Medicare B CONNECTION

FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction 9 Providers October 2013

In this issue

Providers remain 'one step ahead' with First Coast's *eNews*

One of the values that sets Ashford Presbyterian Community Hospital (San Juan, Puerto Rico) apart is its steadfast commitment to the promotion and provision of education for staff members that not only encourages their continued professional growth but also the improvement of the quality of services they provide.

A key part of the hospital's educational initiative is to ensure that its staff remains informed of Medicare's changing policies and regulations through the consistent dissemination of information. First Coast Service Options' (First Coast) *eNews* communications have been instrumental to the achievement of that goal.

According to Luis Rodriguez Félix, Billing Supervisor, and Michelle Vargas, one of the members of the hospital's Medicare claims submissions staff, First Coast's provider-oriented articles have allowed them to be aware of major changes to the dynamic Medicare environment. "For example, through First Coast *eNews*, we found changes in medical policies, what are the trends in documentation and we constantly communicate them to our Medical Records department," said Luis.

The Ashford Presbyterian Community Hospital is one of the hospitals in Puerto Rico that has been at the forefront in monitoring standards and implementing quality models in compliance with all provisions of the Health Insurance Portability and Accountability Act (HIPAA). The hospital monitors the latest news, billing alerts, and information on beneficiary coverage. Michelle, who reports regulation changes from the regulations, stated "When we receive the First Coast *eNews*, we communicate them directly with the biller or the department which is entitled to the information."

"We are aware of the changes in medical policies via First Coast eNews we receive every week. We are continuously monitoring to identify changes and thus prevent claims to be denied."

– Luis Rodríguez Félix, Billing manager

(continued on Page 15)

Contents

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

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

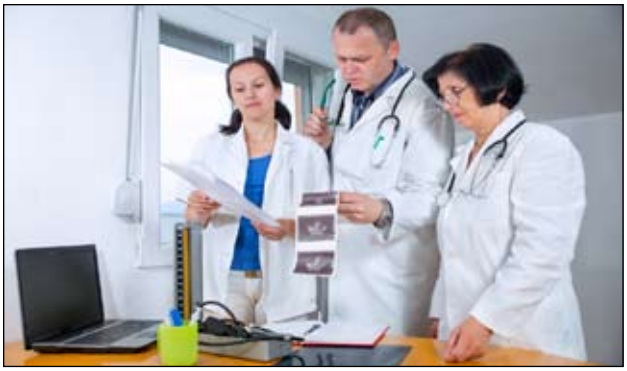
About the *Medicare B Connection*

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

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

Who receives the Connection

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



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

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

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

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

Publication format

The *Connection* is arranged into distinct sections.

- The **Claims** section provides claim submission requirements and tips.
- The **Coverage/Reimbursement** section discusses specific *CPT*® and HCPCS procedure codes. It is arranged by categories (not specialties). For example, "Mental Health" would present coverage information of interest to psychiatrists, clinical psychologists and clinical social workers, rather than listing articles separately under individual provider specialties. Also presented in this section are changes to the Medicare physician fee schedule, and other pricing issues.
- The section pertaining to **Electronic Data Interchange** (EDI) submission also includes information pertaining to the Health Insurance Portability and Accountability Act (HIPAA).
- The **Local Coverage Determination** section features summaries of new and revised local coverage determinations (LCDs) developed as a result of either local medical review or comprehensive data analysis initiatives.
- The **General Information** section includes fraud and abuse, and national provider identifier topics, plus additional topics not included elsewhere.

In addition to the above, other sections include:

- **Educational Resources**, and
- **Contact information** for Florida, Puerto Rico, and the U.S. Virgin Islands.

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

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

Advance beneficiary notices

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

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

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

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

Patient liability notice

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

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

ABN modifiers

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

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

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

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

GA modifier and appeals

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

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

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

2014 annual update for the HPSA bonus payments

Provider types affected

This *MLN Matters*® article is intended for physicians, providers, and suppliers submitting claims to Medicare contractors (fiscal intermediaries (FIs), carriers and A/B Medicare administrative contractors (A/B MACs)) for services to Medicare beneficiaries.

Provider action needed

Change request (CR) 8463, from which this article is taken, alerts you that the annual health professional shortage area (HPSA) bonus payment file for 2014 will be made available by the Centers for Medicare & Medicaid Services (CMS) to your Medicare contractor and will be used for HPSA bonus payments on applicable claims with dates of service on or after January 1, 2014, through December 31, 2014. These files will be posted to the Internet on or about December 1, 2013. You should review *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HPSAPSAPhysicianBonuses/index.html* on the CMS website each year to determine whether you need to add the AQ modifier to your claim in order to receive the bonus payment, or to see if the ZIP code area in which you rendered services will automatically receive the HPSA bonus payment. Note that Medicare contractors will continue to accept the AQ modifier for partially designated HPSA claims. Please be sure that your staffs are aware of this update.

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 is populated using the latest designations as close as possible to November 1 of each year. The HPSA ZIP code file will be made available to CMS contractors in early December of each year. CMS contractors 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.

Additional information

The official instruction, CR 8463, issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2794CP.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: MM8463
Related Change Request (CR) #: CR 8463
Related CR Release Date: September 27, 2013
Effective Date: January 1, 2014
Related CR Transmittal #: R2794CP
Implementation Date: January 6, 2014

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.

NCCI add-on code editing correction for *CPT*® code *96361*

The Centers for Medicare & Medicaid Services (CMS) corrected add-on code edits, which expanded the list of primary codes for *Current Procedural Terminology* (*CPT*®) add-on code *96361* to *CPT*® codes *96360, 96365, 96374, 96409*, and *96413*. This change is retroactive to April 1, 2013. Due to the volume of claims impacted, First Coast Service Options Inc. (First Coast) is automatically adjusting these claims. First Coast anticipates all adjustments will be completed no later than December 31.

Ambulance

Ambulance inflation factor for CY 2014 and productivity adjustment

Provider types affected

This *MLN Matters*® article is intended providers and suppliers submitting claims to Medicare contractors (fiscal intermediaries (FIs), carriers, regional home health intermediaries (RHHIs), durable medical equipment Medicare administrative contractors (DME/MACs) and A/B Medicare administrative contractors (A/B MACs)) for services to Medicare beneficiaries.

What you need to know

This article is based on change request (CR) 8452 which informs Medicare contractors about changes to the ambulance inflation factor (AIF) for calendar year (CY) 2014 and a corresponding productivity adjustment. As a result of these changes, the AIF for CY 2014 is 1.00 percent. Make sure that your billing staffs are aware of these changes. See the *Background* and *Additional information* sections of this article for further details regarding these changes.

Background

CR 8452 furnishes the CY 2014 AIF for determining the payment limit for ambulance services required by section 1834(l)(3)(B) of the Social Security Act (the Act), and updates the *Medicare Claims Processing Manual*, Chapter 15, Section 20.4, which contains a chart tracking the history of the AIF. 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 calendar year (CY) 2014 is 0.80 percent and the CPI-U for 2014 is 1.80 percent. According 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 CY 2014 is 1.00 percent.

Part B coinsurance and deductible requirements apply to payments under the ambulance fee schedule. The 2014 ambulance fee schedule file will be available to Medicare contractors in November 2013 and will be posted at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AmbulanceFeeSchedule/afspuf.html*.

Additional information

The official instruction, CR 8452 issued to your MAC regarding this change may be viewed at *http://cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2788CP.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: MM8452
Related Change Request (CR) #: CR 8452
Related CR Release Date: September 20, 2013
Effective Date: January 1, 2014
Related CR Transmittal #: R2788CP
Implementation Date: January 6, 2014

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Evaluation and Management

Medicare E/M claims for new patients

As previously announced with *MM8165*, Medicare implemented a common working file system edit to identify claims where more than one new patient visit was billed for the same patient within three years. Medicare guidelines only allow one new patient visit by the same provider or different providers in the same group with the same specialty, within a three year period. This guideline is outlined in 100-04 Chapter 12 Section 30.6.7A.

In addition to this new edit, the common working file has established an additional edit which identifies claims where an established patient visit was billed in advance of a new patient visit within a three year period. This edit fails when the rendering provider on the claim with the established patient visit is the same as the rendering provider on the claim with the initial patient visit.

As a result of these new edits, you may begin to see services deny on the original claim submission or you may receive an overpayment request.

If you receive this denial on a new patient visit (not an overpayment request) and you determine that the procedure code should have been filed as an established visit, you can simply call the interactive voice response (IVR) system and request a reopening. Additional IVR reopening information can be found *by clicking here*. If you do not want to use the IVR for this, you have the option of submitting a new claim or writing in for a reopening.

Note: Submitting a new claim for the revised established E/M visit will not result in a duplicate denial since the original visit code was not paid.

