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Medicare Bulletin

Latest Medicare News for J15 Part A


Stay Informed about the Latest Medicare Updates

Please check the Learning and Education section of the CGS Part A website upcoming education sessions. The J15 Part A Provider Outreach and Education (POE) department encourages providers and their staff to attend these sessions to learn about current and upcoming Medicare policy and coverage information.

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You Are Responsible...

The Medicare Bulletin contains coverage, billing, and other information for J15 Part A. This information is not intended to constitute legal advice. It is our official notice to those we serve concerning their responsibilities and obligations as mandated by Medicare regulations and guidelines. This information is readily available at no cost on the CGS website. It is the responsibility of each facility to obtain this information and to follow the guidelines. The Medicare Bulletin includes information provided by the Centers for Medicare & Medicaid Services (CMS) and is current at the time of publication. The information is subject to change at any time. This bulletin should be shared with all health care practitioners and managerial members of the provider staff. Bulletins are available at no-cost from our website at www.CGSmedicare.com/parta.

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GENERAL INFORMATION

2013 Provider Contact Center (PCC) Training and Holiday Closure Schedule

The CGS PCC will continue to close up to eight hours per month for customer service representative (CSR) training and staff development. The Interactive Voice Response (IVR) unit will be available during these scheduled training sessions for automated customer service transactions. You may contact our PCC at 866-590-6703.

Listed below are training closure dates and times for the next several months:

<table>
<thead>
<tr>
<th>Date</th>
<th>PCC/Office Closed</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 1, 2013</td>
<td>PCC closed 2:30 p.m. to 4:30 p.m. ET</td>
</tr>
<tr>
<td>August 8, 2013</td>
<td>PCC closed 2:30 p.m. to 4:30 p.m. ET</td>
</tr>
<tr>
<td>August 15, 2013</td>
<td>PCC closed 2:30 p.m. to 4:30 p.m. ET</td>
</tr>
<tr>
<td>August 22, 2013</td>
<td>PCC closed 2:30 p.m. to 4:30 p.m. ET</td>
</tr>
<tr>
<td>September 2, 2013</td>
<td>Office closed/Labor Day</td>
</tr>
<tr>
<td>September 12, 2013</td>
<td>PCC closed 2:30 p.m. to 4:30 p.m. ET</td>
</tr>
<tr>
<td>September 19, 2013</td>
<td>PCC closed 2:30 p.m. to 4:30 p.m. ET</td>
</tr>
<tr>
<td>September 26, 2013</td>
<td>PCC closed 2:30 p.m. to 4:30 p.m. ET</td>
</tr>
<tr>
<td>October 14, 2013</td>
<td>PCC closed/Columbus Day</td>
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<tr>
<td>November 11, 2013</td>
<td>PCC closed/Veterans Day</td>
</tr>
<tr>
<td>November 28, 2013</td>
<td>Office closed/Thanksgiving</td>
</tr>
<tr>
<td>November 29, 2013</td>
<td>Office closed/Thanksgiving</td>
</tr>
<tr>
<td>December 5, 2013</td>
<td>PCC closed 2:30 pm to 4:30 ET</td>
</tr>
<tr>
<td>December 12, 2013</td>
<td>PCC closed 2:30 pm to 4:30 ET</td>
</tr>
<tr>
<td>December 19, 2013</td>
<td>PCC closed 2:30 pm to 4:30 p.m. ET</td>
</tr>
<tr>
<td>December 24, 2013</td>
<td>Office closed/Christmas Eve</td>
</tr>
<tr>
<td>December 25, 2013</td>
<td>Office closed/Christmas Day</td>
</tr>
</tbody>
</table>
CMS E-NEWS

CMS e-News will contain a week’s worth of Medicare-related messages from the Centers of Medicare & Medicaid Services (CMS). These messages ensure planned, coordinated messages are delivered timely about Medicare-related topics. Please share with appropriate staff. To view the most recently issues, please copy and paste the following links in your Web browser:

July 18, 2013

July 11, 2013

July 4, 2013

June 27, 2013

MULTIPLE PROVIDER INFORMATION

Notice of New Interest Rate for Medicare Overpayments and Underpayments

Medicare Regulation 42 CFR §405.378 provides for the assessment of interest at the higher of the current value of funds rate (one percent for calendar year 2013) or the private consumer rate as fixed by the Department of the Treasury. The Department of the Treasury has notified the Department of Health and Human Services that the private consumer rate has been changed to 10.375 percent effective July 17, 2013, for Medicare overpayments and underpayments.

Billing for Visits to Patients in Swing Bed Facilities

MLN Matters® Number: SE1312
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

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Provider Types Affected
This MLN Matters® Special Edition (Article) is intended for physicians and other providers who submit claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and/or A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries.

What You Need to Know
The CMS Comprehensive Error Rate Testing (CERT) program has identified a significant number of claims paid in error relating to Evaluation and Management (E/M) services provided in swing bed settings.

Background
Hospitals, as defined in the Social Security Act (Section 1861(e); see http://www.ssa.gov/OP_Home/ssact/title18/1861.htm), or Critical Access Hospitals (CAHs) with a Medicare provider agreement that includes CMS approval to furnish swing bed services, may use their beds as needed to furnish either acute or Skilled Nursing Facility (SNF) levels of care.

Through the review of previous Comprehensive Error Rate Testing (CERT) Reports, CMS has learned that there have been a high percentage of errors occurring in billing for E/M services rendered in swing bed facilities. Some providers are inappropriately billing hospital visit codes for E/M services rendered in swing bed facilities (with nursing facility levels of care) when they should be billing nursing facility visit E/M codes. Physicians should bill hospital care codes when the facility is providing inpatient hospital care to the beneficiary, and nursing facility care codes when the swing bed is being used to provide skilled nursing services. The Current Procedure Terminology (CPT) codes involved include:

- 99221-99223 (Initial Hospital Care),
- 99231-99233 (Subsequent Hospital Care), and
- 99238-99239 (Hospital Discharge Day Management)

Example:
A 92 year old female was admitted to a hospital with swing bed approval for nursing facility care on April 30, 2010, and was discharged on May 6, 2010.

A physician billed CPT Code 99232 (Subsequent hospital care) for a date of service May 5, 2010, a day on which the facility was providing services at a skilled nursing level. The date of service (May 5, 2010), was during the stay for nursing facility care at a swing bed approved facility. Therefore, CPT Code 99232 was an overpaid claim.

Additional Information
You can review the “Medicare Claims Processing Manual,” Chapter 12, Section 30.6.9) at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf on the CMS website. This section of the manual provides details on proper coding of hospital visits and swing bed visits.
If you have any questions, please contact your carriers, FIs, or A/B MACs at their toll-free number, which may be found at [http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html](http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html) on the CMS website.

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**National Coverage Determination (NCD) for Transcatheter Aortic Valve Replacement (TAVR) – Implementation of Mandatory Reporting of Clinical Trial Number**

MLN Matters® Number: MM8255 Revised  
Related Change Request (CR) #: CR 8255  
Related CR Release Date: July 11, 2013  
Effective Date: July 1, 2013  
Related CR Transmittal #: R2737CP  
Implementation Date: October 7, 2013

Note: This article was revised on July 12, 2013, to reflect the revised CR8255 issued on July 11. The article has been updated to clarify on page 2 that the addition of “CT” with the registry number is only for paper claims. Also, Web addresses for the articles related to CRs 7897 and 8168 are now in this article. The CR release date, transmittal number and the Web address for accessing CR8255 are revised. All other content remains the same.

**Provider Types Affected**

This MLN Matters® Article is intended for physicians, other providers, and suppliers who submit claims to Medicare contractors (Fiscal Intermediaries (FIs), carriers, and A/B Medicare Administrative Contractors (A/B MACs)) for Transcatheter Aortic Valve Replacement (TAVR) services provided to Medicare beneficiaries.

**Provider Action Needed**

Change Request (CR) 8255 is being issued to require that claims for TAVR carry an approved clinical trial number, effective for claims processed on or after July 1, 2013. Given that TAVR is covered only under Coverage with Evidence Development (CED), the Centers for Medicare & Medicaid Services (CMS) has ensured that the approved clinical trials and approved registry have obtained valid numbers from [http://www.clinicaltrials.gov](http://www.clinicaltrials.gov) and that those numbers are maintained at [http://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/Transcatheter-Aortic-Valve-Replacement-TAVR-.html](http://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/Transcatheter-Aortic-Valve-Replacement-TAVR-.html) on the CMS website. See the Background and Additional Information Sections of this article for further details regarding these changes. Please make sure that your billing staffs are aware of these changes.

**Background**


TAVR (also known as TAVI or transcatheter aortic valve implantation) is a new technology for use in treating aortic stenosis. A bioprosthetic valve is inserted percutaneously using a catheter and implanted in the orifice of the native aortic valve. The procedure is performed in a cardiac catheterization lab or a hybrid operating...
room/cardiac catheterization lab with advanced quality imaging and with the ability to safely accommodate complicated cases that may require conversion to an open surgical procedure. The interventional cardiologist and cardiac surgeon jointly participate in the intra-operative technical aspects of TAVR.

