Medicare A Connection

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FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction N Providers

October 2014

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Enthusiasm for website puts surgery center at cutting edge

If you were to talk with Allison Wakeland about the First Coast Service Options' Web self-service tools, she sounds much like a home shopping network emcee. She talks up the benefits with each Web tool with such enthusiasm, you want to reach for your Visa® card and buy one right away.

Fortunately, for health care providers who service Medicare beneficiaries, these tools are free. And NeuroSpinal Associates, a physician group in Bradenton, FL, and the affiliated RiverWalk Surgical Center, bank on Wakeland's enthusiasm in using them.

Wakeland leads the Medicare billing efforts for the group of surgeons and pitches in to assist with filing facility claims as necessary. In making sure claims are filed timely and correctly, Wakeland has become a super-user of the First Coast Web tools.

She bookmarks her most-used pages and cites a business use for each of the 15 tools available on the site. "I'm in the fee schedule and LCD lookup tools each day. The site stays up on my screen all day because I use them so much," Wakeland says.

"The LCD lookup is really helpful with medical documentation. The LCDs help us educate doctors on what they need to document. It provides a great deal of detail. I will show the doctor the LCD and review with them what they need to document in the way of diagnosis codes," she added.

The ambulatory surgery center and affiliated physician office process more than 300 claims a month. Seventy percent of their patients are Medicare beneficiaries, with nearly a third of those patients enrolled in Medicare Advantage plans. Because of these numbers, NeuroSpinal Associates and RiverWalk need Wakeland to stay on top of the changes in Medicare billing.

"It might take 30 days or more to find out we filed a claim with the wrong payer. This delay can add up quickly," Wakeland says. "The patients don't always know they're covered by an advantage plan. Often, they tell us they're

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CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

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General Information

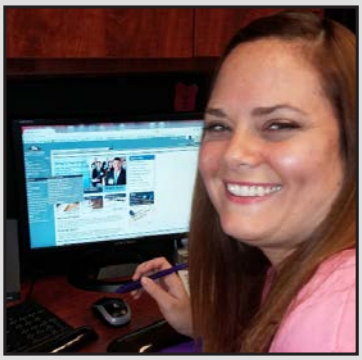
ENTHUSIASM

From front page

enrolled in Medicare." Wakeland says checking a patient's secondary payer status and Medicare eligibility through First Coast's Secure Provider Online Tool (SPOT) has greatly improved office operations.

Several of the First Coast Web self-service tools include integrated features that allow providers to see important information through multiple channels. For example, when Wakeland reviews the fee schedule for a particular procedure, she can click over to the associated LCD document if one exists.

> **"I feel the site gets better each day. And it's all free. I get so much out of using it."**
>
> *– Allison Wakeland, Billing Liaison and Credentialing, Neurospinal Associates*



Allison Wakeland uses the self-service tools on First Coast's website throughout her work day at NeuroSpinal Associates and the RiverWalk Surgical Center. (Photo Courtesy: NeuroSpinal Associates)

The fee schedule lookup tool offers a drop down window for providers to review if filing the claim requires any modifiers. "We check to make sure modifiers are applicable to the *CPT*® (*Current Prodcedural Terminology*®) code the doctor is billing," she says.

The modifier verification and the evaluation and management interactive worksheet play important role in the office's compliance efforts as well. "With the evaluation and management worksheet supporting their billing, Wakeland says the billing team uses it to verify codes dictated by the physicians. "I will have the worksheet up on my screen as I run through what the physician has dictated," Wakeland said.

In addition to the practice of filing clean claims, Wakeland says the tools play a critical role with quality improvement in their offices. She uses provider data summary (PDS) reports to evaluate claim returns. Besides spotting trends in claims processing, Wakeland says the PDS reports are helpful in identifying where her office staff might need additional training. "If we see a list of codes getting missed on a regular basis, I can call up the spreadsheet to see who is entering those codes and come back and train behind it," she said.

Wakeland also takes advantage of the online and in-person training opportunities offered by First Coast. She attended the *Medicare Speaks* seminar in Orlando and listens in on most webinars. "Once I get my certification in medical billing, I intend to take full advantage of the CEU credits available through First Coast University."

When asked what she would say to her peers in other medical practices, she says, "I feel the site gets better each day. And it's all free. I get so much out of using it."

Got a success story using First Coast Web tools?

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

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

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

Update for health professional shortage area bonuses

Provider types affected

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

Provider action needed

Change request (CR) 8942 alerts you that the annual HPSA bonus payment file for 2015 will be made available by the Centers for Medicare & Medicaid Services (CMS) to your MAC and will be used for HPSA bonus payments on applicable claims with dates of service on or after January 1, 2015, through December 31, 2015.

You should review physician bonuses Web page at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HPSAPSAPhysicianBonuses* each year to determine whether you need to add modifier AQ to your claim in order to receive the bonus payment, or to see if the ZIP code in which you rendered services will automatically receive the HPSA bonus payment. Make sure that your billing staffs are aware of these changes.

Background

Section 413(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 mandated an annual update to the automated HPSA bonus payment file. CMS automated HPSA ZIP code file shall be populated using the latest designations as close as possible to November 1 of each year. The HPSA ZIP code file shall be made available to MACs in early December of each year. MACs shall implement the HPSA ZIP code file and, for claims with dates of service January 1 to December 31 of the following year, shall make automatic HPSA bonus payments to physicians providing eligible services in a ZIP code contained on the file. Only areas designated as HPSAs prior to the end of the calendar will be eligible for a bonus payment in the following year.

Additional information

The official instruction, CR 8942, issued to your MAC regarding this change, is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3087CP.pdf*.

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

MLN Matters® Number: MM8942
Related Change Request (CR) #: CR 8942
Related CR Release Date: October 3, 2014
Effective Date: January 1, 2015
Related CR Transmittal #: R3087CP
Implementation Date: January 5, 2015

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Online Medicare refreshers

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

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

Click here to explore the wide away of training opportunities.

Transitioning MAC workloads to new banking contractors

Provider types affected

This *MLN Matters*® article is intended to alert all providers that your Medicare administrative contractor (MAC) may be transitioning their banking to another bank.

What you need to know

This article is informational in nature and is intended to inform you that Medicare has re-competed its banking contracts and has awarded two five-year contracts to US Bank (an incumbent bank) and to Citibank (which replaces the prior contract with JP Morgan Chase). The Centers for Medicare & Medicaid Services (CMS) awarded these contracts July 10, 2014. Change request (CR) 8847 was issued to manage the transition of the MAC workloads from JP Morgan Chase to Citibank.

Background

In 2010, CMS changed its Medicare banking policies by discontinuing the use of time accounts to pay for banking service charges and awarded five-year commercial services contracts through full and open competition to two banks (US Bank and JP Morgan Chase); these two banks disburse MAC authorized payments and demonstration project payments for CMS.

The two current commercial banking contracts are terminating in fiscal year 2015. CMS has awarded five-year contracts through full and open competition to US Bank (incumbent bank) and Citibank (new bank). Each selected bank shall provide both MAC payment services and demonstration payment services and shall be designated financial agents of the U.S. Treasury. CMS is transitioning MAC workloads from JP Morgan Chase to Citibank. The MAC workloads with US Bank will remain with US Bank. The transition began August 2014 and will end in January 2015.

Additional information

The official instruction for CR 8847 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R240FM.pdf*.

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

MLN Matters® Number: MM8847
Related Change Request (CR) #: CR 8847
Related CR Release Date: September 19, 2014
Effective Date: September 19, 2014
Related CR Transmittal #: R240FM
Implementation Date: September 30, 2014

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Hold on certain CAH method II claims for anesthesiologist and CRNA services

Critical access hospital (CAH) method II claims for anesthesiologist and certified registered nurse anesthetist (CRNA) services outside of the normal anesthesia code range (*00100 - 01999*) and billed with revenue code *0963* or *0964* are being held due to inaccurate payments.

Claims will be held until a system correction is implemented November 24, 2014.

Try our E/M interactive worksheet

First Coast Service Options (First Coast) Inc. is proud of its exclusive E/M interactive worksheet, available at *http://medicare.fcso.com/EM/165590.asp*.

This resource was developed to assist providers with identifying the appropriate code to bill for evaluation and management (E/M) services performed during a specific patient visit. This interactive resource is ideal for use as a checklist by physicians or as a quality assurance tool by auditors, billing specialists, and coders.

CMS updates definition of spouse to include same-sex marriages for MSP

Provider types affected

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

Provider action needed

Section 3 of the Defense of Marriage Act (DOMA) provided for purposes of federal law, the term "spouse" could not include individuals in a same-sex marriage.

Because the MSP working-aged provisions only apply to subscribers and their spouses, the working-aged provisions did not apply on the basis of spousal status to individuals in a same-sex marriage.

The United States Supreme Court has invalidated this DOMA provision. Thus, the Centers for Medicare & Medicaid Services (CMS) is no longer prohibited from applying the MSP working-aged provision to individuals in a same-sex marriage.

Effective January 1, 2015, the rules below apply with respect to the term "spouse" under the MSP working-aged provisions. This is true for both opposite-sex and same-sex marriages.

- If an individual is entitled to Medicare as a spouse based upon the Social Security administration's rules, that individual is a "spouse" for purposes of the MSP working-aged provisions.
- If a marriage is valid in the jurisdiction in which it was performed including one of the 50 states, the District of Columbia, or a U.S. territory, or a foreign country, so long as that marriage would also be recognized by a U.S. jurisdiction, both parties to the marriage are "spouses" for purposes of the MSP working-aged provisions.
- Where an employer, insurer, third-party administrator, group health plan (GHP), or other plan sponsor has a broader or more inclusive definition of spouse for purposes of its GHP arrangement, it may (but is not required to) assume primary payment responsibility for the "spouse" in question.

