 End-to-End Testing in April – Registration Opening Soon
- QRDA I and III Submissions for Eligible Professionals eHealth Provider Webinar
- Physician Compare Virtual Office Hour Session

### Announcements

- New CMS Rules Enhance Medicare Provider Oversight; Strengthens Beneficiary Protections
- New Requirements for Prescribers of Medicare Part D Drugs
- ESRD PPS Low-Volume Payment Adjustment: Act by December 31
- Eligible Hospitals Must Attest By December 31 to Receive 2014 EHR Incentive
- Financial Incentives and Ability to Exchange Clinical Information Found to be Top Reasons for EHR Adoption
- HHS Awards $36.3 Million in Affordable Care Act Funding to Reward and Expand Quality Improvement in Health Centers
- See the Big Picture with Open Payments Search Tool Enhancements
- Contractor Assists Hospitals in Reporting Inpatient Quality Data

See **eNEWS**, next page

## eNEWS

From previous page

- Updates to IRIS Software
- Access Your 2013 QRUR
- 2012 Supplemental QRURs Available to Group Practices
- EHR Incentive Programs: Protect Electronic Health Information Core Objective
- Get Ready Now for ICD-10

### Claims, Pricers, and Codes

- January 2015 Average Sales Price Files Now Available

### *Medicare Learning Network*® Educational Products

- "Medicare Fee-For-Service (FFS) International Classification of Diseases, 10th Edition (ICD-10) Testing Approach" *MLN Matters*® Article – *Revised*
- "Provider Enrollment Requirements for Writing Prescriptions for Medicare Part D Drugs" *MLN Matters*® Article – *Revised*
- "Skilled Nursing Facility Billing Reference" Fact Sheet – Revised
- The Basics of Internet-based PECOS for DMEPOS Suppliers" Fact Sheet – Reminder
- New *Medicare Learning Network*® Provider Compliance Fast Fact
- *Medicare Learning Network*® Products Available In Electronic Publication Format
- Submit Your Feedback on the *Medicare Learning Network*® Learning Management System and Product Ordering System

# MLN Connects™ Provider eNews for December 18, 2014

*MLN Connects™ Provider eNews for December 18, 2014*

*View this edition as a PDF*

### CMS Provider Education Message:

Happy holidays from the eNews staff! The next regular edition of the eNews will be released on Thursday, January 8, 2015.

### In this edition:

### MLN Connects™ National Provider Calls

- Medicare Quality Reporting Programs: Data Submission Process – Registration Opening Soon
- IRF PPS: New IRF-PAI Items Effective October 1, 2015 – Registration Now Open
- ESRD QIP Payment Year 2017 and 2018 Final Rule – Registration Now Open
- New MLN Connects™ National Provider Call Video Slideshow, Audio Recording, and Transcript

### CMS Events

- Volunteer for ICD-10 End-to-End Testing in April – Forms Due January 9

### Announcements

- CDC Continues to Recommend a Flu Vaccine as the Best Way to Protect Against the Flu
- Revisions to Certain Patient's Rights Conditions of Participation and Conditions for Coverage Overview
- HIS Data Collection for FY 2016 Annual Payment Update Ends December 31
- IRF-PAI Training Manual Updated with Information on New Items Effective October 1, 2015
- Frequently Asked Questions on DMEPOS 2015 Medicare Payment Final Rule
- Open Payments: Final Rule Changes Related to Continuing Education Events
- Comparative Billing Report on Modifier 59: Dermatology

### Claims, Pricers, and Codes

- Reprocessing of IPPS Claims Assigned to DRG 410, 573 or 907

### *Medicare Learning Network*® Educational Products

- "FAQs – International Classification of Diseases, 10th Edition (ICD-10) End-to-End Testing" *MLN Matters*® Article – Released
- "Medical Privacy of Protected Health Information" Fact Sheet – *Revised*
- *Medicare Learning Network Products*® Available In Electronic Publication Format

# CMS MLN Connects Provider eNews – Special Edition

**Monday, December 22, 2014**

## Results from November ICD-10 acknowledgement testing week

CMS conducted another successful acknowledgement testing week last month. Acknowledgement testing gives providers and others the opportunity to submit claims with ICD-10 codes to the Medicare fee-for-service (FFS) claim systems and receive electronic acknowledgements confirming that their claims were accepted. While providers are welcome to submit acknowledgement test claims anytime, during the November testing week, testers submitted almost 13,700 claims.