CMS has mandated that contractors request overpayments on any claims that were previously paid when either:

- An established patient visit was billed prior to an initial visit within a three year period by the same rendering provider; or
- More than one new patient visit was billed within a three-year period by the same provider or different providers in the same group with the same specialty.

These new system edits were turned on October 1. A large number of paid claims have been identified as overpayments due to the above guidelines. As a result, First Coast Service Options Inc. (First Coast) has initiated recoupment of improper payments related to these claims. The impacted providers will be receiving an overpayment letter soon. To assist providers with questions that they may have relative to these new guidelines, we are providing the following Q&As:

Q: Can I appeal my overpayment?

A: You certainly have the right to appeal any overpayment. However, the overpayment finding will likely be affirmed since Medicare guidelines do not allow more than one new patient visit within three years. Medicare also does not allow payment for a new patient visit billed after an established patient visit by the same rendering provider.

Q: Can I submit a request to change my new patient visit (that generated the overpayment) to an established patient visit?

A: Yes, you can submit a reopening request in writing to change your new patient visit to an established patient visit code if this is the service you actually performed. In your reopening request, you must tell us the specific established visit code you want us to change on your claim. You want to be mindful that there will still likely be an overpayment since established patient visits typically allow less than new patient visits. You also want to note that if you choose to bill another new patient visit code within a three-year period, another overpayment will occur.

Q: I initially billed a claim with an established patient visit in error before I billed my claim for the initial visit. As a result I received an overpayment letter. Can I make corrections to both claims?

A: Yes, you can correct both claims. On your first claim which continued the established patient visit, you can simply call the IVR and request a reopening. You are only allowed to request a reopening if the claim was processed within the previous 12 month period. If it has been longer than 12 months, a reopening should not be submitted.

To correct your second claim, you would need to submit a written request and indicate the correct procedure that should have originally been billed on your claim. It is likely that a small overpayment will still be due since established patient visit codes allow less than new patient visit codes.

Webcast conducted October 25

First Coast conducted a webcast October 25 to discuss this issue. *Click here* to listen to the webcast recording.

Source: CR 8165

Medicare Physician Fee Schedule

CMS reviewing impact of shutdown on Medicare fee for service regulations

The Centers for Medicare & Medicaid Services (CMS) is assessing the impact of the partial government shutdown on completion of the calendar year 2014 Medicare fee for service payment regulations.

CMS intends to issue the final rules on or before November 27, 2013, generally to be effective on January 1, 2014. The impacted regulations include:

- Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (CMS-1526-F)
- CY 2014 Changes to the Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System (CMS-1601-FC)
- CY 2014 Home Health Prospective Payment System Final Rule (CMS-1450-F)
- Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2014 Final Rule with Comment Period (CMS-1600-FC)

Source: PERL 201310-03

Therapy Services

Pre-approval requests for therapy services

First Coast is continuing to receive the form "**Request for pre-approval of therapy services above the $3700 threshold**" for prior authorization of therapy services. In December 2012, First Coast notified providers that the prior authorization of therapy services ended December 17, 2012. First Coast asks that you discontinue submitting pre-approval requests for therapy services. All fax telephone lines for that project have been discontinued.

Claims for dates of service January 1, 2013, that are over the $3,700 threshold are subject to prepayment and/or post payment reviews.

Effective April 1, 2013, recovery auditors began the process of reviewing all therapy claims which have exceeded the $3,700 threshold for the year. When responding to additional documentation requests (ADR) for review of claims over the $3,700 threshold, submit the medical documentation to the following recovery auditor for jurisdiction 9.

Connolly Healthcare
Attention: Medical Record Department
555 North Lane
Suite 6125
Conshohocken, PA 19428

racinfo@connolly.com
866-360-2507 (telephone)
203-529-2995 (fax)

For additional guidance on the manual medical review process for 2013 for therapy claims above the $3,700 threshold, refer to the *May 2013 Medicare B Connection, Pages 13-14*.

General Coverage

The Affordable Care Act and model 4 bundled payments for care improvement

Note: This article was revised September 23, 2013, under the "Model 4 bundled payment provision" section, to clarify the Model 4 hospital's responsibility for payment to providers who would otherwise be paid for professional services under the physician fee schedule (PFS).This article was previously revised July 26, 2013, to reflect a revised change request (CR). The CR added Part B MAC responsibility to the CR's business requirement 18.3. The release date, transmittal number and link to the CR were also changed. This information was previously published in the August 2013 *Medicare B Connection*, Pages 25-28.

Provider types affected

This *MLN Matters*® article is intended for hospitals, physicians, and non-physician providers participating in model 4 of the Bundled Payments for Care Improvement (BPCI) initiative and submitting claims to Medicare contractors (fiscal intermediaries (FIs) and

A/B Medicare administrative contractors (MACs)) for services to Medicare beneficiaries.

What you need to know

This article provides an overview of Medicare's implementation of the model 4 BCPI. General program information is provided along with separate sections containing information of special interest to hospitals and physicians and non-physician providers. It addresses issues related to readmissions, claims crossover, remittance advice, and claims submission, among others. This pilot program is being conducted under the Centers for Medicare & Medicaid Services (CMS) Innovation Center's model testing authority. The program was implemented in October 2013.

Background

The Affordable Care Act provides a number of new tools and resources to help improve health care and lower costs for all Americans. Bundling payment for services that patients receive during a single episode of care, such as heart bypass surgery or a hip replacement, is one way to encourage doctors, hospitals, and other health care providers to work together to better coordinate care for patients, both when they are in the hospital and after they are discharged. Such initiatives can help improve health, improve quality of care, and lower costs.

CMS is working in partnership with providers to develop models of bundling payments through the BPCI initiative. On August 23, 2011, CMS invited providers to apply to help test and develop four different models for bundling payments. Model 4, one of these four models, is discussed in this article. In model 4, the episode of care is defined as the acute care hospital stay and includes inpatient hospital services, Part B services furnished during the hospitalization, and hospital and Part B services for related readmissions.

Information in this article is based on the change requests implemented for BPCI model 4, including CRs 7887, 8070, and 8196.

General BPCI model 4 information

Beneficiary eligibility

In order to be eligible for model 4, the beneficiary must meet the following requirements:

- Beneficiary is eligible for Part A and enrolled in Part B.
- At the time of admission, beneficiary either (a) has at least one day of utilization left and that day is also a day of entitlement or (b) has at least one lifetime reserve day remaining.
- Beneficiary does not have end-stage renal disease
- Beneficiary is not enrolled in any managed care plans.
- Beneficiary must not be covered under the united mine workers.
- Medicare must be the primary payer.

If the beneficiary does not meet all of these requirements, the following codes will be assigned to rejected or cancelled NOAs:

- **Claims adjustment reason code (CARC) B5**: Coverage/program guidelines were not met or were exceeded.

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Bundled *(continued)*

- **Remittance advice remarks code (RARC) N564**: This patient did not meet the inclusion criteria for the demonstration project or pilot program.

Model 4 bundled payment provision

Hospitals that participate in the BPCI model 4 initiative will receive a prospectively established bundled payment for agreed upon Medicare severity diagnosis related groups (MS-DRGs).

- This will not apply to claims that are paid on a transfer per-diem basis.
- This payment will include both the DRG payment for the hospital and a fixed amount for the Part B services anticipated to be rendered during the admission. Separate payment for providers' professional services rendered during the inpatient hospital stay will not be made.
- **Participating model 4 hospitals will receive a model 4 payment and will be responsible for payment to providers who would otherwise be paid for professional services under the physician fee schedule (PFS). As such, physicians and non-physician practitioners should seek payment for professional provider services from the model 4 hospital.**

- **Per the conditions of the agreement between CMS and the model 4 hospital, payment to physicians and non-physician practitioners must be made at a rate that is equivalent to the amount that would otherwise apply under the PFS, unless a different amount has been agreed to in writing by the model 4 hospital and the physician.**
- Claims from physicians will be processed as no-pay claims if they occur between the inpatient hospital admission and discharge date in order to prevent duplicate payment of physicians under the bundled payment.

Copayments, coinsurance, and deductibles

- The regular Part A deductible, including the Part A blood deductible, and daily coinsurance amounts (when applicable) will continue to be applied to the claim.
- The fixed Part B portion of the negotiated bundled payment will first be applied to the Part B deductible, if applicable.
- A fixed Part B copayment will be applied to the claim. This will be the responsibility of the beneficiary and will be calculated as an approximation of what the Part B coinsurance would have been in the absence of model 4.
- Both the copayment and the deductible to be paid by the beneficiary for the Part B services will appear on the MSN along with the Part A deductible and any applicable coinsurance.

Appeals

Payments made under model 4 have no rights of appeal, except in the case of calculation errors.

- **RARC N83**: No appeal rights. Adjudicative decision based on the provisions of a demonstration project.