  If such an individual is reported as a "spouse" through the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) Section 111, Medicare will pay accordingly and pursue recovery, as applicable.

Make sure your billing staffs are aware of these changes.

Background

Based on change request (CR) 8875, effective January 1, 2015, the definition of a spouse for purposes of the working-aged provisions means "a person who is entitled to Medicare as a spouse based upon the Social Security administration's rules or a person whose marriage is valid in the jurisdiction in which it was performed including one of the 50 states, the District of Columbia, or a U.S. territory or a foreign country, so long as that marriage would also be recognized by a U.S. jurisdiction."

The expanded rules for the definition of "spouse," including proper reporting pursuant to MMSEA Section 111, must be implemented with a start date for the coverage in question no later than January 1, 2015.

To the extent an employer, insurer, third-party administrator, GHP or other plan sponsor insurer has chosen to or chooses to utilize the new definitions referenced above or a broader definition of "spouse" for MSP purposes prior to January 1, 2015, it may do so. However, MACs may not apply the revised definition for Medicare purposes for coverage dates prior to January 1, 2015. Nor may MACs accept a definition of spouse broader than that quoted above. In the event, Medicare does pay for coverage prior to January 1, 2015, it will pursue recovery, as applicable.

Additional information

The official instruction, CR 8875, issued to your MAC regarding this change, is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R106MSP.pdf*.

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

MLN Matters® Number: MM8875
Related Change Request (CR) #: CR 8875
Related CR Release Date: October 10, 2014
Effective Date: January 1, 2015
Related CR Transmittal #: R106MSP
Implementation Date: January 1, 2015

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General Coverage

Benson-Henry Institute Cardiac Wellness Program added to ICR benefit

Provider types affected

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

Provider action needed

Change request (CR) 8894 alerts providers that the Benson-Henry Institute Cardiac Wellness Program meets the program requirements set forth by Congress and is a Medicare-covered benefit as of May 6, 2014. Make sure your billing staffs are aware of these changes.

Background

In CR 8894, the Centers for Medicare & Medicaid Services (CMS) explains that on September 3, 2013, it initiated a national coverage analysis (NCA) to consider the expansion of Medicare-coverage of intensive cardiac rehabilitation (ICR) services to include the Benson-Henry Institute Cardiac Wellness Program.

As a result, effective for dates of service on and after May 6, 2014, CMS determines that the evidence is sufficient to expand the ICR benefit to include the Benson-Henry Institute Cardiac Wellness Program, national coverage determination (NCD) NCD 20.31.3.

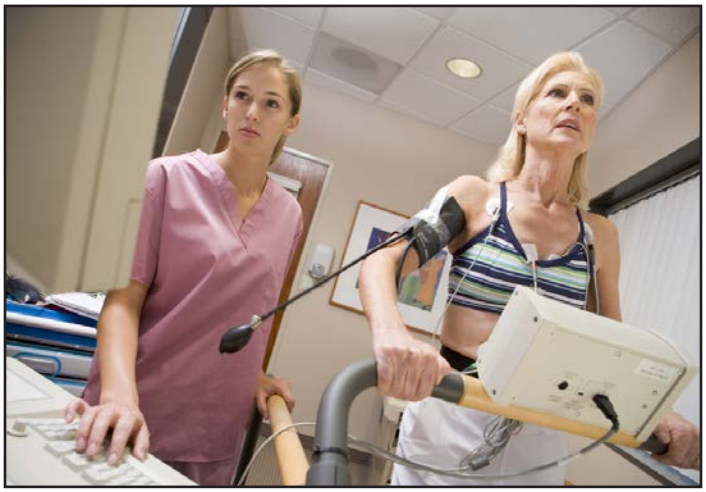
The program meets the ICR program requirements set forth by Congress in Section 1861 (eee)(4)(A) of the Social Security Act and in the regulations at *42 C.F.R. Section 410.49(c)*.

This program has been included on the list of approved ICR programs available at *http://www.cms.gov/Medicare/Medicare-General-Information/MedicareApprovedFacilitie/index.html*.

The current ICR policy and program criteria remain unchanged as follows: ICR refers to a physician-supervised program that furnishes cardiac rehabilitation services more frequently and often in a more rigorous manner. An ICR program must show, in peer-reviewed published research, that it accomplished one or more of the following for its patients:

1. Positively affected the progression of coronary heart disease;
2. Reduced the need for coronary bypass surgery; or
3. Reduced the need for percutaneous coronary interventions.

The ICR program must also demonstrate through peer-reviewed published research that it accomplished a statistically significant reduction in five or more of the following measures for patients from their levels before cardiac rehabilitation services to after cardiac rehabilitation services:



1. Low density lipoprotein;
2. Triglycerides;
3. Body mass index;
4. Systolic blood pressure;
5. Diastolic blood pressure; and
6. The need for cholesterol, blood pressure, and diabetes medications.

For claims with dates of service on or after May 6, 2014, MACs will adjust claims brought to their attention but will not search their files for claims processed prior to implementation of CR 8894.

Note: Providers should refer to CR 6850 for detailed claims processing, coverage, coding, and payment information regarding ICR. No additional claim processing instructions are required to implement CR 8894. You may review the *MLN Matters*® article related to CR 6850 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6850.pdf*.

Remember that MACs will only pay for ICR services when submitted on types of bill (TOB) 13x and 85x. When these services are submitted on other TOBs, note that the services will be denied with a new claim adjustment reason code 171 – Payment is denied when performed by this type of provider in this type of facility.

Additional information

The official instruction, CR 8894, consists of two transmittals. The first updates the NCD manual and is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R175NCD.pdf*. The second updates the *Medicare Claims Processing Manual* and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3084CP.pdf*.

See **WELLNESS**, next page

FDG PET for solid tumor claims

Claims for fluorodeoxyglucose (FDG) positron emission tomography (PET) for solid tumors submitted October 6 through November 10 will be held to ensure Medicare systems can accurately calculate payments.

Specifically, these are claims containing Healthcare Common Procedure Coding System (HCPCS) A9552 for all oncologic conditions.

See *MLN Matters® article MM8739* for additional information.

Resolution

These claims will be processed beginning November 11. To review a table of *current claims processing issues* for both Part A and Part B.

2015 update to the AIC requirements for ALJ and federal district court appeals

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) requires an annual reevaluation of the dollar amount in controversy required for an administrative law judge (ALJ) hearing (third level review) or federal district court (fifth level) review.

ALJ hearing request: The amount that must remain in controversy for ALJ hearing requests filed on or before December 31, 2014, is $140. This amount will rise to $150 for ALJ hearing requests filed on or after January 1, 2015.

Federal district court review: The amount that must remain in controversy for federal district court review requests filed on or before December 31, 2014, is $1,430. This amount increased to $1,460 for appeals to federal district court filed on or after January 1, 2015.

Revised fact sheet on the appeals process

The *Medicare Appeals Process* fact sheet (ICN 006562) was revised and is now available in a downloadable format. This fact sheet is designed to provide education on the five levels of claim appeals in fee-for-service Medicare. It includes details explaining how the Medicare appeals process applies to providers, participating physicians, and participating suppliers, in addition to including more information on available appeals-related resources.

WELLNESS

From previous page

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

The *Decision Memorandum for Intensive Cardiac Rehabilitation (ICR) Program* - Benson-Henry Institute Cardiac Wellness Program (CAG-00434N) is available at *http://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=271*.

To review the CMS booklet titled *Cardiovascular Disease Services* visit *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Cardiovascular-Disease-Services-Booklet-ICN907784.pdf*.

MLN Matters® Number: MM8894
Related Change Request (CR) #: CR 8894
Related CR Release Date: October 3, 2014
Effective Date: May 6, 2014
Related CR Transmittal #: R175NCD and R3084CP
Implementation November 4, 2014

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Local Coverage Determinations

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

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

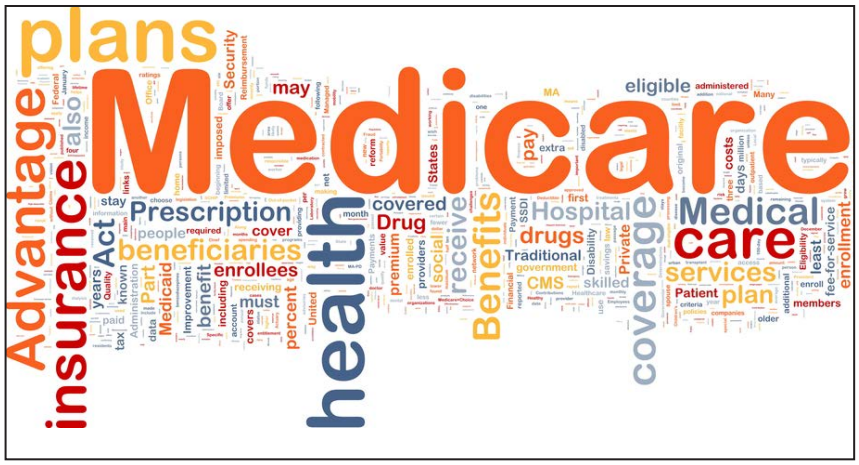
Effective and notice dates

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

More information

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

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



Advance beneficiary notice

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

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

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

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

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

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

New LCDs

Self-administered drug (SAD) list – Part A: Tanzeum™ (albiglutide for injection) J3490/J3590/C9399

The Centers for Medicare & Medicaid Services (CMS) provides instructions to contractors regarding Medicare payment for drugs and biologicals incident to a physician's service.

