Medicare A Connection

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FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction N Providers

March 2020

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COVID-19: Test Pricing; Diagnostic Lab Tests, Pricing & Codes; and EHB Coverage

On March 12, CMS posted a *fact sheet* with information relating to the pricing of both the Centers for Disease Control and Prevention (CDC) and non-CDC tests.

Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment MLN Matters® Article

A new MLN Matters Article MM 11681 on *Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment* is available. Learn about Advanced Diagnostic Laboratory Tests, pricing, and new codes. On page 3, we reference new COVID-19 codes.

Essential Health Benefits (EHB) Coverage

On March 12, CMS issued *Frequently Asked Questions (FAQs)* about EHB to ensure individuals, issuers, and states have clear information on coverage benefits for COVID-19. This action is part of the broader, ongoing effort by the White House Coronavirus Task Force to ensure that all Americans – particularly those at high-risk of complications from the COVID-19 virus – have access to the health benefits that can help keep them healthy while helping to contain the spread of this disease.

These FAQs, and earlier CMS actions in response to the COVID-19 virus, are part of the ongoing White House Task Force efforts. To keep up with the important work the Task Force is doing in response to COVID-19; visit the CDC's *Coronavirus Disease 2019* webpage.

For information specific to CMS, please visit the *Current Emergencies* website.

Contents

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

Articles included in the *Medicare A 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.

New Medicare Beneficiary Identifier (MBI) Get it, Use it

***Note**: We revised the article on March 19, 2020, to clarify that you need the beneficiary's first name, last name, date of birth, and SSN to use MBI llok-up tool. All other information was the same. This information was previously published in the January 2020 Medicare A Connection, pages 5-7.*

Provider type affected

This Special Edition MLN Matters® Article is for physicians, providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs), including Durable Medical Equipment MACs (DME MACs) and Home Health and Hospice MACs, for services provided to Medicare beneficiaries.

Provider action needed

Use MBIs for all Medicare transactions. The Centers for Medicare & Medicaid Services (CMS) replaced the Social Security Number (SSN)-based Health Insurance Claim Numbers (HICNs) with the MBI and mailed new Medicare cards to all Medicare beneficiaries. The cards with MBIs offer better identity protection.

With a few exceptions, Medicare will reject claims you submit with Health Insurance Claim Numbers (HICNs). Medicare will reject all eligibility transactions you submit with HICNs.

There are 3 ways you and your office staff can get MBIs:

1. Ask your Medicare patients

Ask your Medicare patients for their new Medicare cards when they come for care. If they don't bring it with them when they come for care, give them the Get Your New Medicare Card flyer in *English* or *Spanish*.

2. Use the MAC's secure MBI look-up tool

You can look up MBIs for your Medicare patients when they don't or can't give them. *Sign up* for the Portal to use the tool. Even if your patients are in a Medicare Advantage Plan, you can look up their MBIs to bill for things like indirect medical education.

You must have your patient's first name, last name, date of birth and SSN to search. The SSN may differ from the HICN, which uses the SSN of the primary wage earner. If your Medicare patient doesn't want to give the SSN, tell your patient to log into *mymedicare.gov* to get the MBI.

If the look-up tool returns a last name matching error and the beneficiary's last name includes a suffix, such as Jr. Sr. or III, try searching without and with the suffix as part of the last name. You won't get an MBI from the look-up tool if the beneficiary has a date of death greater than 13 months from the date of your search. Instead, we return the date of death. This aligns with timely filing for a claim.

3. Check the remittance advice

If you previously saw a patient and got a claim payment decision based on a claim submission with a HICN before January 1, 2020, look at that remittance advice.

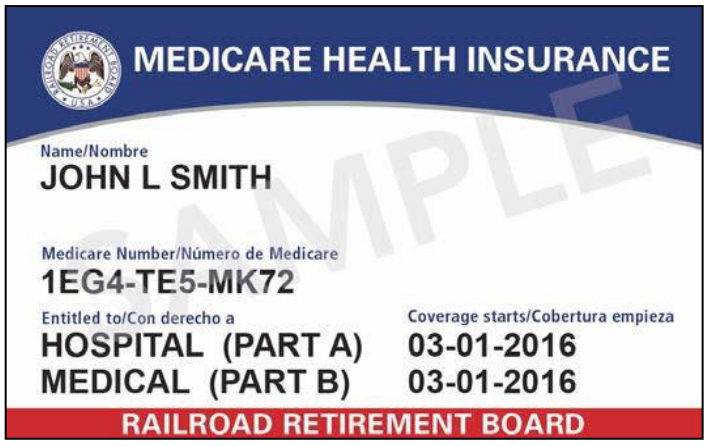
We returned the MBI on every remittance advice when a provider submitted a claim with a valid and active HICN from October 1, 2018 through December 31, 2019.