Information for hospitals

Notification of admission (NOA)

Hospitals participating in this initiative should submit a notice of admission (NOA) when a beneficiary expected to be included in the model is admitted. Timely filing of the NOA allows subsequent Part B claims submitted before the hospital claim to be properly processed as "no-pay" claims, which indicates that payment for these claims are to be included in hospital payments under model 4. By extension, these Part B claims will then be included timely on weekly Part B reports provided to the hospital to be used in calculating payments for Part B providers.

- Hospitals will be paid a $500 payment upon submission of the NOA and will receive the balance of the prospectively established bundled payment when the hospital claim is processed.
  - **RARC N568**: Initial payment based on the notice of admission (NOA) under the bundled payment model IV initiative.
  - If the patient ultimately does not qualify for a model 4 prospective payment based on the MSDRG ultimately assigned to their inpatient stay, or if the NOA is cancelled, the $500 NOA payment will be recouped.
  - Medicare systems will initiate a "look back" into the claims history records upon receipt of a canceled NOA to identify model 4 BPCI claims i.e., Part B physician or other professional claims, which were processed as "no pay" as a result of the NOA being opened. If such claims were processed, the Medicare contractor will adjust the claims automatically

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Bundled *(continued)*

and remit payment for services rendered based on regular Medicare fee-for-service claim processing rules.

- Hospitals must submit the final claim within 60 days of the beneficiary's hospital admission or submit an interim claim during that time period to demonstrate that the beneficiary is still an inpatient. Otherwise, the beneficiary will be considered not subject to episode payment and the $500 will be recouped.
  - The following codes will be assigned when a model 4 claim matches an NOA for admission date and beneficiary, but not provider.
    - **CARC 208**: National provider identifier - not matched
    - **RARC N562**: The provider number of your incoming claim does not match the processed notice of admission (NOA) for this bundled payment
  - The following codes shall be assigned when an NOA is cancelled because a matching claim is not received within 60 days. A match consists of beneficiary, admit date, and provider.
    - **CARC 226**: Information requested from the billing/rendering provider was not provided or not provided timely or was insufficient/incomplete
    - **RARC N560**: This pilot program requires an interim or final claim within 60 days of the notice of admission. A claim was not received

Readmissions

Model 4 hospitals will not be paid for readmissions that occur to the same hospital (i.e., another admission with a date of admission within 30 days of discharge of the model 4 stay) under this model unless the MS-DRG assigned to that readmission is expressly excluded as unrelated to the MS-DRG assigned to the original admission.

- Unrelated readmissions have been defined by CMS, and a list of DRGs defining unrelated readmissions has been provided for each included MS-DRG to every model 4 participating hospital. This list can also be found on the bundled payments collaboration site, accessible to model 4 awardees.
- Related readmissions to a hospital other than the original treating hospital, as well as payments for physicians' services during related readmissions to hospitals other than the original treating hospital, will be reconciled retrospectively by a BPCI payment reconciliation contractor and payment will be recouped, as applicable, by the model 4 awardee.
  - If claims for a model 4 anchor admission and a readmission are submitted out of order, the readmission claim will be canceled and must be resubmitted to receive payment. The following codes will be used in this situation:
    - **CARC 249**: This claim has been identified as a readmission.
    - **RARC N561**: The bundled payment for the episode of care includes payment for related readmissions. You may resubmit your claim to receive a corrected payment.

Payment rate updates and adjustors

Payment rates may be updated as often as quarterly to allow for ongoing updates to Medicare payment rates, including regular recurring changes made to the physicians fee schedule (PFS) and inpatient prospective payment system (IPPS). Indirect medical education (IME) and disproportionate share hospital (DSH) payments, as well as outlier payments and hospital capital payments to model 4 hospitals will be calculated based on the non-discounted base DRG payment that would have been made in the absence of the model. This is true for both anchor admissions and related readmissions to the model 4 hospital. In the case of readmissions, these payments will be denoted by the following:

- **CARC 249**: This claim has been identified as a readmission.
- **RARC N524**: Based on policy this payment constitutes payment in full.

Other applicable payment adjustors will also be calculated based on the base DRG that would otherwise have applied to the case, as opposed to the prospectively established amount paid through this initiative, which will be higher as it includes payment for Part B services in addition to the base DRG payment.

Information for physicians and non-physician providers

Claims submission and processing

Physicians and non-physician practitioners shall submit claims for dates of service during an episode of care included in model 4 BPCI as usual.

Physicians and non-physician practitioners shall be required to accept assignment for all claims covered under the model 4 BPCI payment.

For those Part B services rendered during a model 4 admission or a related readmission to that model 4 hospital, Medicare will process claims as no-pay.

In processing no-pay professional claims, Medicare will assign the following:

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Bundled *(continued)*

- **CARC 234**: This procedure is not paid separately.
- **RARC N67**: Professional provider services not paid separately. Included in facility payment under a demonstration project. Apply to that facility for payment, or resubmit your claim if: the facility notifies you the patient was excluded from this demonstration; or, if you furnished these services in another location on the date of admission or discharge from a demonstration hospital. If services furnished in a facility not involved in the demonstration on the same date the patient was discharged from or admitted to a demonstration facility, you must report the provider ID number for the non-demonstration facility on the new claim.

Physicians submitting claims should take care not to include on the same claim services that are both within the dates (admission and discharge) of a model 4 BPCI episode and outside the dates of the episode. If such claims with both model 4 and non-model 4 services are received, Medicare contractors will reject the claims and advise the physician to separate the services and rebill. The following remittance messages will be used in this situation:

- **CARC 239**: Claim spans eligible and ineligible periods of coverage. Rebill separate claims.
- **RARC N61**: Rebill services on separate claims.

Incentive payments

Bonus or incentive payments calculated by CMS, such as HPSA bonus payments, will not be affected by physician or non-physician practitioner participation in the bundled payments initiative.

Participation declination

Physicians have the right to decline participation in this program. Declination will be indicated by including a HCPCS modifier on each claim. Further details will be provided at a future date.

Readmissions

Part B services provided during a related readmission to the original treating hospital will not be paid separately. If Part B claims were processed prior to receipt of the hospital's readmission claim, Medicare will take steps to recover payments to the physician.

- **CARC A1**: Claim/service denied
- **RARC N68**: Prior payment being cancelled as we were subsequently notified this patient was covered by a demonstration project in this site of service. Professional services were included in the payment to the facility. You must contact the facility for payment. Prior payment made to you by the patient or another insurer for this claim must be returned within 30 days.

Claim crossover

In association with this initiative, CMS will make changes to allow for the reporting of two new CARCs within the 2320 claim adjustment segment (CAS), so that supplemental payers can more easily determine these amounts when adjudicating Medicare Health Insurance Portability and Accountability Act (HIPAA) 837 institutional coordination of benefits (COB)/ crossover claims.

- **CARC 247** will be defined as "Part B deductible on a Part A claim."
- **CARC 248** will be defined as "Part B coinsurance on a Part A claim."
- An adjusted RARC M137 will be defined as "Part B coinsurance under a demonstration project or pilot program.

This initiative will also result in the reporting of a new value code within the 2300 health care information codes (HI) value information (qualifier BE) portion of outbound HIPAA 837 institutional COB/crossover claims.

Additional information

The official instruction, CR 8070, issued to your Medicare contractor regarding this change may be viewed at *http://www.cms.gov/Regulations-andGuidance/Guidance/Transmittals/Downloads/R1251OTN.pdf*.

In addition, CR 8196 is available at *http://www.cms.gov/Regulations-andGuidance/Guidance/Transmittals/Downloads/R1189OTN.pdf* and CR 7887 is available at *http://www.cms.gov/Regulations-andGuidance/Guidance/Transmittals/Downloads/R1240OTN.pdf*.

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

MLN Matters® Number: MM8070 *Revised*
Related Change Request (CR) #: 8070
Related CR Release Date: June 27, 2013
Effective Date: July 1, 2013
Related CR Transmittal #: R1251OTN
Implementation Date: July 1, 2013

Claim status category and claim status codes update

Provider types affected

This *MLN Matters*® article is intended for physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries (FI), regional home health intermediaries (RHHIs), Medicare administrative contractors (A/B MACs), and durable medical equipment Medicare administrative contractors (DME MACs)) for services to Medicare beneficiaries.

What you need to know

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 8446, from which this article is taken, and requires Medicare contractors to use only national Code Maintenance Committee-approved claim status category codes and claim status codes when sending Medicare healthcare status responses (277 transactions) to report the status of your submitted claim(s). Proprietary codes may not be used in the x12 276/277 to report claim status.

All code changes approved during the September 2013 committee meeting will be posted on or about November 1, 2013, at *http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-categorycodes/* and *http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-codes/* and reflected in the x12 277 transactions issued on and after the date of implementation of CR 8446 (January 1, 2014).