The instructions also provide contractors with a process for determining if an injectable drug is usually self-administered and therefore, not covered by Medicare.

Guidelines for the evaluation of drugs for the list of excluded self-administered injectable drugs incident to a physician's service are in the *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf#page=50.2*

Effective for services rendered on or after December 1, 2014, the following drug has been added to the MAC J-N Part A SAD list.

- J3490/J3590/C9399 albiglutide for injection (Tanzeum™ for subcutaneous use) 30 mg

The evaluation of drugs for addition to the self-administered drug (SAD) list is an on-going process. Providers are responsible for monitoring the SAD list for the addition or deletion of drugs.The First Coast Service Options Inc. (First Coast) SAD lists are available through the CMS Medicare Coverage Database at: *http://medicare.fcso.com/Self-administered_drugs/.*

Revised LCDs

Hemophilia clotting factors – revision to the Part A LCD

LCD ID number: L28851 (Florida)
LCD ID number: L28884 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for hemophilia clotting factors was revised based on the Center's for Medicare & Medicaid Services (CMS) change request 8873 (October 2014 Update of the Hospital Outpatient Prospective Payment System [OPPS]). Healthcare Common Procedure Coding System (HCPCS) code C9135 (Factor ix [antihemophilic factor, recombinant], Alprolix, per 10 i.u.) was added to the "*CPT*®/HCPCS Codes" section of the LCD. Additionally, based on the Food and Drug Administration's approval of Eloctate (antihemophilic factor VIII [recombinant], Fc Fusion Protein), HCPCS codes C9399 and J7199 were added to the "*CPT*®/HCPCS Codes" section of the LCD. Also, the "Type of Bill Code" section of the LCD was revised to remove type of bill 21x and add type of bill 12x.

Effective date

The LCD revision to add HCPCS code C9135 is effective for services rendered **on or after October 1, 2014**. The LCD revision to add HCPCS codes C9399 and J7199 is effective for services rendered **on or after October 14, 2014**.

The LCD revision related to type of bill changes is effective for claims processed **on or after October 20, 2014**.First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Take the time to 'chat' with the website team

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

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

Revised LCDs

Update of the outpatient PPS for clinical diagnostic laboratory tests – revision to the Part A LCDs

LCD ID number: L28772/L28810/L28852/ L28886/L28896/L28902/L28945/L28983/ L28984/L28989/ L29044/L28995/L29000/ L29042 (Florida)

LCD ID number: L28773/L28817/L28885/ L28908/L28918/L28924/L28966/L29016/ L29017/L29021/ L29045/L29027/L29032/ L29043 (Puerto Rico/U.S. Virgin Islands)

LCD ID number: L31267/L32096/L31231/ L33017/L30866 (Florida/Puerto Rico/U.S. Virgin Islands)

Based on change request (CR) 8572, the "*CPT*®/HCPCS Codes" sections of the LCDs listed below were updated to add the following verbiage: "beginning in 2014, payment for most laboratory tests (except for molecular pathology tests) will be packaged under the outpatient prospective payment system (OPPS), therefore the clinical laboratory tests listed below, for type of bill (TOB) 13x (outpatient hospital), are packaged in this setting."

- Allergy testing
- B-Type natriuretic peptide (BNP)
- Circulating tumor cell testing
- Creatine kinase (CK), (CPK)
- Flow cytometry
- Hepatitis B surface antibody and surface antigen
- Hepatitis C antibody in the ESRD and non-ESRD setting
- Ionized calcium
- Magnesium
- Parathormone (parathyroid hormone)
- Sedimentation rate, erythrocyte
- Serum phosphorus

- Susceptibility studies
- Syphilis test
- Total calcium
- Transplantation immune cell function assay (ImmuKnow)
- Troponin
- Urinalysis
- Vitamin D; 25 hydroxy, includes fraction(s), if performed

Effective date

These LCD revisions are effective for services rendered **on or after January 1, 2014**.First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Puzzled about your enrollment status?

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

Viscosupplementation therapy for knee – revision to the Part A LCD

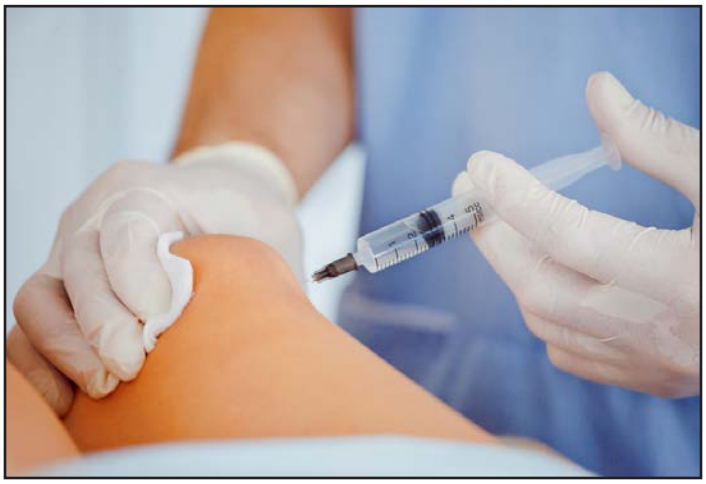
LCD ID number: L29005 (Florida)
LCD ID number: L29037 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination for viscosupplementation therapy for knee has been revised based on an evaluation of the drug Monovisc™ which was approved by the Food and Drug Administration (FDA) for the treatment of pain in osteoarthritis of the knee in patients who have failed to respond adequately to conservative non-pharmacologic therapy and to simple analgesics.

Monovisc™ is a sterile, non-pyrogenic, viscoelastic solution of hyaluronan contained in a single-use syringe which is equivalent to three injections of Orthovisc.

A revision has been made to add HCPCS codes C9399 -unclassified drugs or biologicals (Hyaluronan, Monovisc™, for intra-articular injection, single injection, 4 mL) and HCPCS code J3490-unclassified drugs (Hyaluronan, Monovisc™, for intra-articular injection, single injection, 4 mL) to the "*CPT*®/HCPCS Codes" section of the LCD. HCPCS codes C9399 and J3490 were added under the sub-heading of the "ICD-9 Codes that Support Medical Necessity" section of the LCD.

Under the "Utilization Guidelines" section of the LCD, Monovisc™ was added as a medication with total dosage and description of duration of treatment. The "Sources of Information and Basis for Decision" section of the LCD has also been updated to add the references for this revision.



Effective date

This LCD revision is effective for claims processed **on or after September 26, 2014**, for services rendered **on or after February 25, 2014**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Learn the secrets to billing Medicare correctly

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

You do – visit the *Tools to improve your billing* section where you'll discover the tools you need to learn how to consistently bill Medicare correctly – the first time.

You'll find First Coast's most popular self-audit resources, including the E/M interactive worksheet, provider data summary (PDS) report, and the comparative billing report (CBR).

Electronic Data Interchange

Electronic funds transfer upgrades to the Internet-based PECOS system

Over the last year, the Centers for Medicare & Medicaid Services (CMS) listened to your feedback about *Internet-based provider enrollment, chain, and ownership system (PECOS)* and made improvements to increase access to more information. PECOS is easier to use than ever with electronic funds transfer (EFT) upgrades that are now available.

If a provider/supplier wishes to submit a change to the EFT information, they should select "Perform a change of Information to current enrollment information." **Note**: All EFT changes must be made through the change of information scenario.

Providers/suppliers are able to edit all EFT Information, except the routing transit number and/or depositor account number, once entered and saved.

Once saved, if a provider/supplier needs to update the routing transit number and/or depositor account number, the providers/supplier must delete all information and re-enter new information.

PECOS will now collect an EFT effective date and termination date to capture the timeframe when the financial information is valid. The effective date is the date on which funds will be directed to the account information entered. The termination date is the date on which funds will no longer be directed to the account information entered.

PECOS has also been updated to display the most current CMS-588 form which now collects the financial institution's street address and financial institution's ZIP code under "Financial Institution Information."

ICD-10-CM guidelines for coding and reporting available

The *2015 ICD-10-CM Official Guidelines for Coding and Reporting* is now available on the *2015 ICD-10-CM and GEMs* Web page and also on the *Centers for Disease Control and Prevention* website.