Background

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) required CMS to remove SSNs from all Medicare cards. CMS replaced the SSN-based HICN with a new, randomly generated MBI. **The new MBI hyphens on the card are for illustration purposes: don't include the hyphens or spaces on transactions.** The MBI uses numbers 0-9 and all uppercase letters except for S, L, O, I, B, and Z. We exclude these letters to avoid confusion when differentiating some letters and numbers **(for example, between "0" and "O").** Review the *MBI specifications format*.

The Railroad Retirement Board (RRB) also mailed Medicare cards with MBIs. There is a RRB logo in the upper left corner and "Railroad Retirement Board" at the bottom, but you can't tell from looking at the MBI if your patient is eligible for Medicare because they're a railroad retiree. You can identify them by the RRB logo on their card, and we return a "Railroad Retirement Medicare Beneficiary" message on the Fee-For-Service (FFS) MBI eligibility transaction response.

RRB issued Medicare card



Use the MBI the same way you used the HICN.

See **MBI**, page 4

MBI from page 3

This also applies to reporting informational only and no-pay claims. **Don't use hyphens or spaces with the MBI to avoid rejection of your claim.** Use the MBI on Medicare transactions including Billing, Eligibility Status, and Claim Status. The effective date of the MBI is the date each beneficiary was or is eligible for Medicare. If you don't use the MBI, we will reject claims, with few exceptions. You will get:

- Electronic claims- Reject codes: Claims Status Category Code of A7 (acknowledgment rejected for invalid information), a Claims Status Code of 164 (entity's contract/member number), and an Entity Code of IL (subscriber)
- Paper claims- paper notice; Claim Adjustment Reason Code (CARC) 16 "Claim/service lacks information or has submission/billing error(s)" and Remittance Advice Remark Code (RARC) N382 "Missing/incomplete/ invalid patient identifier"

The beneficiary or their authorized representative can request an MBI change. CMS can also change an MBI. An example is if the MBI is compromised. It's possible for your patient to seek care before getting a new card with the new MBI:

If you get a HETS eligibility transaction error code (AAA 72) of "invalid member ID," your patient's MBI may have changed. There are different scenarios for using the old or new MBIs:

FFS claims submissions with:

- Dates of service before the MBI change date – use old or new MBIs.
- Span-date claims with a "From Date" before the MBI change date – use old or new MBIs.
- Dates of service that are entirely on or after the effective date of the MBI change – use new MBIs

FFS eligibility transactions when the:

- Inquiry uses new MBI – we'll return all eligibility data.
- Inquiry uses the old MBI and request date or date range overlap the active period for the old MBI – we'll return all eligibility data. We'll also return the old MBI termination date.
- Inquiry uses the old MBI and request date or date range are entirely on or after the effective date of the new MBI – we'll return an error code (AAA 72) of "invalid member ID."

When the MBI changes, we ask the beneficiary to share the new MBI with you. You can also get the MBI from your MAC's secure MBI lookup tool.

Exceptions

You MUST submit claims using MBIs, no matter what date you performed the service, with a few exceptions:

- Appeals – You can use either HICNs or MBIs for claim appeals and related forms.
- Claim status query – You can use the HICN or MBI to check the status of a claim (276 transactions) if the earliest date of service on the claim is before January 1, 2020. If you are checking the status of a claim with a date of service on or after January 1, 2020, you must use the MBI.
- Span-date claims – You can use HICNs or MBIs for 11X-Inpatient Hospital, 32X- Home Health (home health final claims and Request for Anticipated Payments [RAPs]) and 41X-Religious Non-Medical Health Care Institution claims if the "From Date" is before the end of the transition period (December 31, 2019). If a patient starts getting services in an inpatient hospital, home health, or religious non-medical health care institution before December 31, 2019, you may submit a claim using either the HICN or the MBI, even if you submit it after December 31, 2019.

Medicare crossover claims

Medicare's Coordination of Benefits Agreement (COBA) trading partners (supplemental insurers, Medigap plans, Medicaid, etc.) must submit the MBI to get Medicare crossover claims. *Exceptions* on use of HICN on outbound Medicare crossover claims will apply.

Remember:

The MBI doesn't change Medicare benefits. **Protect the MBI as Personally Identifiable Information (PII); it is confidential like the HICN**.

Medicare Advantage and Prescription Drug plans continue to assign and use their own identifiers on their health insurance cards. For patients in these plans, continue to ask for and use the plans' health insurance cards.

Additional information

If you have questions, your MACs may have more information. Find their website at *https://go.cms.gov/MAC-website-list*. To sign up for your MAC's secure portal MBI look-up tool, visit *https://www.cms.gov/Medicare/New-Medicare-Card/Providers/MACs-Provider-Portals-by-State.pdf*. The MBI format specifications, which provide more details on the construct of the MBI, are available at *https://www.cms.gov/Medicare/New-Medicare-Card/Understanding-the-MBI.pdf*.