More than 500 providers, suppliers, billing companies, and clearinghouses participated in the testing week last month. Testers included small and large physician practices, small and large hospitals, labs, ambulatory surgical centers, dialysis facilities, home health providers, ambulance providers, and several other physician specialties. Acceptance rates improved throughout the week with Friday's acceptance rate for test claims at 87 percent. Nationally, CMS accepted 76 percent of total test claims. Testing did not identify any issues with the Medicare FFS claims systems. This testing week allowed an opportunity for testers and CMS alike to learn valuable lessons about ICD-10 claims processing.

To ensure a smooth transition to ICD-10, CMS verified all test claims had a valid diagnosis code that matched the date of service, a national provider identifier (NPI) that was valid for the submitter ID used for testing, and an ICD-10 companion qualifier code to allow for processing of claims. In many cases, testers intentionally included errors in their claims to make sure that the claim would be rejected, a process often referred to as "negative testing." The majority of rejections on professional claims were common rejects related to an invalid NPI. Some claims were rejected because they were submitted with future dates. Acknowledgement testing cannot accept claims for future dates. Additionally, claims using ICD-10 must have an ICD-10 companion qualifier code. Claims that did not meet these requirements were rejected.

Mark your calendar for upcoming acknowledgement testing weeks on March 2-6, 2015, and June 1-5, 2015. In addition to the special testing weeks, providers are welcome to submit acknowledgement test claims anytime up to the October 1, 2015, implementation date. Contact your *Medicare administrative contractor* for more information.

*For more information:*

- *MLN Matters® article MM8858*, "ICD-10 Testing – Acknowledgement Testing with Providers"
- *MLN Matters® special edition article SE1409*, "Medicare FFS ICD-10 Testing Approach," which also includes information on opportunities for end-to-end testing with FFS Medicare


## Registration reminder for DMEPOS competitive bidding: round two recompete & national mail-order recompete

CMS would like to remind all suppliers that registration is now open for those interested in participating in the Round 2 Recompete and/or the national mail-order recompete of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. In order to submit a bid(s) for the Round 2 Recompete and/or the national mail-order recompete, you must first register in the Individuals Authorized Access to CMS Computer Services (IACS) online application. Once you have registered in IACS, you will receive a user ID and password to access the online DMEPOS Bidding System (DBidS). You must register even if you registered during a previous round of competition (Round 1 Recompete, Round 2, or the national mail-order competition). Only suppliers who have a user ID and password will be able to access DBidS; suppliers that do not register will not be able to submit a bid.

If you are a supplier interested in bidding, you must designate one individual listed as an authorized official (AO) on your organization's CMS-855S enrollment application in the Provider Enrollment, Chain, and Ownership System (PECOS) to act as your AO for registration purposes. After an AO successfully registers, other individuals listed as an AO on the CMS-855S in PECOS may register as backup authorized officials (BAOs).The AO must approve a BAO's request to register. The AO and BAOs can designate other individuals not listed as an AO on the CMS-855S in PECOS to serve as end users (EUs).BAOs and EUs must also register for a user ID and password in IACS in order to access DBidS. The name and Social Security number of the AO and BAO entered in IACS must match exactly with what is recorded on the CMS-855S and on file in PECOS to register successfully. Bidders are prohibited from sharing user IDs and passwords.

CMS strongly urges all AOs to register no later than January 6, 2015, to ensure that BAOs and EUs have time to register. We recommend that BAOs register no later than January 20, 2015, so that they will be able to assist

See **SPECIAL**, next page

## SPECIAL

From previous page

AOs with approving EU registration before bidding begins on January 22, 2015.