- Narrative changes appear in bold text
- Items underlined have been moved within the guidelines since the fiscal year 2014 version
- Italics are used to indicate revisions to heading changes

Get ready for ICD-10

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

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

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

Online ICD-10 guide

ICD-10 basics for large medical practices

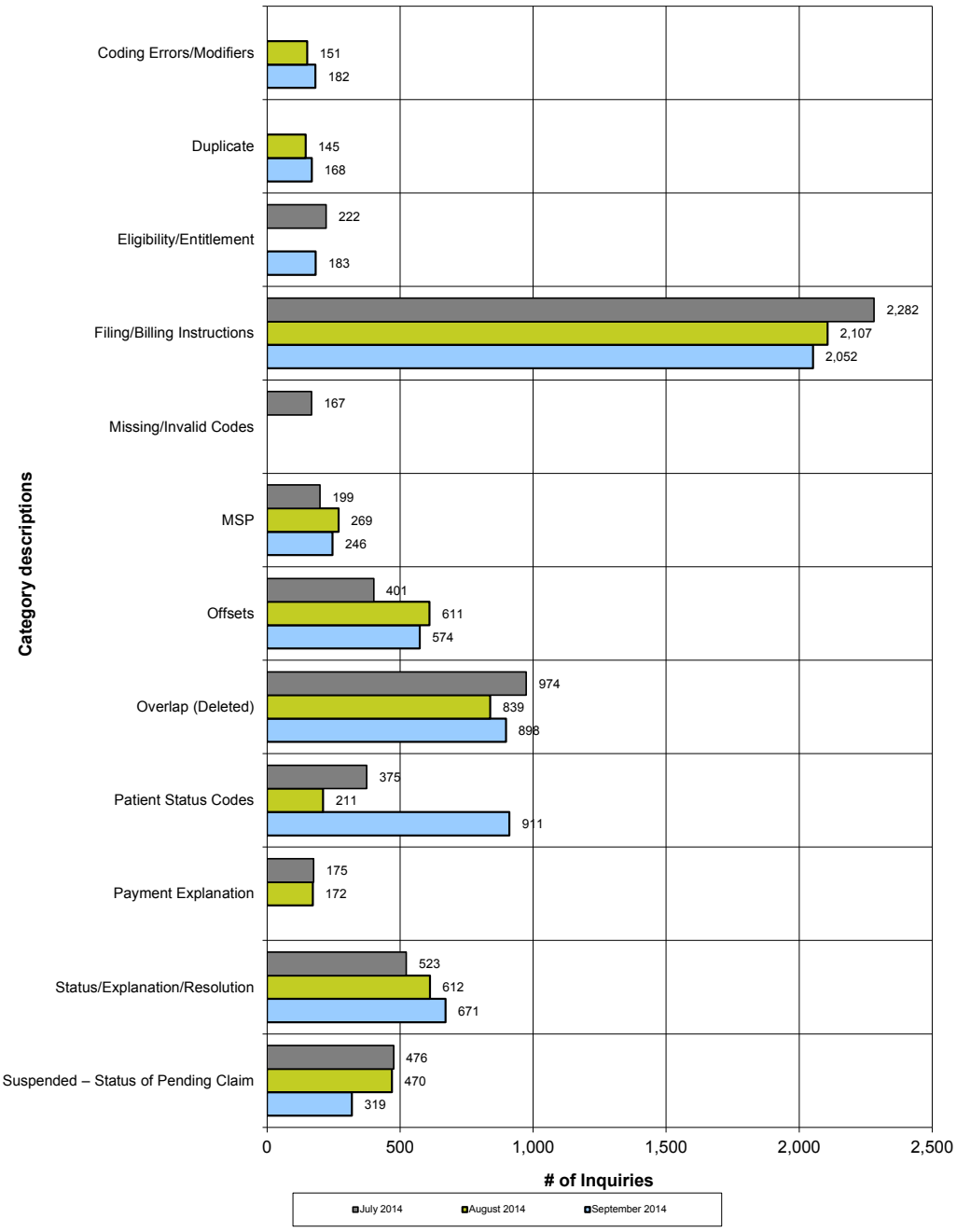
Claims and Inquiry Summary Data

Top inquiries, rejects, and return to provider claims

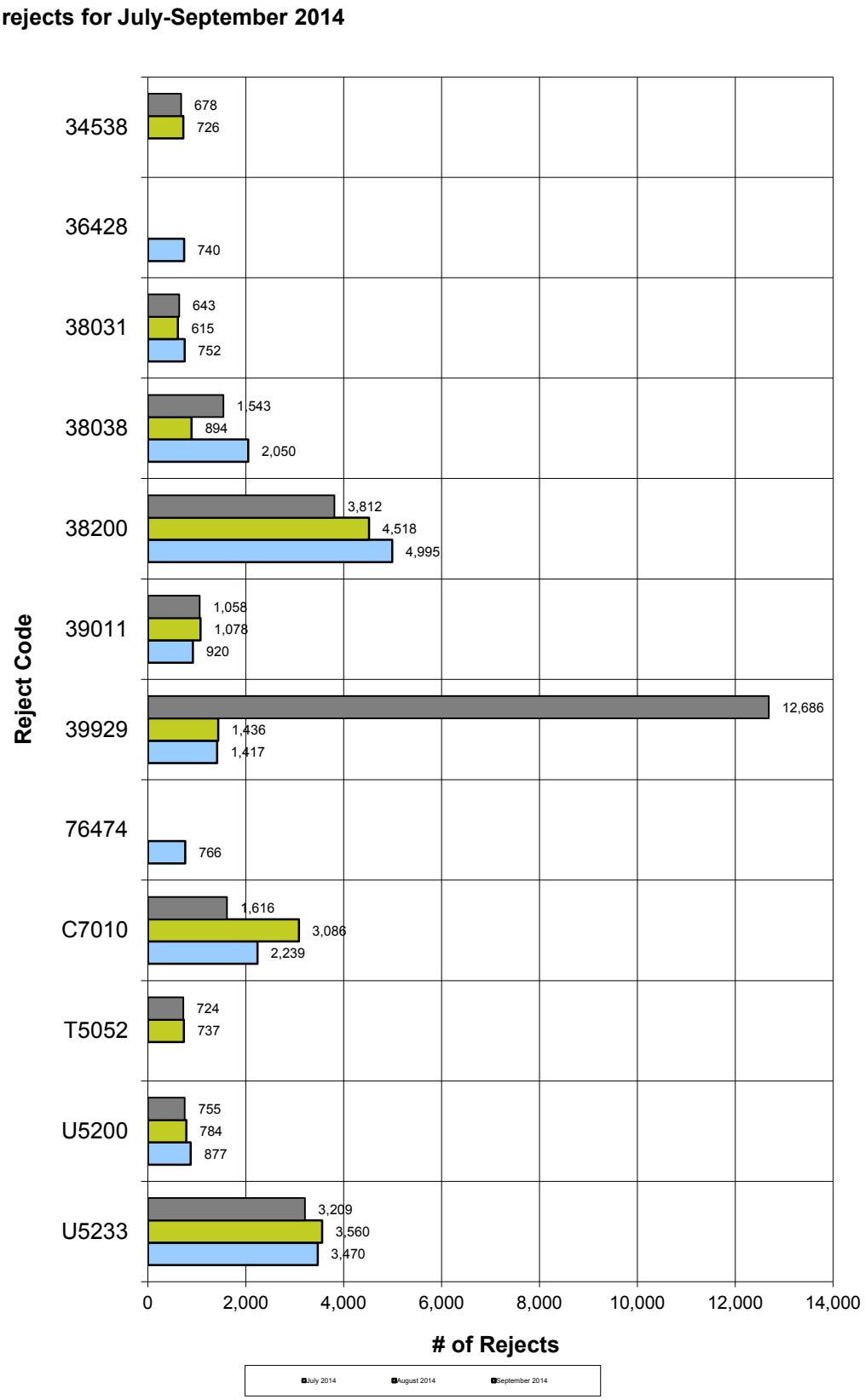
The following charts provide the most frequent inquiries and reason codes for rejected and returned to provider (RTP) claims submitted to First Coast Service Options Inc. (First Coast), by providers in Florida, Puerto Rico, and the U.S. Virgin Islands during July 2014 through September 2014.

