Medicare A Connection

medicare.fcso.com

FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction N Providers

August 2020

In this issue

Post-payment service-specific reviews

First Coast is tasked with preventing inappropriate Medicare payments. One of the ways this is conducted is through medical review of claims. Medical review of claims helps to ensure that Medicare pays for services that are covered, correctly coded, and medically reasonable and necessary.

First Coast performs data analysis on a regular basis on all services billed to Medicare to identify services that are frequently not billed and coded correctly per Medicare guidelines. Post-pay service-specific reviews are performed based on results of a widespread data analysis that focuses on specific topics.

If you bill Medicare for these services, you may receive an additional development request (ADR) letter asking for documentation. This allows First Coast to validate that you have billed the services correctly according to Medicare guidelines.

Once the ADR is received, you will have 45 days to respond to the request with the supporting medical record documentation.

The review will be completed within 60 days of receipt of the documentation. When the review is completed, you will be notified of the results.

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.

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 Affairs at:

Medical Affairs 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.

New LCD/Article

Implantable continuous glucose monitors (I-CGM) - new Part A and Part B LCD and billing and coding article

LCD and Article ID numbers: L38664/A58136 (Florida, Puerto Rico/U.S. Virgin Islands)

This new local coverage determination (LCD) addresses coverage indications, limitations, and medical necessity requirements for implantable continuous glucose monitors (I-CGM) for the treatment of Medicare beneficiaries with diabetes mellitus that require multiple daily administrations of insulin and frequent adjustments to their insulin treatment regimen.

Also, the related billing and coding article (A58136) addresses coding guidelines in support of the reasonable and necessary services outlined in the LCD.

Effective date

This new LCD and related billing and coding article are effective for services rendered **on or after October 11, 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 (when present) 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*.

Revised LCDs/Articles

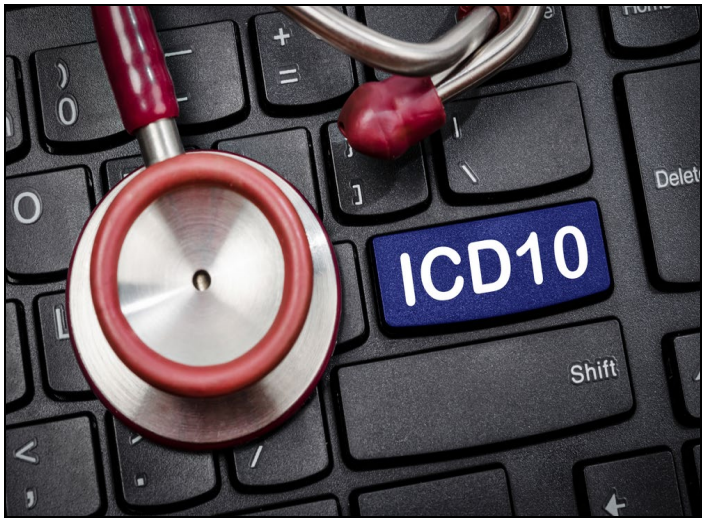
Gastrointestinal pathogen (GIP) panels utilizing multiplex nucleic acid amplification techniques (NAATs) - revision to the Part A and Part B billing and coding article

Article ID number: A56638 (Florida, Puerto Rico/U.S. Virgin Islands)

Based on a review of the local coverage determination (LCD) and billing and coding article for gastrointestinal pathogen (GIP) panels utilizing multiplex nucleic acid amplification techniques (NAATs), the billing and coding article was revised to remove the dual diagnosis requirement for ICD-10-CM diagnosis code R19.7. Therefore, the "CPT®/HCPCS Codes/Group 2 Codes:" section of the billing and coding article was removed (Current Procedural Terminology [CPT®] codes 87507 and 0097U are now listed under the Group 1 Codes) Also, the "ICD-10 Codes that Support Medical Necessity/ Group 2 Codes:" section of the billing and coding article was removed and the "ICD-10 Codes that Support Medical Necessity/Group 3 Codes:" section was renamed to "Group 2 Codes".

Effective date

This billing and coding article revision is effective for **claims processed on or after August 13, 2020**, for services rendered **on or after December 30, 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 (when present) 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*.

Application of skin substitute grafts for treatment of DFU and VLU of lower extremities - revision to the Part A and Part B billing and coding article

Article ID number: A57680 (Florida, Puerto Rico/U.S. Virgin Islands)

Based on review of this billing and coding article, the "Coding Guidance" section was updated to include proper coding information in regards to skin replacement surgery application codes and non-graft wound dressings (e.g., gel, powder, ointment, foam, liquid) or injected skin substitutes.

Effective date

This billing and coding article revision is effective for claims processed **on or after August 13, 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 (when present) 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*.

Retired LCD/Article

Hyperbaric oxygen (HBO) therapy - retired Part A and Part B LCD/billing and coding article

LCD and Article ID numbers: L36504/A57800 (Florida, Puerto Rico/U.S. Virgin Islands)

Based on review of the local coverage determination (LCD) and billing and coding article for hyperbaric oxygen (HBO) therapy, it was determined that they are no longer required and therefore, are being retired.

Effective date

This LCD and billing and coding article retirement is effective for services rendered **on or after August 27, 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 (when present) 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*.