See **MBI**, page 5

MBI from page 4

Document history

Date of change	Description
March 19, 2020	We revised the article to clarify that you need the beneficiary's first name, last name, date of birth, and SSN to use the MBI look-up tool. All other information remains the same
February 12, 2020	We revised the article to add a sentence to the MBI look-up tool option for getting an MBI to show what happens if the beneficiary record has a date of death. All other information remains the same..
January 2, 2020	We reissued the article to update certain language to show the use of the MBI is fully implemented.
August 19, 2019	We reissued this article to show that all new Medicare cards have been mailed, to encourage providers to use MBIs now to protect patients' identities, to emphasize that providers must use MBIs beginning January 1, 2020, and to explain the rejection codes providers will get if they submit a HICN after January 1, 2020.
March 6, 2019	We revised this article to add language that the MBI look-up tool can be used to obtain an MBI even for patients in a Medicare Advantage Plan. All other information remains the same.
December 10, 2018	The article was revised to update the language regarding when MACs can return an MBI through the MBI look up tool (page 1). All other information remains the same.
July 11, 2018	This article was revised to provide additional information regarding the format of the MBI not using letters S, L, O, I, B, and Z (page 2).
June 25, 2018	This article was revised to provide additional information regarding the ways your staff can get MBIs (*Provider action needed* section).
June 21, 2018	The article was revised to emphasize the need to submit the MBI without hyphens or spaces to avoid rejection of your claim. All other information remains the same.
May 25, 2018	Initial article released.

MLN Matters® Number: SE18006 *Revised*
Article Release Date: March 19, 2020
Related CR Transmittal Number: N/A
Related Change Request (CR) Number: N/A
Effective Date: N/A
Implementation N/A

FQHC: Mass adjustment of claims

As a result of the Further Consolidated Appropriations Act of 2020 (FCAA), Medicare administrative contractors (MACs) will be mass adjusting certain Federally Qualified Health Center (FQHC) claims with dates of service on or after January 1 through March 1, 2020.

MSI reminder announcement: There is still time to evaluate our services!

There is still time to share your experiences about the services we provide. Please complete the MAC Satisfaction Indicator (MSI) survey. These survey results will help us gain valuable insights and determine process improvements.

https://www.surveygizmo.com/s3/5439699/?MAC_BRNC=9&MAC=JN-First_Coast

Processing Issue

SNF claims incorrectly canceled

Issue

From January 26 through February 16, 2020, a software issue caused skilled nursing facility (SNF) claims to be incorrectly canceled with a message that there was no three day-qualifying hospital stay.

Resolution

This issue has been corrected.

Status/date resolved

Open. The system was corrected March 5, 2020.

Provider action

If your claims were incorrectly canceled, rebill them in sequential order to receive payment.

- Claims need to process in date of service order for each stay for the variable per diem (VPD) to calculate correctly.
- Submit claims in sequence and wait at least two weeks before billing subsequent claims.
- Some of the affected claims with older dates of service will require a timely filing exception; enter "Resubmission due to non-qualifying stay" in the remarks field.
- This issue was not caused by the recent implementation of the SNF patient driven payment model.

Current processing issues

Here is a link to a table of *current processing issues* for both Part A and Part B.

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 (MAC) jurisdiction N (JN) Part A LCDs and review guidelines are consistent with accepted standards of medical practice.

Refer to our *LCDs/Medical Coverage webpage* 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 enter your email address and select the subscription option that best meets your needs.

More information

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

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

Looking for LCDs?

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

Advance beneficiary notice

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

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

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

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

Find fees faster: Try First Coast's fee schedule lookup

Find the fee schedule information you need fast - with ***First Coast's fee schedule lookup***. This exclusive online resource features an intuitive interface that allows you to search for fee information by procedure code. Plus, you can find any associated local coverage determinations (LCDs) with just the click of a button.

Revised LCDs / Articles

Vascular endothelial growth factor inhibitors for the treatment of ophthalmological diseases -- revision to the Part A and Part B billing and coding article

Article ID number: A56716 (Florida, Puerto Rico/U.S. Virgin Islands)

Based on a reconsideration request, ICD-10-CM diagnosis codes E11.3551, E11.3552, E11.3553, E11.3591, E11.3592, and E11.3593 were added to the "ICD-10 Codes that Support Medical Necessity/Group 4 Codes:" section of the billing and coding article for the Food and Drug Administration (FDA) indication of diabetic retinopathy for Healthcare Common Procedure Coding System (HCPCS) code J0178.

Effective date

This billing and coding article revision is effective for claims processed **on or after February 19, 2020**, for services rendered **on or after May 13, 2019**.

LCDs are available through the CMS Medicare coverage database at:

https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx.

A billing and coding article for an LCD may be found by selecting "Related Local Coverage Documents" in the "Section Navigation" drop-down menu at the top of the LCD page.

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

Major joint replacement (hip and knee) -- revision to the Part A and Part B billing and coding article

Article ID number: A57765 (Florida, Puerto Rico/U.S. Virgin Islands)

The billing and coding article for major joint replacement (hip and knee) was revised to add ICD-10-CM diagnosis codes T84.195A, T84.195D, and T84.195S to the "ICD-10 Codes that Support Medical Necessity/Group 1 Codes:" section.