CR8255 requires that claims for TAVR carry an approved clinical trial number. Specific claims processing instructions are as follows:

- For professional claims processed on or after July 1, 2013, Medicare expects this numeric, 8-digit clinical trial (CT) registry number to be preceded by the alpha characters of “CT” in Field 19 of paper Form CMS-1500 claims or entered similarly BUT WITHOUT THE “CT” prefix in the electronic 837P in Loop 2300 REF01 (REF01=P4).

- Professional claim lines for 0256T, 0257T, 0258T, 0259T, 33361, 33362, 33363, 33364, 33365, and 0318T must have the CT registry number, a Q0 modifier, and a secondary diagnosis code of V70.7 (ICD-10=Z00.6). Such claims lines will be returned as unprocessable if the CT registry number, the modifier Q0, or the V70.7 (ICD-10=Z00.6) is not present.

Claims for TAVR submitted without the CT registry number will be returned as unprocessable with the following messages:

- Claims Adjustment Remarks Code (CARC) 16: “Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.”;

Remittance Advice Remarks Code (RARC) MA50: “Missing/incomplete/invalid Investigational Device Exemption number for FDA-approved clinical trial services.”;

- RARC MA130: “Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.”; and

- Group Code-Contractual Obligation (CO).

- TAVR claims submitted without the Q0 modifier will be returned as unprocessable with the following messages:

  - CARC 4: “The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”;


  - RARC MA130: “Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.”; and

  - Group Code-Contractual Obligation (CO).
For claims processed on or after July 1, 2013, the claim lines for 0256T, 0257T, 0258T, 0259T, 33361, 33362, 33363, 33364, 33365 & 0318T will be returned as unprocessable when billed without secondary diagnosis code V70.7 (ICD-10=Z00.6) with the following messages:

- CARC 16: “Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.”);

- RARC M76: “Missing incomplete/invalid diagnosis or condition.”;

- RARC MA130: “Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.”; and

- Group Code-Contractual Obligation (CO).

Medicare also requires the CT registry number on hospital claims for TAVR for inpatient hospital discharges on or after July 1, 2013. Claims for TAVR for inpatient discharges on or after July 1, 2013, that do not have the registry number will be rejected. Medicare is ensuring the presence of the procedure codes and associated diagnosis and condition codes per CR7897/TR2552, issued September 24, 2012.

**Additional Information**


**Note:** CR8255 does not eliminate the previous instructions contained in CRs 7897 and 8168 that were not formally replaced/revised. Links to the related articles for these CRs may be found below.

For more information regarding the Medicare approved registry and the Medicare approved clinical trials which have been reviewed and determined to meet the requirements of coverage go to [http://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/Transcatheter-Aortic-Valve-Replacement-TAVR.html](http://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/Transcatheter-Aortic-Valve-Replacement-TAVR.html) on the CMS website.

**Duplicate Claims - Outpatient**

MLN Matters® Number: SE1314  
Related Change Request (CR) #: N/A  
Related CR Release Date: N/A  
Effective Date: N/A  
Related CR Transmittal #: N/A  
Implementation Date: N/A

**Provider Types Affected**  
This MLN Matters® Special Edition (SE) Article is intended for providers submitting claims to Medicare contractors for services to Medicare beneficiaries.

**What You Need to Know**  
Recovery Auditors continue to conduct automated reviews of claims to identify duplicate services billed and reimbursed under Medicare. Specific codes are listed in the Background section of this article.

**Provider Action Needed**  
The Centers for Medicare & Medicaid Services (CMS) is publishing this article to alert providers to include the appropriate modifier when billing for multiple diagnostic services on the same day. Providers, coders, and billing staff should review the claims submitted, and verify that appropriate modifiers are used for claims that are submitted for the same beneficiary, for the same date of service, with the same codes, but are verified to be unique.

**Background**  
An issue may exist when duplicate services are billed and reimbursed under Medicare. Outpatient claims submitted by a facility for the same service to a particular individual on a specified date of service that was included in a previously submitted claim will be audited for duplicate payments. Exact duplicate data fields submitted for outpatient facility claims including same beneficiary, same provider, same dates of service, same types of services, same place of service, same procedure codes, and same billed amount will be audited for duplicate payments.

The following Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes were involved in this audit:

- HCPCS - A codes - Ambulance/Transportation services;  
- HCPCS - B&C codes - Enteral and Parenteral Therapy;  
- HCPCS - D codes - Dental Procedures;  
- HCPCS - E codes - Durable Medical Equipment;  
- HCPCS - G&H codes - Temporary Procedures and Professional Services and Mental Health;  
- HCPCS codes - J Codes - Drugs Administered Other Than Oral Method;
• HCPCS codes - L Codes-Orthotic Procedures;
• HCPCS codes - M-P Codes-Medical Services & Pathology/Laboratory;
• HCPCS codes - Q-R-S Codes-Temporary Codes;
• HCPCS codes - V Codes-Vision Codes;
• CPT codes- Anesthesia - 00100 to 01999;
• CPT codes-Medicine - 90281 to 99607 (excluding E/M 99201 to 99499);
• CPT codes-Path & Lab - 80047 to 89356;
• CPT codes-Radiology - 70010 to 79999; and
• CPT codes-Surgery -10021 to 69990.

Case Studies

Example 1: A provider received duplicate payments of $87.45 on 4/13/12 and 5/5/12 for CPT 71020 (Chest x-ray) with billed date of service of 3/29/12. Both claims were billed for same patient, same provider, and same date of service, same charge, same CPT code, and same units, without a modifier. The duplicate billing increased the subscriber’s liability by $53.00.

Resolution: Billing of modifier 76 (repeat procedure or service by the same physician or other qualified health care professional) or 77 (repeat procedure or service by another physician or other qualified health care professional) should be used to report the performance of multiple diagnostic services on the same day if these were not actually duplicate claims.

Example 2: A provider received duplicate payments of $64.19 on 2/22/12 and 4/20/12 for CPT 77080 Dual-energy X-ray absorptiometry (DXA), Bone Density axial) with billed date of service of 1/31/12. Both claims were billed for the same patient, same provider, and same date of service, same charge, same CPT code, and same units, without a modifier.

Resolution: Billing of modifier 76 or 77 should be used to report the performance of multiple diagnostic services on the same day if these were not actually duplicate claims.

Additional Information
Coding Requirements for Laboratory Specimen Collection Update

MLN Matters® Number: MM8339 Revised
Related Change Request (CR) #: CR 8339
Related CR Release Date: June 20, 2013
Effective Date: July 16, 2013
Related CR Transmittal #: R2730CP
Implementation Date: July 16, 2013

Note: This article was revised on June 24, 2013, to reflect the revised CR 8339 issued on June 20. The narrative for CPT 36415 has been revised. The CR release date, transmittal number and the Web address for accessing the CR were also revised. All other information remains the same.

Provider Types Affected
This MLN Matters® Article is intended for providers and suppliers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs) and A/B Medicare Administrative Contractors (MACs)) for services to Medicare beneficiaries.

What You Need to Know
This article is based on Change Request (CR) 8339, which advises you that the current Centers for Medicare & Medicaid Services (CMS) instructions found at the “Medicare Claims Processing Manual,” Chapter 16, Section 60.1.4, are being updated due to questions received from the laboratory industry. The CR corrects the codes listed in the manual for claims for laboratory specimen collection services. There is no change in policy or in claims processing. CMS is just updating the manual.

Background
Current CMS instructions have a terminated code listed in the manual for the routine venipuncture for collection of specimens. CMS is releasing this update to these manual instructions to list the active code and address questions received from the laboratory industry. Since the fee schedules and systems were updated when the coding change occurred, there is no need to include any system or fee schedule updates.

“The Medicare Claims Processing Manual,” Chapter 16, Section 60.1.4 - Coding Requirements for Specimen Collection, is revised to add the following:

“The following Health Care Common Procedure Coding System (HCPCS) codes and terminology must be used:

- CPT code 36415 - Collection of venous blood by venipuncture
- HCPCS code P96l5 - Catheterization for collection of specimen(s)”

The allowed amount for specimen collection in each of the above circumstances is included in the laboratory fee schedule distributed annually by CMS.
Additional Information

Billing Social Work and Psychological Services in Comprehensive Outpatient Rehabilitation Facilities (CORFs)

MLN Matters® Number: MM8257 Revised
Related Change Request (CR) #: CR 8257
Related CR Release Date: June 28, 2013
Effective Date: October 1, 2012
Related CR Transmittal #: R2736CP
Implementation Date: October 7, 2013

Note: This article was revised on July 1, 2013, to reflect the revised CR8257 issued on June 28. In this article, the CR release date, transmittal number, and the Web address for accessing the CR were revised. All other information remains the same.

Provider Types Affected
This MLN Matters® article is intended for Comprehensive Outpatient Rehabilitation Facilities (CORFs) submitting claims to Medicare Contractors (Fiscal Intermediaries (FIs) and A/B Medicare Administrative Contractors (MACs)) for services to Medicare beneficiaries.

What You Need to Know
This article is based on Change Request (CR) 8257, which updates the list of Healthcare Procedure Coding System (HCPCS) codes billable in a CORF. It also manualizes billing instructions for a National Coverage Determination (NCD) related to CORFs that was previously omitted from the ‘Medicare Claims Processing Manual.’ CR 8257 contains no new policy. It updates Medicare system edits and billing instructions to more accurately reflect current policy.