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

Top inquiries for July-September 2014

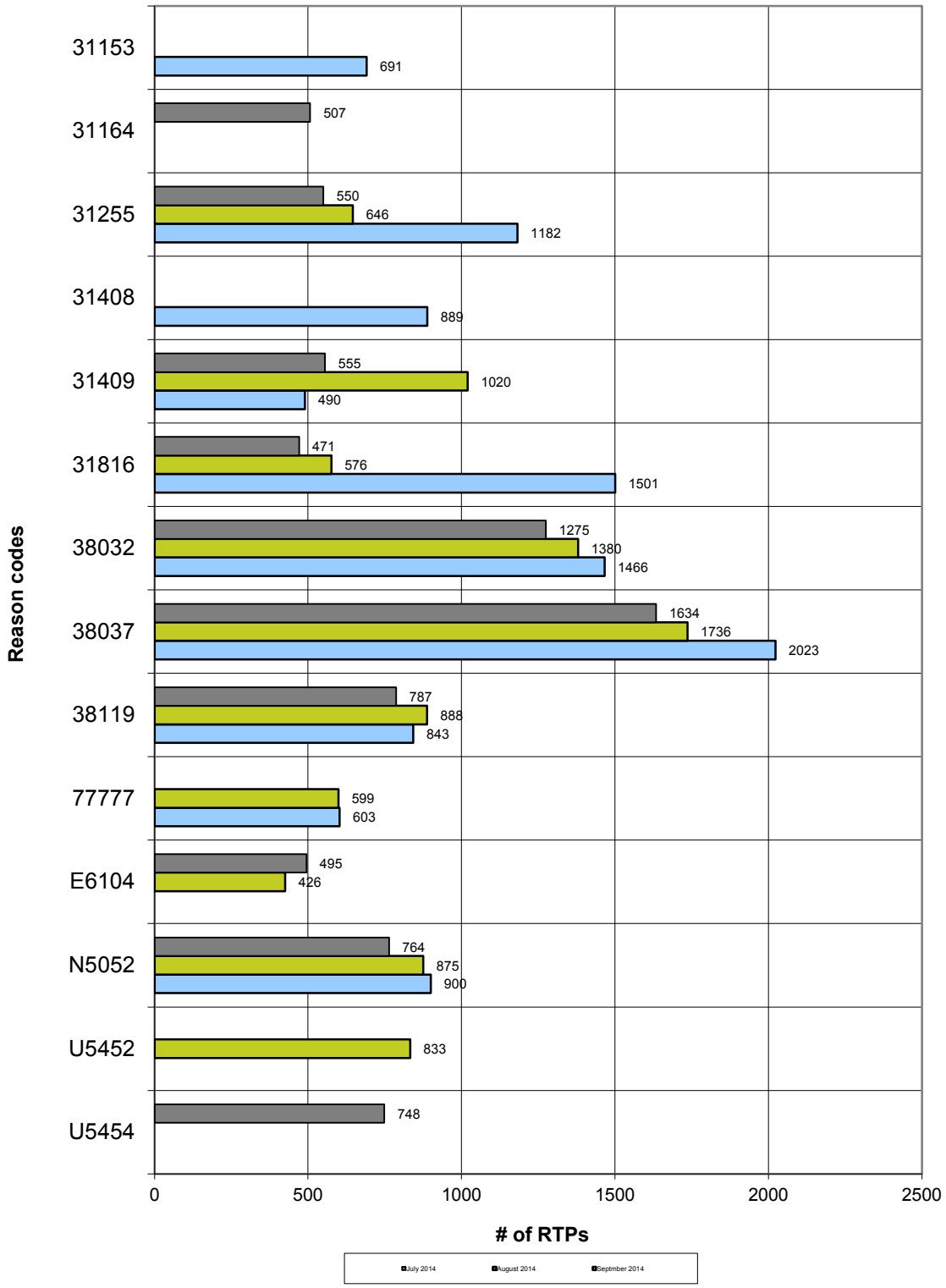


Part A top rejects for July 2014 through September 2014



Part A top return to providers July - September 2014

Top RTPs for July-September 2014



Reimbursement

Ambulance inflation factor and productivity adjustments

***Note**: This article was revised October 9, 2014, to reflect the revised change request (CR) 8895 issued October 7. The CR was revised to update the multifactor productivity adjustment which then adjusts the inflation factor. In addition, the CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same. This information was previously published in the* *September 2014 Medicare A Connection, Page 44.*

Provider types affected

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

Provider action needed

CR 8895 furnishes the 2015 ambulance inflation factor (AIF) for determining the payment limit for ambulance services. Make sure that your billing staffs are aware of the change.

Background

CR 8895 furnishes the 2015 AIF for determining the payment limit for ambulance services required by Section 1834(l)(3)(B) of the Social Security Act (the Act).

Section 1834(l)(3)(B) of the Act provides the basis for an update to the payment limits for ambulance services that is equal to the percentage increase in the consumer price index for all urban consumers (CPI-U) for the 12-month period ending with June of the previous year.

Section 3401 of the Affordable Care Act amended Section 1834(l)(3) of the Act to apply a productivity adjustment to this update equal to the 10-year moving average of changes in economy-wide private nonfarm business multi-factor productivity (MFP) beginning January 1, 2011. The resulting update percentage is referred to as the AIF.

The MFP for 2015 is 0.60 percent and the CPI-U for 2015 is 2.10 percent. Under to the Affordable Care Act, the CPI-U is reduced by the MFP, even if this reduction results in a negative AIF update. Therefore, the AIF for 2015 is 1.50 percent.

Part B coinsurance and deductible requirements apply to payments under the ambulance fee schedule. The 2015

ambulance fee schedule file will be available to MACs in November 2014. It may be updated with each quarterly common working file (CWF) update.

Additional information

The official instruction, CR 8895 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3090CP.pdf*.

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

MLN Matters® Number: MM8895 *Revised*
Related Change Request (CR) #: CR 8895
Related CR Release Date: October 7, 2014
Effective Date: January 1, 2015
Related CR Transmittal #: R3090CP
Implementation Date: January 5, 2015

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

January 2015 quarterly average sales price Medicare Part B drug pricing files

Provider types affected

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

Provider action needed

Change request (CR) 8912 instructs Medicare administrative contractors (MACs) to download and implement the January 2015 and, if released by the Centers for Medicare & Medicaid Services (CMS), the revised October 2014, July 2014, April 2014, and January 2014, average sales price (ASP) drug pricing files for Medicare Part B drugs.

Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after January 5, 2015, with dates of service January 1, 2015, through March 31, 2015. MACs will not search and adjust claims that have already been processed unless brought to their attention. Make sure your billing staffs are aware of these changes.

Background

The ASP methodology is based on quarterly data submitted that manufacturers submit to CMS. CMS will supply MACs with the ASP and not otherwise classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis.

Payment allowance limits under the outpatient prospective payment system (OPPS) are incorporated into the outpatient code editor (OCE) through separate instructions that are in Chapter 4, Section 50, of the *Medicare Claims Processing Manual* which is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf*.

The following table shows how the quarterly payment files will be applied:

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

Files	Effective dates of service
April 2014 ASP and ASP NOC	April 1, 2014, through June 30, 2014
January 2014 ASP and ASP NOC	January 1, 2014, through March 31, 2014

Additional information

The official instruction, CR 8912, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3072CP.pdf*.

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

MLN Matters® Number: MM8912
Related Change Request (CR) #: CR 8912
Related CR Release Date: September 19, 2014
Effective Date: January 1, 2015
Related CR Transmittal #: R3072CP
Implementation Date: January 5, 2015

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2015 annual code update of SNF consolidated billing

Provider types affected

This *MLN Matters*® article is intended for physicians, other providers, and suppliers submitting claims to Medicare administrative contractors (MACs), including home health & hospice (HH&H) MACs and durable medical equipment (DME) MACs, for services provided to Medicare beneficiaries who are in a Part A covered skilled nursing facility (SNF) stay.

Provider action needed

Stop – impact to you

If you provide services to Medicare beneficiaries in a Part A covered SNF stay, information in change request (CR) 8943 could impact your payments.

CR 8943 provides the 2015 annual update of Healthcare Common Procedure Coding System (HCPCS) codes for SNF consolidated billing (SNF CB) and explains how the updates affect edits in Medicare claim processing systems.

By the first week in December 2014, the new code files for B MAC processing, and the new Excel and PDF files for A MAC processing will be available at *http://www.cms.gov/SNFConsolidatedBilling*; and become effective on January 1, 2015.

It is important and necessary to read the *General Explanation of the Major Categories* PDF file located at the bottom of each year's MAC update in order to understand the major categories, including additional exclusions not driven by HCPCS codes.

Medicare's claim processing systems currently have edits in place for claims received for beneficiaries in a Part A covered SNF stay, as well as for beneficiaries in a non-covered stay. These edits allow separate payment for only those services that are excluded from consolidated billing.

Changes to HCPCS codes and Medicare physician fee schedule designations are used to revise these edits to allow MACs to make appropriate payments in accordance with policy for SNF CB, found in the *Medicare Claims Processing Manual*, Chapter 6 (SNF Inpatient Part A Billing and SNF Consolidated Billing), Sections 20.6 and 110.4.1. You may view this manual at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c06.pdf*.

Additional information

The official instruction, CR 8943, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3088CP.pdf*.

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

MLN Matters® Number: MM8943
Related Change Request (CR) #: CR 8943
Related CR Release Date: October 3, 2014
Effective Date: January 1, 2015
Related CR Transmittal #: R3088CP
Implementation Date: January 5, 2015

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Hold on FQHC Medicare Advantage PPS claims

Federally qualified health center (FQHC) Medicare Advantage (MA) claims for providers that are paid under the prospective payment system (PPS) will be held by Medicare administrative contractors (MACs) for procedure codes G0466, G0467, G0468, G0469, or G0470 (FQHC visit: new patient, established patient, initial preventive physical examination or annual wellness visit, new patient mental health, or established patient mental health) from October 1, 2014, until a systems correction is implemented on October 27, 2014.

October 2014 update of the hospital outpatient prospective payment system

Note: This article was revised September 30, 2014, to reflect the revised change request (CR) 8873 issued September 26. In the article, the long descriptor for HCPCS code C9135 in Table 2 is revised and the APC code for HCPCS code J9171 in Table 7 has been revised. The CR release date, transmittal number, and the Web address for accessing the CR are also changed. All other information remains the same. This article was previously published in the August 2014 edition of Medicare A Connection, Pages 68-71.

Provider types affected

This *MLN Matters*® article is intended for providers and suppliers who submit claims to Medicare administrative contractors (MACs), including home health & hospice (HH&H) MACs for services provided to Medicare beneficiaries.

Provider action needed

CR 8873 describes changes to and billing instructions for various payment policies implemented in the October 2014 hospital outpatient prospective payment system (OPPS) update. Make sure your billing staff is aware of these changes.

Background

The October 2014 integrated outpatient code editor (I/OCE) and OPPS pricer will reflect the Healthcare Common Procedure Coding System (HCPCS), ambulatory payment classification (APC), HCPCS modifier, status indicator (SI), and revenue code additions, changes, and deletions identified in CR 8873.

The October 2014 revisions to I/OCE data files, instructions, and specifications are provided in the October 2014 I/OCE (CR 8879). The *MLN Matters*® article related to CR 8879 will be available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8879.pdf* as soon as that CR is released. Key changes to and billing instructions for various payment policies implemented in the October 2014 OPPS update are:

Changes to device edits for October 2014

The most current list of device edits can be found under *Device and Procedure Edits* at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/*. Failure to pass these edits will result in the claim being returned to the provider.