Effective date

This billing and coding article revision is effective for claims processed **on or after February 18, 2020**, for services rendered **on or after October 1, 2015**.

LCDs are available through the CMS Medicare coverage database at:

https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx.

A billing and coding article for an LCD may be found by selecting "Related Local Coverage Documents" in the "Section Navigation" drop-down menu at the top of the LCD page.

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

BRCA1 and BRCA2 genetic testing -- revision to the Part A and Part B billing and coding article

Article ID number: A57449 (Florida, Puerto Rico/U.S. Virgin Islands)

Based on further review of the BRCA1 and BRCA2 genetic testing billing and coding article, the "CPT®/HCPCS Codes/Group 1 Codes:" and "ICD-10 Codes that Support Medical Necessity/Group 1 Paragraph:" sections of the billing and coding article were revised to remove Proprietary Laboratory Analyses (PLA) code 0134U.

Effective date

This billing and coding article revision is effective for claims processed **on or after February 17, 2020**, for services rendered **on or after February 8, 2020**.

LCDs are available through the CMS Medicare coverage database at

https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx.

A billing and coding article for an LCD may be found by selecting "Related Local Coverage Documents" in the "Section Navigation" drop-down menu at the top of the LCD page.

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

Trastuzumab - trastuzumab biologics -- revision to the Part A and Part B Billing and Coding Article

Article ID number: A56660 (Florida, Puerto Rico/U.S. Virgin Islands)

Based on the Food and Drug Administration (FDA) approval of Enhertu (fam-trastuzumab deruxtecan- nxki), Healthcare Common Procedural Coding System (HCPCS) code C9399 was added to the "CPT®/HCPCS Codes/ Group 1 Paragraph:/Codes:" section of this billing and coding article for Part A and Part B.

Also, HCPCS code J9999 was added to the "CPT®/ HCPCS Codes/Group 2 Paragraph:/Codes:" section of this billing and coding article for Part B. In addition, HCPCS codes C9399 and J9999 were added to the "ICD-10 Codes that Support Medical Necessity/Group 1 Paragraph:" section of this billing and coding article.

Effective date

This billing and coding article revision is effective for claims processed **on or after February 26, 2020**, for services rendered **on or after December 20, 2019**.

LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

A billing and coding article for an LCD may be found by selecting "Related Local Coverage Documents" in the "Section Navigation" drop-down menu at the top of the LCD page.

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

Pegfilgrastim -- revision to the Part A and Part B local coverage determination and billing and coding article

LCD/Article ID number: L33747/A57725 (Florida, Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for pegfilgrastim was revised to add the new Food and Drug Administration (FDA) approved biosimilar drug pegfilgrastim-bmez to the "Coverage Indications, Limitations, and/or Medical Necessity" section of the LCD under "History/ Background and/or General Information", "Covered Indications" and "Limitations". In addition, the "Sources of Information" section of the LCD was updated. Also, the billing and coding article was revised to add the new FDA approved biosimilar drug Ziextenzo™ (pegfilgrastim-bmez) (Healthcare Common Procedure Coding System [HCPCS] codes C9399/J3590) to the "CPT®/HCPCS Codes/Group 1 Paragraph:" and "ICD-10 Codes that Support Medical Necessity/Group 1 Paragraph:" sections.

Effective date

This billing and coding article revision is effective for claims processed **on or after February 26, 2020**, for services rendered **on or after November 4, 2019**. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

A billing and coding article for an LCD may be found by selecting "Related Local Coverage Documents" in the "Section Navigation" drop-down menu at the top of the LCD page.

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

Stereotactic radiosurgery (SRS) and stereotactic body radiation therapy (SBRT) – revision to the Part A and Part B local coverage determination and billing and coding article

LCD/Article ID number: L33410/A57275 (Florida, Puerto Rico/U.S. Virgin Islands)

The intention of this stereotactic radiosurgery (SRS) and stereotactic body radiation therapy (SBRT) local coverage determination (LCD) revision is to update the coverage guidelines based on more current data and literature.

This LCD recognizes two distinct treatment approaches and is specific to treatment delivery: stereotactic radiosurgery (SRS) and stereotactic body radiation therapy (SBRT) are noninvasive means of administering high-dose radiotherapy to discreet tumor foci in cranial or extracranial locations respectively.

Also, the related billing and coding article (A57275) addresses coding guidelines in support of the reasonable and necessary services as outlined in the LCD.

Effective date

This billing and coding article revision is effective for claims processed **on or after April 19, 2020**. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

A coding article for an LCD may be found by selecting "Related Local Coverage Documents" in the "Section Navigation" drop-down menu at the top of the LCD page.