Background
In 2008, the Centers for Medicare & Medicaid Services (CMS) issued CR 5898, entitled ‘Comprehensive Outpatient Rehabilitation Facility (CORF) Billing Requirement Updates for Fiscal Year (FY) 2008.’ That CR established a number of edits in Medicare claims processing systems that ensure the correct Current Procedural Terminology (CPT)/HCPCS code and revenue code combinations are billed on CORF claims (type of bill (TOB) 75X). One of these edits required that CPT code 96152 was the only code that could be billed with medical social services or behavioral health revenue codes on CORF claims.

In September 2009, Medicare issued CR 6005, entitled Comprehensive Outpatient Rehabilitation Facility (CORF) Services. CR 6005 created a new HCPCS code, G0409, for billing of social work and psychological services in the CORF setting. At that time, Medicare did not update the claims processing system to replace CPT code 96152 with HCPCS code G0409 in the edit created by CR 5898. CR 8257 corrects this oversight. On
TOB 75X, G0409 can only be billed with revenue codes 0569 or 0911. Also, note that Medicare only allows revenue codes 0270, 0274, 0279, 029x, 0410, 0412, 0419, 042x, 043x, 044x, 0550, 0559, 0569, 0636, 0771, 0911 and 0942 to be billed on TOB 75X.

With CR 8257, Medicare is also correcting another oversight in the therapy chapter of the ‘Medicare Claims Processing Manual.’ In 2001, Medicare issued CR 1535, which implemented an NCD regarding biofeedback training for the treatment of urinary incontinence. CR 1535 established CORF claims (type of bill 75X) as a valid type of bill for payment of biofeedback training as defined by the NCD.

**Additional Information**

**HOSPITAL INFORMATION**

**Post-Acute Care Transfer – Underpayments**

MLN Matters® Number: SE1317  
Related Change Request (CR) #: Not applicable  
Related CR Release Date: N/A  
Effective Date: N/A  
Related CR Transmittal #: N/A  
Implementation Date: N/A

**Provider Types Affected**  
This MLN Matters® Special Edition is intended for inpatient hospitals submitting claims to Medicare contractors (Fiscal Intermediaries (FIs) and A/B Medicare Administrative Contractors (MACs)) for services to Medicare beneficiaries.

**What You Need to Know**  
This article informs you that Medicare’s Recovery Auditors conducted an automated review of inpatient claims with qualifying Diagnosis-Related Groups (DRGs) that were identified with discharge disposition to an acute care inpatient facility (02), Skilled Nursing Facility (03), home health (06), inpatient rehab facility (62), long-term care facility (63), or psychiatric facility (65). These inpatient claims fall under the Post-Acute Care Transfer (PACT) policy and are reimbursed on a per diem rate, up to full Medicare Severity Diagnosis Related Group (MS-DRG) code reimbursement.

Specifically, the Recovery Auditors examined hospital claims that indicated the patient was discharged to another facility as noted in the preceding paragraph. However, in a number of cases, the auditors did not find a claim from a separate facility showing these patients were received by another facility. There are instances where this can legitimately occur, such as the patient dies en route to the other facility or the other facility is a non-Medicare participating facility. In such situations, Medicare may not receive a subsequent claim, but the transfer to another facility coding could be correct.
The key point is that a claim coded to show transfer to another facility is paid differently from a claim where no discharge to another facility occurs. If the discharge disposition is miscoded, the miscoded claim may be paid incorrectly. To avoid payment errors, please remind staff to code claims as transfers only if the beneficiary is discharged to another facility.

**Background**

PACT rules are found in the Code of Federal Regulations (CFR) at 42 CFR Section 412.4.

The Code of Federal Regulations (CFR) at 42 CFR Sections 405.980 (b) and (c), and Section 405.986, states that a Medicare contractor may reopen an initial determination made on a claim between 1 year and 4 years from the date of the initial determination when good cause exists. If a contractor performs data analysis on claims and finds potential claims errors, that may constitute new and material evidence, as it relates to good cause for reopening the claims. Justification for reopening these claims was due to improper payments found in the results of the data analysis.

When Medicare reopens such claims and the resulting analysis shows an error occurred, Medicare will adjust the initial claim accordingly. To avoid this situation, providers should strive to ensure accuracy in submitting inpatient claims with discharge disposition to an acute care inpatient facility (02), skilled nursing facility (03), home health (06), inpatient rehab facility (62), long-term care facility (63), or psychiatric facility (65).

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

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**Additional/Subsequent Procedures Performed During the 90 Day Global Period for Major Surgeries**

MLN Matters® Number: SE1323  
Related Change Request (CR) #: N/A  
Related CR Release Date: NA  
Effective Date: N/A  
Related CR Transmittal #: NA  
Implementation Date: N/A

**Provider Types Affected**
This MLN Matters® Special Edition (SE) Article is intended for physicians who perform and bill for surgery on Medicare beneficiaries. This article may also be of interest to Hospitals, Multispecialty Clinics, and Accountable Care Organizations.
Provider Action Needed
The Centers for Medicare & Medicaid Services (CMS) is publishing this article to remind providers of the Global Surgery Period and to educate providers on how to correctly bill for additional/subsequent procedures performed in the 90 day global period. You and your billing staff should review and be familiar with the payment guidelines for Evaluation and Management (E/M) services provided during the Global Surgery Period.

Background
CMS is reminding providers of the Global Surgical Package (GSP) and the services which are included. Recovery Auditor reviews have determined that providers are incorrectly billing E/M services provided by the surgeon the day before major surgery, the day of minor surgery, 0-10 days after minor surgery, and up to 90 days after major surgery. The GSP was established by CMS to ensure that all components of surgery (including pre- and post-operative services) were bundled into one payment.

Under Medicare Physician Fee Schedule rules, most surgical procedures include pre- and postoperative E/M services. Physicians can indicate that E/M services rendered during the global period are not included in the GSP by submitting modifiers 24 (Unrelated E/M Service by same Physician during Postoperative Period), 25 (Significant, Separately identifiable E/M Service by the same Physician on the same day of the Procedure or Other Service), and 57 (Decision for Surgery made within Global Surgical Period) with the E/M service.

In addition, where appropriate, modifier 79 (Unrelated Procedure or Service by the same Physician during the Postoperative Period) may be used. CMS established modifier 79 to simplify billing for services provided to a patient by the same physician during the postoperative period that were unrelated to the original surgical procedure and not included in the payment for the surgical procedure.

Make certain you and/or your billing staff are NOT billing for E/M services that are already included in the payment for global surgery. Your staff may want to review the payment guidelines for E/M services provided during the global period of surgery. These instructions can be found in the “Medicare Claims Processing Manual,” Chapter 12, Section 40, which is available at [http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf) on the CMS website.

Additional Information

Add-on HCPCS/CPT Codes Without Primary Codes
MLN Matters® Number: SE1320
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

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Provider Types Affected
This MLN Matters® Special Edition Article is intended for providers who submit claims to Medicare contractors (Fiscal Intermediaries (FIs) and/or A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries.

Provider Action Needed
An add-on code is a Health Care Common Procedure System (HCPCS) code or Current Procedural Terminology (CPT) code that describes a service that, with one exception (see Background Section below), is always performed in conjunction with another primary service. An add-on code is eligible for payment only if it is reported with an appropriate primary procedure performed by the same practitioner on the same date of service.

The Centers for Medicare & Medicaid Services (CMS) has learned from Recovery Auditor reports that some providers are billing only Add-on HCPCS/CPT codes without their respective primary codes resulting in overpayments.

This MLN Matters® Special Edition Article provides an overview of billing for HCPCS/CPT Add-on codes, and it is based on CMS manuals and publications including the “Medicare Claims Processing Manual,” (Chapter 12, Sections 30(D) and 30.6.12(I). Change Request (CR) 7501 (Transmittal 2636 dated January 16, 2013) titled “National Correct Coding Initiative (NCCI) Add-On Codes Replacement of Identical Letter, Dated December 19, 1996 with Subject Line, Correct Coding Initiative Add-On (ZZZ) Codes – ACTION.”

Background
An add-on code is a HCPCS/CPT code that describes a service that is always performed in conjunction with the primary service. An add-on code is eligible for payment only if it is reported with the appropriate primary procedure performed by the same practitioner.

The “Medicare Claims Processing Manual,” Chapter 12, Section 30.6.12(I) requires a provider to report CPT code 99292 (Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)), without its primary code CPT code 99291 (Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes). If two or more physicians of the same specialty in a group practice provide critical care services to the same patient on the same date of service.

For the same date of service only one physician of the same specialty in the group practice may report CPT code 99291 with or without CPT code 99292, and the other physician(s) must report their critical care services with CPT code 99292. See Change Request (CR) 7501 at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2636CP.pdf on the CMS website for current information regarding add-on codes in addition to the manual section mentioned above.
The following shows an example of this issue:

**Example**
A provider submitted a claim with CPT Code 26863 for one unit for date of service May 5, 2010, without billing for the primary CPT Code 26862. Add-on codes billed without their primary codes are considered an overpayment. Overpayment for add-on CPT Code 26863 was retracted as a billing error.