Background

The Health Insurance Portability and Accountability Act (HIPAA) requires all health care benefit payers to use only national Code Maintenance Committee-approved claim status category codes and claim status codes to explain the status of submitted claims. These codes, which have been adopted as the national standard to explain the status of submitted claim(s), are the only such codes permitted for use in the x12 276/277 health care claim status request and response format.

The national Code Maintenance Committee meets three times each year (February, June, and October) in conjunction with the Accredited Standards Committee (ASC) x12 trimester meeting, and makes decisions about additions, modifications, and retirement of existing codes. The Committee has decided to allow the industry six months for implementation of the newly added or changed codes.

Therefore, on and after the date of implementation of CR 8446 (January 1, 2014), your Medicare contractor will:

1. Complete the entry of all applicable code text changes and new codes;
2. Terminate the use of deactivated codes; and
3. Use these new codes for editing all x12 276 transactions and reflect them in the x12 277 transactions that they issue.

Additional information

The official instruction, CR 8446 issued to your MAC regarding this change may be viewed at *http://cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2792CP.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-complianceinteractive-map/index.html*.

MLN Matters® Number: MM8446
Related Change Request (CR) #: CR 8446
Related CR Release Date: September 20, 2013
Effective Date: January 1, 2014
Related CR Transmittal #: R2792CP
Implementation Date: January 6, 2014

Medicare Remit Easy Print enhancement

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8467 which informs Medicare contractors about the following annual changes to the Medicare Remit Easy Print (MREP) software. Those changes are:

- Revise the MREP remittance advice layout to remove the blank line after each set of claim line details and
- Revise the MREP remittance advice layout by adding the claim adjustment reason code (CARC) adjustment amount (CARC-AMT) to the fields subtotaled for each claim.

Make sure that your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) developed the MREP software to help providers to transition from paper to electronic format of the remittance advice. The electronic remittance advice (ERA) must be the standard format adopted under the Health Insurance Accountability and Portability Act (HIPAA). Currently the HIPAA adopted standard is the ASC x12 transaction 835 version 005010A1. MREP users can view and print the ERA in humanly readable format and can send a hard copy remittance advice with their claims to payers after Medicare. Additionally, MREP users can run and download a number of special reports that have been added in response to enhancement requests from users. This software is available for free and has been updated on a yearly basis since its introduction in October 2005. CR 8467 is instructing VIPs – the software developer – to update MREP based on requests received from users through the MACs and/or the CMS website.

Additional information

The official instruction, CR 8467 issued to your Medicare contractor regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2795CP.pdf*.

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

MLN Matters® Number: MM8467
Related Change Request (CR) #: CR 8467
Related CR Release Date: September 27, 2013
Effective Date: January 1, 2014
Related CR Transmittal #: R2795CP
Implementation Date: January 6, 2014

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Find out first: Subscribe to First Coast *eNews*

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

Redaction of health insurance claim numbers in Medicare redetermination notices

Note: This article was revised September 27, 2013, to reflect the release of a new change request (CR), dated September 25, 2013. The revised CR instructs contractors not auto-populate the HICNs on reconsideration request forms. The transmittal number, CR release date and Web address for the CR also changed. All other information remains the same. This information was previously published in the August 2013 *Medicare B Connection*, Page 34.

Provider types affected

This *MLN Matters*® article is intended for physicians, providers and suppliers submitting claims to Medicare contractors (fiscal intermediaries (FIs), carriers, home health and Hospice Medicare administrative contractors (MACs), durable medical equipment MACs, and A/B MACs) for services to Medicare beneficiaries.

What you need to know

This article is based on CR 8268, which instructs the MACs to redact HICNs on all MRNs. Make sure that your billing staffs are aware of this change.

Background

Medicare contractors are required to issue a notice of Medicare redetermination after an appeal is requested in accordance with 42 CFR Section 405.956. One of the elements in the MRN is the beneficiary's HICN. To ensure that contractors protect personally identifiable information, the Centers for Medicare & Medicaid Services (CMS) is requesting that all contractors redact the HICNs in the MRNs. The HICNs will be redacted by replacing five or more values of the HICN with Xs or asterisks (*) with the last four or five digits of the HICN displayed. This applies to HICNs with both alpha and numeric digits.

Additional information

The official instruction, CR 8268, issued to your Medicare contractor regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1296OTN.pdf*.

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

MLN Matters® Number: MM8268 *Revised*
Related Change Request (CR) #: CR 8268
Related CR Release Date: September 25, 2013
Effective Date: January 1, 2014
Related CR Transmittal #: R1296OTN
Implementation Date: January 6, 2014

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eNews *(continued from front page)*

'La Escuelita' takes the hospital back to the classroom

In January 2012, Ashford Presbyterian Community Hospital created "La Escuelita," or little school, as part of their initiative for continuous improvement. This idea was prompted by the need to establish better communication channels between their billing staff and other departments. The hospital currently has approximately 350 doctors and health care professionals, from various medical specialties and subspecialties, and it is essential to provide a unified message for all areas.

For the billing department, First Coast's *eNews* represents useful and easily accessible information. "When we receive additional articles, we forward the email to the appropriate department and if in doubt, we discuss the issue further," said Vargas.

During the hospital's "La Escuelita" sessions, Michelle distributes First Coast's *eNews* to each participant. "The new publications are communicated to all staff that plays an important role within a given process. In the meetings also nurses and doctors participate." says Luis.

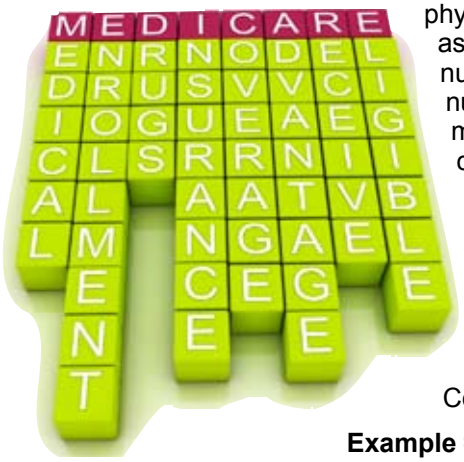
To keep track of the latest Medicare news and receive information customized to your needs, subscribe to *First Coast's eNews*.

Enrollment denials when overpayment exists

Note: This article was revised October 17, 2013, to reflect the revised change request (CR) 8039 issued August 1. Several examples and clarifying statements have been added. In addition, the transmittal number and the Web address for accessing CR 8039 were revised. This information was previously published in the August 2013 *Medicare B Connection*, Page 37.

Provider types affected

This *MLN Matters*® article is intended for physicians, providers, and suppliers, including current owners of an enrolling provider or supplier or the enrolling physician or non-physician practitioner, submitting enrollment applications to Medicare contractors (fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), carriers, durable medical equipment (DME) Medicare administrative contractors (MACs), and A/B MACs).



What you need to know

This article, based on CR 8039, informs you that Medicare contractors may deny a Form CMS-855 enrollment application if the current owner of the enrolling provider or supplier or the enrolling physician or non-physician practitioner has an existing or delinquent overpayment that has not been repaid in full at the time an application for new enrollment or change of ownership (CHOW) is filed.

Background

Under 42 Code of Federal Regulations (CFR) Section 424.530(a)(6), an enrollment application may be denied if the current owner (as that term is defined in 42 CFR Section 424.502) of the applying provider or supplier, or the applying physician or non-physician practitioner has an existing or delinquent overpayment that has not been repaid in full at the time the application was filed.

(Under 42 CFR 424.502, the term "owner" means any individual or entity that has any partnership interest in, or that has 5 percent or more direct or indirect ownership of the provider or supplier as defined in Sections 1124 and 1124A(A) of the Social Security Act) of the applying provider or supplier)

Overpayments are Medicare payments that a provider or beneficiary has received in excess of amounts due and payable under the statute and regulations. Once a determination of an overpayment has been made, the amount is a debt owed by the debtor to the United States Government.

Upon receipt of a CMS-855A, CMS-855B, or CMS-855S application, the Medicare contractor will determine – whether any of the owners listed in Section 5 or 6 of the application has an existing or delinquent Medicare overpayment.

Upon receipt of a CMS-855I application, the Medicare contractor will determine whether the physician or non-physician practitioner has an existing or delinquent Medicare overpayment. (For purposes of this requirement, the term "non-physician practitioner" includes physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives, clinical social workers, clinical psychologists, and registered dietitians or nutrition professionals.)

If an owner, physician, or non-physician practitioner has such an overpayment, the contractor shall deny the application, using 42 CFR 424.530(a)(6) as the basis.

Consider the following examples:

Example #1: Hospital X has a $200,000 overpayment. It terminates its Medicare enrollment. Three months later, it reopens as Hospital Y and submits a new CMS-855A application for enrollment as such. A denial is not warranted because §424.530 (a)(6) only applies to physicians, practitioners, and owners.