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

Revision to the Part A and Part B Billing and Coding Article A57077

Article ID number: A57077 (Florida, Puerto Rico/U.S. Virgin Islands)

Based on review of the controlled substance monitoring and drugs of abuse testing billing and coding article, the "CPT®/HCPCS Codes/Group 1 Codes:" and "ICD-10 Codes that Support Medical Necessity/Group 1 Paragraph:" sections of the billing and coding article were revised to remove Current Procedural Terminology (CPT®) code 83789 as it is not a test for drugs.

Effective date

This billing and coding article revision is effective for claims processed **on or after March 6, 2020**, for services rendered **on or after January 1, 2016**.

LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

A billing and coding article for an LCD may be found by selecting "Related Local Coverage Documents" in the "Section Navigation" drop-down menu at the top of the LCD page.

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

Revision to the Part A and Part B billing and coding article A57778

Article ID number: A57778 (Florida, Puerto Rico/U.S. Virgin Islands)

Based on a review, this billing and coding article was revised to add the new Food and Drug Administration (FDA) approved drug Panzyga ® (immune globulin intravenous, human – IFAS) (Healthcare Common Procedure Coding System [HCPCS] codes C9399/J1599) to the "CPT®/HCPCS Codes/Group 1 Paragraph:/Group 1Codes:" and "ICD-10 Codes that Support Medical Necessity/Group 1 Paragraph:" sections.

Effective date

This billing and coding article revision is effective for claims processed **on or after March 16, 2020**, for services rendered **on or after August 2, 2018**.

LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

A billing and coding article for an LCD may be found by selecting "Related Local Coverage Documents" in the "Section Navigation" drop-down menu at the top of the LCD page.

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

Revision to the Part A and Part B article A52571

Article ID number: A52571 (Florida, Puerto Rico/U.S. Virgin Islands)

The Centers for Medicare & Medicaid Services (CMS) provide 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 Medicare Benefit Policy Manual, Pub. 100-02, Chapter 15, Section 50.2.

The following drugs have been added to the Medicare administrative contractor (MAC) Jurisdiction N (JN) self-administered drug (SAD) list: Tremfya® (guselkumab) (J1628) and Stelara® (ustekinumab) subcutaneous (J3357).

This article revision is effective for services rendered **on or after May 3, 2020**.

The evaluation of drugs for addition to the 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 list is available at: *https://medicare.fcso.com/Self-administered drugs*.

Upcoming provider outreach and educational events

Evaluation and management (E/M): Hospital Services - are you coding correctly?

Date: April 30, 2020
Time: 10 a.m. - 11:30 a.m. ET
Type of Event: Webcast

View our complete calendar of events

Note: Unless otherwise indicated, designated times for educational events 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 *First Coast University*, 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 *Create 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* for details and newly scheduled educational events (teleconferences, webcasts, etc.).

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.

CMS MLN Connects®

The Centers for Medicare & Medicaid Services (CMS) *MLN Connects®* 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 *MLN Connects®* to its membership as appropriate.

MLN Connects® for February 20, 2020

MLN Connects® for February 20, 2020

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Compliance

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- Administrative Simplification: EFT and ERA Transactions

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*

MLN Connects® for February 27, 2020

MLN Connects® for February 27, 2020

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News

- Quality Payment Program: MIPS 2019 Data Submission Period Open through March 31
- Anesthesia Modifiers: Comparative Billing Report in March

Compliance

- Inpatient Rehabilitation Facility Services: Follow Medicare Billing Requirements

Claims, Pricers & Codes

- COVID-19: New ICD-10-CM Code and Interim Coding Guidance
- SNF PDPM Claims Issue
- FQHC: Mass Adjustment of Claims

Events

- Dementia Care: CMS Toolkits Call -- March 3
- Part A Providers: QIC Appeals Demonstration Call -- March 5
- Ground Ambulance Organizations: Data Collection for Public Safety-Based Organizations Call -- March 12
- Open Payments: Your Role in Health Care Transparency Call -- March 19

MLN Matters® Articles

- Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - April 2020 Update
- Implementation of the Long Term Care Hospital (LTCH) Discharge Payment Percentage (DPP) Payment Adjustment
- Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging- Approval of Using the K3 Segment for Institutional Claims -- Revised
- Accepting Payment from Patients with a Medicare Set-Aside Arrangement -- Revised
- January 2020 Integrated Outpatient Code Editor (I/OCE) Specifications Version 21.0 -- Revised

Publications

- Medicare Quarterly Provider Compliance Newsletter, Volume 10, Issue 2
- Quality Payment Program: 2020 Resources

MLN Connects® Special Edition for March 4, 2020

CMS Announces Actions to Address Spread of Coronavirus

CMS calls on all health care providers to activate infection control practices and issues guidance to inspectors as they inspect facilities affected by Coronavirus

On March 4, the Centers for Medicare & Medicaid Services (CMS) announced several actions aimed at limiting the spread of the Novel Coronavirus 2019 (COVID-19). Specifically, CMS is issuing a call to action to health care providers across the country to ensure they are implementing their infection control procedures, which they are required to maintain at all times. Additionally, CMS is announcing that, effective immediately and, until further notice, State Survey Agencies and Accrediting Organizations will focus their facility inspections exclusively on issues related to infection control and other serious health and safety threats, like allegations of abuse – beginning with nursing homes and hospitals. Critically, this shift in approach, first announced yesterday by Vice President Pence, will allow inspectors to focus their energies on addressing the spread of COVID-19.