- Add-on CPT code 26863 Description: Fuse/Graft added joint – Arthrodesis, interphalangeal joint with or without internal fixation; with autograft, each additional joint. List separately in addition to code for primary procedure.
- Primary CPT Code 26862 Description: Fusion/graft of finger – Arthrodesis, interphalangeal joint, without internal fixation; with autograft. This is a parent CPT Code and can be reported with add-on CPT code 26863.

**Additional Information**

You can review the “Medicare Claims Processing Manual” (Chapter 12, Section 30.6.12(I) Critical Care Services Provided by Physicians in Group Practice(s)) at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf on the CMS website.

**Pre-admission Diagnostic Testing Review**
MLN Matters® Number: SE1324
Related Change Request (CR) #: Not Applicable
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

**Provider Types Affected**
This MLN Matters® Special Edition is intended for inpatient hospitals submitting claims to Medicare contractors (Fiscal Intermediaries (FIs) and A/B Medicare Administrative Contractors (MACs)) for services provided to Medicare beneficiaries.

**Impact to You**
This article is to inform you that the Recovery Auditors have identified pre-admission diagnostic testing services being reimbursed in addition to reimbursement of the Inpatient Prospective Payment System (IPPS) Hospital for services provided during the defined temporal window as a source of overpayments. What You
Need to Know
Diagnostic services (including clinical diagnostic laboratory tests) provided to a beneficiary by the admitting hospital, or by an entity wholly owned or operated by the admitting hospital (or by another entity under arrangements with the admitting hospital), within 3 days prior to and including the date of the beneficiary’s admission are deemed to be inpatient services and included in the inpatient payment, unless there is no Part A Coverage.

- The technical portion of all services that are not diagnostic, other than ambulance and maintenance renal dialysis services, provided by the hospital (or an entity wholly owned or operated by the hospital) on the date of a beneficiary’s inpatient admission are deemed related to the admission and therefore, must be included on the bill for the inpatient stay.

- The technical portion of outpatient services that are not diagnostic, other than ambulance and maintenance renal dialysis services, provided by the hospital (or an entity wholly owned or operated by the hospital) on the first, second, and the third calendar days (1 calendar day for a non-subsection (d) hospital) immediately preceding the date of admission are deemed related to the admission and, therefore, must be billed with the inpatient stay, unless these services are unrelated to the inpatient hospital claim (that is, these preadmission services are clinically distinct or independent from the reason for the beneficiary’s inpatient admission).

What You Need to Do
Make sure that your billing staffs are aware of these billing requirements in order to avoid billing errors that may lead to overpayments.

Background

Medicare Policy
Section 102(a)(1) of the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010 (PACMBPRA) provides that, for outpatient services furnished on or after June 25, 2010, the technical portion of all services that are not diagnostic, other than ambulance and maintenance renal dialysis services, provided by the hospital (or an entity wholly owned or operated by the hospital) on the date of a beneficiary’s inpatient admission are deemed related to the admission and thus, must be included on the bill for the inpatient stay.

Also, the technical portion of outpatient services that are not diagnostic, other than ambulance and maintenance renal dialysis services, provided by the hospital (or an entity wholly owned or operated by the hospital) on the first, second, and the third calendar days (1 calendar day for a non-subsection (d) hospital) immediately preceding the date of admission are deemed related to the admission and, therefore, must be billed with the inpatient stay, unless these services are unrelated to the inpatient hospital claim (that is, these preadmission services are clinically distinct or independent from the reason for the beneficiary’s inpatient admission).
Claims Examples

**Example 1:** An outpatient claim was submitted for CPT codes 36415 - Routine Venipuncture; 80053 - Comprehensive Metabolic Panel; 86304 - Immunoassay, Tumor, CA 125; 83725 - Assay of Magnesium; and 85025 - Complete CBC w/auto diff WBC for Date of Service (DOS) 2/18/2011. The patient was also admitted to inpatient with the same DOS, 2/18/2011. The admitting diagnostic codes were 183.0 Malignant Neoplasm Ovary and V58.11 Antineoplastic Chemotherapy and Immunotherapy.

**Finding:** Diagnostic services (including clinical diagnostic laboratory tests) provided to a beneficiary by the admitting hospital, or by an entity wholly owned or operated by the admitting hospital (or by another entity under arrangements with the admitting hospital), within 3 days prior to and including the date of the beneficiary’s admission are deemed to be inpatient services and included in the inpatient payment, unless there is no Part A coverage. For example, if a patient is admitted on a Wednesday, outpatient services provided by the hospital on Sunday, Monday, Tuesday, or Wednesday are included in the inpatient Part A payment.

**Example 2:** An outpatient claim was submitted for CPT codes 36415 - Routine Venipuncture; 80053 - Comprehensive Metabolic Panel; 83615 - Lactate (LD) (LDH) Enzyme; 85025 - Complete CBC w/auto diff WBC; 86850 - RBC Antibody Screen; 86900 - Blood typing ABO; 86901 - Blood Typing RD (D); and 86923 - Compatibility Test for DOS 3/15/2011. The patient was admitted to inpatient on the following day, 3/16/2011. The admitting diagnostic codes were 285.9 Anemia NOS and 162.8 Malignant Neoplasm Bronchus or Lung NEC.

**Finding:** When a beneficiary receives outpatient hospital services during the day immediately preceding the hospital admission, the outpatient hospital services are treated as inpatient services if the beneficiary has Part A coverage. Hospitals and FIs apply this provision only when the beneficiary is admitted to the hospital before midnight of the day following receipt of outpatient services. The day on which the patient is formally admitted as an inpatient is counted as the first inpatient day.

When this provision applies, services are included in the applicable PPS payment and not billed separately. When this provision applies to hospitals and units excluded from the hospital PPS, services are shown on the bill and are included in the Part A payment.

**Where to Read About this Policy**

The “Medicare Claims Processing Manual,” Chapter 3 - Inpatient Hospital Billing, Section 40.3 - Outpatient Services Treated as Inpatient Services, which is available at [http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf) on the CMS website, states:

“Diagnostic services (including clinical diagnostic laboratory tests) provided to a beneficiary by the admitting hospital, or by an entity wholly owned or operated by the admitting hospital (or by another entity under arrangements with the admitting hospital), within 3 days prior to and including the date of the beneficiary’s admission are deemed to be inpatient services and included in the inpatient payment, unless there is no Part A coverage. For example, if a patient is admitted on a Wednesday, outpatient services provided by the hospital on Sunday, Monday, Tuesday, or Wednesday are included in the inpatient Part A payment.”
“This provision does not apply to ambulance services and maintenance renal dialysis services (see the “Medicare Benefit Policy Manual,” Chapters 10 and 11, respectively). Additionally, Part A services furnished by Skilled Nursing Facilities (SNFs), Home Health Agencies (HHAs), and hospices are excluded from the payment window provisions.”

“For services provided on or after October 31, 1994, for hospitals and units excluded from IPPS, this provision applies only to services furnished within one day prior to and including the date of the beneficiary’s admission. The hospitals and units that are excluded from IPPS are: psychiatric hospitals and units; Inpatient Rehabilitation Facilities (IRF) and units; Long-Term Care Hospitals (LTCH); children’s hospitals; and cancer hospitals.”

“Critical Access Hospitals (CAHs) are not subject to the 3-day (nor 1-day) DRG payment window.”

“An entity is considered to be “wholly owned or operated” by the hospital if the hospital is the sole owner or operator. A hospital need not exercise administrative control over a facility in order to operate it. A hospital is considered the sole operator of the facility if the hospital has exclusive responsibility for implementing facility policies (i.e., conducting or overseeing the facilities routine operations), regardless of whether it also has the authority to make the policies.”

**Guidance To Reduce Mohs Surgery Reimbursement Issues**

MLN Matters® Number: SE1318
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

**Provider Types Affected**
This MLN Matters® Special Edition Article is intended for physicians and hospitals submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs) and A/B Medicare Administrative Contractors (MACs)) for providing Mohs Micrographic Surgical (MMS) services to Medicare beneficiaries.

**What You Need to Know**
Medicare will only reimburse for MMS services when the Mohs surgeon acts as both surgeon and pathologist. You may not bill Medicare for these procedures if preparation or interpretation of pathology slides is performed by a physician other than the Mohs surgeon.

**Background**
Mohs Micrographic Surgery (MMS) is a precise, tissue-sparing, microscopically controlled surgical technique used to treat selected skin cancers. It is an approach that aims to achieve the highest possible cure rates, and minimize wound size and consequent distortions at critical sites such as the eyes, ears, nose, and lips.
MMS is a two-step process in which: 1) The tumor is removed in stages, followed by immediate histologic evaluation of the margins of the specimen(s); and 2) Additional excision and evaluation is performed until all margins are clear. Further, the physician performing MMS serves both as surgeon and pathologist; performing not only the excision but also the histologic evaluation of the specimen(s).

Specifically, the descriptions for these Mohs-specific Current Procedural Terminology (CPT) codes are:

- **CPT Code 17311** - Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (e.g., hematoxylin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; first stage, up to 5 tissue blocks.

