President signs SGR patch legislation with ICD-10 delay

On April 1, the President signed into law H.R. 4302, the "Protecting Access to Medicare Act of 2014." This legislation continues the 0.5% update to Medicare physician payments through Dec. 31, 2014 and provides a 0% freeze to payments Jan. 1-March 31, 2015. It also delays the transition to ICD-10 for at least one year. Other provisions in the legislation include:

- Extending the 1.0 work Geographic Practice Cost Index (GPCI) floor and therapy cap exceptions process for one year
- Creating new Medicare policies for clinical diagnostic laboratory tests
- Putting in place "appropriate use" criteria for certain imaging services, and requiring prior authorization for certain ordering providers identified as "outliers"
- Creating a new process for identifying "misvalued codes" in the Medicare Physician Fee Schedule
- Making adjustments to 2024 Medicare physician payment cuts resulting from sequestration, implementing a 4% cut Jan.-June and a 0% cut for the remainder of the year

For more detailed information, access the committee summary or view the full legislative text.

Medicare is Only Accepting Revised CMS 1500 Claim Form (02/12) Starting

April 1, 2014

Starting with claims received on April 1, 2014, Medicare will only accept professional and supplier paper claims on the revised CMS 1500 claim form (02/12).

Medicare began receiving claims on the revised CMS 1500 claim form (02/12) on January 6, 2014. The CMS 1500 claim form is the required format for submitting professional and supplier claims to Medicare on paper, when submitting paper claims is permissible. The dual-use period during which Medicare also accepted the old CMS 1500 claim form began on January 6, 2014, and will end on March 31, 2014.

The revised form, among other changes, notably adds the following functionality:

- Indicators for differentiating between ICD-9-CM and ICD-10-CM diagnosis codes
- Expansion of the number of possible diagnosis codes to 12
- Qualifiers to identify the following provider roles (on item 17):
  - *Ordering
  - *Referring
  - *Supervising

- Inpatient Medicare severity-related diagnosis-related groups (MS-DRG)
- Billing Coverage for Drug Wastage
- DDE System Access Requests
- Medical Documentation “two midnight rule”
- New HCPCS C-codes
- Research: Coverage of Devices
Clinical laboratory fee schedule update on travel allowances and specimen collection fees


The Centers for Medicare & Medicaid Services (CMS) updated payment rates for travel allowances and specimen collection fees when billed on a per mileage basis or when billed on a flat rate basis for 2014. [MM8641]

Fee schedule news

Revised 2014 annual update for clinical laboratory fee schedule


The Centers for Medicare & Medicaid Services (CMS) revised the 2014 clinical laboratory fee schedule to include several codes inadvertently left off of the previous 2014 fee schedule files. [MM8695]

Clinical lab

New waived tests

April update to the 2014 Medicare physician fee schedule


Change request 8664 update amends the payment files based upon the 2014 Medicare physician fee schedule scheduled final rule, scheduled for implementation April 7, 2014. [MM8664]

Fee schedule news

Information regarding the holding of April 2014 claims for services paid under the 2014 Medicare physician fee schedule


The Centers for Medicare & Medicaid Services (CMS) has instructed Medicare administrative contractors to hold physician fee schedule claims April 1, 2014, through April 14, 2014.

Take a closer look at your claims on ‘the SPOT’

Beginning March 17, the Secure Provider Online Tool’s (the SPOT) enhanced Claims Status feature will allow you to control the depth of focus on each claim.

Customizable queries and information displays

The SPOT’s new streamlined Claims Status query form helps you to customize your search based upon the type of information you require and resubmit previously submitted queries, when you need to review claims data acquired during the same session.

If you would like to search for claims associated with one beneficiary, you may specify the beneficiary’s Medicare number as well as the dates of service in which the services were provided. You may also broaden your search to include all of the claims that fall within a specified time period by entering only the dates of service.

Once you’ve submitted your query, the SPOT lets you manage the level of detail displayed and to focus your examination only on the data you need.

The first level of results offers a quick “snapshot” of each claim that falls within the parameters of your search in a convenient, sortable summary table. This high-level view shows you only the essentials, including the current status of each claim as well as the associated dates of service and the beneficiaries for whom services were provided. You also have the option to export the data contained within the summary table to either an Excel spreadsheet or to a PDF for future reference.