As the agency responsible for Medicare and Medicaid, CMS requires facilities to maintain infection control and prevention policies as a condition for participation in the programs. CMS is also issuing three memoranda to State Survey Agencies, State Survey Agency directors and Accrediting Organizations – to inspect thousands of Medicare-participating health care providers across the country, including nursing homes and hospitals.

“Today’s actions, taken together, represent a call to action across the health care system,” said CMS Administrator Seema Verma. “All health care providers must immediately review their procedures to ensure compliance with CMS’ infection control requirements, as well as the guidelines from the Centers for Disease Control and Prevention (CDC). We sincerely appreciate the proactive efforts of the nursing home and hospital associations that have already galvanized to provide up-to-the-minute information to their

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members. We must continue working together to keep American patients and residents safe and healthy and prevent the spread of COVID-19."

The first memorandum provides important detail with respect to the temporary focus of surveys on infection control and other emergent issues. Importantly, it notes that, in addition to the focused inspections, statutorily-required inspections will also continue in the 15,000 nursing homes across the country using the approximately 8,200 state survey agency surveyors. Surveys will be conducted according to the following regime:

- All immediate jeopardy complaints (a situation in which entity noncompliance has placed the health and safety of recipients in its care at risk for serious injury, serious harm, serious impairment or death or harm) and allegations of abuse and neglect;
- Complaints alleging infection control concerns, including facilities with potential COVID-19 or other respiratory illnesses;
- Statutorily required recertification surveys (Nursing Home, Home Health, Hospice, and ICF/IID facilities);
- Any re-visits necessary to resolve current enforcement actions;
- Initial certifications;
- Surveys of facilities/hospitals that have a history of infection control deficiencies at the immediate jeopardy level in the last three years;
- Surveys of facilities/hospitals/dialysis centers that have a history of infection control deficiencies at lower levels than immediate jeopardy

The memorandum also includes protocols for the inspection process in situations in which COVID-19 is identified or suspected. These protocols include working closely with CMS regional offices, coordinating with CDC, and other relevant agencies at all levels of government. The agency is also providing key guidance related to inspectors' usage of adequate personal protective equipment.

The other two memoranda provide critical answers to common questions that nursing homes and hospitals may have with respect to addressing cases of COVID-19. For example, the memoranda discuss concerns like screening staff and visitors with questions about recent travel to countries with known cases and the severity of infection that would warrant hospitalization instead of self-isolation.

They detail the process for transferring patients between nursing homes and hospitals in cases for which COVID-19 is suspected or diagnosed. They also describe the circumstances under which providers should take precautionary measures (like isolation and mask wearing) for patients and residents diagnosed with COVID-19, or showing signs and symptoms of COVID-19.

Finally, the agency is announcing that it has deployed an infection prevention specialist to CDC's Atlanta headquarters to assist with real-time in guidance development.

These actions from CMS are focused on protecting American patients and residents by ensuring health care facilities have up-to-date information to adequately respond to COVID-19 concerns while also making it clear to providers that as always, CMS will hold them accountable for effective infection control standards.

The agency is also supplying inspectors with necessary and timely information to safely and accurately inspect facilities.

To view each memo, please visit:

- *Suspension of Survey Activities*
- *Guidance for Infection Control and Prevention Concerning Coronavirus Disease (COVID-19): FAQs and Considerations for Patient Triage, Placement and Hospital Discharge*
- *Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in nursing homes*

MLN Connects® for March 5, 2020

MLN Connects® for March 5, 2020

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News

- DMEPOS Suppliers: HCPCS Codes Affected by Further Consolidated Appropriations Act
- Medicare Promoting Interoperability Program: CAH Reconsideration Forms due March 6
- Medicare Promoting Interoperability Program: Submit Proposals for New Measures by July 1
- PEPPERs for Short-term Acute Care Hospitals
- 2018 Geographic Variation Public Use File
- Help Your Patients Make Informed Food Choices

Compliance

- Ambulance Fee Schedule and Medicare Transports

Claims, Pricers & Codes

- Average Sales Price Files: April 2020

Events

- Ground Ambulance Organizations: Data Collection for Public Safety-Based Organizations Call — March 12
- Open Payments: Your Role in Health Care Transparency Call — March 19
- Anesthesia Modifiers: Comparative Billing Report Webinar — March 19
- Ground Ambulance Organizations: Data Collection for Medicare Providers Call — April 2
- LTCH and IRF Quality Reporting Programs: SPADEs In-Depth Training Event — June 9-10