Your Feedback Matters

To ensure that our website meets the needs of our provider community, we carefully analyze your feedback and implement changes to better meet your needs. Discover the results of your feedback on our "*Website enhancements*" page. You'll find the latest enhancements to our provider websites and find out how you can share your thoughts and ideas with First Coast's Web team.

Upcoming provider outreach and educational events

Medicare Quarterly Updates (A)

Date: September 15
Time: 10 - 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 Thursday, July 23, 2020

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News

- Peripheral Vascular Intervention for Claudication: Comparative Billing Report
- Physician Compare Preview Period Open through August 20

Claims, Pricers & Codes

- SNF Patient Driven Payment Model Interrupted Stay Issue

Events

- Telemedicine Hack: A 10-Week Learning Community to Accelerate Telemedicine Implementation for Ambulatory Providers: July 22–September 23
- National CMS/CDC Nursing Home COVID-19 Training Series Webcast — July 23

MLN Matters® Articles

- Change to the Payment of Allogeneic Stem Cell Acquisition Services
- July 2020 Update of the Hospital Outpatient Prospective Payment System (OPPS) — Revised

Multimedia

- Part A Cost Report Call: Audio Recording and Transcript

MLN Connects - Special Edition – Thursday, July 23, 2020

Trump Administration Announces New Resources to Protect Nursing Home Residents Against COVID-19

As part of the unprecedented efforts taken by the Trump Administration, President Trump announced several new CMS initiatives designed to protect nursing home residents from Coronavirus Disease 2019 (COVID-19).

"From the moment the threat of this virus materialized, the Trump Administration has placed a priority on protecting nursing home residents," said CMS Administrator Seema Verma. "Today's multi-pronged intervention represents the latest efforts in fulfilling that unwavering commitment.

As caseloads continue to increase in areas around the country, it has never been more important that nursing homes have what they need to maintain a sturdy defense against the virus. These measures will help them do exactly that."

New Funding:

HHS will devote $5 billion of the *Provider Relief Fund* authorized by the Coronavirus Aid, Relief, and Economic Security (CARES) Act to Medicare-certified long term care facilities and state veterans' homes ("nursing homes"), to build nursing home skills and enhance nursing homes' response to COVID-19, including enhanced infection control. This funding could be used to address critical needs in nursing homes including hiring additional staff, implementing infection control "mentorship" programs with subject matter experts, increasing testing, and providing additional services, such as technology so residents can connect with their families if they are not able to visit.

Nursing homes must participate in the Nursing Home COVID-19 Training (described below) to be qualified to receive this funding. This new funding is in addition to the $4.9 billion previously announced to offset revenue losses and assist nursing homes with additional costs related to responding to the COVID-19 public health emergency and the shipments of personal protective equipment provided to nursing homes by the Federal Emergency Management Agency "President Trump is committed to strengthening Medicare and lowering costs for patients.

Today's rule advances competition by creating a level playing field for providers so they can compete for patients on the basis of quality and care," said CMS Administrator Seema Verma.

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"The final policies remove unnecessary and inefficient payment differences so patients can have more affordable choices and options."

Enhanced Testing:

Building on the initiative HHS announced last week, in which rapid point-of-care diagnostic testing devices will be distributed to nursing homes, and the new funding from the Provider Relief Fund, CMS will begin requiring, rather than recommending, that all nursing homes in states with a 5% positivity rate or greater test all nursing home staff each week. This new staff testing requirement will enhance efforts to keep the virus from entering and spreading through nursing homes by identifying asymptomatic carriers.

More than 15,000 testing devices will be deployed over the next few months to help support this mandate, with over 600 devices shipping this week. Funds from the Provider Relief Fund can also be used to pay for additional testing of visitors.

Additional Technical Assistance & Support:

The Trump administration recently deployed federal Task Force Strike Teams to provide onsite technical assistance and education to nursing homes experiencing outbreaks in an effort to help reduce transmission and the risk of COVID-19 spread among residents.

The first deployments took place in 18 nursing homes in Illinois, Florida, Louisiana, Ohio, Pennsylvania and Texas between July 18 and July 20. The Task Force Strike Teams are composed of clinicians and public health service officials from CMS, the Centers for Disease Control & Prevention (CDC), and the Office of the Assistant Secretary for Health.

The Task Force Strike Teams went into nursing homes based on data they reported to the CDC that indicated an increase in COVID-19 cases. The teams focused on the four key areas of support, including keeping COVID-19 out of facilities, detecting COVID-19 cases quickly, preventing virus transmission, and managing staff.

The goal was to determine what immediate actions nursing homes needed to take to help reduce the spread and risk of COVID-19 among residents, and to better understand what federal, state, and local resources nursing homes need to ensure the health and safety of their residents. CMS and its partners plan to use what is learned on the ground to determine remote education and other critical needs to support nursing homes and mitigate future outbreaks.

In addition, CMS, in partnership with the CDC, is rolling out an online, self-paced, on-demand Nursing Home COVID-19 Training focused on infection control and best practices.

The training being offered has 23 educational modules and a scenario-based learning modules that include materials on cohorting strategies and using telehealth in nursing homes to assist facilities as they continue to work to mitigate the virus spread in their facilities.

This program supplements training already underway to better equip nursing homes to contain and stop the spread of COVID-19.

The training is a requirement for nursing homes to receive the additional funding from the Provider Relief Fund Program.

