Medicare A CONNECTION

FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction 9 Providers July 2012

In this issue

Update to hospice payment rates, cap, wage index and Pricer for FY 2013

Provider types affected

This *MLN Matters*® article is intended for hospices submitting claims to Medicare contractors (fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), and A/B Medicare administrative contractors (MACs)) for services provided to Medicare beneficiaries.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 7857, which provides the annual update to the hospice payment rates, hospice wage index and Pricer for fiscal year (FY) 2013, and the annual update of the hospice cap amount for the 2013 cap year. Be sure your billing staffs are aware of these changes, which are described in the *Background* and *Key points* sections.

Background

Payment rates for hospice care, the hospice aggregate cap amount, and the hospice wage index are updated annually. Section 1814(i)(1)(C)(ii) of the Social Security Act (the Act) stipulates that the payment rates for hospice care for fiscal years after 2002 will increase by the market basket update for the FY. This payment methodology has been codified in regulations found at 42 Code of Federal Regulations (CFR) Section 418.306(a) and (b). The Affordable Care Act requires that, beginning in FY 2013, the market basket update be reduced by a productivity adjustment. Additionally, the Affordable Care Act requires that, in FY 2013, the market basket update also be reduced by 0.3 percentage point. These changes found in the Affordable Care Act are now part of the Social Security Act at Section 1814(i)(1)(C)(iv).

Hospice aggregate cap

The hospice aggregate cap amount is updated annually in accordance with Section 1814(i)(2)(B) of the Act and provides for an increase (or decrease) in the hospice cap amount. Specifically, the cap amount is increased or decreased for accounting years after 1984 by the same percentage as the percentage increase or decrease, respectively, in the medical care expenditure category of the consumer price index for all urban consumers.

Hospice wage index

The hospice wage index is used to adjust payment rates to reflect local differences in wages according to the revised wage index. The hospice wage index is updated annually in accordance with recommendations made by a negotiated rulemaking advisory committee as published in the *Federal Register* on August 8, 1997, and on August 8, 2008. 42 CFR Section 418.306(c) requires that the updated hospice wage index be issued annually in the *Federal Register*.

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Medicare A Connection subscription

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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.

J0490 Benlysta® (belimumab)

Benlysta® (belimumab) is indicated for the treatment of adult patients with active, autoantibody-positive, systemic lupus erythematosus (SLE) who are receiving standard therapy. Benlysta® was approved by the Food and Drug Administration (FDA) March 9, 2011.

Benlysta® is supplied as a sterile, preservative-free lyophilized powder for reconstitution, dilution, and intravenous infusion provided in single-use glass vials with a latex-free rubber stopper and a flip-off seal. Each 5-mL vial contains 120 mg of belimumab. Each 20-mL vial contains 400 mg of belimumab. As approved by the FDA, the recommended dosage regimen for belimumab is 10 mg/kg at 2-week intervals for the first three doses and at four-week intervals thereafter.

In the absence of a national coverage determination (NCD) or local coverage determination (LCD), Medicare can consider coverage of a drug that is usually not self-administered per the FDA indication when administered incident to a physician service or in the hospital setting. The medical record must clearly document and support the diagnosis of systemic lupus erythematosus, using the appropriate ICD-9-CM code 710.0, as well as the FDA label related to the appropriate administration of this drug.

J9315 Istodax® (romidepsin)

Istodax® (romidepsin) is a histone deacetylase (HDAC) inhibitor indicated for treatment of cutaneous T-cell lymphoma (CTCL) in patients who have received at least one prior systemic therapy or treatment of peripheral T-cell lymphoma (PTCL) in patients who have received at least one prior therapy. Istodax® was approved by the Food and Drug Administration (FDA) for CTCL on November 05, 2009, and for PTCL on June 16, 2011.

Istodax® is supplied as a kit which includes a sterile, lyophilized powder in a single-use vial containing 10 mg of romidepsin and 20 mg of the bulking agent, povidone, USP. In addition, each kit includes one sterile vial containing 2 mL (deliverable volume) of the Diluent composed of 80 percent propylene glycol, USP, and 20 percent dehydrated alcohol, USPA. As approved by the FDA, the recommended dose of romidepsin is 14 mg/m² administered intravenously over a 4-hour period on days 1, 8, and 15 of a 28-day cycle. Cycles should be repeated every 28 days provided that the patient continues to benefit from and tolerates the drug.

In the absence of a national coverage determination (NCD) or local coverage determination (LCD), Medicare can consider coverage of a drug that is usually not self-administered per the FDA indication when administered incident to a physician's service or in the hospital setting. The medical record must clearly document the patient's prior therapy and support the diagnosis of either cutaneous T-cell lymphoma or peripheral T-cell lymphoma, using the appropriate ICD-9-CM diagnosis code of 202.10-202.28 or 202.60-202.88 (Other malignant neoplasm's of lymphoid and histiocytic tissue) and FDA guidance for use as well as the administration.