Example #2: Dr. John Smith's practice ("Smith Medicine") is set up as a sole proprietorship. He incurs a $50,000 overpayment. He terminates his Medicare enrollment. Six months later, he tries to enroll as a sole proprietorship; his practice is named "JS Medicine." A denial is warranted because §424.530 (a)(6) applies to physicians and the $50,000 overpayment was attached to him as the sole proprietor.

Example #3: Dr. John Smith's practice ("Smith Medicine") is set up as a sole proprietorship. He incurs a $50,000 overpayment. He terminates his Medicare enrollment. Six months later, he tries to enroll as an LLC of which he is only a 30 percent owner; the practice is named "JS Medicine, LLC." A denial is not warranted because the provision applies to "all" owners collectively and, again, the $50,000 overpayment was attached to him.

Example #4: Jane Smith is a nurse practitioner in a solo practice. Her practice ("Smith Medicine") is set up as a closely-held corporation, of which she is the 100 percent owner. Smith Medicine is assessed a $20,000 overpayment. She terminates her Medicare enrollment. Nine months later, she submits a CMS-855I application to enroll Smith Medicine as a new supplier. The business will be established as a sole proprietorship. A denial is not warranted because the $20,000 overpayment was attached to Smith Medicine, not to Jane Smith.

(continued on next page)

Enrollment *(continued)*

Excluded from denial under §424.535(a)(6) are individuals or entities (1) on a Medicare-approved plan of repayment or (2) whose overpayments are currently being offset or being appealed.

Note that CR 8039 applies only to initial enrollments and new owners in a CHOW. Note also that if the Medicare contractor determines that the overpayment existed at the time the application was filed, but the debt was paid in full by the time the contractor performed its review, the contractor will not deny the application because of that overpayment.

Additional information

The official instruction, CR 8039, issued to your Medicare contractor regarding this change, may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R479PI.pdf*.

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

MLN Matters® Number: MM8039 *Revised*
Related Change Request (CR) #: CR 8039
Related CR Release Date: August 1, 2013
Effective Date: October 1, 2013
Related CR Transmittal #: R479PI
Implementation Date: October 7, 2013

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Customer service representatives cannot provide claim status via the toll-free service line

Medicare guidelines, specifically, the Internet-only manual (IOM) Publication, 100-09 Chapter 6 Section 50.1 requires that providers call the interactive voice response system (IVR) to obtain claim status. Service associates responding to calls via our toll-free service line are not allowed to provide claim status. To do so would be in violation of Medicare service guidelines.

First Coast Service Options' (First Coast's) customer service representatives (CSRs) continue to receive a large volume of calls from providers asking for claim status. In the majority of cases the calls are coming from entities representing Medicare providers. Because many providers have chosen to outsource their claims monitoring activities, they may not be aware that the entities representing them are calling the toll-free CSR service line for status of claims instead of using the IVR.

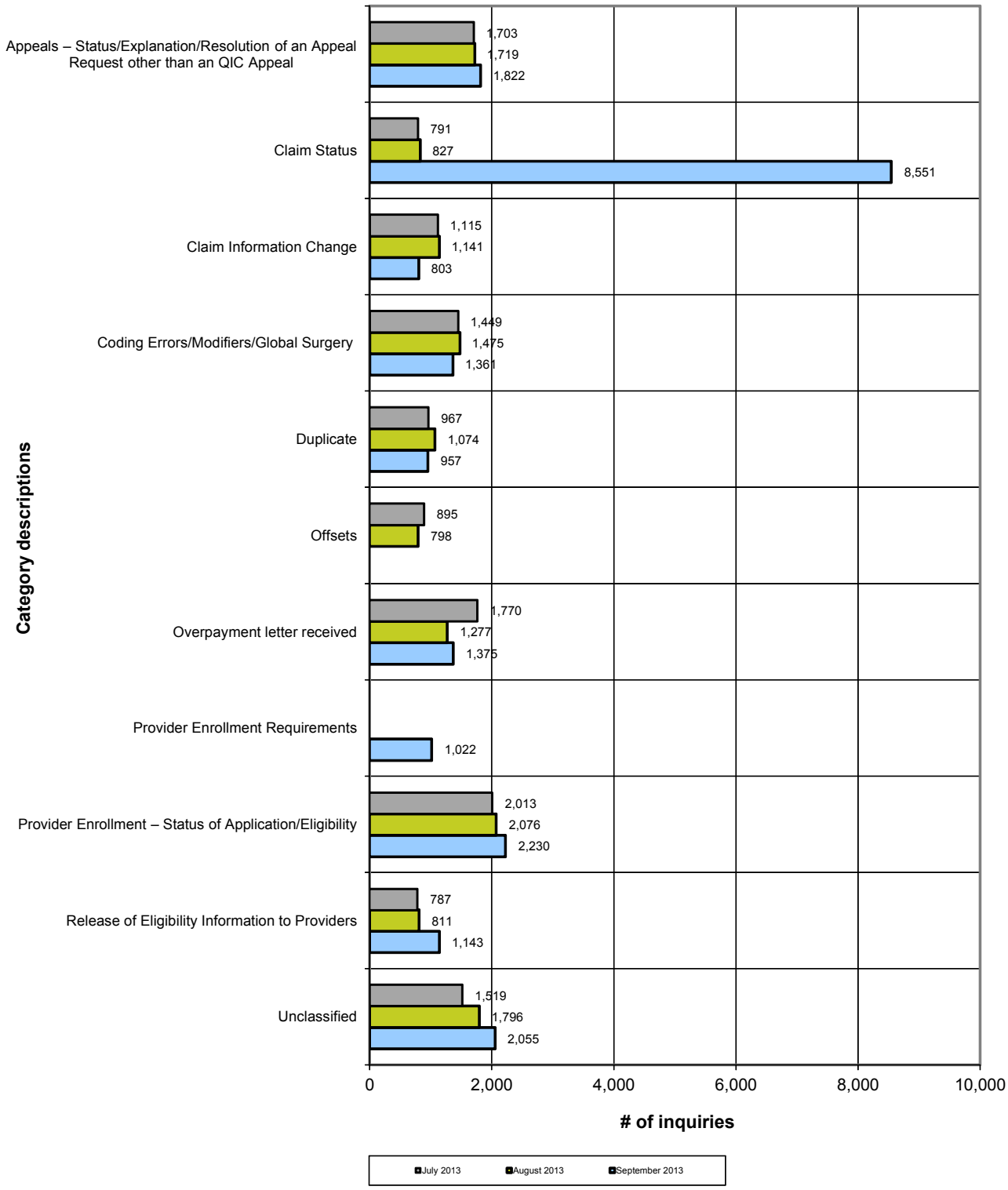
When claim status calls are made to the toll-free CSR service line, it slows our response time for other calls coming into our call center because service associates are attempting to explain to customers that status cannot be released via the general inquiry service line. It is the responsibility of Medicare providers to notify the entities representing them that claim status inquiries must be made via the IVR or our new Internet portal **the SPOT**. See *http://medicare.fcso.com/Landing/256747.asp*.

Top inquiries, denials, and return unprocessable claims

The following charts provide the most frequent inquiries, denials, and return unprocessable claims (RUC) submitted to First Coast Service Options Inc. (First Coast), by providers in Florida, Puerto Rico, and the U.S. Virgin Islands during July-September 2013.

For tips and resources to help providers 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*.