In addition, for the first time, Part B providers will share the ability currently enjoyed by Part A Direct Data Entry (DDE) users: To not only view claim-level data but also to examine line-item detail.

Coming soon: Changes to Benefits/Eligibility

The enhancements to the SPOT’s Claims Status interface are only a preview of more exciting changes scheduled to be implemented on First Coast’s most popular provider resource in 2014. What’s next? Changes to Benefits/Eligibility will be coming soon and will not only feature more in-depth information but also enhancements to the query form and result displays.

So, if you don’t have an account, register now. Let the SPOT help you focus on your success in Medicare billing.

Stay connected to ‘the SPOT’

Follow us on Twitter @theSPOTportal

Please click here to view First Coast's eNews archive for the SPOT.
Common claim denials -- Part B

Reduce your claim submission errors

The following is a listing of the most common reasons Medicare Part B claims submitted by jurisdiction 9 (J9) providers are denied by First Coast Service Options Inc. (First Coast). These codes link to tips and resources to help you avoid and reduce many of these issues.

- For a list of all possible codes and their definitions, refer to the Washington Publishing Company’s website at www.wpc-edi.com/content/view/695/1. Please share this information with all who need to know, such as your billing and IT staff, contracted billing service or clearinghouse, and software vendor. Correctly billing Medicare the first time saves everyone time and money.

Denial codes, descriptions, and tips or frequently-asked questions (FAQs)

Note: Under current guidelines, any reference to "UPIN" within the definitions of codes should be interpreted as "NPI."

- OA-18
- CO-29 Claims timely filing guidelines frequently-asked question (FAQ)
- PR-22
- PR-27
- PR-49
- CO-50/PR-50
- CO-58
- PR-96
- CO-97
- PR-119
- PR-170
- CO-236
- CO-B7
- PR-B9

Frequently-asked questions regarding claim denials -- click here

Other common tips on inquiries and denials -- click here

Additional tips

Use the following tips to help you find the answers you need about these additional topics:

- Click here for questions about accessing claim status, patient eligibility (Medicare, MSP and Medicare Advantage [formerly Medicare HMO]), deductible information, and financial information (last three checks, month/year to date dollar amounts).

Did you review your batch detail control listing?

Claims submission errors may be obtained in a timely fashion through your electronic data interchange (EDI) gateway mailbox on a report titled batch detail control listing. Referring to this report will allow you to correct and resubmit claims quickly, resulting in a dramatically reduced turnaround time. This report will also inform you of any major problems with your claims, so they can be corrected before creating an interruption in your cash flow.

Did you know you can create an account and receive your personalized Provider Data Summary (PDS) report?

The Provider Data Summary (PDS) is a comprehensive billing report designed to be utilized along with Medicare remittance notices (MRNs) and other provider-accessible billing resources to help identify potential Medicare billing issues through a detailed analysis of your personal billing patterns in comparison with those of similar providers. Use the PDS portal to request this useful report and enhance the accuracy and efficiency of your Medicare billing process.
PQRS News

The PQRS measure documents for the current program year may be different from the PQRS measure documents for a prior year. Eligible professionals are responsible for ensuring that they are using the PQRS measure documents for the correct program year. The 2014 PQRS CMS-1500 claim is an example of how an individual National Provider Identifier (NPI) reporting on a single CMS-1500 claim for 2014 PQRS should look. The following document that contains the 2014 PQRS CME Quality Incentive Program (QIP) website improvements: New Resources for Providers

CMS has revamped the End-Stage Renal Disease (ESRD) Quality Incentive Program (QIP) website for the renal community. This reorganized and expanded website includes details about ESRD QIP Payment Years (PY), program results, Frequently Asked Questions documents, archived presentations, and program timelines.