- **CPT Code 17312** - Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (e.g., hematoxylin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; each additional stage after the first stage, up to 5 tissue blocks (list separately in addition to code for primary procedure).

- **CPT Code 17313** - Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (e.g., hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; first stage, up to 5 tissue blocks.

- **CPT Code 17314** - Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (e.g., hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; each additional stage after the first stage, up to 5 tissue blocks (list separately in addition to code for primary procedure).

- **CPT Code 17315** - Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (e.g., hematoxylin and eosin, toluidine blue), each additional block after the first 5 tissue blocks, any stage (list separately in addition to code for primary procedure).

**The Identified Coding Problems**

During an audit of the CPT codes associated with MMS across several states in a region, Medicare Recovery Auditors found instances in which the preparation and/or interpretation of the slides of tissue removed during the procedures was performed by someone other than the surgeon (or his/her employee). Examples of findings from this audit follow:

- **Example 1**: A physician billed CPT Code 17311 (Mohs Micrographic Surgery), while on the same date of service CPT Code 88305 (Surgical Pathology, gross and microscopic examination) for the preparation and interpretation of the slides taken during the procedure, was separately billed for a specimen examination by a different practitioner without a modifier. CPT Code 17311 was, therefore, an overpaid claim.
• **Example 2**: A physician billed CPT Code 17313 (Mohs Micrographic Surgery) while on the same date of service CPT Code 88305 (Surgical Pathology, gross and microscopic examination) for the preparation and interpretation of the slides during the procedure was separately billed for a specimen examination by a different practitioner without a modifier. CPT Code 17313 was, therefore an overpaid claim.

**Coding and Documentation Guidance to Help Prevent Reimbursement Problems**
The majority of skin cancers can be managed by simple excision or destruction techniques. The medical record of a patient undergoing MMS should clearly show that this procedure was chosen because of the complexity (e.g. poorly defined clinical borders, possible deep invasion, prior irradiation), size or location (e.g. maximum conservation of tumor-free tissue is important). Medicare will consider reimbursement for MMS for accepted diagnoses and indications, which you must document in the patient’s medical record as being appropriate for MMS and that MMS is the most appropriate choice for the treatment of a particular lesion.

Additionally, you should be aware of Mohs Medicare coverage limitations: 1) Only physicians (MD/DO) may perform MMS; 2) The physician performing MMS must be specifically trained and highly skilled in MMS techniques and pathologic identification; and 3) As mentioned above, if the surgeon performing the excision using MMS does not personally provide the histologic evaluation of the specimen(s), the CPT codes for MMS cannot be used, rather the codes (11600-11646) for the standard excision of malignant lesions should be chosen.

If MMS on a single site cannot be completed on the same day because the patient could not tolerate further surgery and the additional stages were completed the following day, you must start with the primary code (CPT code 17311) on day two. Computer edits will reject claims where a secondary code (e.g., CPT code 17312) is billed without the primary code (e.g., CPT code 17311) also appearing on same date of service, and the same claim.

Your documentation in the patient’s medical record should support the medical necessity of this procedure and of the number and locations of the specimens taken. The operative notes and pathology documentation should clearly show that the procedure was performed using accepted MMS technique, in which you acted in two integrated, but distinct, capacities as surgeon and pathologist. The notes should also contain the location, number, and size of the lesion(s), the number of stages performed, and the number of specimens per stage.

You must describe the histology of the specimens taken in the first stage. That description should include depth of invasion, pathological pattern, cell morphology, and, if present, perineural invasion or presence of scar tissue. For subsequent stages, you may note that the pattern and morphology of the tumor (if still seen) is as described for the first stage; or, if differences are found, note the changes. There is no need to repeat the detailed description documented for the first stage, presuming that the description would fit the tumor found on subsequent stages.

**Additional Information**
There are a number of Local Coverage Determinations and Articles that address Mohs surgery in more detail. To access those LCDs, visit [http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=All&KeyWord=mohs&KeyWordLookUp=Title&KeyWordSearchType=And&bc=gAAAAAAABAAAAA%3d%3d](http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=All&KeyWord=mohs&KeyWordLookUp=Title&KeyWordSearchType=And&bc=gAAAAAAABAAAAA%3d%3d) on the CMS website.
PROVIDER ENROLLMENT INFORMATION

Update to Chapter 15 of the Program Integrity Manual (PIM)

MLN Matters® Number: MM8341
Related Change Request (CR) #: CR 8341
Related CR Release Date: July 5, 2013
Effective Date: October 8, 2013
Related CR Transmittal #: R474PI
Implementation Date: October 8, 2013

Provider Types Affected
This MLN Matters® Article is intended for physicians, other providers, and suppliers submitting claims to Medicare contractors (fiscal intermediaries (FIs), carriers, Regional Home Health Intermediaries (RHHIs) and A/B Medicare Administrative Contractors (A/B MACs)) for services to Medicare beneficiaries.

Provider Action Needed
This article is based on Change Request (CR) 8341, which incorporates certain provider enrollment policy and operational clarifications into chapter 15 of the” Program Integrity Manual” (PIM).

Background
The key clarifications/updates of interest to providers are as follows:

- If a contractor returns an enrollment revalidation application, the contractor shall – unless an existing Centers for Medicare & Medicaid Services (CMS) instruction or directive dictates otherwise– deactivate the provider’s Medicare billing privileges under 42 CFR 424.535(a)(1) if the applicable time period for submitting the revalidation application has expired.

- If a contractor returns a revalidation application and the applicable time period for submitting the revalidation application has not expired, the contractor shall deactivate the provider’s billing privileges after the applicable time period expires unless the provider has resubmitted the revalidation application. If the provider resubmits the revalidation application and the contractor returns it again, rejects it, or denies it, the contractor shall - unless an existing CMS instruction or directive dictates otherwise– deactivate the provider’s billing privileges, assuming the applicable time period has expired.

- If the contractor rejects or denies a revalidation application, the contractor shall – unless an existing CMS instruction or directive dictates otherwise– deactivate the provider’s Medicare billing privileges under 42 CFR 424.535(a)(1) if the applicable time period for submitting the revalidation application has expired.

- If the contractor rejects or denies a revalidation application and the applicable time period for submitting the revalidation application has not expired, the contractor shall deactivate the provider’s billing privileges after the applicable time period expires unless the provider has resubmitted the revalidation application. If the provider resubmits the revalidation application and the contractor rejects it again, returns it, or denies it, the contractor shall - unless an existing CMS instruction or directive dictates otherwise– deactivate the provider’s billing privileges, assuming the applicable time period has expired.
• Absent a CMS instruction or directive to the contrary, the contractor shall send a denial letter to the provider or supplier (1) no later than 5 business days after the contractor concludes that the provider or supplier’s application should be denied, or (2) if the denial requires prior CMS authorization, no later than 5 business days after CMS notifies the contractor of such authorization.

Additional Information

SKILLED NURSING FACILITY (SNF) INFORMATION

Medicare Part A Skilled Nursing Facility (SNF) Prospective Payment System (PPS) Pricer Update FY 2014

MLN Matters® Number: MM8329
Related Change Request (CR) #: CR 8329
Related CR Release Date: June 21, 2013
Effective Date: October 1, 2013
Related CR Transmittal #: R2731CP
Implementation Date: October 7, 2013

Provider Types Affected
This MLN Matters® Article is intended for Skilled Nursing Facilities (SNFs) submitting claims to Medicare contractors (Fiscal Intermediaries (FIs) and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries paid under the SNF Prospective Payment System (PPS).

Provider Action Needed
This article is based on CR 8329 which describes the updates to the payment rates used under the Prospective Payment System (PPS) for Skilled Nursing Facilities (SNFs), for Fiscal Year (FY) 2013, as required by statute. Be sure that your billing staff is aware of these changes.

Background
Annual updates to the Prospective Payment System (PPS) rates are required by the Social Security Act (Section 1888(e)), as amended by the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (the BBRA), the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (the BIPA), and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (the MMA), relating to Medicare payments and consolidated billing for SNFs.

Each July, the Centers for Medicare & Medicaid Services (CMS) publishes the Skilled Nursing Facility (SNF) payment rates for the upcoming fiscal year (that is, beginning October 1, 2013 through September 30, 2014) in the Federal Register, available online at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/List-of-SNF-Federal-Regulations.html on the CMS website. The update methodology is
identical to that used in the previous year, which includes a forecast error adjustment whenever the difference between the forecasted and actual change in the SNF market basket exceeds 0.5 percentage point. The statute mandates an update to the Federal rates using the latest SNF full market basket adjusted for productivity. The payment rates will be effective October 1, 2013.

Additional Information
The official instruction, CR 8329 issued to your Medicare FIs and A/B MACs regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2731CP.pdf on the CMS website.

Expedited Determinations for Provider Service Terminations

MLN Matters® Number: MM7903 Revised
Related Change Request (CR) #: CR 7903
Related CR Release Date: May 24, 2013
Effective Date: August 26, 2013
Related CR Transmittal #: R2711CP
Implementation Date: August 26, 2013

Note: This article was revised on July 1, 2013, to correct a reference in the first sentence of the “NOMNC Preparation and Delivery” section on page 3 to state Medicare patient number, instead of Medicare provider number. All other information remains the same.