Part B top inquiries for July-September 2013



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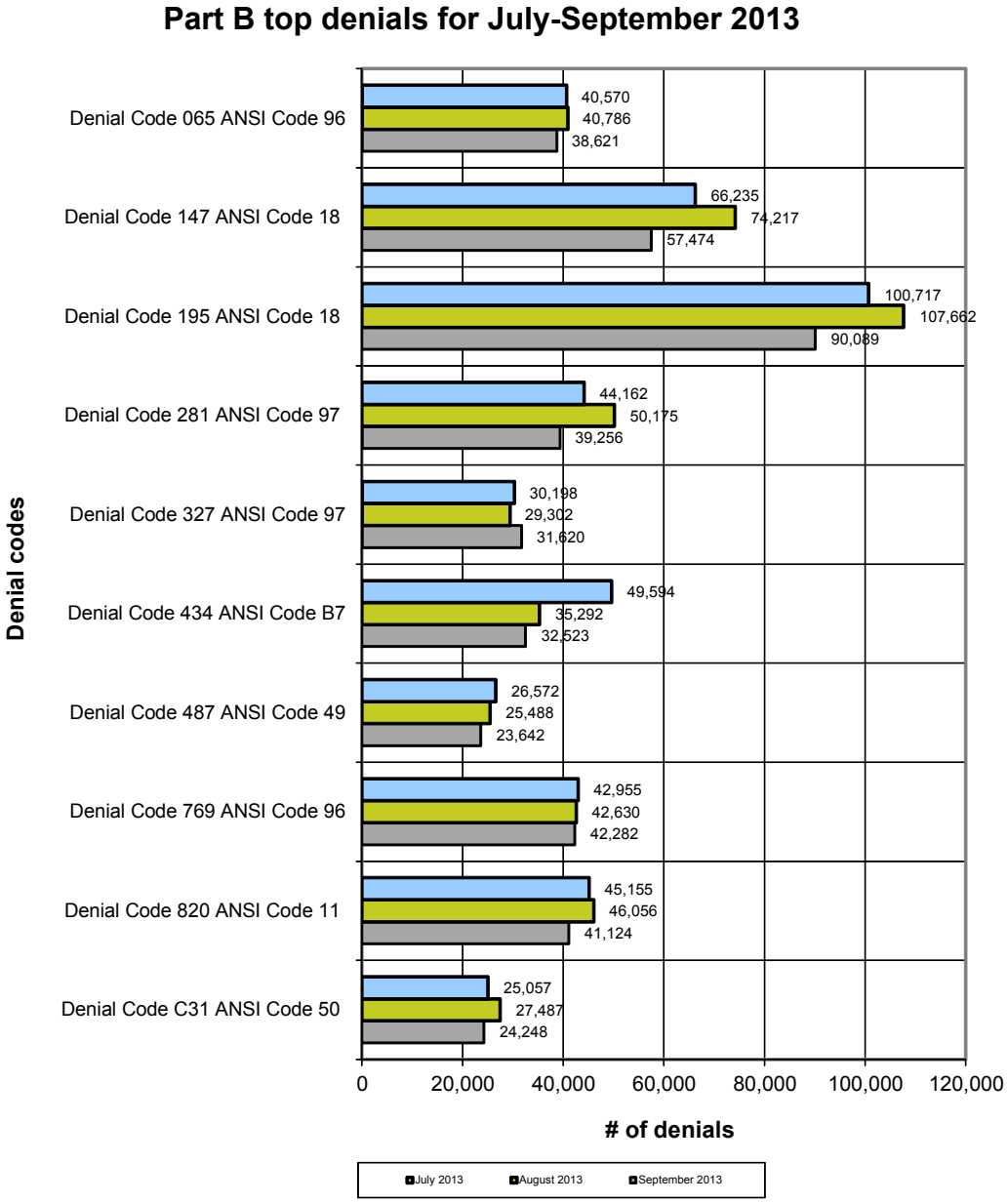
Top *(continued)*



What to do when your claim is denied

Before contacting customer service, check claim status though the IVR. The IVR will release necessary details around claim denials.

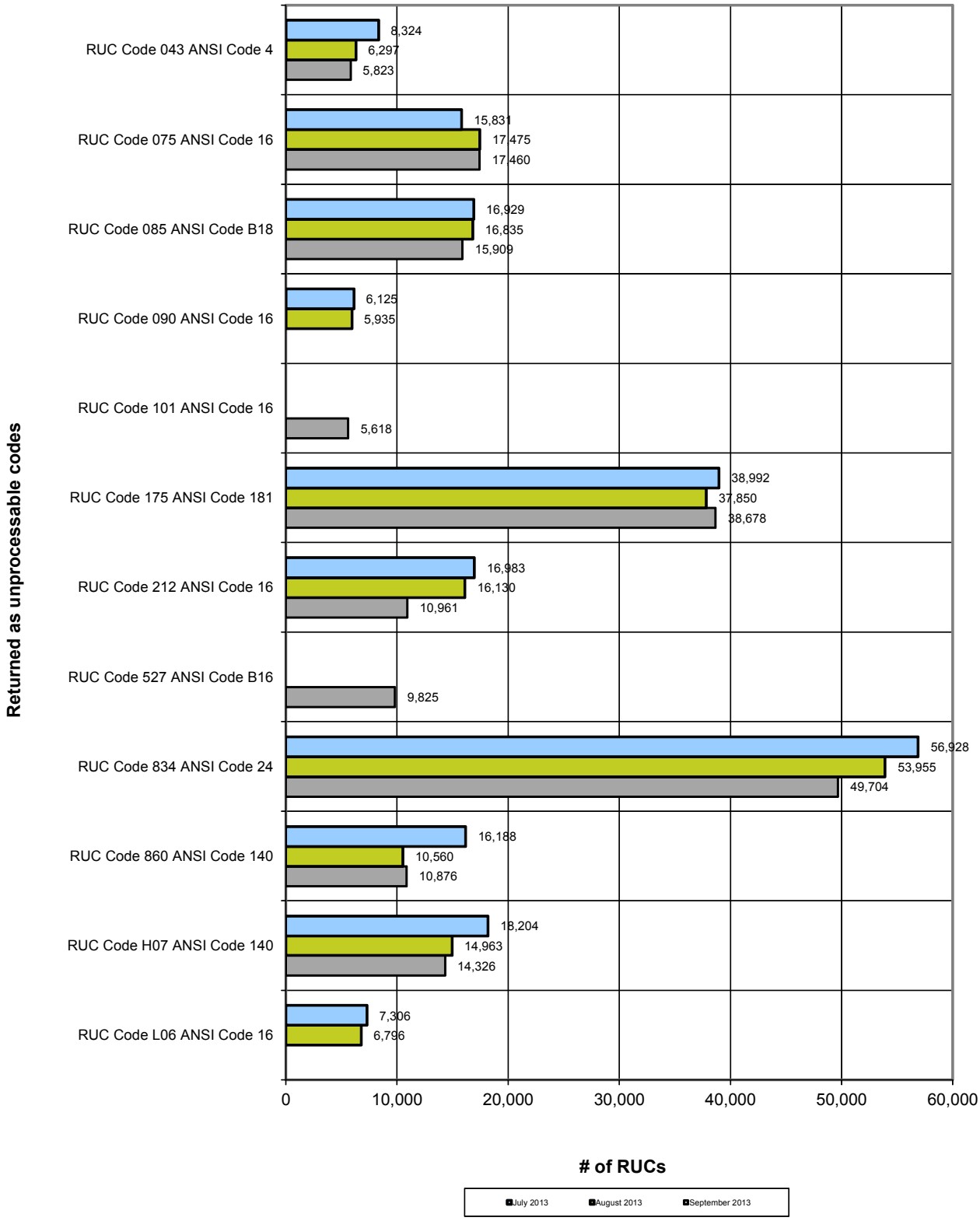
Ensure all information on a claim is correct before submitting to Medicare. Example: The date(s) of service (DOS) on the claim should correspond to the number of units/days being billed.

Refer to the *Claim completion FAQs*, *Billing issues FAQs*, and *Unprocessable FAQs* on the First Coast Medicare provider website for additional information on why claims may deny and how to correct this.

You may also refer to the *Top Part B claim denials* and *RUCs* tip sheets for tips and resources on correcting and avoiding certain claim denials.

Top *(continued)*

Part B top return as unprocessable claims for July-September 2013



This section of *Medicare B Connection* features summaries of new and revised local coverage determinations (LCDs) developed as a result of either local medical review or comprehensive data analysis initiatives. These initiatives are designed to ensure the appropriateness of medical care and to make sure that the Medicare administrative contractor (MAC) jurisdiction 9 (J9) Part A LCDs and review guidelines are consistent with accepted standards of medical practice.

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

Effective and notice dates

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

Electronic notification

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

More information

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

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

Contents

Advance beneficiary notice

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

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

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

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

Looking for LCDs?

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

Additional Information

Independent diagnostic testing facility (IDTF) – revision to the Part B LCD "Coding Guidelines" attachment

LCD ID number: L29195 (Florida)
LCD ID number: L29330 (Puerto Rico/U.S. Virgin Islands)

The "Coding Guidelines" attachment of the local coverage determination (LCD) for independent diagnostic testing facility (IDTF) was most recently revised July 9, 2013. Since that time, based on change request (CR) 8386, the "Coding Guidelines" attachment has been revised under the "Level of Physician Supervision" section of the 'Credentialing Matrix' to change the level of physician supervision to "1" for *Current Procedural Terminology*® (*CPT*®) codes *95782* and *95783*.

Effective date

This revision to the LCD "Coding Guidelines" attachment is effective for claims processed **on or after October 7, 2013**, for services rendered **on or after January 1, 2013**. 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 for jurisdiction 9 (J9), please *click here*.

Looking for LCDs?

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

Educational Events

Upcoming provider outreach and educational events
November 2013

E/M issues: Does your documentation justify 99215?

When: Wednesday, November 20
Time: 11:30 a.m.-12:30 p.m.

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

Two easy ways to register

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

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

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

Please Note:

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

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Provider Address: _____

City, State, ZIP Code: _____

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

Never miss a training opportunity

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

Take advantage of 24-hour access to free online training

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

Preventive Resources

2013-2014 influenza resources for health care professionals

Provider types affected

This *MLN Matters*® special edition article is intended for all health care professionals who order, refer, or provide flu vaccines and vaccine administration to Medicare beneficiaries.