Registration extends into the bidding period and will close on Tuesday, February 17, 2015, at 9pm prevailing ET– no AOs, BAOs, or EUs can register after registration closes. Bidding will close on Wednesday, March 25, 2015.

To register, go to the Competitive Bidding Implementation Contractor (CBIC) website, *www.dmecompetitivebid.com*, click on Round 2 & National Mail-Order Recompete, and then click on "Registration is Open" above the Registration clock. CMS strongly recommends that you:

- Review the *IACS Reference Guide*,
- Watch the short and very helpful *instructional video*, "How to Register to Submit a Bid," on your computer, tablet, or phone, and
- Use the *IACS: Getting Started Registration Checklist*.

CMS would also like to remind you to:

- **Review and update your enrollment records**. Suppliers must maintain accurate information on their CMS-855S enrollment application with the national supplier clearinghouse (NSC) and in PECOS. It is important to note that if your record is not current at the time of registration, you may experience delays and/or be unable to register and bid. We will also validate your bid data against your enrollment record in PECOS during bid evaluation. If it is not current or accurate, your bid(s) may be disqualified.
- **Get licensed**. Supplier locations must be licensed as applicable by the state in which it furnishes, or will furnish, products and services under the DMEPOS Competitive Bidding Program.
- **Get accredited**. Supplier locations must be accredited by a CMS-approved accrediting organization for the products and services it furnishes, or will furnish, under the DMEPOS Competitive Bidding Program.

The CBIC is the official information source for bidders. All suppliers interested in bidding are urged to sign up for E-mail Updates on the home page of the *CBIC website*. For information about the Round 2 Recompete and the national mail-order recompete, please refer to the bidder education materials located under Round 2 & National Mail-Order Recompete > Bidding Suppliers on this website. The CBIC participates in numerous educational events to assist stakeholders in understanding the rules that govern the DMEPOS Competitive Bidding Program. Visit the CBIC website for a listing and schedule of educational events under the Educational Information section of the Round 2 & National Mail-Order Recompete page.

In addition to viewing the information on the CBIC website, suppliers are encouraged to call the CBIC customer service center toll-free, at 877-577-5331, with their questions. During registration and bidding periods, the customer service center will be open from 9am to 9pm ET.

# Timeline for the DMEPOS competitive bidding round two recompete/national mail-order recompete

### DMEPOS competitive bidding – bidder education program begins

### Bidding timeline

CMS has announced the *bidding timeline* for the round two recompete and the national mail-order recompete of the Medicare durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program.

### Bidder education program

CMS has also launched a comprehensive bidder education program. This program is designed to ensure that DMEPOS suppliers interested in bidding receive the information and assistance they need to submit complete bids in a timely manner.

The CBIC is the official information source for bidders and the focal point for bidder education. The CBIC website features an array of important and helpful information for suppliers, including bidding rules, user guides, fact sheets, checklists, and bid preparation worksheets.

The education program also includes a new video series to assist and guide bidders through the entire bidding process. The short – but helpful and engaging – *instructional videos* are posted on the CBIC website. When a new video is posted, the CBIC will announce its availability through a CBIC e-mail update. To sign up to receive video announcements and other key registration and bidding information, subscribe to *CBIC E-Mail Updates*.

In addition to viewing the information on the CBIC website, suppliers are encouraged to call the CBIC customer service center toll-free, at 1-877-577-5331, with questions. During registration and bidding periods, the customer service center will be open from 9am to 9pm ET.