The training will be available to all 15,400 nursing homes nationwide along with specialized technical assistance to nursing homes who have been found to have infection prevention deficiencies in their most recent CMS inspection and had recent COVID-19 cases based upon their data submissions to CDC.

A certificate of completion is offered and recognition badges can be downloaded for nursing homes to display on their website.

Weekly Data on High Risk Nursing Homes:

Early on during this pandemic, CMS required nursing homes to inform residents, their families and representatives of COVID-19 cases in their nursing homes. Starting in May, CMS and CDC began collecting weekly data on each nursing home including their number of COVID-19 cases.

Now that this data collection process has matured, the White House and CMS will release a list of nursing homes with an increase in cases that will be sent to states each week as part of the weekly Governor's report to ensure states have the information needed to target their support to the highest risk nursing homes.

This announcement builds on the unprecedented and aggressive actions CMS has taken to address the impact of COVID-19 in nursing homes.

See the full text of this excerpted *CMS Press Release* (issued July 22), including a list of actions CMS took to address the impact of COVID-19 in nursing homes.

MLN Connects® for Thursday, July 30, 2020

MLN Connects® for Thursday, July 30, 2020

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News

- CMS Updates Data on COVID-19 Impacts on Medicare Beneficiaries
- Short-Term Acute Care Hospitals: Submit Occupational Mix Surveys by September 3
- PEPPERs for SNFs, Hospices, IRFs, IPFs, CAHs, and LTCHs
- Hospice Quality Reporting Program: HART v1.6.0
- Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier

Claims, Pricers & Codes

- COVID-19: Laboratory Claims Requiring the NPI of the Ordering/Referring Professional — Update
- Medicare Diabetes Prevention Program: Valid Claims

Events

- National CMS/CDC Nursing Home COVID-19 Training Series Webcast — July 30

MLN Matters® Articles

- Addition of the QW Modifier to Healthcare Common Procedure Coding System (HCPCS) Code 87426
- Overview of the Repetitive, Scheduled Non-Emergent Ambulance Prior Authorization Model — Revised
- Modify Edits in the Fee for Service (FFS) System when a Beneficiary has a Medicare Advantage (MA) Plan — Revised

Publications

- Medicare Quarterly Provider Compliance Newsletter, Volume 10, Issue 4
- Home Health, IRF, LTCH, and SNF Quality Reporting Programs: COVID-19 PHE

MLN Connects - Special Edition – Thursday, July 30, 2020

Payment for COVID-19 Counseling, Reporting Hospital Therapeutics, Out-of-Pocket Drug Costs

- *CMS and CDC Announce Provider Reimbursement Available for Counseling Patients to Self-Isolate at Time of COVID-19 Testing*
- *CMS Announces New Hospital Procedure Codes for Therapeutics in Response to the COVID-19 Public Health Emergency*
- *Trump Administration Continues to Keep Out-of-Pocket Drug Costs Low for Seniors*

CMS and CDC Announce Provider Reimbursement Available for Counseling Patients to Self-Isolate at Time of COVID-19 Testing

On July 30, CMS and the Centers for Disease Control and Prevention (CDC) are announcing that payment is available to physicians and health care providers to counsel patients, at the time of Coronavirus Disease 2019 (COVID-19) testing, about the importance of self-isolation after they are tested and prior to the onset of symptoms.

The transmission of COVID-19 occurs from both symptomatic, pre-symptomatic, and asymptomatic individuals emphasizing the importance of education on self-isolation as the spread of the virus can be reduced significantly by having patients isolated earlier, while waiting for test results or symptom onset.

The CDC models show that when individuals who are tested for the virus are separated from others and placed in quarantine, there can be up to an 86 percent reduction in the transmission of the virus compared to a 40 percent decrease in viral transmission if the person isolates after symptoms arise.

Provider counseling to patients, at the time of their COVID-19 testing, will include the discussion of immediate need for isolation, even before results are available, the importance to inform their immediate household that they too should be tested for COVID-19, and the review of signs and symptoms and services available to them to aid in isolating at home. In addition, they will be counseled that if they test positive, to wear a mask at all times, and they will be contacted by public health authorities and asked to provide information for contact tracing and to tell their immediate household and recent contacts in case it is appropriate for these individuals to be tested for the virus and to self-isolate as well.

CMS will use existing evaluation and management payment codes to reimburse providers who are eligible to bill CMS for counseling services no matter where a test is administered, including doctor's offices, urgent care clinics, hospitals, and community drive-thru or pharmacy testing sites.

For More Information:

- *Medicare Fee-For-Service (FFS) Response to the Public Health Emergency on the Coronavirus (COVID-19)* MLN Matters Special Edition Article SE20011
- *Counseling Check List,* including resource links

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CMS Announces New Hospital Procedure Codes for Therapeutics in Response to the COVID-19 Public Health Emergency

With the emergence of Coronavirus Disease 2019 (COVID-19) and the new treatments that have followed, it is critical to be able to track the use of these treatments and their effectiveness in real-time. CMS responded to this need, and in record time is implementing new procedure codes to allow Medicare and other insurers to identify the use of the therapeutics remdesivir and convalescent plasma for treating hospital in-patients with COVID-19. These new codes, which go into effect August 1, will enable CMS to conduct real-time surveillance and obtain real-world evidence in how these drugs are working and provide critical information on their effectiveness and how they can protect patients. These codes can be reported to Medicare and other insurers may also use the codes to identify the use of COVID-19 therapies and help facilitate monitoring and data collection on their use.