What you need to know

- Keep this special edition *MLN Matters*® article and refer to it throughout the 2013 - 2014 flu season.
- Take advantage of each office visit as an opportunity to encourage your patients to protect themselves from the flu and serious complications by getting a flu shot.
- Continue to provide the flu shot as long as you have vaccine available, even after the New Year.
- Don't forget to immunize yourself and your staff.

Introduction

The Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare Part B reimburses health care providers for flu vaccines and their administration. (Medicare provides coverage of the flu vaccine without any out-of-pocket costs to the Medicare patient. No deductible or copayment/ coinsurance applies.)

You can help your Medicare patients reduce their risk for contracting seasonal flu and serious complications by using every office visit as an opportunity to recommend they take advantage of Medicare's coverage of the annual flu shot.

As a reminder, please help prevent the spread of flu by immunizing yourself and your staff!

Know what to do about the flu!

Educational products for health care professionals

The *Medicare Learning Network*® (MLN®) has developed a variety of educational resources to help you understand Medicare guidelines for seasonal flu vaccines and their administration.

***1. MLN*® influenza-related products for health care professionals**

- *MLN Matters*® article MM8433: Influenza Vaccine Payment Allowances – Annual Update for 2013-2014 Season – *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8433.pdf*
- Quick reference information: Medicare Part B Immunization Billing chart – *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/qr_immun_bill.pdf*
- Quick reference information: Preventive services chart – *http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/Downloads/MPS_QuickReferenceChart_1.pdf*
- *Preventive Immunizations* booklet – *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Preventive-Immunizations-ICN907787.pdf*
- *MLN*® Preventive services educational products Web page – *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/PreventiveServices.html*
- Preventive services educational products PDF – *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/education_products_prevserv.pdf*

2. Other CMS resources

- Seasonal Influenza Vaccines 2013 Pricing – *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/2013ASPFiles.html*
- Immunizations Web page is located at *http://www.cms.gov/Medicare/Prevention/Immunizations/index.html*

(continued on next page)

Influenza *(continued)*

- Prevention general information is located at *http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/index.html*
- CMS frequently asked questions - *http://questions.cms.gov/faq.php*
- *Medicare Benefit Policy Manual* - Chapter 15, Section 50.4.4.2 – Immunizations - *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf*
- *Medicare Claims Processing Manual* – Chapter 18, Preventive and Screening Services *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf*

3. Other resources

The following non-CMS resources are just a few of the many available where you may find useful information and tools for the 2013-2014 flu season:

- Advisory Committee on Immunization Practices – *http://www.cdc.gov/vaccines/acip/index.html*
- Flu clinic locator – *http://www.fluclinicslocator.org*
- Other sites with helpful information include the following:
  - Centers for Disease Control and Prevention – *http://www.cdc.gov/flu*
  - Flu.gov – *http://www.flu.gov*
  - Food and Drug Administration – *http://www.fda.go*
  - Immunization Action Coalition – *http://www.immunize.org*
  - Indian Health Services – *http://www.ihs.gov/*
  - National Alliance for Hispanic Health – *http://www.hispanichealth.org*
  - National Foundation For Infectious Diseases – *http://www.nfid.org/influenza*
  - National Library of Medicine and NIH Medline Plus – *http://www.nlm.nih.gov/medlineplus/immunization.html*
  - National Network for Immunization Information – *http:/www.immunizationinfo.org*
  - National Vaccine Program – *http://www.hhs.gov/nvpo*
  - Office of Disease Prevention and Health Promotion – *http://odphp.osophs.dhhs.gov*
  - Partnership for Prevention – *http://www.prevent.org*
  - World Health Organization – *http://www.who.int/en*

Beneficiary information

For information to share with your Medicare patients, please visit *http://www.medicare.gov*.

Medicare provides coverage for one seasonal influenza virus vaccine per influenza season for all Medicare beneficiaries. Medicare generally provides coverage of pneumococcal vaccination and its administration once in a lifetime for all Medicare beneficiaries; however, Medicare may cover additional pneumococcal vaccinations based on risk or uncertainty of beneficiary pneumococcal vaccination status. Medicare provides coverage for these vaccines and their administration with no co-pay or deductible.

Don't forget to immunize yourself and your staff. Protect yourself from the flu.

Remember – Influenza vaccine plus its administration is a covered Part B benefit. Influenza vaccine is **not** a Part D covered drug. For more information on coverage and billing of the flu vaccine and its administration, please visit the *CMS Medicare Learning Network® Preventive Services Educational Products* and *CMS Immunizations* Web pages.

While some health care professionals may offer the flu vaccine, others can help their patients locate a vaccine provider within their local community. *HealthMap Vaccine Finder* is a free, online service where users can search for locations offering flu vaccines.

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Related CR Release Date: NA
Effective Date: NA
Related CR Transmittal #: NA
Implementation Date: NA

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.

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 are links to the latest e-News:

- "MLN Connects™ Provider eNews': September 26, 2013 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-09-26-final.pdf*
- "MLN Connects™ Provider eNews': October 17, 2013 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-10-17-enews.pdf*
- "MLN Connects™ Provider eNews': October 24, 2013 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-10-24-enews.pdf*

Source: CMS PERL 201309-05, 201310-02, 201310-04

Additional Resources

CMS issues new online ICD-10 implementation guide

The Centers for Medicare & Medicaid Services (CMS) has developed *an online ICD-10 implementation guide* to help health care providers prepare for the transition from the ninth edition of the International Classification of Diseases (ICD) to ICD-10.

This Web-based tool includes a basic overview of ICD-10 as well as step-by-step guidance on how to transition to ICD-10 for providers and medical practices of all sizes. The online guide also includes links to CMS ICD-10 resources and other tools to help with the ICD-10 transition.

ICD-10 allows for greater specificity and detail in describing a patient's diagnosis and in classifying inpatient procedures, so reimbursement can better reflect the intensity of the patient's condition and diagnostic needs. The International Classification of Diseases (ICD) code set defines diseases, signs, symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or disease.

Keep up to date on ICD-10 through the *CMS ICD-10 website*.

Information contained within this article was previously released in an edition of the weekly "CMS MLN Connects ™ Provider e-News."

Medicare Learning Network®

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

Mail directory

Claims submissions

Routine paper claims
Medicare Part B
P. O. Box 2525
Jacksonville, FL 32231-0019

Participating providers
Medicare Part B participating providers
P. O. Box 44117
Jacksonville, FL 32231-4117

Chiropractic claims
Medicare Part B chiropractic unit
P. O. Box 44067
Jacksonville, FL 32231-4067

Ambulance claims
Medicare Part B ambulance dept.
P. O. Box 44099
Jacksonville, FL 32231-4099

Medicare secondary payer
Medicare Part B secondary payer dept.
P. O. Box 44078
Jacksonville, FL 32231-4078

ESRD claims
Medicare Part B ESRD claims
P. O. Box 45236
Jacksonville, FL 32232-5236

Communication

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

Fair hearing requests
Medicare hearings
P.O. Box 45156
Jacksonville FL 32232-5156

Freedom of Information Act
Freedom of Information Act requests
P.O. Box 2078
Jacksonville, Florida 32231

Administrative law judge hearing
Q2 Administrators, LLC
Part B QIC South Operations
P.O. Box 183092
Columbus, Ohio 43218-3092
Attn: Administration manager

Status/general inquiries
Medicare Part B correspondence
P. O. Box 2360
Jacksonville, FL 32231-0018

Overpayments
Medicare Part B financial services
P. O. Box 44141
Jacksonville, FL 32231-4141

Durable medical equipment (DME)

DME, orthotic or prosthetic claims
CGS Administrators, LLC
P.O. Box 20010
Nashville, Tennessee 37202

Electronic media claims (EMC)

Claims, agreements and inquiries
Medicare EDI
P. O. Box 44071
Jacksonville, FL 32231-4071

Additional development

Pending request:
Medicare Part B Claims
P. O. Box 2537
Jacksonville, FL 32231-0020

Denied request for lack of response: Submit as a new claim, to:
Medicare Part B Claims
P. O. Box 2525
Jacksonville, FL 32231-0019

Miscellaneous

Provider participation and group membership issues; written requests for UPINs, profiles & fee schedules:
Medicare Enrollment
P. O. Box 44021
Jacksonville, FL 32231-4021

Provider change of address:
Medicare Enrollment
P. O. Box 44021
Jacksonville, FL 32231-4021
and
Provider Enrollment Department
Blue Cross Blue Shield of Florida
P. O. Box 41109
Jacksonville, FL 32203-1109

Provider education

Educational purposes and review of customary/prevailing charges or fee schedule:
Medicare Part B
Provider Outreach and Education
P. O. Box 2078
Jacksonville, FL 32231-0048

Education event registration:
Medicare Part B
Medicare Education and Outreach
P. O. Box 45157
Jacksonville, FL 32232-5157

Limiting charge issues:
Processing errors:
Medicare Part B
P. O. Box 2360
Jacksonville, FL 32231-0048

Refund verification:
Medicare Part B
Compliance Monitoring
P. O. Box 2078
Jacksonville, FL 32231-0048

Medicare claims for Railroad retirees:
Palmetto GBA
Railroad Medicare Part B
P. O. Box 10066
Augusta, GA 30999-0001

Fraud and abuse
First Coast Service Options Inc.
Complaint Processing Unit
P. O. Box 45087
Jacksonville, FL 32232-5087

Phone numbers

Providers

Toll-Free
Customer Service:
1-866-454-9007

Interactive Voice Response (IVR):
1-877-847-4992

Email address: *AskFloridaB@fcso.com*

FAX: 1-904-361-0696

Beneficiary

Toll-Free:
1-800-MEDICARE
Hearing Impaired:
1-800-754-7820

Note: The toll-free customer service lines are reserved for Medicare beneficiaries only. Use of this line by providers is not permitted and may be considered program abuse.