EHR Incentive Program: Medicare EPs Must Attest by March 31 to Receive 2013 Incentive

Due to the large volume of providers attesting, please submit your data as soon as possible and during non-peak hours to avoid system delays. If you are an eligible professional (EP), the last day you can register and attest to demonstrating meaningful use for the 2013 Medicare Electronic Health Record (EHR) Incentive Program is March 31, 2014. You must successfully attest by 11:59pm ET on March 31, to receive an incentive payment for your 2013 participation. CMS extended the deadline for eligible professionals to attest to meaningful use for the Medicare EHR Incentive Program to allow more time for providers to submit their meaningful use data and receive an incentive payment for the 2013 program year.

Medicaid Eligible Professionals Eligible professionals participating in the Medicaid EHR Incentive Program need to refer to their state deadlines for attestation information. If you are only eligible to participate in the Medicaid EHR Incentive Program, you are not subject to payment adjustments.

Payment Adjustments Payment adjustments for EPs will be applied beginning January 1, 2015, to Medicare participants

NCD FOR BETA AMYLOID PET

NCD for beta amyloid PET in dementia and neurodegenerative disease


This article was revised April 4 to reflect the revised change request (CR) 8526 issued March 27. In the article, the CR release date, transmittal numbers, and the Web addresses for accessing the two transmittals of CR 8526 were revised. [MM8526]

MLN Connects™ Provider eNews

MLN Connects™ Provider e-News Edition for

Thursday, March 27, 2014

This edition includes the latest information on registering for the PQRS group reporting option, electronic health record (EHR) incentive program deadlines, and more.

Processing Issues

Codes G0461-26 and G0426-26 denied in error

Claims submitted with procedure codes G0461-26 and G0426-26 with units of service greater than one were denied in error for dates of service January 1, 2014, through March 25, 2014.

Post-Operative Period

First Coast recently conducted data analysis to evaluate procedure codes with a global periods of 0, 10, and 90 days. The findings revealed that services were incorrectly paid during global period without an appropriate modifier. Click link, below.

Global surgery post-operative period of 0, 10, and 90 days

Billing news

Incorrect overpayments and denials for some new patient visit claims

The Centers for Medicare & Medicaid Services (CMS) has identified issues related to processing of claims for new patient visits billed by the same physician or physician group within the past three years.

Reporting Principal and Interest Amounts When Refunding Previously Recouped Money on the Remittance Advice (RA)

Skin Substitutes and Changes to FDG PET Scans Coverage

Medical policy news
Skin substitutes – clarification of coverage

FDG - PET Scans
Changes affecting Medicare coverage of fluorodeoxyglucose (FDG) positron emission tomography (PET) scans

Observation care codes may not be billed for hospital inpatients

The appropriate hospital visit codes should be used when billing for inpatient services. Steps will be taken by A/B Medicare administrative contractors to prepare and implement the non-payment of claim lines after detection of observation care codes billed for a beneficiary who is currently receiving inpatient care services.

Edits will be implemented on or about January 20, 2014, in the multi-carrier system (MCS) only.

GENETIC TESTING FOR LYNSCH SYNDROME

Genetic testing for lynch syndrome – new LCD

Effective date

This new LCD is effective for services rendered on or after March 17, 2014. First Coast Service Options Inc.

LCDs are available through the CMS Medicare Coverage Database at http://www.cms.gov/medicare-coveragedatabase/

NERVE CONDUCTION STUDIES AND ELECTROMYOGRAPHY

LCD ID number: L34480 (Florida/ Puerto Rico/U.S. Virgin Islands)

The current LCD titled electromyography and nerve conduction studies will be retired when this new LCD becomes effective.

This new LCD addresses the indications and limitations of coverage and/or medical necessity, Current Procedural Terminology (CPT®)/HCPCS codes, diagnosis codes, documentation requirements, provider training and credentialing, and utilization guidelines for nerve conduction and electromyography studies.

Effective date

This new LCD is effective for services rendered on or after March 17, 2014. First Coast Service Options Inc.

LCDs are available through the CMS Medicare Coverage Database at http://www.cms.gov/medicare-coveragedatabase/

overview-and-quick-search.aspx. Coding Guidelines for an LCD (when present) may be found by selecting “LCD Attachments” in the “Jump to Section...” drop-down menu at the top of the LCD page.