These new codes are being implemented into the International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS). ICD-10-PCS is the Health Insurance Portability and Accountability Act (HIPAA) designated code set for reporting hospital inpatient procedures, which is developed and maintained by CMS and can be used by other health insurers.

The implementation of these new procedure codes is part of the Trump Administration's ongoing efforts to protect the health and safety of COVID-19 patients across the country during the public health emergency.

For more information, see *ICD-10 MS-DRGs Version 37.2 Effective August 1*.

Trump Administration Continues to Keep Out-of-Pocket Drug Costs Low for Seniors

On July 29, CMS announced the average basic premium for Medicare Part D prescription drug plans, which cover prescription drugs that beneficiaries pick up at a pharmacy. Under the leadership of President Trump, for the first time seniors that use insulin will be able to choose a prescription drug plan in their area that offers a broad set of insulins for no more than $35 per month per prescription.

The average basic Part D premium will be $30.50 in 2021. The 2021 and 2020 average basic premiums are the second lowest and lowest, respectively, average basic premiums in Part D since 2013. This trend of lower Part D premiums, which have decreased by 12 percent since 2017, means that beneficiaries have saved nearly $1.9 billion in premium costs over that time. Further, Part D continues to be an extremely popular program, with enrollment increasing by 16.7 percent since 2017.

"At every turn, the Trump Administration has prioritized policies that introduce choice and competition in Part D," said CMS Administrator Seema Verma. "The result is lower prices for life-saving drugs like insulin, which will be available to Medicare beneficiaries at this fall's Open Enrollment for no more than $35 a month. In short, Part D premiums continue to stay at their lowest levels in years even as beneficiaries enjoy a more robust set of options from which to choose a plan that meets their needs."

In addition to the $1.9 billion in premium savings for beneficiaries since 2017, the Trump Administration has produced substantial Part D program savings for taxpayers. With about 200 additional standalone prescription drug plans and 1,500 additional Medicare Advantage plans with prescription drug coverage joining the program between 2017 and 2020, and that trend expected to continue in 2021, increased market competition has led to lower costs and lower Medicare premium subsidies, which has saved taxpayers approximately $8.5 billion over the past four years.

Earlier this year, CMS launched the Part D Senior Savings Model, which will allow Medicare beneficiaries to choose a plan that provides access to a broad set of insulins at a maximum $35 copay for a month's supply. Starting January 1, 2021, beneficiaries who select these plans will save, on average, $446 per year, or 66 percent, on their out-of-pocket costs for insulin. Beneficiaries will be able to choose from more than 1,600 participating standalone Medicare Part D prescription drug plans and Medicare Advantage plans with prescription drug coverage, all across the country this open enrollment period, which runs from October 15 through December 7. And because the majority of participating Medicare Advantage plans with prescription drug coverage do not charge a Part D premium, beneficiaries who enroll in those plans will save on insulin and not pay any extra premiums.

In January 2020, CMS, through the Part D Payment Modernization Model, offered an innovative new opportunity for Part D plan sponsors to lower costs for beneficiaries, while improving care quality. Under this model, Part D sponsors can better manage prescription drug costs through all phases of the Part D benefit, including the catastrophic phase. Through the use of better tools and program flexibilities, sponsors are better able to negotiate on high cost drugs and design plans that increase access and lower out-of-pocket costs for beneficiaries. For CY 2021, there will be nine plan options in Utah, New Mexico, Idaho and Pennsylvania that participate in this model.

In Medicare Part D, beneficiaries choose the prescription drug plan that best meets their needs, and plans have to improve quality and lower costs to attract beneficiaries. This competitive dynamic sets up clear incentives that drive towards value. CMS has taken steps to modernize the Part D program by providing beneficiaries the opportunity to choose among plans with greater negotiating tools that have been developed in the private

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market and by providing patients with more transparency on drug prices. Improvements to the Medicare Part D program that CMS has made to date include:

- Beginning in 2021, providing more information on out-of-pocket costs for prescription drugs to beneficiaries by requiring Part D plans to provide a real time benefit tool to clinicians with information that they can discuss with patients on out-of-pocket drug costs at the time a prescription is written
- Implementing Part D legislation signed by President Trump to prohibit "gag clauses," which keep pharmacists from telling patients about lower-cost ways to obtain prescription drugs
- Beginning in 2021, requiring the Explanation of Benefits document that Part D beneficiaries receive each month to include information on drug price increases and lower-cost therapeutic alternatives
- Providing beneficiaries with more drug choices and empowering beneficiaries to select a plan that meets their needs by allowing plans to cover different prescription drugs for different indications, an approach used in the private sector
- Reducing the maximum amount that low-income beneficiaries pay for certain innovative medicines known as "biosimilars," which will lower the out-of-pocket cost of these innovative medicines for these beneficiaries
- Empowering Medicare Advantage to negotiate lower costs for physician-administered prescription drugs for seniors for the first time, as well allowing Part D plans to substitute certain generic drugs on plan formularies more quickly during the year, so beneficiaries immediately have access to the generic, which typically has lower cost sharing than the brand
- Increasing competition among plans by removing the requirement that certain Part D plans have to "meaningfully differ" from each other, making more plan options available for beneficiaries