Provider Types Affected
This MLN Matters® article is intended for Home Health Agencies (HHAs), Comprehensive Outpatient Rehabilitation Facilities (CORFs), Hospices and Skilled Nursing Facilities (SNFs) providing services to Medicare beneficiaries.

What You Need to Know
Medicare beneficiaries, or a representative acting for a beneficiary, can appeal their provider service terminations to a Quality Improvement Organization (QIO) through the Expedited Determinations process. You have provider responsibilities in this process which, if not completed correctly, could impact your reimbursement.

Background
Excerpts from these manual changes are summarized below.

Health Care Settings in Which the Expedited Determination Process is Available to Beneficiaries
This expedited determination process is available to beneficiaries in Original Medicare whose Medicare covered services are being terminated in the following settings:

• Home Health Agencies (HHA)
• Comprehensive Outpatient Rehabilitation Facilities (CORF)
• Hospice

Skilled Nursing Facilities (SNF), including services covered under a Part A stay, as well as Part B services provided under consolidated billing (i.e., physical therapy, occupational therapy and speech therapy). For example, a beneficiary exhausts their SNF Part A 100-day benefit, but remains in the facility under a private pay stay and receives covered physical and occupational therapy under Medicare Part B. A Notice of Medicare Non-Coverage (NOMNC) must be delivered by the SNF at the end of a Part A stay or when all of the Part B therapies are ending.

Note: Skilled Nursing Facilities includes beneficiaries receiving Part A and B Services in Swing Beds.

Care Settings in which NOMNC Delivery Does Not Apply
The following care settings do not qualify for NOMNC delivery for termination of services:

• When beneficiary never received Medicare covered care in one of the covered settings (for example, an admission to a SNF will not be covered due to the lack of a qualifying hospital stay, or a face-to-face visit was not conducted for the initial episode of home health care);
• When services are being reduced (for example, an HHA providing physical therapy and occupational therapy discontinues the occupational therapy);
• When beneficiaries are moving to a higher level of care (for example, home health care ends because a beneficiary is admitted to a SNF);
• When beneficiaries exhaust their benefits (for example, a beneficiary reaches 100 days of coverage in a SNF, thus exhausting their Medicare Part A SNF benefit);
• When beneficiaries end care on their own initiative (for example, a beneficiary decides to revoke their Hospice benefit and return to standard Medicare coverage);
• When a beneficiary transfers to another provider at the same level of care (for example, a beneficiary transfers from one SNF to another while remaining in a Medicare-covered SNF stay); or
• When a provider discontinues care for business reasons (for example, an HHA refuses to continue care at a home with a dangerous animal or because the beneficiary was receiving physical therapy and the provider’s physical therapist leaves the HHA for another job).

Notice of Medicare Non-Coverage (NOMNC)
Medicare providers are responsible for the delivery of the NOMNC. You must deliver a NOMNC to all beneficiaries eligible for the expedited determination process, even if they agree with the termination of services.

The NOMNC is two page document, subject to the Paperwork Reduction Act Process and approval by the Office of Management and Budget (OMB). As such, it can only be modified according to its accompanying instructions, as unapproved modifications may invalidate it.
Further, while you may include your business logo and contact information at the top of the notice, this cannot cause a shift in text – the NOMNC must remain two pages. You can also include information in the optional “Additional Information” section relevant to the beneficiary’s situation. Please note that including information in this section that would normally be found in the Detailed Explanation of Non-Coverage (DENC), does not satisfy your responsibility to deliver the DENC, if otherwise required. You can find the notices and accompanying instructions online at [http://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.html](http://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.html) on the CMS website.

**NOMNC Preparation and Delivery**

When you prepare the NOMNC, you must use the OMB approved form (CMS-10123), and type or write in the appropriate fields: 1) The patient’s name; 2) the Medicare patient number; 3) The type of coverage ((SNF, Home Health, CORF, or Hospice); and 4) The effective date (last day of coverage), which is always the last day beneficiaries will receive coverage for their services. While you may formally delegate the delivery of the notices to a designated agent such as a courier service, you should remember that all of the requirements of valid notice delivery apply to designated agents. It should be delivered to the beneficiary at least two days before Medicare covered services end, or the second to last day of service if care is not being provided daily, or no later than the next to last visit before Medicare covered services end for home health services that are being provided less frequently than daily.

Note: Beneficiaries have no liability for services received on this date, but may face charges for services received the day following the effective date of the NOMNC for home health, hospice, and CORF services. Because SNFs cannot bill the beneficiary for services furnished on the day of (but before the actual moment of) discharge, beneficiaries may leave a SNF the day after the effective date and not face liability for such services.

There are some exceptions to these required delivery timeframes:

1. You may deliver the NOMNC earlier than two days preceding the end of covered services; however, its delivery should be closely tied to the impending end of coverage;

2. You should not routinely give the notice at the time services begin, unless the services are expected to last fewer than two days; and

3. You should deliver the NOMNC sooner than two days or the next to last visit before coverage ends when a beneficiary receiving home health services is unexpectedly found to no longer be homebound, and thus ineligible for covered home health care.

Finally, you must ensure that the beneficiary or representative signs and dates the NOMNC to demonstrate that they received the notice and understand that the termination decision can be disputed. If the beneficiary refuses to sign the NOMNC, you should annotate the notice to that effect, and indicate the date of refusal on the notice. The date of refusal is considered to be the date of notice receipt. Please note that beneficiaries who refuse to sign the NOMNC still remain entitled to an expedited determination.

You may deliver NOMNC to representatives whom the beneficiary has authorized and appointed to act on their behalf during the appeal process. A beneficiary may designate an appointed representative via the “Appointment of Representative” form, the CMS-1696 which can be found at [http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf](http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf) on the CMS website.
You should inform the representative of the beneficiary’s right to appeal a coverage termination decision, and include the following information:

- The beneficiary’s last day of covered services, and the date when the beneficiary’s liability is expected to begin;
- The beneficiary’s right to appeal a coverage termination decision;
- A description of how to request an appeal by a QIO;
- The deadline to request a review as well as what to do if the deadline is missed; and
- The telephone number of the QIO to request the appeal.

If you choose to contact the representative by telephone, the date you communicate the information is considered the NOMNC’s receipt date. You should annotate the NOMNC to document the telephone contact with the beneficiary on the day that you make telephone contact, reflecting that all of the information indicated above was included in the communication. The annotated NOMNC should also include the name of the staff person initiating the contact, the name of the representative contacted by phone, the date and time of the telephone contact, and the telephone number called. You must place a dated copy of the annotated NOMNC in the beneficiary’s medical file, and mail a NOMNC to the representative the day the telephone contact is made.

If you choose to communicate the information in writing, a hard copy of the NOMNC must be sent to the representative by certified mail, return receipt requested, or any other delivery method that can provide signed verification of delivery (e.g. FedEx, UPS). You should keep in mind that the burden is on you to demonstrate that timely contact was attempted with the representative and that the notice was delivered. The date that someone at the representative’s address signs (or refuses to sign) the receipt is considered the date received. Place a copy of the annotated NOMNC in the beneficiary’s medical file.

As an alternative to both telephone or hardcopy contact, if both you and the representative agree, you may send the notice by fax or e-mail; however your fax and e-mail systems must meet the HIPAA privacy and security requirements.

Finally, in all cases of delivering the NOMNC, you must retain the original signed document in the beneficiary’s file; and send the beneficiary copies of all notices that include all of the required information such as the effective date and covered service at issue.

**Amending the NOMNC Date**

If you have already delivered the initial NOMNC to a beneficiary and the effective date has changed, you should amend the notice to reflect the new date; and verbally notify the beneficiary, and deliver the amended NOMNC to the beneficiary (retaining a copy in their file). Further, if an expedited determination is already in progress, you must immediately notify the QIO of the change and also provide them an amended notice.
**Beneficiary Responsibilities**

A beneficiary who receives a NOMNC, and disagrees with the termination of services, may request an expedited determination by the appropriate QIO for the state where the services were provided. The beneficiary must contact the QIO (either by telephone or in writing) by noon of the day before the NOMNC’s effective date. (If the QIO is unable to accept the request, the beneficiary must submit the request by noon of the next day the QIO is available).

The beneficiary: 1) Must be available to answer questions or supply information requested by the QIO; 2) May (but is not required to) supply additional information to the QIO that he or she believes is pertinent to the case; and 3) Must obtain a physician certification stating that failure to continue (home health or CORF services only) is likely to place his or her health at significant risk.

Without such a certification statement a QIO may not make a determination for service terminations in these settings, although the beneficiary may request an expedited determination from a QIO before obtaining this certification of risk. Once the QIO is aware of a review request, it will instruct the beneficiary on how to obtain the necessary certification from a physician.

Note: You may not bill a beneficiary who has timely filed an expedited determination for disputed services until the review process (including a reconsideration by a QIO, if applicable) is complete.

If the beneficiary makes an untimely request (by not meeting the timeliness requirements described above), the QIO will accept the request for review, but is not required to complete the review within its usual 72-hour deadline. Beneficiaries have up to 60 days from the effective date of the NOMNC to make an untimely request to a QIO. When the beneficiary is still receiving services, the QIO must make a determination and notify the parties within 7 days of receipt of the request. When the beneficiary is no longer receiving services, the QIO will make a determination within 30 days of the request.