J9999/C9399 Elelyso™ (taliglucerase alfa)

Elelyso™ (taliglucerase alfa) for injection is a hydrolytic lysosomal glucocerebroside-specific enzyme indicated for long-term enzyme replacement therapy (ERT) for adults with a confirmed diagnosis of Type 1 Gaucher disease. Elelyso™ was approved by the Food and Drug Administration (FDA) on May 1, 2012.

Elelyso™ (taliglucerase alfa) is available as a lyophilized powder 200 unit single-use vial. As approved by the FDA, the recommended dose is 60 units/kg administered every other week as a 60-120 minute intravenous infusion.

In the absence of a national coverage determination (NCD) or local coverage determination (LCD), Medicare can consider coverage of a drug that is usually not self-administered per the FDA indication when administered incident to a physician service or in the hospital setting. The medical record must clearly document the patient's history and physical, prior treatment regimen and Type 1 Gaucher-disease related progression. The patient's medical record must also support the diagnosis of Type 1 Gaucher disease using the appropriate ICD-9-CM code of 272.7 (Lipidoses) and FDA guidance for use as well as the administration.

J9999/C9399 Kyprolis™ (carfilzomib)

Kyprolis™ (carfilzomib) for injection, a proteasome inhibitor, is approved for the treatment of patients with multiple myeloma who have received at least two prior therapies, including bortezomib and an immunomodulatory agent, and have demonstrated disease progression on or within 60 days of completion of the last therapy. Kyprolis™ was approved by the Food and Drug Administration (FDA) on July 20, 2012.

Kyprolis™ (carfilzomib) for injection is supplied as an individually cartoned single-use vial containing a dose of 60mg of carfilzomib as a white to off-white lyophilized cake or powder. Kyprolis™ is administered intravenously over two to ten minutes, on two consecutive days, each week for three weeks (days 1, 2, 8, 9, 15, and 16), followed by a 12-day rest period (days 17 through 28). Each 28-day period is considered one treatment cycle. As approved by the FDA, the recommended Cycle 1 dose is 20 mg/m². If tolerated in Cycle 1, the dose should be escalated to 27 mg/m ² beginning in Cycle 2 and continued at 27 mg/m² in subsequent cycles.

In the absence of a national coverage determination (NCD) or local coverage determination (LCD), Medicare can consider coverage of a drug that is usually not self-administered per the FDA indication when administered incident to a physician service or in the hospital setting. The medical record must clearly document the patient's prior chemotherapy regimens, disease progression and body surface area. The patient's medical record must also support the diagnosis of multiple myeloma, using the appropriate ICD-9-CM code(s) of 203.00 (Multiple myeloma, without mention of having achieved remission/failed remission) or 203.02 (Mutliple Myeloma, in relapse) and FDA guidance for use as well as the administration.

J9999/C9399 Perjeta™ (pertuzumab)

Perjeta™ (pertuzumab) is a HER2/neu receptor antagonist indicated in combination with trastuzumab and docetaxel for the treatment of patients with HER2-positive metastatic breast cancer who have not received prior anti-HER2 therapy or chemotherapy for metastatic disease. Perjeta™ was approved by the Food and Drug Administration (FDA) June 8, 2012.

Perjeta ™ is supplied as a 420mg/mL (30mg/mL) single-use vial containing preservative free solutions. As approved by the FDA, the recommended initial dosage regimen for pertuzumab is 840mg administered as a 60-minute intravenous infusion, followed every three weeks thereafter by a dose of 420 mg administered as an intravenous infusion over 30 to 60 minutes.

When administered with Perjeta™, the recommended initial dose of trastuzumab is 8 mg/kg administered as a 90-minute intravenous infusion, followed every three weeks thereafter by a dose of 6 mg/kg administered as an intravenous infusion over 30 to 90 minutes.

When administered with Perjeta™, the recommended initial dose of docetaxel is 75 mg/ḿ administered as an intravenous infusion. The dose may be escalated to 100 mg/ḿ administered every three weeks if the initial dose is well tolerated.

In the absence of a national coverage determination (NCD) or local coverage determination (LCD), Medicare can consider coverage of a drug that is usually not self-administered per the FDA indication when administered incident to a physician service or in the hospital setting. The medical record must clearly document the patient has HER2-positive metastatic breast cancer and which chemotherapy agent(s) is being used in combination with pertuzumab. The patient's medical record must also support the diagnosis of metastatic breast cancer, using the appropriate ICD-9-CM code(s) of 174.0-174.9 (Malignant neoplasm of female breast) or 175.0-175.9 (Malignant neoplasm of male breast) and FDA guidance for use as well as the administration.

Billing and coverage for drug wastage

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

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

Extracorporeal photopheresis (ICD-10)

Note: This article was revised on July 11, 2012, to reflect the revised change request (CR) 7806 issued on July 10. The CR release date, transmittal number, and the Web address for accessing CR 7806 were revised. All other information is the same. This information was previously published in the June 2012 *Medicare A Connection*, Pages 15-18.