For More Information:

- *Part D Senior Savings Model* webpage
- *Ratebooks & Supporting Data webpage:* View the 2021 Part D base beneficiary premium, the Part D national average monthly bid amount, the Part D regional low-income premium subsidy amounts, the de minimis amount, the Medicare Advantage employer group waiver plan regional payment rates, and the Medicare Advantage regional PPO benchmarks Fact Sheet

MLN Connects - Special Edition – Friday, July 31, 2020

FY 2021 Medicare payment policies for IPFs, SNFs, and hospices

- *CMS Updates Medicare Payment Policies for IPFs, SNFs, and Hospices*
- *COVID-19: Coverage of Physician Telehealth Services Provided to SNF Residents*

CMS updates Medicare payment policies for IPFs, SNFs, and hospices

On July 31, CMS finalized three Medicare payment rules that further advance our efforts to strengthen the Medicare program by better aligning payments for Inpatient Psychiatric Facilities (IPFs), Skilled Nursing Facilities (SNFs), and hospices.

Inpatient Psychiatric Facilities:

The final rule updates Medicare payment policies and rates for the IPF Prospective Payment System (PPS) for FY 2021.

In this final rule, CMS is finalizing a 2.2 percent payment rate update and finalizing its proposal to adopt revised Office of Management and Budget (OMB) statistical area delineations resulting in wage index values being more representative of the actual costs of labor in a given area. CMS is finalizing updates to allow advanced practice providers, including physician assistants, nurse practitioners, psychologists, and clinical nurse specialists to operate within the scope of practice allowed by state law by documenting progress notes in the medical record of patients for whom they are responsible, receiving services in psychiatric hospitals.

Skilled Nursing Facilities:

The final rule updates the Medicare payment rates and the quality programs for SNFs. These updates include routine technical rate-setting updates to the SNF PPS payment rates, as well as finalizes adoption of the most recent OMB statistical area delineations and applies a 5 percent cap on wage index decreases from FY 2020 to FY 2021.

CMS is also finalizing changes to the ICD-10 code mappings that would be effective beginning in FY 2021 in response to stakeholder feedback. CMS projects aggregate payments to SNFs will increase by $750 million, or 2.2 percent, for FY 2021, compared to FY 2020.

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Hospices:

For FY 2021, hospice payment rates are updated by the market basket percentage increase of 2.4 percent ($540 million).

Hospices that fail to meet quality reporting requirements receive a 2 percentage point reduction to the annual market basket percentage increase for the year.

The hospice payment system includes a statutory aggregate cap.

The aggregate cap limits the overall payments made to a hospice annually.

The final hospice cap amount for the FY 2021 cap year is $30,683.93, which is equal to the FY 2020 cap amount ($29,964.78) updated by the final FY 2021 hospice payment update percentage of 2.4 percent.

For More Information:

- IPF *Final Rule* and *Fact Sheet*
- SNF *Final Rule* and *Fact Sheet*
- Hospice *Final Rule* and *Fact Sheet*

COVID-19: Coverage of physician telehealth services provided to SNF residents

The current COVID-19 Public Health Emergency (PHE) does not waive any requirements related to Skilled Nursing Facility (SNF) Consolidated Billing (CB); however, CMS added CPT codes 99441, 99442, and 99443, to the *list of telehealth codes* coverable under the waiver during the COVID-19 PHE. These codes designate three different time increments of telephone evaluation and management service provided by a physician. You can bill for these physician services separately under Part B when furnished to a SNF's Part A resident.

Medicare Administrative Contractors (MACs) will reprocess claims for CPT codes 99441, 99442, and 99443 with dates of service on or after March 1, 2020, that were denied due to SNF CB edits. You do not have to do anything. If you already received payment from the SNF for these physician services, return that payment to the SNF once the MAC reprocesses your claim.

MLN Connects - Special Edition – Tuesday, August 4, 2020

- *Trump Administration Proposes to Expand Telehealth Benefits Permanently for Medicare Beneficiaries Beyond the COVID-19 Public Health Emergency and Advances Access to Care in Rural Areas*
- *Trump Administration Proposes Policies to Provide Seniors with More Choices and Lower Costs for Surgeries*
- *CMS Updates Medicare Payment Policies for IRFs*

Trump Administration Proposes to Expand Telehealth Benefits Permanently for Medicare Beneficiaries Beyond the COVID-19 Public Health Emergency and Advances Access to Care in Rural Areas

CMS is proposing changes to expand telehealth permanently, consistent with the Executive Order on Improving Rural and Telehealth Access that President Trump signed. The Executive Order and proposed rule advance our efforts to improve access and convenience of care for Medicare beneficiaries, particularly those living in rural areas. Additionally, the proposed rule implements a multi-year effort to reduce clinician burden under our Patients Over Paperwork initiative and to ensure appropriate reimbursement for time spent with patients. This proposed rule also takes steps to implement President Trump's Executive Order on Protecting and Improving Medicare for our Nation's Seniors and continues our commitment to ensure that the Medicare program is sustainable for future generations.