New services

The new service in Table 1 is assigned for payment under the OPPS, effective October 1, 2014.

Table 1 – New service effective October 1, 2014

HCPCS	Effective date	SI	APC	Short descriptor	Long descriptor	Payment	Minimum unadjusted copayment
C9741	10/01/2014	T	0319	Impl pressure sensor w/angio	Right heart catheterization with implantation of wireless pressure sensor in the pulmonary artery, including any type of measurement, angiography, imaging supervision, interpretation, and report, includes provision of patient home electronics unit	$15,509.99	$3,102.00

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Billing for drugs, biologicals, and radiopharmaceuticals

a. Drugs and biologicals with payments based on average sales price (ASP) effective October 1, 2014

In the 2014 OPPS/ASC final rule with comment period, the Centers for Medicare & Medicaid Services (CMS) stated that payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. In cases where adjustments to payment rates are necessary based on the most recent ASP submissions, CMS will incorporate changes to the payment rates in the October 2014 release of the OPPS pricer.

The updated payment rates, effective October 1, 2014, will be included in the October 2014 update of the OPPS Addendum A and Addendum B, which will be posted at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html*.

b. Drugs and biologicals with OPPS pass-through status effective October 1, 2014

Four drugs and biologicals have been granted OPPS pass-through status effective October 1, 2014. These items, along with their descriptors and APC assignments, are identified in Table 2.

Table 2 – Drugs and biologicals with OPPS pass-through status effective October 1, 2014

HCPCS code	Long descriptor	APC	Status indicator
C9023	Injection, testosterone undecanoate, 1 mg	1487	G
C9025	Injection, ramucirumab, 5 mg	1488	G
C9026	Injection, vedolizumab, 1 mg	1489	G
C9135	Factor ix (antihemophilic factor, recombinant), Alprolix, per i.u.	1486	G

c. New HCPCS codes effective October 1, 2014 for certain drugs and biologicals

Two new HCPCS codes have been created for reporting certain drugs and biologicals (other than new pass-through drugs and biological listed in Table 2) in the hospital outpatient setting for October 1, 2014. These codes are listed in Table 3, and are effective for services furnished on or after October 1, 2014.

Table 3 – New HCPCS codes for certain drugs and biologicals effective October 1, 2014

HCPCS code	Long descriptor	APC	Status indicator effective 10/1/14
Q9972	Injection, epoetin beta, 1 microgram, (For ESRD On Dialysis)	N/A	E
Q9973	Injection, epoetin beta, 1 microgram, (Non-ESRD use)	N/A	E

d. Revised status indicator for HCPCS codes J9160 and J9300

Effective October 1, 2014, the status indicator for HCPCS codes J9160 (Injection, denileukin diftitox, 300 micrograms) and J9300 (Injection, gemtuzumab ozogamicin, 5 mg) will change from SI=K (Paid under OPPS; separate APC payment) to SI=E (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)). Table 4 includes the drugs and biologicals with revised status indicators.

Table 4 – Drugs and biologicals with revised status indicators

HCPCS code	Long descriptor	APC	Status indicator	Effective date
J9160	Injection, denileukin diftitox, 300 micrograms	N/A	E	10/1/2014
J9300	Injection, gemtuzumab ozogamicin, 5 mg	N/A	E	10/1/2014

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e. Reassignment of one skin substitute product that was new for 2014 from the low-cost to the high-cost group

In the 2014 OPPS/ASC final rule, CMS finalized a policy to package payment for skin substitute products into the associated skin substitute application procedure. For packaging purposes, CMS created two groups of application procedures: application procedures that use high cost skin substitute products (billed using *CPT*® codes *15271-15278*) and application procedures that use low cost skin substitute products (billed using HCPCS codes C5271 - C5278).

Assignment of skin substitute products to the high cost or low cost groups depended upon a comparison of the July 2013 payment rate for the skin substitute product to $32, which is the weighted average payment per unit for all skin substitute products using the skin substitute utilization from the 2012 claims data and the July 2013 payment rate for each product. Skin substitute products with a July 2013 payment rate that was above $32 per square centimeter are paid through the high cost group and those with a July 2013 payment rate that was at or below $32 per square centimeter are paid through the low cost group for 2014.

CMS also finalized a policy that for any new skin substitute products approved for payment during 2014, and CMS will use the $32 per square centimeter threshold to determine mapping to the high or low cost skin substitute group. Any new skin substitute products without pricing information were assigned to the low cost category until pricing information becomes available. There is now pricing information available for three of the new skin substitute products. Table 5 shows the new products and the low/high cost status based on the comparison of the price per square centimeter for the products to the $32 square centimeter threshold for 2014.

Table 5 – Revised low/high cost status for certain skin substitute codes

HCPCS code	Long descriptor	Status indicator	Low/high cost status	Effective date
Q4137	Amnioexcel or Biodexcel, Per Square Centimeter	N	High	07/01/2014
Q4138	BioDfence DryFlex, Per Square Centimeter	N	High	10/01/2014
Q4140	BioDfence, Per Square Centimeter	N	High	10/01/2014

f. Updated payment rate for HCPCS Code J9171, effective January 1, 2014, through March 31, 2014

The payment rate for HCPCS code J9171 was incorrect in the January 2014 OPPS pricer. The corrected payment rate is listed in Table 6, and has been installed in the October 2014 OPPS pricer, effective for services furnished on January 1, 2014, through March 31, 2014. Your MAC will not automatically adjust claims already processed with the incorrect rate, but they will adjust such claims that you bring to the MAC's attention.

Table 6 – Updated payment rate for HCPCS J9171, effective January 1, 2014, through March 31, 2014

HCPCS code	Status indicator	APC	Short descriptor	Corrected payment rate	Corrected minimum unadjusted copayment
J9171	K	0823	Docetaxel injection	$4.63	$0.93

g. Updated payment rates for certain HCPCS effective April 1, 2014, through June 30, 2014

The payment rate for three HCPCS codes were incorrect in the April 2014 OPPS pricer. The corrected payment rates are listed in Table 7, and have been installed in the October 2014 OPPS pricer, effective for services furnished on April 1, 2014 through June 30, 2014.

Your MAC will not automatically adjust claims already processed with the incorrect rates, but they will adjust such claims that you bring to the MAC's attention.

Table 7 – Updated payment rates for certain HCPCS effective April 1, 2014, through June 30, 2014

HCPCS code	Status indicator	APC	Short descriptor	Corrected payment rate	Corrected minimum unadjusted copayment
J7335	K	9268	Capsaicin eight percent patch	$25.49	$5.10
J8700	K	1086	Temozolomide	$6.94	$1.39
J9171	K	0823	Docetaxel injection	$4.35	$0.87

See **OUTPATIENT**, next page

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h. Updated payment rates for certain HCPCS effective July 1, 2014, through September 30, 2014

The payment rate for two HCPCS codes were incorrect in the July 2014 OPPS pricer. The corrected payment rates are listed in Table 8, and have been installed in the October 2014 OPPS pricer, effective for services furnished on July 1, 2014, through September 30, 2014. Your MAC will not automatically adjust claims already processed with the incorrect rate, but they will adjust such claims that you bring to the MAC's attention.

Table 8 – Updated payment rates for certain HCPCS effective July 1, 2014, through September 30, 2014

HCPCS code	Status indicator	APC	Short descriptor	Corrected payment rate	Corrected minimum unadjusted copayment
J9047	G	9295	Injection, carfilzomib, 1 mg	$29.67	$5.93
J9315	K	9265	Romidepsin injection	$270.24	$54.05

Incorrect national unadjusted copayment for APC 0066 (Level I Stereotactic Radiosurgery) in 2014 OPPS final rule

CMS incorrectly calculated the national unadjusted copayment for APC 0066 (Level I Stereotactic Radiosurgery) in the 2014 OPPS final rule. The national unadjusted copayment for APC 0066 was set to an explicit value, but it should have been set to the minimum unadjusted copayment equivalent to a coinsurance percentage of 20 percent. CMS corrected this error in the July 2014 pricer, and CMS is making the change for the copayment associated with APC 0066 retroactive to January 1, 2014. The correct copayment is included in the July 2014 update of the OPPS Addendum A and Addendum B at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html*.

Providers should refer to the recent edition of the *MLN Connects Provider eNews* which instructs

1. contractors to reprocess claims, and
2. providers to reimburse beneficiaries for any overpayment of beneficiary copayment created by correcting the national unadjusted copayment associated with APC 0066.

You can subscribe to *MLN Connects Provider eNews* at *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/index.html*, and you can find archived copies of the *MLN Connects Provider eNews* at *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive.html*.

Coverage determinations

The fact that a drug, device, procedure or service is assigned a HCPCS code and a payment rate under the OPPS does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the program. MACs determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, MACs determine that it is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment.

Additional information

The official instruction, CR 8873 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3080CP.pdf*.

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

MLN Matters® Number: MM8873 *Revised*
Related Change Request (CR) #: CR 8873
Related CR Release Date: September 26, 2014
Effective Date: October 1, 2014
Related CR Transmittal #: R3080CP
Implementation Date: October 6, 2014

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2015 update for psychiatric facilities PPS

Note: *This article was revised October 2, 2014, to reflect the revised change request (CR) 8889 issued September 30. In the article, the CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same. It was previously published in the September 2014 issue of Medicare A Connection, Pages 46-48.*

Provider types affected

This *MLN Matters*® article is intended for providers who submit claims to Medicare administrative contractors (MACs) for services provided to inpatient Medicare beneficiaries and are paid under the inpatient psychiatric facilities prospective payment system (IPF PPS).