### For More Information

*Press release*

*Fact sheet*

# Phone numbers

### Customer service

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

### Education event registration hotline

904-791-8103 (NOT toll-free)

### Electronic data interchange (EDI)

888-670-0940

### Electronic funds transfers (EFT) (CMS-588)

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

### Fax number (for general inquiries)

904-361-0696

### Interactive voice response (IVR) system

877-847-4992

### Provider enrollment

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

### The SPOT help desk

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

# Addresses

### Claims

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

### Redeterminations

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

### Redetermination of overpayments

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

### Reconsiderations

Q2 Administrators, LLC
Part B QIC South Operations
ATTN: Administration Manager
P.O. Box 183092
Columbus, Ohio 43218-3092

### General inquiries

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

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

### Provider enrollment

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

### Medical policy

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

### Medicare secondary payer

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

### Electronic data interchange (EDI)

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

### Overpayments

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

### Medicare Education and Outreach

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

### Fraud and abuse

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

### Freedom of Information Act requests

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

### Overnight mail and/or special courier service

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

# Websites

### Provider

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

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

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

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

### Beneficiaries

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

# Phone numbers

### Customer service

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

### Education event registration hotline

904-791-8103 (NOT toll-free)

### Electronic data interchange (EDI)

888-670-0940

### Electronic funds transfers (EFT) (CMS-588)

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

### Fax number (for general inquiries)

904-361-0696

### Interactive voice response (IVR) system

877-847-4992

### Provider enrollment

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

### The SPOT help desk

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

# Addresses

### Claims

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

### Redeterminations

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

### Redetermination of overpayments

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

### Reconsiderations

Q2 Administrators, LLC
Part B QIC South Operations
ATTN: Administration Manager
P.O. Box 183092
Columbus, Ohio 43218-3092

### General inquiries

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

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

### Provider enrollment

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

### Medical policy

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

### Medicare secondary payer

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

### Electronic data interchange (EDI)

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

### Overpayments

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

### Medicare Education and Outreach

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

### Fraud and abuse

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

### Freedom of Information Act requests

FOIA USVI
P.O. Box 45073
Jacksonville, FL 32231-5073

### Special courier service

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

# Websites

### Provider

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

*http://medicare.fcso.com*

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

Centers for Medicare & Medicaid Services

*http://www.cms.gov*

First Coast University

*http://www.fcsouniversity.com/*

### Beneficiaries

Centers for Medicare & Medicaid Services

*http:// www.medicare.gov*

# Phone numbers

### Customer service

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

### Education event registration hotline

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

### Electronic data interchange (EDI)

888-875-9779

### Electronic funds transfers (EFT) (CMS-588)

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

### General inquiries

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

### Interactive voice response (IVR) system

877-847-4992

### Provider enrollment

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

### The SPOT help desk

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

# Addresses

### Claims

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

### Redeterminations

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

### Redetermination of overpayments

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

### Reconsiderations

Q2 Administrators, LLC
Part B QIC South Operations
ATTN: Administration Manager
P.O. Box 183092
Columbus, Ohio 43218-3092

### General inquiries

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

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

### Provider enrollment

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

### Medical policy

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

### Medicare secondary payer

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

### Electronic data interchange (EDI)

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

### Overpayments

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

### Medicare Education and Outreach

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

### Fraud and abuse

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

### Freedom of Information Act requests

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

### Special courier service

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

# Websites

### Provider

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

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

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

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

### Beneficiaries

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

# Order form for Medicare Part B materials

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

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

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| **2015 fee schedule –** The Medicare Part B Physician and Nonphysician Practitioner Fee Schedules, effective for services rendered January 1 through December 31, 2015, are available free of charge online at *http://medicare.fcso.com/Data_files/* (English) or *http://medicareespanol.fcso.com/Fichero_de_datos/* (Español). Additional copies are available for purchase. The fee schedules contain payment rates for all localities. These items do not include the payment rates for injectable drugs, clinical lab services, mammography screening, or DMEPOS items.<br>**Note:** Requests for hard copy paper disclosures will be completed as soon as CMS provides the direction to do so. Revisions to fees may occur; these revisions will be published in future editions of the Medicare Part B publication. | 40300270 | $12 | | |
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**P.O. Box 406443**
**Atlanta, GA 30384-6443**