Education event registration (not toll-free):

1-904-791-8103

Electronic data interchange (EDI)

1-888-670-0940

Option 1 -Transaction support

Option 2 - PC-ACE support

Option 4 - Enrollment support

Option 5 - 5010 testing

Option 6 - Automated response line

DME, orthotic or prosthetic claims

CGS Administrators, LLC
1-866-270-4909

Medicare Part A

Toll-Free:
1-888-664-4112

Medicare websites

Provider

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

Centers for Medicare & Medicaid Services
www.cms.gov

Beneficiaries

Centers for Medicare & Medicaid Services
www.medicare.gov

Mail directory

Claims, additional development, general correspondence

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

Flu rosters

First Coast Service Options Inc.
P. O. Box 45031
Jacksonville, FL 32232-5031

Electronic data interchange (EDI)

First Coast Service Options Inc.
Medicare EDI
P. O. Box 44071
Jacksonville, FL 32231-4071

Part B debt recovery, MSP inquiries and overpayments, and cash management

First Coast Service Options Inc.
P.O. Box 45013
Jacksonville, FL 32232-5013

Provider enrollment

Where to mail provider/supplier applications
Provider Enrollment
P.O. Box 44021
Jacksonville, FL 32231-4021

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

and

Provider Registration Department
Blue Cross Blue Shield of Florida
P. O. Box 41109
Jacksonville, FL 32231-1109

Durable medical equipment (DME)

DME, orthotic or prosthetic claims
CGS Administrators, LLC
P.O. Box 20010
Nashville, Tennessee 37202

Redeterminations

First Coast Service Options Inc.
P. O. Box 45024
Jacksonville, FL 32232-5091

Redetermination overpayment

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

Freedom of Information Act requests (FOIA)

First Coast Service Options Inc.
P. O. Box 45073
Jacksonville, FL 32232-5073

Congressional inquiries

First Coast Service Options Inc.
Attn: Carla-Lolita Murphy
P. O. Box 2078
Jacksonville, FL 32231-0048

Provider education

Educational purposes and review of customary/prevailing charges or fee schedule:
Medicare Part B
Provider Outreach and Education
P. O. Box 2078
Jacksonville, FL 32231-0048

Education event registration:
Medicare Part B
Medicare Education and Outreach
P. O. Box 45157
Jacksonville, FL 32232-5157

Medicare claims for railroad retirees

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

Fraud and abuse

First Coast Service Options Inc.
Complaint Processing Unit
P. O. Box 45087
Jacksonville, FL 32232-5087

Local coverage determinations

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

Post pay medical review

First Coast Service Options Inc.
P. O. Box 44288
Jacksonville, FL 32231-4288

Overnight mail and/or other special courier services

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

Medicare websites

Provider

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

Centers for Medicare & Medicaid Services

www.cms.gov

Beneficiaries

Centers for Medicare & Medicaid Services
www.medicare.gov

Phone numbers

Provider customer service

1-866-454-9007

Interactive voice response (IVR)

1-877-847-4992

Email address:
AskFloridaB@fcso.com

FAX: 1-904-361-0696

Beneficiary customer service

1-800-MEDICARE
Hearing Impaired:
1-800-754-7820

Note: The toll-free customer service lines are reserved for Medicare beneficiaries only. Use of this line by providers is not permitted and may be considered program abuse.

Education event registration

1-904-791-8103

Electronic data interchange (EDI)

1-888-670-0940

Option 1 -Transaction support

Option 2 - PC-ACE support

Option 4 - Enrollment support

Option 5 - 5010 testing

Option 6 - Automated response line

DME, orthotic or prosthetic claims

CGS Administrators, LLC
1-866-270-4909

Medicare Part A

Toll-Free:
1-888-664-4112

Puerto Rico Contact Information

Addresses

Claims
Additional documentation
General mailing
Congressional mailing
First Coast Service Options Inc.
P.O. Box 45036
Jacksonville, FL 32232-5036

Redeterminations
First Coast Service Options Inc.
P.O. Box 45056
Jacksonville, FL 32232-5056

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

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

Freedom of Information Act (FOIA) related requests
First Coast Service Options Inc.
P.O. Box 45092
Jacksonville, FL 32232-5092

Medicare fraud and abuse
First Coast Service Options Inc.
P.O. Box 45087
Jacksonville, FL 32232-5087

Provider enrollment
Mailing address changes
First Coast Service Options Inc.
Provider Enrollment
Post Office Box 44021
Jacksonville, FL 32231-4021

Electronic Data Interchange (EDI)
First Coast Service Options Inc.
Medicare EDI
P.O. Box 44071
Jacksonville, FL 32231-4071

Flu vaccinated list
First Coast Service Options Inc.
P.O. Box 45031
Jacksonville, FL 32232-5031

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

Debt collection
Overpayments, questions about Medicare as a secondary payer, cash management
First Coast Service Options Inc.
P.O. Box 45040
Jacksonville, FL 32232-5040

Overnight mail and other special handling postal services
First Coast Service Options Inc.
532 Riverside Avenue
Jacksonville, FL 32202-4914

Other Medicare contractors and intermediaries

Durable Medical Equipment Regional Carrier (DMERC)
CGS Administrators, LLC
P. O. Box 20010
Nashville, Tennessee 37202

Regional Home Health & Hospice Intermediary
Palmetto Goverment Benefit Administrators
Medicare Part A
P.O. Box 100238
Columbia, SC 29202-3238

Railroad Medicare
Palmetto Government Benefit Administrators
P. O. Box 10066
Augusta, GA 30999-0001

Phone numbers

Providers
Customer service – free of charge
Monday to Friday
8:00 a.m. to 4:00 p.m.
1-877-715-1921

For the hearing and speech impaired (TDD)
1-888-216-8261

Interactive voice response (IVR)
1-877-847-4992

Beneficiary
Customer service – free of charge
1-800-MEDICARE
1-800-633-4227

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

Electronic Data Interchange
1-888-875-9779

Educational Events Enrollment
1-904-791-8103

Fax number
1-904-361-0407

Website for Medicare

Providers
First Coast – MAC J9
medicare.fcso.com
medicareespanol.fcso.com

Centers for Medicare & Medicaid Services
www.cms.gov

Beneficiary
Centers for Medicare & Medicaid Services
www.medicare.gov

Order form for Medicare Part B materials

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

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

Item	Acct Number	Cost per item	Quantity	Total cost
Part B subscription – The Medicare Part B jurisdiction 9 publications, in both Spanish and English, are available free of charge online at *http://medicare.fcso.com/Publications_B/index.asp* (English) or *http://medicareespanol.fcso.com/Publicaciones/* (Español). Nonprovider entities or providers who need additional copies may purchase an annual subscription. This subscription includes all issues published from October 2013 through September 2014.	40300260	$33		
2013 Fee Schedule – The Medicare Part B Physician and Nonphysician Practitioner Fee Schedules, effective for services rendered January 1 through December 31, 2013, are available free of charge online at *http://medicare.fcso.com/Data_files/* (English) or *http://medicareespanol.fcso.com/Fichero_de_datos/* (Español). Additional copies are available for purchase. The fee schedules contain payment rates for all localities. These items do not include the payment rates for injectable drugs, clinical lab services, mammography screening, or DMEPOS items. **Note:** Revisions to fees may occur; these revisions will be published in future editions of the Medicare Part B publication.	40300270	$12		
Language preference: **English** [ ] **Español** [ ]				
Please write legibly			Subtotal	$
			Tax (***add % for your area***)	$
			Total	$

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Medicare Publications
P.O. Box 406443
Atlanta, GA 30384-6443

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Provider/Office Name: _____

Phone: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

(Checks made to "purchase orders" not accepted; all orders must be prepaid)