MLN Matters® Articles

- Standard Elements for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Order, and Master List of DMEPOS Items Potentially Subject to a Face-to-Face Encounter and Written Orders Prior to Delivery and, or Prior Authorization Requirements
- Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update
- Quarterly Update for the Temporary Gap Period of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP) - April 2020
- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs) — July 2020 Update

Publications

- Administrative Simplification: Claim Status Basics
- Hospice Quality Reporting Program: Timeliness Compliance Threshold for HIS Submissions
- Guide to Reducing Chronic Kidney Disease Disparities in the Primary Care Setting

Multimedia

- Ambulance Services Call: Audio Recording and Transcript

MLN Connects® Special Edition for March 6, 2020

CMS Develops Additional Code for Coronavirus Lab Tests

Agency Issues Fact Sheets Detailing Coverage under Programs

On March 6, CMS took additional actions to ensure America's patients, healthcare facilities and clinical laboratories are prepared to respond to the 2019-Novel Coronavirus (COVID-19).

CMS has developed a second Healthcare Common Procedure Coding System (HCPCS) code that can be used by laboratories to bill for certain COVID-19 diagnostic tests to help increase testing and track new cases. In addition, CMS released new fact sheets that explain Medicare, Medicaid, Children's Health Insurance Program, and Individual and Small Group Market Private Insurance coverage for services to help patients prepare as well.

"CMS continues to leverage every tool at our disposal in responding to COVID-19," said CMS Administrator Seema Verma. "Our new code will help encourage doctors and laboratories to use these essential tests for patients who need them. At the same time, we are providing critical information to our 130 million beneficiaries, many of whom are understandably wondering what will be covered when it comes to this virus. CMS will continue to devote every available resource to this effort, as we cooperate with other

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government agencies to keep the American people safe."

HCPCS is a standardized coding system that Medicare and other health insurers use to submit claims for services provided to patients. Last month, CMS developed the first HCPCS code (U0001) to bill for tests and track new cases of the virus. This code is used specifically for CDC testing laboratories to test patients for SARS-CoV-2. The second HCPCS billing code (U0002) allows laboratories to bill for non-CDC laboratory tests for SARS-CoV-2/2019-nCoV (COVID-19). On February 29, 2020, the Food and Drug Administration (FDA) issued a new, streamlined policy for certain laboratories to develop their own validated COVID-19 diagnostics. This second HCPCS code may be used for tests developed by these additional laboratories when submitting claims to Medicare or health insurers. CMS expects that having specific codes for these tests will encourage testing and improve tracking.

The Medicare claims processing systems will be able to accept these codes starting on April 1, 2020, for dates of service on or after February 4, 2020. Local Medicare Administrative Contractors (MACs) are responsible for developing the payment amount for claims they receive for these newly created HCPCS codes in their respective jurisdictions until Medicare establishes national payment rates. Laboratories may seek guidance from their MAC on payment for these tests prior to billing for them. As with other laboratory tests, there is generally no beneficiary cost sharing under Original Medicare.

To ensure the public has clear information on coverage and benefits under CMS programs, the agency also released three fact sheets that cover diagnostic laboratory tests, immunizations and vaccines, telemedicine, drugs, and cost-sharing policies.

Medicare Fact Sheet Highlights: In addition to the diagnostic tests described above, Medicare covers all medically necessary hospitalizations, as well as brief "virtual check-ins," which allows patients and their doctors to connect by phone or video chat.

Medicaid and Children's Health Insurance Program (CHIP) Fact Sheet Highlights: Testing and diagnostic services are commonly covered services, and laboratory and x-ray services are a mandatory benefit covered and reimbursed in all states. States are required to provide both inpatient and outpatient hospital services to beneficiaries. All states provide coverage of hospital care for children and pregnant women enrolled in CHIP. Specific questions on covered benefits should be directed to the respective state Medicaid and CHIP agency.

Individual and Small Group Market Insurance Coverage: Existing federal rules governing health insurance coverage, including with respect to viral infections, apply to the diagnosis and treatment of with Coronavirus (COVID-19). This includes plans purchased through HealthCare.gov. Patients should contact their insurer to determine specific benefits and coverage policies. Benefit and coverage details may vary by state and by plan. States may choose to work with plans and issuers to determine the coverage and cost-sharing parameters for COVID-19 related diagnoses, treatments, equipment, telehealth and home health services, and other related costs.

Summary of CMS Public Health Action on COVID-19 to date:

On March 4, 2020, CMS issued a call to action to healthcare providers nationwide to ensure they are implementing longstanding infection control procedures and issued important guidance to help State Survey Agencies and Accrediting Organizations prioritize their inspections of healthcare facilities to focus exclusively on issues related to infection control and other serious health and safety threats. For more information on CMS actions to prepare for and respond to COVID-19, visit: *CMS Announces Actions to Address Spread of Coronavirus*.

On February 13, 2020, CMS issued a new HCPCS code for healthcare providers and laboratories to test patients for COVID-19 using the CDC-developed test. For more information about this code: *Public Health News Alert: CMS Develops New Code for Coronavirus Lab Test*.