You should also be aware that the coverage protections discussed above will not apply to a beneficiary who makes an untimely request to the QIO.

**Provider Responsibilities**

When a QIO notifies you of a beneficiary request for an expedited determination, you must deliver the beneficiary a DENC by close of business the day they are notified, supply the QIO with copies of the NOMNC and DENCs by close of business of the day of the QIO notification, and also supply (by telephone, in writing, or electronically) all information, including medical records, that the QIO requests. If you do this by telephone, you must place a written record of the information you that you provided into the patient record.

In addition, you must (at their request) furnish the beneficiary with access to, or copies of, any documentation you provide to the QIO. You may charge the beneficiary a reasonable amount to cover the costs of duplicating and delivering the documentation, which must be provided to the beneficiary by close of business of the first day after the material is requested.
The DENC is subject to the Paperwork Reduction Act Process and approval by the Office of Management and Budget. OMB-approved notices may only be modified as per their accompanying instructions. Unapproved modifications may invalidate the DENC. The DENC must contain the following information:

- A specific and detailed explanation of why services are either no longer reasonable and necessary or no longer covered;
- A description of, and citations to, the Medicare coverage rule, instruction, or other policies applicable to the review; and
- The facts specific to the beneficiary’s discharge and provider’s determination that coverage should end.

You should make insertions on the notice in Spanish, if necessary. If this is impossible, additional steps should be taken to ensure that the beneficiary comprehends the content of the notice. Providers may resource CMS multilingual services provided through the 1-800-MEDICARE help line if needed.

The delivery must occur in person by close of business of the day the QIO notifies you that the beneficiary has requested an expedited determination. You may also choose to deliver the DENC with the NOMNC. It does not require a signature, but should be annotated in the event of a beneficiary’s refusal to sign upon delivery.

Please note that an HHA is not required to make a separate trip to the beneficiary’s residence solely to deliver a DENC. Upon notification from the QIO of a beneficiary’s request for an expedited determination, an HHA may telephone the beneficiary to provide the information contained on the DENC, annotate the DENC with the date and time of telephone contact, and file it in the beneficiary’s records. A hard copy of the DENC should be sent to the beneficiary via tracked mail or other personal courier method by close of business of the day the QIO notifies the provider that the beneficiary has requested an expedited determination. The burden is on the provider to demonstrate that timely contact was attempted with the beneficiary and that the notice was delivered.

**Effect of QIO Determination on Continuation of Care**

If the QIO decision extends coverage beyond a point covered by the physician’s orders (either because of the duration of the expedited determination process, or because the physician has already concurred with the termination of care) providers cannot deliver care. In the event of a QIO decision favorable to a beneficiary without physician orders, the ordering physician should be made aware the QIO has ruled coverage should continue, and be given the opportunity to reinstate orders. The beneficiary may also seek other personal physicians to write orders for care as well as find another service provider. The expedited determination process does not override regulatory or State requirements that physician orders are required for a provider to deliver care.
If a QIO decision is favorable to the beneficiary and the beneficiary resumes covered services, a new NOMNC should be delivered for the new course of care per the usual requirements described above. If the beneficiary again disagrees with the termination of care, a new request to the QIO must be made.

**Example 1:** If covered home health care continues following a favorable QIO decision for the beneficiary, the HHA would resume issuance of Home Health Advance Beneficiary Notices (HHABN) as warranted for the remainder of this home health episode. If the QIO decides that Medicare covered care should end and the patient wishes to continue receiving care from the HHA even though Medicare will not pay, an HHABN with Option Box 1 (use when item(s) and/or services(s) may be provided that will not be paid for by Medicare) must be issued to the beneficiary since this would be an initiation of non-covered care.

**Example 2:** If covered SNF care continues, following a favorable QIO decision for the beneficiary, but later ends due to the end of Medicare coverage; and the patient wishes to continue receiving uncovered care at the SNF, a Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) must be issued to the beneficiary.

Please keep in mind that delivery of the NOMNC does not replace the required delivery of other mandatory notices, including ABNs. Notice of delivery must be determined by the individual NOMNC requirements (per cite) and ABN delivery requirements per Section 1879 of the Social Security Act and guidance found in the Medicare Claims Processing Manual, Chapter 30 (Financial Liability Protections). In certain instances, both the NOMNC and an ABN may be required, whereas in others, one, two, or even no notices may be required.

**Example When One Notice is Required:** The following is an example of an instance in which only one notice may be required when Medicare covered care is ending: A beneficiary is receiving Comprehensive Outpatient Rehabilitation Facility (CORF) services, and all covered CORF care is ending. A NOMNC must be delivered at least two days, or two visits, prior to the end of coverage. If the beneficiary does not wish to continue the CORF services, an ABN should not be given.

**Example When Two Notices are Required:** The following is an example of an instance in which two notices may be required when Medicare covered care is ending: A beneficiary’s Part A stay is ending because a skilled level of care is no longer medically necessary and the beneficiary wishes to remain in the SNF receiving custodial-level care. The beneficiary must receive the NOMNC two days prior to the end of coverage, and a SNFABN must also be delivered before custodial level care begins.

**Example When No Notice is Required:** As mentioned above, it is also possible that no notice is required when Medicare coverage is ending. The following is an example of such an instance: A beneficiary exhausts the 100 day benefit in a SNF. In this instance, neither the NOMNC nor the SNFABN should be delivered, although the latter can be issued voluntarily, as a courtesy to the beneficiary.

Finally, please keep in mind that a beneficiary for whom coverage is denied, continues to receive services of the type at issue in the expedited determination after the coverage end date, may appeal the denial within the standard claims appeal process (See the Medicare Claims Processing Manual, Chapter 29 Appeals of Claims Decisions), which you can find at [http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912.html](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912.html) on the CMS website.
Additional Information

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If you have any questions concerning this *Medicare Bulletin*, please contact the Provider Contact Center at (866) 590-6703.

This advisory should be shared with all health care practitioners and managerial members of the provider/supplier staff. *Medicare Bulletins* are available at no cost from the CGS website at [http://cgsmedicare.com/parta/](http://cgsmedicare.com/parta/).

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**Address Changes**

**Have you changed your address or other significant information recently?** To update this information, please complete and submit a CMS 855A form. To obtain the form plus information on how to complete and submit it – visit the CGS website ([http://cgsmedicare.com/parta/](http://cgsmedicare.com/parta/)).
### Contact Information for CGS Part A

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<th>Department</th>
<th>Contact Information</th>
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<tr>
<td>• Requests for Redeterminations (first level appeals)</td>
<td></td>
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<tr>
<td>• 935 Appeals related to Overpayments</td>
<td></td>
</tr>
<tr>
<td><strong>Note:</strong> appeals must be filed within <strong>120 days</strong> of the initial claim determination, with very few exceptions. You must complete the first level of appeal before filing a subsequent level of appeal.</td>
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<tr>
<td><strong>Mailing address:</strong></td>
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<tr>
<td>CGS J15 Part A Appeals</td>
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<tr>
<td>PO Box 20006</td>
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<tr>
<td>Nashville, TN 37202</td>
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<tr>
<td>Fax: (803) 462-2585</td>
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<tr>
<td><strong>Fed Ex/UPS/Certified Mail:</strong></td>
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<td>CGS J15 Part A Appeals</td>
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<td>2 Vantage Way</td>
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<td>Nashville, TN 37228</td>
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<td><strong>935 appeals related to overpayments:</strong></td>
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<tr>
<td>CGS J15 Part A Overpayments Appeals</td>
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<tr>
<td>PO Box 20022</td>
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<td>Nashville, TN 37202</td>
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<tr>
<td><strong>Beneficiary Customer Service Center</strong></td>
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<tr>
<td>(only Medicare beneficiaries should use this number)</td>
<td>1-800-MEDICARE (1-800-633-4227) TTY: 877-486-2048 <a href="http://www.medicare.gov">www.medicare.gov</a></td>
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<tr>
<td>Department</td>
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<tr>
<td><strong>Cost Reports, including:</strong></td>
<td><strong>Cost Reports (no checks):</strong></td>
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<tr>
<td>• Checks related to cost reports</td>
<td><strong>Fed Ex/UPS/Overnight Courier:</strong></td>
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<td>CGS</td>
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<td>J15 Cost Report:</td>
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<tr>
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<td>3021 Montvale Drive, Suite C</td>
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<td></td>
<td>Springfield, IL 62704</td>
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<td><strong>Cost Report Overpayment Address (checks only):</strong></td>
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<td><strong>Ohio providers:</strong></td>
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<td>CGS</td>
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<td>Part A Ohio - Lockbox # 957635</td>
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<td>1005 Convention Plaza</td>
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<td>SL-MO-C1WS</td>
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<td>St. Louis, MO 63101</td>
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<td><strong>Kentucky providers:</strong></td>
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<td>Part A KY - Lockbox # 957582</td>
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<td><strong>Credit Balance Reporting</strong></td>
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<td><strong>Regular and Certified Mail:</strong></td>
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<td>CGS</td>
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<td>Attn: J15 Credit Balance Reporting</td>
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<td>PO Box 20023</td>
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<td>Nashville, TN 37202</td>
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<td>Nashville, TN 37228</td>
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<td><strong>Reports may be faxed to:</strong></td>
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<td>MCBR Receipts</td>
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<td>Attn: Credit Balance Reporting</td>
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<td>(803) 462-2584</td>
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<td>VRU: (803) 763-6418</td>
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<td><strong>All e-mail inquiries:</strong></td>
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<td></td>
<td><a href="mailto:Credit.Balance@PalmettoGBA.com">Credit.Balance@PalmettoGBA.com</a></td>
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<tr>
<td>Department</td>
<td>Contact Information</td>
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</table>
| **Electronic Data Interchange (EDI), including:** | J15 - Part A EDI  
CGS Administrators, LLC  
PO Box 20014  
Nashville, TN 37202  
**EDI Help Desk:** 866-590-6703 (choose option 2) |
| • EDI enrollment                               |                                                                                                         |
| • Administrative Simplification and Compliance Act (ASCA) |                                                                                                         |
| • Electronic Remittance Advice (ERA)           |                                                                                                         |
| • PC-ACE Pro 32 (billing software)             |                                                                                                         |
| • Direct Data Entry (billing software): enrollment, RACF IDs, passwords, problems with your claims being accepted (for other DDE questions, call 866-590-6703, option 1, to speak with a customer service representative) |                                                                                                         |