Provider action needed

CR 8889 identifies changes that are required as part of the annual IPF PPS update from the fiscal year (FY) 2015 IPF PPS final rule displayed on August 1, 2014. These changes are applicable to IPF discharges occurring October 1, 2014, through September 30, 2015. Make sure your billing staffs are aware of these IPF PPS changes for FY 2015.

Background

The Centers for Medicare & Medicaid Services (CMS) published a final rule in the *Federal Register* on November 15, 2004, that established the IPF PPS under the Medicare program in accordance with provisions of the Medicare, Medicaid and SCHIP Balance Budget Refinement Act of 1999 (BBRA; Section 124 of Public Law 106-113).

Payments to IPFs under the IPF PPS are based on a federal per diem base rate that includes both inpatient operating and capital-related costs (including routine and ancillary services), but excludes certain pass-through costs (i.e., bad debts, and graduate medical education). CMS is required to make updates to this prospective payment system annually.

CR 8889 identifies changes that are required as part of the annual IPF PPS update from the IPF PPS FY 2015 final rule. These changes are applicable to IPF discharges occurring during the FY October 1, 2014, through September 30, 2015.

Inpatient psychiatric facilities quality reporting program (IPFQR)

Section 1886(s)(4) of the Social Security Act (The Act) requires the establishment of a quality data reporting program for the IPF PPS beginning in FY 2014. CMS finalized new requirements for quality reporting for IPFs in the "Hospital Inpatient Prospective Payment System for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Fiscal Year 2013 Rates" final rule (August 31, 2012) (*77 FR 53258*, *53644* through *53360*).

Section 1886(s)(4)(A)(i) of the Act requires that, for FY 2014 and each subsequent fiscal year, the Secretary of Health and Human Services shall reduce any annual update to a standard federal rate for discharges occurring during the FY by two percentage points for any IPF that does not comply with the quality data submission requirements with respect to an applicable year.

Therefore, CMS is applying a 2 percentage point reduction to the federal per diem base rate and the electroconvulsive therapy (ECT) base rate as follows:

- For IPFs that fail to submit quality reporting data under the IPF quality reporting program, CMS is applying a 0.1 percent annual update (that is 2.1 percent reduced by two percentage points in accordance with section 1886(s)(4)(A)(ii) of the Act) and the wage index budget neutrality factor of 1.0002 to the FY 2014 federal per diem base rate of $713.19, yielding a federal per diem base rate of $714.05 for FY 2015.
- Similarly, CMS is applying the 0.1 percent annual update and the 1.0002 wage index budget neutrality factor to the FY 2014 electroconvulsive therapy (ECT) base rate of $307.04, yielding an ECT base rate of $307.41 for FY 2015.

Market basket update

For FY 2015, CMS used the FY 2008-based rehabilitation, psychiatric, and long term care (RPL) market basket to update the IPF PPS payment rates (that is the federal per diem and ECT base rates).

The Social Security Act (Section 1886(s)(2)(A)(ii); see *http://www.ssa.gov/OP_Home/ssact/title18/1886.htm*), requires the application of an "Other Adjustment" that reduces any update to the IPF PPS base rate by percentages specified in the Social Security Act (Section 1886(s)(3)) for rate year (RY) beginning in 2010 through the FY beginning in 2019.

For the FY beginning in 2014 (that is, FY 2015), the Act (Section 1886(s)(3)(B)) requires the reduction to be 0.3

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percentage point. CMS is implementing that provision in the FY 2015 final rule.

In addition, the Act Section 1886(s)(2)(A)(i) requires the application of the productivity adjustment described in the Act (Section 1886(b)(3)(B)(xi)(II)) to the IPF PPS for the RY beginning in 2012 (that is, a RY that coincides with a FY), and each subsequent FY. For the FY beginning in 2014 (that is FY 2015), the reduction is 0.5 percentage point. CMS is implementing that provision in the FY 2015 final rule.

Specifically, CMS has updated – the IPF PPS base rate for FY 2015 by applying the adjusted market basket update of 2.1 percent (which includes the RPL market basket increase of 2.9 percent, an ACA required 0.3 percent reduction to the market basket update, and an ACA required productivity adjustment reduction of 0.5 percent) and the wage index budget neutrality factor of 1.0002 to the FY 2014 federal per diem base rate of $713.19 yields a Federal per diem base rate of $728.31 for FY 2015.

Similarly, applying the adjusted market basket update of 2.1 percent and the wage index budget neutrality factor of 1.0002 to the FY 2014 ECT rate of $307.04 yields an ECT rate of $313.55 for FY 2015.

Pricer updates for FY 2015

- The federal per diem base rate is $728.31;
- The federal per diem base rate is $714.05 (when applying the two percentage point reduction.);
- The fixed dollar loss threshold amount is $8,755;
- The IPF PPS will use the FY 2014 unadjusted pre-floor, pre-reclassified hospital wage index;
- The labor-related share is 69.294 percent;
- The non-labor related share is 30.706 percent;
- The ECT rate is $313.55; and
- The ECT rate is $307.41 (when applying the two percentage point reduction).

Cost to charge ratio (CCR) for the IPF prospective payment system FY 2015

Cost to Charge Ratio	Median	Ceiling
Urban	0.4710	1.6582
Rural	0.6220	1.8590

CMS is applying the national CCRs to the following situations:

- New IPFs that have not yet submitted their first Medicare cost report. For new facilities, CMS is using these national ratios until the facility's actual CCR can be computed using the first tentatively settled or final settled cost report, which will then be used for the subsequent cost report period.
- The IPFs whose operating or capital CCR is in excess of three standard deviations above the corresponding national geometric mean (that is, above the ceiling).
- Other IPFs for whom the MAC obtains inaccurate or incomplete data with which to calculate either an operating or capital CCR or both.

MS-DRG update

- The code set and adjustment factors are unchanged for IPF PPS FY 2015.

FY 2014 Pre-floor, pre-reclassified hospital wage index

- CMS is using the updated wage index and the wage index budget neutrality factor of 1.0002.

COLA adjustment for the IPF PPS FY 2015

The Office of Personal Management (OPM) began transitioning from cost of living adjustment (COLA) factors to a locality payment rate in FY 2010.

The 2009 COLA factors were frozen in order to allow this transition. In the FY 2013 IPPS/LTCH final rule (*77 FR 53700 through 53701*), CMS established a new methodology to update the COLA factors for Alaska and Hawaii.

In this FY 2015 IPF PPS update, CMS adopted this new COLA update methodology and is updating the COLA rates (as published in FY 2014 IPPS/LTCH final rule (78 FR 50986), using the new methodology). The COLAs for Alaska and Hawaii are shown in the following tables:

Alaska	Cost of living adjustment factor
City of Anchorage and 80-kilometer (50-mile) radius by road	1.23
City of Fairbanks and 80-kilometer 50-mile) radius by road	1.23
City of Juneau and 80-kilometer (50-mile) radius by road	1.23
Rest of Alaska	1.23

Hawaii	Cost of living adjustment factor
City and County of Honolulu	1.25
County of Hawaii	1.19
County of Kauai	1.25
County of Maui and County of Kalawao	1.25

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Update to clarify claim processing for laboratory services

Provider types affected

This *MLN Matters*® article is intended for Medicare practitioners providing laboratory services to Medicare beneficiaries and billing Medicare administrative contractors (MACs) or durable medical equipment Medicare (DME) MACs for those services.

Provider action needed

Change request (CR) 8883 updates the *Medicare Claims Processing Manual* to clarify that the location where the independent laboratory performed the test determines the appropriate billing jurisdiction for specimen collection fees and travel allowance.

The changes are intended to clarify the existing policies and no system or processing changes are anticipated. Make sure your billing staffs are aware of these policies.

Key points

The manual updates, which are attached to CR 8883, are as follows:

The location where the independent laboratory performed the test determines the appropriate billing jurisdiction. If the sample originates in a different jurisdiction from where the sample is being tested, the claim must be filed in the jurisdiction where the test was performed.

Claims filing jurisdiction for the specimen collection fee and travel allowance is also determined by the location where the test was performed. When billed by an independent laboratory, the specimen collection fee and travel allowance must be billed in conjunction with a covered laboratory test.

- The specimen collection fee is paid based on the location of the independent laboratory where the test is performed and is billed in conjunction with a covered laboratory test.

Additional information

The official instruction, CR 8883, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3071CP.pdf*.

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

MLN Matters® Number: MM8883
Related Change Request (CR) #: CR 8883
Related CR Release Date: September 19, 2014
Effective Date: December 22, 2014
Related CR Transmittal #: R3071CP
Implementation Date: December 22, 2014

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Additional information

The official instruction, CR 8889 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3082CP.pdf*.

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

MLN Matters® Number: MM8889

Related Change Request (CR) #: CR 8889
Related CR Release Date: September 30, 2014
Effective Date: October 1, 2014
Related CR Transmittal #: R3082CP
Implementation October 6, 2014

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Educational Events

Provider outreach and educational events December 2014

How to register for SPOT

When: Tuesday, December 3
Time: 9:00 p.m. - 10:30 a.m. ET – Delivery language: English
Type of Event: Webcast
http://medicare.fcso.com/Events/274584.asp

Medicare Part A changes and regulations

When: Tuesday, December 9
Time: 10:30 a.m. - 11:30 a.m. ET – Delivery language: English
Type of Event: Webcast
http://medicare.fcso.com/Events/273901.asp

Two easy ways to register

1. **Online** – Visit *www.fcsouniversity.com*, logon to your account and select the course you wish to register. Class materials are available under "My Courses" no later than one day before the event**. First-time user?** Set up an account by completing "Request a New Account" online. Providers with no national provider identifier may enter "99999" in the NPI field. You will receive logon information within 72 hours of your request.
2. **Fax** – Providers without Internet access may request a fax registration form through our Registration Hotline at 904-791-8103. Class materials will be faxed to you the day of the event.