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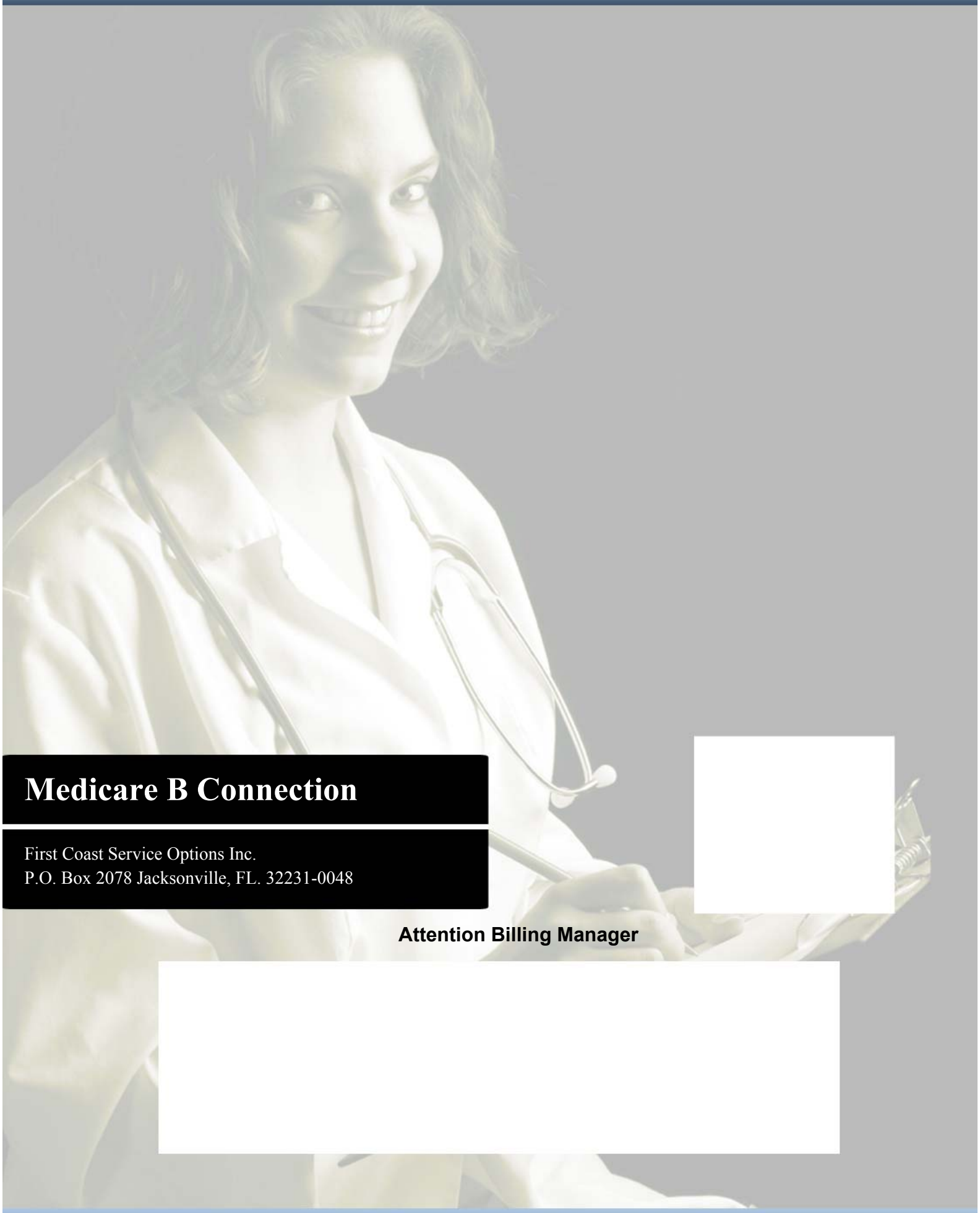

# Medicare B Connection

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

**Attention Billing Manager**