Note: To review active, future, and retired LCDs for jurisdiction 9 (J9), please click here.
Prepayment review for initial and subsequent hospital evaluation and management services CPT® codes 99223 and 99233

First Coast Service Options Inc. (First Coast) recently conducted data analysis due to the high comprehensive error rate testing (CERT) error rates for evaluation and management services pertaining to Common Procedural Terminology® (CPT®) codes 99223 (initial hospital visit) and 99233 (subsequent hospital visit). The CERT November 2014 forecasting report indicates a projected error rate of 44 percent for CPT® code 99223 and a projected error rate of 34.5 percent for CPT® code 99233. The data indicates that the specialty of internal medicine is the primary contributor to the CERT error rate: internal medicine error rates are currently trending at 32 percent for CPT® code 99233 and 40 percent for CPT® code 99223.

Documentation requirements

The American Medical Association (AMA) CPT® manual defines code 99223 as follows:

*Initial hospital care, per day, for the evaluation and management of a patient, which requires these three key components:*

- A comprehensive history;
- A comprehensive examination; and
- Medical decision making of high complexity

*Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the problem(s) requiring an admission are of high severity. Typically, 70 minutes are spent at the bedside and on the patient’s hospital unit.*

The AMA CPT® manual defines code 99233 as follows:

*Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components:*

- A detailed interval history;
- A detailed examination;
- Medical decision making of high complexity

*Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family needs. Usually, the patient is unstable or has developed a significant new problem. Typically, 35 minutes are spent at the bedside and on the patient’s hospital unit.*

In responses to the high percentage of error rates and the continual risks of improper payments associated with hospital care visits billed by internal medicine specialists, First Coast will be implementing a prepayment medical review edit for CPT® codes 99223 and 99233 billed by internal medicine specialty. The new edit will be based on a predetermined percentage of claims in an effort to reduce the error rates for these hospital services.
Medicaid

Prior Authorization Process for Ultrasound and Biophysical Profile Codes

Effective May 1, 2014, certain ultrasound and biophysical procedures that are over the Medicaid allowed limit of three (3) ultrasounds and two (2) biophysical profiles require authorization through eQHealth Solutions, Inc. (eQHealth). The applicable codes are 76815, 76816, and 76817 for ultrasounds; and 76818 and 76819 for biophysical profiles. If the service has been performed, but not billed, eQHealth will review for retroactive authorization. Previously, claims were suspended for review and adjudication.

eQHealth will host a series of web-based training sessions for physicians during the month of April. The times and dates for each training session will be available on eQHealth’s website. Please visit the website to register for the training(s) of your choice.

Florida Medicaid 2014 Winter Bulletin

Florida Medicaid Fee Schedules
http://portal.flmmis.com/FLPublic/Provider_ProviderSupport/Provider_ProviderSupport_FeeSchedules/tabId/44/Default.aspx

Medicaid Office of Billing Compliance Newsletter

Medicaid Health Care Alert April 2014

Provider Type(s): 67, 96, 98 Speech Therapy Assessment Code

Effective January 1, 2014 the following speech therapy assessment evaluation codes 92506UC and 92506U6, were replaced with the following new codes:

- 92521UC and 92521U6 Evaluation of speech fluency (e.g., stuttering, cluttering)
- 92522UC and 92521U6 Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria)
- 92523UC and 92521U6 Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (e.g., receptive and expressive language)
- 92524UC and 92521U6 Behavioral and qualitative analysis of voice and resonance

Claims with a date of service on or after January 1, 2014 must be submitted using the new codes.

All four codes are reimbursed at the rate of $48.50. Providers will only be allowed to receive reimbursement for one of the four codes every 150 days. We are working to modify our system which will allow providers to bill multiple procedure codes at the appropriate rate. However, you will still receive the maximum reimbursement fee of $48.50 whether one or multiple codes are billed. You must have actually performed the specific evaluation in order to bill for the service.