On February 6, 2020, CMS issued a *memo* to help the nation's healthcare facilities take critical steps to prepare for COVID19.

On February 6, 2020, CMS also gave CLIA-certified laboratories information about how they can test for SARS-CoV-2. Read more: *Suspension of Survey Activities* memorandum

For the updated information on the range of CMS activities to address COVID-19, visit the *Current Emergencies* webpage.

MLN Connects® Special Edition for March 9, 2020

COVID-19 Response: CMS Issues FAQs to Assist Medicare Providers

On March 6, CMS issued *frequently asked questions and answers (FAQs)* for health care providers regarding Medicare payment for laboratory tests and other services related to the 2019-Novel Coronavirus (COVID-19). The agency is receiving questions from providers and created this document to be transparent and share answers to some of the most common questions.

Included in the FAQs is:

- Guidance on how to bill and receive payment for testing patients at risk of COVID-19.
- Details of Medicare's payment policies for laboratory and diagnostic services, drugs, and vaccines under Medicare Part B, ambulance services, and other medical services delivered by physicians, hospitals, and facilities accepting government resources.
- Information on billing for telehealth or in-home provider services. Since 2019, the Trump Administration has expanded flexibilities for CMS to pay providers for virtual check-ins and other digital communications with patients, which will make it easier for sick patients to stay home and lower the risk of spreading the infection.

This FAQ, and earlier CMS actions in response to the COVID-19 virus are part of the ongoing White House Task Force efforts. To keep up with the important work CMS is doing in response to COVID-19, visit the *Current Emergencies* website.

Below is an updated list of CMS' actions to date:

- *March 5*: Issued a second Healthcare Common Procedure Coding System (HCPCS) code for certain COVID-19 laboratory tests, in addition to three fact sheets about coverage and benefits for medical services related to COVID-19 for CMS programs
- *March 4*: Issued a call to action to health care providers nationwide and offered important guidance to help State Survey Agencies and Accrediting Organizations prioritize their inspections of healthcare
- *February 13*: Issued a new HCPCS code for providers and laboratories to test patients for COVID-19
- *February 6*: Gave CLIA-certified laboratories information about how they can test for SARS-CoV-2
- *February 6*: Issued a memo to help the nation's health care facilities take critical steps to prepare for COVID-19

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MLN Connects® for March 12, 2020

MLN Connects® for March 12, 2020

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News

- CMS Sends More Detailed Guidance to Providers about COVID-19
- HHS Finalizes Historic Rules to Provide Patients More Control of Their Health Data
- Quality Payment Program: MIPS 2019 Data Submission Deadline March 31
- Hospital Quality Reporting: Comment on Draft QRDA I Implementation Guide by April 1
- Inclusion of Lower Limb Prosthetics in DMEPOS Prior Authorization
- Clean Hands Count: Prevent and Control Infections
- March is National Colorectal Cancer Awareness Month

Compliance

- Incorrect Billing of HCPCS L8679 - Implantable Neurostimulator, Pulse Generator, Any Type

Events

- Open Payments: Your Role in Health Care Transparency Call — March 19
- Medicare Promoting Interoperability Program Call for Measures Webinar — March 19
- Ground Ambulance Organizations: Data Collection for Medicare Providers Call — April 2
- Interoperability and Patient Access Final Rule Call — April 7
- LTCH and IRF Quality Reporting Programs: SPADEs Webinar — April 14

MLN Matters® Articles

- NCD 20.4 Implantable Cardiac Defibrillators (ICDs)
- Section 1876 and 1833 Cost Plan Enrollee Access to Care through Original Medicare
- April 2020 Integrated Outpatient Code Editor (I/OCE) Specifications Version 21.1
- Proper Use of Modifier 59 — Revised
- Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - April 2020 Update — Revised

Publications

- Evacuating and Receiving Patients in the Midst of a Wildfire
- Administrative Simplification: Eligibility and Benefits Transaction Basics

Multimedia

- Dementia Care Call: Audio Recording and Transcript

Medicare A Connection

Medicare A Connection is published monthly and is available online in both English and Spanish. All of CMS's MIN Connects and Special Editions can be found in our monthly newsletters. These are found in the Publication tab by clicking ***here***.

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

Overpayments
904-791-6029

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

Provider websites
English
Spanish

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

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)
EDOC-CS-FLINQA@fcso.com (FL/USVI)
EDOC-CS-PRINQA@fcso.com (PR)

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 44179
Jacksonville, FL 32231-4179

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 3409
Mechanicsburg, PA 17055-1849

Special or overnight deliveries
Provider Enrollment
2020 Technology Parkway Suite 100
Mechanicsburg, PA 17055-1849

Redetermination
Florida:
Medicare Part A Redetermination/Appeals
P. O. Box 3409
Jacksonville, FL 32232-5053

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)
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)

Beneficiary customer service
1-800-MEDICARE (1-800-633-4227)

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