Expanding Beneficiary Access to Care through Telehealth:

Over the last three years, as part of the Fostering Innovation and Rethinking Rural Health strategic initiatives, CMS has been working to modernize Medicare by unleashing private sector innovations and improve beneficiary access to services furnished via telecommunications technology. Starting in 2019, Medicare began paying for virtual check-ins, meaning patients across the country can briefly connect with doctors by phone or video chat to see whether they need to come in for a visit. In response to the COVID-19 pandemic, CMS moved swiftly to significantly expand payment for telehealth services and implement other flexibilities so that Medicare beneficiaries living in all areas of the country can get convenient and high-quality care from the comfort of their home while avoiding unnecessary exposure to the virus. Before the Public Health Emergency (PHE), only 14,000 beneficiaries received a Medicare telehealth service in a week, while over 10.1 million beneficiaries have received a Medicare telehealth service during the PHE from mid-March through early-July. For more information on Medicare's unprecedented increases in telemedicine and its impact on the health care delivery system, visit the *CMS Health Affairs blog.*

As directed by President Trump's Executive Order on Improving Rural and Telehealth Access, through this rule, CMS is taking steps to extend the availability of certain telemedicine services after the PHE ends, giving Medicare beneficiaries more convenient ways to access health care particularly in rural areas where access to health care providers may otherwise be limited.

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"Telemedicine can never fully replace in-person care, but it can complement and enhance in-person care by furnishing one more powerful clinical tool to increase access and choices for Americas seniors," said CMS Administrator Seema Verma. "The Trump Administration's unprecedented expansion of telemedicine during the pandemic represents a revolution in health care delivery, one to which the health care system has adapted quickly and effectively. Never one merely to tinker around the edges when it comes to patient-centered care, President Trump will not let this opportunity slip through our fingers."

During the PHE, CMS added 135 services such as emergency department visits, initial inpatient and nursing facility visits, and discharge day management services that could be paid when delivered by telehealth. CMS is proposing to permanently allow some of those services to be done by telehealth, including home visits for the evaluation and management of a patient (in the case where the law allows telehealth services in the patient's home) and certain types of visits for patients with cognitive impairments.

CMS is seeking public input on other services to permanently add to the telehealth list beyond the PHE in order to give clinicians and patients time as they get ready to provide in-person care again. CMS is also proposing to temporarily extend payment for other telehealth services, such as emergency department visits for a specific time period, through the calendar year in which the PHE ends. This will also give the community time to consider whether these services should be delivered permanently through telehealth outside of the PHE.

Prioritizing Investment in Preventive Care and Chronic Disease Management:

Under our Patients Over Paperwork initiative, the Trump Administration has taken steps to eliminate burdensome billing and coding requirements for Evaluation and Management (E/M) (for office/outpatient visits) that make up 20 percent of the spending under the Physician Fee Schedule.

These billing and documentation requirements for E/M codes were established 20 years ago and have been subject to longstanding criticism from clinicians that they do not reflect current care practices and needs. After extensive stakeholder collaboration with the American Medical Association and others, simplified coding and billing requirements for E/M visits will go into effect January 1, 2021, saving clinicians 2.3 million hours per year in burden reduction. As a result of this change, clinicians will be able to make better use of their time and restore the doctor-patient relationship by spending less time on documenting visits and more time on treating their patients.

Additionally, last year, the Trump Administration finalized historic changes to increase payment rates for office/outpatient E/M visits beginning in 2021. The higher payment for E/M visits takes into account the changes in the practice of medicine, recognizing that additional resources are required of clinicians to take care of their Medicare patients, of which two-thirds have multiple chronic conditions. The prevalence of certain chronic conditions in the Medicare population is growing. For example, as of 2018, 68.9% of beneficiaries have 2 or more chronic conditions. In addition, between 2014 and 2018, the percent of beneficiaries with 6 or more chronic conditions has grown from 14.3% to 17.7%.

In this rule, CMS is proposing to similarly increase the value of many services that are comparable to or include office/outpatient E/M visits, such as maternity care bundles, emergency department visits, end-stage renal disease capitated payment bundles, physical and occupational therapy evaluation services, and others. The proposed adjustments, which implement recommendations from the American Medical Association, help to ensure that CMS is appropriately recognizing the kind of care where clinicians need to spend more face-to-face time with patients, like primary care and complex or chronic disease management.

Bolstering the Health Care Workforce/Patients Over Paperwork:

CMS is also taking steps to ensure that health care professionals can practice at the top of their professional training. During the COVID-19 public health emergency, CMS announced several temporary changes to expand workforce capacity and reduce clinician burden so that staffing levels remain high in response to the pandemic. As part of its Patients over Paperwork initiative to reduce regulatory burden for providers, CMS is proposing to make some of these temporary changes permanent following the PHE. Such proposed changes include:

- Nurse practitioners, clinical nurse specialists, physician assistants, and certified nurse-midwives (instead of only physicians) to supervise others performing diagnostic tests consistent with state law and licensure, providing that they maintain the required relationships with supervising/collaborating physicians as required by state law
- Clarifying that pharmacists can provide services as part of the professional services of a practitioner who bills Medicare
- Allowing physical and occupational therapy assistants (instead of only physical and occupational therapists) to provide maintenance therapy in outpatient settings
- Allowing physical or occupational therapists, speech-language pathologists, and other clinicians who directly bill Medicare to review and verify (sign and date), rather than re-document, information already entered by other members of the clinical team into a patient's medical record

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For More Information:

- *CY 2021 Physician Fee Schedule and Quality Payment Program Proposed Rule:* Public comments are due by October 5, 2020.
- *CY 2021 Physician Fee Schedule Proposed Rule* Fact Sheet
- *CY 2021 Quality Payment Program Proposed Rule* Fact Sheet
- *Medicare Diabetes Prevention Program* Fact Sheet

Trump Administration Proposes Policies to Provide Seniors with More Choices and Lower Costs for Surgeries

Outpatient Prospective Payment System (OPPS) & Ambulatory Surgical Center (ASC) proposed rule advances CMS' commitment to increasing competition

As directed by President Trump's Executive Order on Protecting and Improving Medicare for Our Nation's Seniors, CMS is proposing several policies that would give Medicare beneficiaries more choices in where they seek care and lower their out-of-pocket costs for surgeries. The proposed rule takes steps that would allow hospitals and ambulatory surgical centers to operate with better flexibility and patients to have what they need to make informed decisions on where they receive care.

"President Trump's mandate is to put patients and doctors back in charge of health care," said CMS Administrator Seema Verma. "Following through on that mandate entails loosening the stranglehold of government control that has accumulated over decades. Surgeries can be expensive. Patients should have as many options as possible for lowering their costs while getting quality care. These proposed changes, if finalized, would do exactly that, help put patients and doctors back in the driver's seat and in a position to make decisions about their own care."

For patients having surgery, hospital outpatient departments are subject to the same quality and safety standards as inpatient settings under Medicare rules. With this in mind, for 2021, CMS proposes to expand the number of procedures that Medicare would pay for in the hospital outpatient setting by eliminating the "Inpatient Only list," which includes procedures for which Medicare will only make payment when performed in the hospital inpatient setting.

This proposed change would remove regulatory barriers to give beneficiaries the choice to receive these services in a lower cost setting and convenience to go home as early as the same day after a procedure, when their clinician decides such a setting is appropriate. CMS would phase-in this proposal over three years and would gradually allow over 1,700 additional services to be paid when furnished in the hospital outpatient setting. In 2021, approximately 300 musculoskeletal services (such as certain joint

replacement procedures) would be newly payable in the hospital outpatient setting. The proposed change would be the largest one-time reduction to the Inpatient Only list by far; from 2017 through 2020, approximately 30 services total were removed from the Inpatient Only list.

Medicare pays for most services furnished in ASCs at a lower rate than hospital outpatient departments. As a result, when receiving care in an ASC rather than a hospital outpatient department, patients can potentially lower their out-of-pocket costs for certain services. For example, for one of the most common cataract surgeries, currently, on average, a Medicare beneficiary pays $101 if the procedure is done in a hospital outpatient department compared to $51 if done in a surgery center.

CMS proposes to expand the number of procedures that Medicare would pay for when performed in an ASC, which would give patients more choices in where they receive care and ensure CMS does not favor one type of care setting over another. For CY 2021, we propose to add eleven procedures that Medicare would pay for when provided in an ASC, including total hip arthroplasty. Since 2018, CMS has added 28 procedures to the list of surgical services that can be paid under Medicare when performed in ASCs.

Additionally, we propose two alternatives that would further expand our goals of increasing access to care at a lower cost. Under the first alternative, CMS would establish a process where the public could nominate additional services that could be performed in ASCs based on certain quality and safety parameters. Under the other proposed alternative, we would revise the criteria used to determine the procedures that Medicare would pay for in an ASC, potentially adding approximately 270 procedures that are already payable when performed in the hospital outpatient setting to the ASC list. Under this alternative, we solicit comment on whether the ASC conditions for coverage (the baseline health and safety requirements for Medicare-participating ASCs) should be revised given the potential for a significant expansion in the nature of services that would be added under this alternative proposal.

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As part of the Trump Administration's commitment to lowering drug prices, CMS is proposing a change that would lower beneficiaries' out-of-pocket drug costs for certain hospital outpatient drugs. In 2018 and 2019, CMS implemented a payment policy to help beneficiaries save on coinsurance for drugs that were administered at hospital outpatient departments and acquired through the 340B program, which allows certain hospitals to buy outpatient drugs at lower costs. Due to CMS' policy change, which was recently upheld by the United States Court of Appeals for the D.C Circuit, Medicare beneficiaries now benefit from the steep discounts that 340B-enrolled hospitals receive when they purchase drugs through the 340B program.

For 2021, CMS would provide even larger discounts for beneficiaries by proposing to further reduce the payment rate for drugs purchased through the 340B Program based on hospital survey data on drug acquisition costs. CMS is proposing to pay for 340B acquired drugs at average sales price minus 28.7 percent. With this proposed change, CMS estimates that, in 2021, Medicare beneficiaries would save an additional $85 million on out-of-pocket payments for these drugs and that OPPS payments for 340B drugs would be reduced by approximately $427 million. The savings from this change would be reallocated on an equal percentage basis to all hospitals paid under the OPPS. We propose that children's hospitals, certain cancer hospitals, and rural sole community hospitals would continue be excepted from these drug payment reductions. In the alternative, and in light of the court's recent decision, we propose to continue our current policy of paying ASP minus 22.5% for 340B drugs.