Please note:

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

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Provider Address: _____

City, State, ZIP Code: _____

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

Never miss a training opportunity

If you were unable to attend one of our past Medicare educational webcasts, you still have the opportunity to learn about the topics covered during the training session. Visit *medicare.fcso.com*, download the recording of the event, and listen to the webcast when you have the time.

Take advantage of 24-hour access to free online training

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

CMS MLN Connects™ Provider eNews

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

To improve consistency and to streamline operations in messaging to the FFS provider community across all Medicare information channels, CMS conducted a pilot that ended September 30, 2012; however, CMS has extended it until further notice. The following articles link to recent *MLN Connects*™ e-News:

MLN Connects™ Provider eNews for September 25, 2014

MLN Connects™ Provider eNews for September 25, 2014

View this edition as a PDF

In this edition:

MLN Connects™ National Provider Calls

- Hospital Compare Star Ratings: Overview of HCAHPS Star Ratings – Registration Opening Soon
- Hospital Appeals Settlement Update – Registration Now Open
- Transitioning to ICD-10 – Register Now
- New MLN Connects™ National Provider Call Video Slideshow

Announcements

- Volunteers Sought for ICD-10 End-to-End Testing in January: Forms due October 3
- National Partnership to Improve Dementia Care Exceeds Goal to Reduce Use of Antipsychotic Medications in Nursing Homes: CMS Announces New Goal
- Hospital Appeals Settlement: New FAQs Posted
- Groups: Remember to Register for 2014 PQRS GPRO Participation by September 30
- 2014 PQRS 2nd Quarter Interim Feedback Dashboard Reports Available
- 2013 PQRS and eRx Incentive Program Incentive Payments Available
- 2013 PQRS and eRx Incentive Program Feedback Reports Available
- 2012 eRx Incentive Program and 2012 PQRS Supplemental Incentive Payments Available
- Completion and Submission Timeframes for Hospice Item Set Records
- Important Skill Sets for Doctors and Nurses: CME Articles Available on Medscape
- New Resources and Webinars from National Health IT Week
- PQRS: New Quality Reporting Training Modules to Help Ensure Satisfactory 2014 Reporting
- 2014 CAHPS for PQRS Survey
- New PQRS FAQs Available
- New and Updated FAQs for the EHR Incentive Programs

Claims, Pricers, and Codes

- FDG PET for Solid Tumor Claims

MLN Educational Products

- "Medicare Billing Information for Rural Providers and Suppliers" Booklet – Revised
- "Rural Health Clinic" Fact Sheet – Revised
- "Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians" Fact Sheet – Revised
- "Critical Access Hospital" Fact Sheet – Revised
- Subscribe to the Medicare Learning Network® Educational Products and MLN Matters® Electronic Mailing Lists

MLN Connects™ Provider eNews for October 2, 2014

MLN Connects™ Provider eNews for October 2, 2014

View this edition as a PDF

In this edition:

MLN Connects™ National Provider Calls

- Hospital Compare Star Ratings: Overview of HCAHPS Star Ratings — Last Chance to Register
- Hospital Appeals Settlement Update — Last Chance to Register
- Overview of the 2013 Quality and Resource Use Reports — Registration Opening Soon
- Transitioning to ICD-10 — Register Now
- New MLN Connects™ National Provider Call Audio Recording and Transcript
- CMS Events
- Special Open Door Forum: Star Ratings on Dialysis Facility Compare

Announcements

- National Breast Cancer Awareness Month
- CMS Makes First Wave of Drug and Device Company Payments to Teaching Hospitals and Physicians Public
- Get Ready for DMEPOS Competitive Bidding – Common Ownership and Common Control
- PQRS GPRO Registration Extended Until October 3
- Volunteers Sought for ICD-10 End-to-End Testing in January: Forms due October 3
- Comply with MAC Request for Fingerprints within 30 Days
- CMS Announces Availability of 2013 Quality and Resource Use Reports
- EHR Incentive Program: CMS Attestation System Open
- ICD-10 Compliance Date Is October 1, 2015

Claims, Pricers, and Codes

- ICD-10-CM Official Guidelines for Coding and Reporting Available

MLN Educational Products

- "Hospital-Acquired Conditions and Present on Admission Indicator Reporting Provision" Fact Sheet – Revised
- "Medicare Appeals Process" Fact Sheet – Revised
- *Medicare Learning Network*® Products Available In Electronic Publication Format
- New *Medicare Learning Network*® Provider Compliance Fast Fact

MLN Connects™ Provider eNews for October 9, 2014

MLN Connects™ Provider eNews for October 9, 2014

View this edition as a PDF

In this edition:

MLN Connects™ National Provider Calls

- Overview of the 2013 Quality and Resource Use Reports — Registration Now Open
- CMS 2014 Certified EHR Technology Flexibility Rule — Registration Now Open
- Transitioning to ICD-10 — Register Now
- MLN Connects™ Videos
- Monthly Spotlight: Physician Quality Reporting System

Announcements

- CMS Announces Two Medicare Quality Improvement Initiatives
- New Outreach & Education Page at CMS.gov
- Work with Older Adult Patients? New Medscape Video for CME Credit
- Electronic Funds Transfer Upgrades to the Internet-based PECOS System
- Open Payments: Know the Numbers and Decode the Data
- CMS is Accepting Suggestions for Potential PQRS Measures
- PQRS: Physician Compare 2013 Group Practice Quality Measure Preview Period through November 7
- New FAQs for PQRS
- EHR Incentive Programs: Hardship Exception Applications to Avoid 2015 Payment Adjustment due November 30
- EHR Incentive Programs: Eligible Hospitals and Requirements for CEHRT to Participate in 2015
- EHR Incentive Programs: Learn How to Report 2014 eCQMs through the QualityNet Portal

MLN Educational Products

- "Dual Eligible Beneficiaries Under the Medicare and Medicaid Programs" Fact Sheet – Revised
- *Medicare Learning Network*® Products Available in Electronic Publication Format

MLN Connects™ Provider eNews for October 16, 2014

MLN Connects™ Provider eNews for October 16, 2014

View this edition as a PDF

In this edition:

MLN Connects™ National Provider Calls

- Hospital Appeals Settlement Update 2 – Registration Opening Soon
- Overview of the 2013 Quality and Resource Use Reports – Last Chance to Register
- CMS 2014 Certified EHR Technology Flexibility Rule – Register Now
- Transitioning to ICD-10 – Register Now
- MLN Connects™ Videos
- New Videos on ICD-10: Medicare Testing Plans and Home Health Conversion
- Did You Miss the Hospital Appeals Settlement Video?

Announcements

- Proposed Rule on Conditions of Participation for HHAs – Comments due December 8
- Get Ready for DMEPOS Competitive Bidding
- Cutting-edge Colorectal Cancer Screening Now Covered

Claims, Pricers, and Codes

- Hold on Certain CAH Method II Claims for Anesthesiologist and CRNA Services
- Hold on FQHC Medicare Advantage PPS Claims

MLN Educational Products

- "Quick Reference Information: Coverage and Billing Requirements for Medicare Ambulance
- Transports" Educational Tool – Released
- "Reading a Professional Remittance Advice (RA)" Booklet – Released
- "Reading the Institutional Remittance Advice (RA)" Booklet – Released
- "Medicare Disproportionate Share Hospital" Fact Sheet – Revised
- "Medicare Secondary Payer Provisions" Web-Based Training Course – Revised
- "CMS Website Wheel" Educational Tool – Reminder
- "The Basics of Medicare Enrollment for Physicians and Other Part B Suppliers" Fact Sheet – Reminder
- *Medicare Learning Network*® Product Available in Electronic Publication Format

Availability of auxiliary aids and services

Section 504 of the Rehabilitation Act of 1973 (Section 504), 29 U.S.C. § 794 prohibits discrimination on the basis of disability in federally assisted and federally conducted programs and activities.

For information about the availability of auxiliary aids and services, please visit *http://www.medicare.gov/about-us/nondiscrimination/nondiscrimination-notice.html*.

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First Coast Service Options Phone Numbers

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

Customer service
Monday to Friday
8:00 a.m. to 4:00 p.m

888-664-4112 (FL/USVI)
877-908-8433 (Puerto Rico)
877-660-1759 (TDD-FL/USVI)
888-216-8261 (TDD-Puerto Rico)

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

Interactive Voice Response
877-602-8816

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

Overpayments
904-791-6281

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

Websites
medicare.fcso.com
medicareespanol.fcso.com

First Coast Service Options Addresses

Claims/correspondence
Florida/ U.S. Virgin Islands

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

Puerto Rico

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

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

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

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

General Inquiries
Online Form (Click here)

Email: AskFloridaA@fcso.com

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

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

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

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

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

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

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

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

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

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

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

Puerto Rico

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

Special delivery/courier services
First Coast Service Options Inc.
532 Riverside Avenue
Jacksonville, FL 32202-4914

Other Medicare carriers and intermediaries

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

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

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

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

Contact CMS

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

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

ROATLFM@CMS.HHS.GOV

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

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

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