The current speech therapy assessment policy is still applicable as stated in the coverage and limitations handbooks.
Commonly Used Anti-Kickback Statute Safe Harbors*

- Investment interests
- Space rental
- Equipment rental
- Personal services and management contracts
- Sale of practice
- Referral services
- Discounts
- Employees
- Group purchasing organizations
- Waiver of beneficiary coinsurance and deductible amounts
- Price reductions offered to health plans
- Practitioner recruitment
- Investments in group practices
- Ambulatory surgical centers
- Referral arrangements for specialty services
- Price reductions offered to eligible managed care organizations

Commonly Used Physician Self-Referral Law Exceptions*

**General Exceptions Related to Ownership/Investment and Compensation Arrangements (411.355)**

- Physician Services
- In-Office Ancillary Services
- Services Furnished by an Organization to Enrollees
- Academic Medical Centers
- Implants Furnished by an ASC
- EPO and Other Dialysis-Related Drugs
- Preventive Screening Tests, Immunizations, and Vaccines
- Eyeglasses and Contact Lenses Following Cataract Surgery
- Intra-Family Rural Referrals

**Exceptions Related to Ownership or Investment Interests (411.356)**

- Publicly-Traded Securities
- Mutual Funds
- Specific Providers (Rural Providers, Hospitals in Puerto Rico, “Whole” Hospitals)

**Exceptions Related to Compensation Arrangements (411.357)**

- Rental of Office Space
- Rental of Equipment
- Bona Fide Employment Relationships

**Commonly Used Physician Self-Referral Law Exceptions*, continued**

- Personal Services Arrangements
- Payments by a Physician
- Physician Recruitment
- Isolated Transactions
- Certain Arrangements with Hospitals (remuneration unrelated to DHS)
- Group Practice Arrangements with Hospitals
Inpatient Medicare severity-related diagnosis-related groups (MS-DRG)

Inpatient DRG FAQ

Follow this link to view frequently-asked questions pertaining to inpatient diagnosis-related groups.

April 2014 Policy Updates

The following is a summary of the policy updates made by WPS Medicare for April 2014, which includes new, retired, and revised policies. View details about these policy updates on our website at http://www.wpsmedicare.com/j5macparta/policy/updates/. The changes to the policies will be reflected on the CMS (http://www.cms.gov/medicare-coverage-database/) and WPS Medicare websites on 03/31/2014. To access Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs) on the WPS Medicare website, please visit our Active/Final Policies web page at http://www.wpsmedicare.com/j5macparta/policy/active/.

- Chemotherapy Drugs and their Adjuncts - Effective 04/01/2014
- Immune Globulins - Effective 04/01/2014
- Mohs Micrographic Surgery - Effective 04/01/2014
- Nerve Conduction Studies and Electromyography - Effective 04/01/2014
- Non-coronary Vascular Stents - Effective 04/01/2014
- Non-Invasive Vascular Testing - Effective 04/01/2014
- Transesophageal Echocardiography (Including IntraoperativeTEE) - Effective 04/01/2014

Billing and coverage for Drug Wastage

First Coast Service Options Inc. (First Coast) will consider payment for the unused and discarded portion of a single-use drug/biological product after administration of the appropriate (reasonable and necessary) dosage for the patient's condition. This applies to drugs priced through the Average Sales Price (ASP) drug/biological program. The Centers for Medicare & Medicaid Services (CMS) encourages physicians, hospitals, and other providers to provide injectable drug therapy incident to a physician's services in a fashion that maximizes efficiency of therapy in a clinically appropriate manner. If a physician, hospital, or other provider must discard the unused portion of a single-use vial or other single-use package after administering a dose/quantity appropriate to the clinical context for a Medicare beneficiary, the program provides payment for the entire portion of drug or biological indicated on the vial or package label.

If less than a complete vial is administered at the time of service, and the unused portion is discarded, drug wastage must be documented in the patient's medical record with the date, time, and quantity wasted. Upon review, any discrepancy between amount administered to the patient and the billed amount will be denied, unless wastage is clearly documented. The amount billed as "wastage" must not be administered to another patient or billed again to Medicare. All procedures for drug storage, reconstitution and administration should conform to applicable Federal Drug Administration (FDA) guidelines and provider scope of practice.