In continuing the agency's Patients Over Paperwork Initiative to reduce burden for health care providers, CMS is proposing to establish, update, and simplify the methodology to calculate the Overall Hospital Quality Star Rating (Overall Star Rating) beginning with CY 2021. The Overall Star Rating summarizes a variety of quality measures published on the Medicare.gov Hospital Compare tool for common conditions that hospitals treat, such as heart attacks or pneumonia. Along with publicly reported data on Hospital Compare, the Overall Star Rating helps patients make better informed health care decisions.

Responding to stakeholder feedback about the current methodology used to calculate the Overall Star Rating, CMS is proposing revisions on how to calculate the ratings and grouping hospitals in the Readmission measure group by the hospital's percentage of patients who are dually enrolled in Medicare and Medicaid, which would help provide better insight on health disparities. These and other proposed changes are intended to reduce provider burden, improve the predictability of the star ratings, and make it easier to compare ratings between similar hospitals.

As part of the agency's Rethinking Rural Health Initiative, in the FY 2020 Inpatient Prospective Payment System (IPPS) final rule, CMS increased the wage index for certain low wage index hospitals for at least four years, beginning in FY 2020. In the CY 2020 OPPS/ASC Payment System final rule, CMS adopted changes to the wage index for outpatient hospitals as were finalized in the FY 2020 IPPS final rule, including the increase in wage index for certain low wage index hospitals. The OPPS wage index adjusts hospital outpatient payment rates to account for local differences in wages that hospitals face in their respective labor markets. For 2021, under the OPPS, CMS proposes to continue to adopt the IPPS post-reclassified wage index, including the wage index increase for certain low wage index hospitals. The increase would address a common concern that the current wage index system contributes to disparities between high and low wage index hospitals. Overall, CMS estimates that payment for outpatient services in rural hospitals across the country would increase by 3 percent, which is 0.5 percent higher than the national average increase of 2.5 percent.

For More Information:

- *Proposed Rule*
- *Fact Sheet*

CMS Updates Medicare Payment Policies for IRFs

On August 4, CMS finalized a Medicare payment rule that further advances our efforts to strengthen the Medicare program by better aligning payments for Inpatient Rehabilitation Facilities (IRFs). The final rule updates Medicare payment policies and rates for facilities under the IRF Prospective Payment System (PPS) for FY 2021. This final rule also includes making permanent the regulatory change to eliminate the requirement for physicians to conduct a post admission visit since much of the information is included in the pre-admission visit. This flexibility was offered during the Coronavirus Disease 2019 (COVID-19) Public Health Emergency (PHE), and the rule would make this flexibility permanent beyond the expiration of the PHE. In recognition of the interdisciplinary role that non-physician practitioners are currently performing with patients in the IRF, CMS is also finalizing that a non-physician practitioner may perform one of the three required visits in lieu of the physician in the second and later weeks of a patient's care when consistent with the non-physician practitioner's state scope of practice. Additionally, for FY 2021, CMS is updating the IRF PPS payment rates by 2.4 percent.

For More Information:

- *Final Rule*
- *Fact Sheet*

MLN Connects® for Thursday, August 6, 2020

MLN Connects® for Thursday, August 6, 2020

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News

- Electronic Prescribing of Controlled Substances in Medicare Part D: Request for Information
- Release of the IRF Web Pricer
- Subsequent Nursing Facility E/M Services: Comparative Billing Report
- Nursing Home Compare Refresh
- Medicare Ground Ambulance Data Collection System: Updated Documents
- MACs Resume Medical Review on a Post-Payment Basis
- Renewed ABN: Deadline Extended to January 1
- COVID-19: Telemedicine, Clinical Experiences, Resources for Hospitals and Urgent Care Centers
- Protect Your Patients Against Vaccine-Preventable Diseases

Events

- National CMS/CDC Nursing Home COVID-19 Training Series Webcast — August 6
- COVID-19: Lessons from the Front Lines Call — August 7
- Physician Fee Schedule Proposed Rule: Understanding 4 Key Topics Listening Session — August 13
- Dr. Todd Graham Pain Management Study Listening Session — August 27

MLN Matters® Articles

- New Waived Tests
- Penalty for Delayed Request for Anticipated Payment (RAP) Submission – Implementation

MLN Connects® for Thursday, August 13, 2020

MLN Connects® for Thursday, August 13, 2020

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News

- Trump Administration Announces Initiative to Transform Rural Health
- Physician Compare Preview Period Open through August 20
- Management of Acute and Chronic Pain – Stakeholder Engagement Opportunity: Reply by August 21
- SNF Provider Preview Reports: Review Your Data by August 30
- PEPPERs for HHAs and PHPs
- Hospitals: Three Year Geographic Reclassification Data for FY 2022 MGCRB Applications
- Opioids: Co-Prescribing Naloxone

Events

- National CMS/CDC Nursing Home COVID-19 Training Series Webcast — August 13
- Dr. Todd Graham Pain Management Study Listening Session — August 27

MLN Matters® Articles

- Billing for Home Infusion Therapy Services On or After January 1, 2021
- Correction to Editing Update for Vaccine Services
- International Classification of Diseases, 10th Revision (ICD10) and Other Coding Revisions to National Coverage Determination (NCDs) – January 2021 Update
- Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment
- Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) – October 2020 Update
- Update to Osteoporosis Drug Codes Billable on Home Health Claims
- Influenza Vaccine Payment Allowances – Annual Update for 2020-2021 Season — Revised

Multimedia

- HQRP Training Resources Web-Based Training Course

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 Affairs 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