| Investigational Device Exemption Requests      |                                                                                                         |
| **Medical Affairs**                            |                                                                                                         |
| • Carrier Medical Director                     |                                                                                                         |
| **Email:** J15IDE@cgsadmin.com                  |                                                                                                         |

| Medical Review                                  |                                                                                                         |
| • Responding to Additional Documentation Requests (ADRs) |                                                                                                         |
| • Responses to our requests for medical records  |                                                                                                         |
| **Email:** CMD.inquiry@cgsadmin.com              |                                                                                                         |

| Medicare Secondary Payer (MSP): Coordination of Benefits Contractor |                                                                                                         |
| • Questions regarding beneficiary’s primary or secondary records |                                                                                                         |
| **COBC:** (800) 999-1118                                        |                                                                                                         |
| **TTY/TDD:** (800) 318-8782 for the hearing and speech impaired. |                                                                                                         |
| Hours: Monday through Friday from 8 a.m. to 8 p.m. ET, except holidays. |                                                                                                         |
| **Mailing address:** Medicare - Coordination of Benefits |                                                                                                         |
| PO Box 33847  
Detroit, MI 48232 |                                                                                                         |
<table>
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<tr>
<th>Department</th>
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<tr>
<td><strong>Overpayments</strong></td>
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<td>• Overpayments</td>
<td>CGS - J15 Part A Kentucky</td>
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<td></td>
<td>St. Louis, MO 63195-7582</td>
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<td>• Checks for cost report and credit balances</td>
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<td>PO Box 957635</td>
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<td>St. Louis, MO 63195-7635</td>
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<td>• Immediate offset requests</td>
<td><strong>Extended Repayment Schedules:</strong></td>
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<td>J15 Part A Overpayments</td>
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<td>CGS Administrators</td>
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<td></td>
<td>PO Box 22029</td>
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<td></td>
<td>Nashville, TN 37202-2029</td>
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<td><strong>Provider Inquiries:</strong></td>
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<td></td>
<td>For telephone assistance regarding overpayments, please call the Provider Contact Center at 866-590-6703</td>
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<td>To request an immediate offset, fax your request, including this form to (615) 664-5958</td>
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<td><strong>Provider Audit, including issues related to:</strong></td>
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<td><strong>Provider Audit (regular and overnight delivery):</strong></td>
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<td>J15 Provider Audit</td>
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<td>3021 Montvale Drive, Suite C</td>
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<td>Springfield, IL 62704</td>
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<td><strong>Appeals and Reopenings:</strong></td>
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<td>J15 Appeals and Reopenings</td>
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<td>Columbia, SC 29202</td>
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<td>J15 Appeals and Reopenings</td>
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<td>2300 Springdale Dr. (AG-350), Building One</td>
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<td>Camden, SC 29020</td>
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<td><strong>Email address for filing cost report appeals:</strong></td>
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<td><a href="mailto:J15.CR.appeals@palmettogba.com">J15.CR.appeals@palmettogba.com</a></td>
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<td><strong>Email address for filing cost report reopenings:</strong></td>
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<tr>
<td><strong>Provider Enrollment</strong></td>
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<tr>
<td>• General Enrollment questions</td>
<td>J15 Part A Provider Enrollment</td>
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<tr>
<td>• Initial Enrollment and Change of Ownership questions</td>
<td>PO Box 20004</td>
</tr>
<tr>
<td>• Change address, add a location</td>
<td>Nashville, TN 37202</td>
</tr>
<tr>
<td>• Electronic Funds Transfer (EFT) CMS 588 form</td>
<td>For telephone assistance, please call the Provider Contact Center at (866) 590-6703</td>
</tr>
<tr>
<td>• How to obtain a National Provider Identifier (NPI)</td>
<td>Access Internet-based PECOS at:</td>
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<td><a href="https://pecos.cms.hhs.gov/pecos/login.do">https://pecos.cms.hhs.gov/pecos/login.do</a></td>
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<td></td>
<td><em>(Note: your facility’s Authorized Official must register first)</em></td>
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<td></td>
<td>Obtain electronic CMS 855 application forms at:</td>
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<td><a href="http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html">www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html</a></td>
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<tr>
<td><strong>Provider Outreach and Education (POE)</strong></td>
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<tr>
<td>• Request education or training</td>
<td>J15 Part A POE</td>
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<tr>
<td>• Request a speaker for association meetings in your state</td>
<td>PO Box 20200</td>
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<td>Nashville, TN 37202</td>
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<td></td>
<td>To complete your request electronically go to:</td>
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<td><a href="http://www.cgsmedicare.com/parta/help/forms/pdf/eduation_request.pdf">www.cgsmedicare.com/parta/help/forms/pdf/eduation_request.pdf</a></td>
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<tr>
<td><strong>Provider Reimbursement</strong></td>
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<tr>
<td>• Interim rate information</td>
<td>J15 Provider Reimbursement</td>
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<tr>
<td>• Reimbursement issues</td>
<td>PO Box 20020</td>
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<tr>
<td>• Reimbursement specialist</td>
<td>Nashville, TN 37202</td>
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<tr>
<td>• Submission of certificates</td>
<td><strong>Phone:</strong> (803) 763-5554</td>
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<tr>
<td></td>
<td><strong>Email:</strong> <a href="mailto:J15.reimbursement@palmettogba.com">J15.reimbursement@palmettogba.com</a></td>
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<tr>
<td><strong>Quality Improvement Organization (QIO) - Ohio</strong></td>
<td>Ohio KePro</td>
</tr>
<tr>
<td>• Quality of care concerns regarding Medicare beneficiaries</td>
<td>Rick Run Center, Suite 100</td>
</tr>
<tr>
<td>• Quality Improvement Plans</td>
<td>5700 Lombardo Center Drive</td>
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<tr>
<td>• Electronic Health Records (EHR) and Meaningful Use of Technology</td>
<td>Seven Hills, OH 44131</td>
</tr>
<tr>
<td></td>
<td><strong>Phone:</strong> 800-385-5080</td>
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<tr>
<td></td>
<td><strong>Website:</strong> <a href="http://www.ohiokepro.com">www.ohiokepro.com</a></td>
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<tr>
<td><strong>Quality Improvement Organization (QIO) - Kentucky</strong></td>
<td>Health Care Excel of Kentucky, Incorporated</td>
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<tr>
<td>• Quality of care concerns regarding Medicare beneficiaries</td>
<td>1941 Bishop Lane, Suite 400</td>
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<tr>
<td>• Quality Improvement Plans</td>
<td>Louisville, KY 40218</td>
</tr>
<tr>
<td></td>
<td><strong>Phone:</strong> (502) 454.5112</td>
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<tr>
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<td><strong>Website:</strong> <a href="http://www.hce.org">www.hce.org</a></td>
</tr>
<tr>
<td>Department</td>
<td>Telephone Number</td>
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</tbody>
</table>
| **Qualified Independent Contractor (QIC) Part A West Jurisdiction (KY and OH)** | MAXIMUS Federal Services, Inc.  
QIC Part A West Project  
PO Box 62410  
King of Prussia, PA 19406  
**Standard Reconsiderations:** (484) 688-8900  
**Website:** www.maximus.com |
| **Second-Level Appeals (Reconsiderations)**    |                                                                                   |
| **Reopenings**                                | Please access the Clerical Error Reopening Form at:  
CGS  
J15 Part A Claims  
PO Box 20211  
Nashville, TN 37202 |
| **Zone Program Integrity Contractor (ZPIC)**   | Cahaba Safeguard Administrators, LLC  
375 Riverchase Parkway East  
Birmingham, AL 35244  
**Website:** http://cahabasafeguard.com |
| **Suspected fraud**                            |                                                                                   |
| **Potential abuse**                            |                                                                                   |
| **Questionable billing practices**             |                                                                                   |