Note: For billing purposes, First Coast does not require the use of modifier JW. Drug wastage is billed by combining on a single line the wastage and administered dosage amount.
**LOCAL COVERAGE DETERMINATIONS (LCD)**

**Tositumomab and iodine I 131 tositumomab (Bexxar®) therapy -- retirement of the Part A LCD**
*Modified: 4/10/2014* Location: FL, PR, USVI Line of Business: Part A

This Mac J9 local coverage determination (LCD) is being retired.

**Stereotactic radiosurgery (SRS) and stereotactic body radiation therapy (SBRT) -- revision to the Part A LCD**
*Modified: 4/10/2014* Location: FL, PR, USVI Line of Business: Part A

Revisions were made to this LCD for Medicare administrative contractor (MAC) jurisdiction 9.

**Psychiatric diagnostic evaluation and psychotherapy services -- revision to the Part A LCD**
*Modified: 4/10/2014* Location: FL, PR, USVI Line of Business: Part A

Several revisions were made to this LCD for Medicare administrative contractor (MAC) jurisdiction 9.

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**New Electronic Process for DDE Systems Access Requests**

Effective February 3, 2014, a new process was implemented for the submission of Direct Data Entry (DDE) systems access requests to the WPS Medicare FISS workloads.

To learn more about the change, please visit the Electronic Form Process for DDE Systems Access Requests page at:


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**Claim Submission Guidelines**

**Part A to B rebilling tips and reminders**
*Modified: 4/10/2014* Location: FL, PR, USVI Line of Business: Part A

To facilitate the successful completion of Part A to B rebilling, First Coast Service Options’ (First Coast) has prepared these tips to help submitters avoid billing errors.
Medical documentation “Two Midnight Rule” Probe Review

‘Probe and educate’ clarifications: Timeframes for additional documentation requests and education
Modified: 4/10/2014 Location: FL, PR, USVI Line of Business: Part A

Hospitals that have submitted claims to Medicare administrative contractors (MAC) in response to Medicare's “two-midnight” probes will receive a grace period of 45 days before MACs request additional documentation on these claims.

Publications Medicare PartA

March 2014 Medicare A Connection [PDF]
Modified: 4/9/2014 Location: FL, PR, USVI Line of Business: Part A

The March 2014 edition of Medicare A Connection includes information about documenting therapy and rehabilitation services, denial of hospice-related claims, and upcoming educational events.

ABN Modifiers

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

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

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

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

Refer to the April 2014 Update of the Hospital Outpatient Prospective Payment System (OPPS) or the April 2014 Update of the Ambulatory Surgical Center (ASC) Payment System change request (CR) documents for payment and other information about these HCPCS C-code(s). These documents can be found at: http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2014-Transmittals.html.

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<td>Cystourethroscopy, with insertion of transprostatic implant; 1 to 3 implants</td>
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<td>Cystourethroscopy, with insertion of transprostatic implant; 4 or more implants</td>
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<td>New procedure code effective 4/1/2014.</td>
</tr>
</tbody>
</table>
Clinical trials
Coverage of devices and clinical trial background
Modified: 2/28/2014
A listing of useful links is provided regarding devices and clinical trial processes.

Frequently asked questions about clinical trials and device coverage
Modified: 2/28/2014
Review answers to frequently-asked questions regarding clinical trials and device coverage.

Post-approval and 510K extension studies for carotid artery stenting

“Payment for Routine Costs in a Clinical Trial” Q & A

**Question:** If the research sponsor pays for the routine costs provided to an indigent non-Medicare patient (the provider has determined that the patient is indigent due to a valid financial hardship) may Medicare payment be made for Medicare beneficiaries?

**Answer:** If the routine costs of the clinical trial are not billed to indigent non-Medicare patients because of their inability to pay (but are being billed to all the other patients in the clinical trial who have the financial means to pay even when his/her private insurer denies payment for the routine costs), then a legal obligation to pay exists. Therefore, Medicare payment may be made and the beneficiary (who is not indigent) will be responsible for the applicable Medicare deductible and coinsurance amounts. As noted at [http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/FAQ_Uninsured.pdf](http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/FAQ_Uninsured.pdf), “nothing in the Centers for Medicare & Medicaid Services’ (CMS’) regulations or Program Instructions prohibit a hospital from waiving collection of charges to any patients, Medicare or non-Medicare, including low-income, uninsured or medically indigent individuals, if it is done as part of the hospital’s indigency policy. By “indigency policy” we mean a policy developed and utilized by a hospital to determine patients’ financial ability to pay for services. By “medically indigent,” we mean patients whose health insurance coverage, if any, does not provide full coverage for all of their medical expenses and that their medical expenses, in relationship to their income, would make them indigent if they were forced to pay full charges for their medical expenses. In addition to CMS’ policy, the Office of Inspector General (OIG) advises that nothing in OIG rules or regulations under the Federal anti-kickback statute prohibits hospitals from waiving collection of charges to uninsured patients of limited means, so long as the waiver is not linked in any manner to the generation of business payable by a Federal health care program – a highly unlikely circumstance, Thus the provider of services should bill the patient for co-payments and deductible, but may waive that payment for patients who have a valid financial hardship.
For more resources, you may visit the Office of Billing Compliance Web Page at www.obc.med.miami.edu
If you have any questions on Coding, Billing and Documentation or compliance concerns you may call our office at 305-243-5842

Email address: officeofbillingcompliance@med.miami.edu

or call our Toll Free 1-877-415-HELP (4357).

Calls may remain anonymous.

Our On-line Billing Compliance Educational Program by accessing the Ulearn website at: www.Ulearn.miami.edu.

Coding, Billing and Documentation Training Modules (CBLs) available of the Professional Component:

• Billing Compliance Training Fraud Waste and Abuse
• Critical Care Services
• Evaluation and Management (E&M) Services Module I
• Evaluation and Management (E&M) Services Module II
• Major Surgery Global Fee and Minor Surgery Rules
• Medicare Rule for Teaching Physicians
• Psychiatry Services
• Routine Costs in Clinical Trials Billing Guidelines
• Diagnostic Tests Billing Guidelines

For Residents, Fellows and other non-UM employees the links to the CBLs are as follows:

• http://ppto.miami.edu/external/compliance/CriticalCareServiceWeb/index.html
• http://ppto.miami.edu/external/compliance/EMSservices_Module1Web/index.html
• http://ppto.miami.edu/external/compliance/EMSservices_Module2Web/index.html
• http://ppto.miami.edu/external/compliance/MajorSurgeryGlobalFeeWeb/index.html
• http://ppto.miami.edu/external/compliance/MedicareRuleWeb/index.html
• http://ppto.miami.edu/external/compliance/PsychiatryWeb/index.html
• http://ppto.miami.edu/external/Compliance/ClinicalTrialsBillingGuidelines/index.html

HOSPITAL COMPLIANCE TRAINING MODULES (CBLS)

• Hospital Compliance Orientation
• Billing Compliance Training
• Observation Billing & Documentation Guidelines
• Facility Fee – Clinic Visits Billing & Documentation Guidelines
• An Important Message from Medicare
• Inpatient Hospital Services
• Advanced Beneficiary Notice (ABN)
Live Coding, Billing and Documentation Educational Sessions

April 14, 2014 from 3pm to 4pm at the Mailman Center 8th Floor Auditorium—Surgery
April 15, 2014 from 8:30am to 9:30am at the Mailman Center 8th Floor Auditorium—Psychiatry
April 15, 2014 from 4pm to 5pm at the Mailman Center 8th Floor Auditorium—Surgery
April 28, 2014 from 12pm to 1pm at the Holtz Large Conference Room 2034 — Pathology
April 28, 2014 from 3pm to 4pm at the Mailman Center 8th Floor Auditorium—Surgery
April 29, 2014 from 7am to 8am at the Mailman Center 8th Floor Auditorium—Medicine
April 29, 2014 from 12pm to 1pm at the Mailman Center 8th Floor Auditorium—Pediatrics
April 29, 2014 from 4pm to 5pm at the Mailman Center 8th Floor Auditorium—Genetics
April 30, 2014 from 7am to 8am at CRB 1179 Conference Room —OB/GYN
April 30, 2014 from 5pm to 6pm at the Mailman Center 8th Floor Auditorium—Ortho/Rehab
Gemma Romillo/Assistant Vice President for Clinical Billing
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