Provider types affected

This *MLN Matters*® article is intended for physicians and other providers who bill Medicare carriers, fiscal intermediaries (FIs), or Medicare administrative contractors (A/B MACs) for providing extracorporeal photopheresis procedures for the treatment of bronchiolitis obliterans syndrome (BOS) following lung allograft transplantation.

Provider action needed

Effective for claims with dates of service on and after April 30, 2012, Medicare will cover extracorporeal photopheresis for the treatment of bronchiolitis obliterans syndrome (BOS) following lung allograft transplantation, but only when provided under an approved clinical research study that meets specific requirements to assess the effect of extracorporeal photopheresis for the treatment of BOS following lung allograft transplantation. You should make sure that your billing staffs are aware of the expanded coverage provided in this NCD.

Background

Extracorporeal photopheresis is a second-line treatment for a variety of oncological and autoimmune disorders that is performed in the hospital inpatient, hospital outpatient, and critical access hospital (CAH) settings. In the procedure, some of a patient's removed white blood cells are exposed first to the drug 8-methoxypsoralen (8-MOP) and then to ultraviolet A (UVA) light. After UVA light exposure, the treated white blood cells are re-infused into the patient, stimulating their immune system in a series of cascading reactions. This activation of the immune system then impacts the illness being treated.

Currently, Medicare covers extracorporeal photopheresis for the following indications:

- Palliative treatment of skin manifestations of CTCL that has not responded to other therapy;
- Patients with acute cardiac allograft rejection whose disease is refractory to standard immunosuppressive drug treatment; and
- Patients with chronic graft versus host disease whose disease is refractory to standard immunosuppressive drug treatment.

On August 4, 2011, the Centers for Medicare & Medicaid Services (CMS) accepted a formal request for a reconsideration to add coverage for extracorporeal photopheresis treatment for patients who have received lung allografts and then developed progressive BOS refractory to immunosuppressive drug treatment.

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Photopheresis *(continued)*

As a result of the reconsideration, effective for claims with dates of service on and after April 30, 2012, Medicare will begin to cover extracorporeal photopheresis for the treatment of BOS following lung allograft transplantation; but only when provided under a clinical research study that meets specific requirements to assess its effect in the treatment of BOS following lung allograft transplantation.

NCD clinical research study requirements

This is a national coverage determination (NCD). In keeping with this NCD, any clinical research study that includes Medicare coverage of extracorporeal photopheresis for the treatment of BOS following lung allograft transplantation must be approved by meeting the requirements listed below. Additionally, consistent with section 1142 of the Social Security Act, AHRQ supports clinical research studies that CMS determines meet these standards and address the research questions.

An approved clinical research study:

1. Must address one or more aspects of the following question:

   Prospectively, do Medicare beneficiaries who have received lung allografts, developed BOS refractory to standard immunosuppressive therapy, and received extracorporeal photopheresis, experience improved patient-centered health outcomes as indicated by:

   a. Improved forced expiratory volume in one second (FEV1);

   b. Improved survival after transplant; and/or

   c. Improved quality of life?

2. Must adhere to the following standards of scientific integrity and relevance to the Medicare population:

   a. Its principal purpose is to test whether extracorporeal photopheresis potentially improves the participants' health outcomes;

   b. It is well supported by available scientific and medical information or it is intended to clarify or establish the health outcomes of interventions already in common clinical use;

   c. It does not unjustifiably duplicate existing studies;

   d. Its design is appropriate to answer the research question being asked in the study;

   e. It is sponsored by an organization or individual capable of successfully executing the proposed study;

   f. It is in compliance with all applicable federal regulations concerning the protection of human subjects found at 45 *Code of Federal Regulations* CFR Part 46. If a study is regulated by the Food and Drug Administration (FDA), it must also be in compliance with 21 CFR parts 50 and 56;

   g. All of its aspects are conducted according to appropriate standards of scientific integrity (see *http://www.icmje.org*);

   h. It has a written protocol that clearly addresses, or incorporates by reference, the standards listed here as Medicare requirements for coverage with evidence development (CED) coverage;

   i. It is not designed to exclusively test toxicity or disease pathophysiology in healthy individuals. Trials of all medical technologies measuring therapeutic outcomes as one of the objectives meet this standard only if the disease or condition being studied is life threatening as defined in 21 CFR Section 312.81(a) and the patient has no other viable treatment options;

   j. It is registered on the ClinicalTrials.gov website (*http://clinicaltrials.gov*) by the principal sponsor/investigator prior to the enrollment of the first study subject;

   k. Its protocol specifies the method and timing of public release of all prespecified outcomes to be measured including release of outcomes if outcomes are negative or study is terminated early. The results must be made public within 24 months of the end of data collection. If a report is planned to be published in a peer reviewed journal, then that initial release may be an abstract that meets the requirements of the International Committee of Medical Journal Editors (*http://www.icmje.org*).

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Photopheresis *(continued)*

l. It explicitly discusses subpopulations affected by the treatment under investigation, particularly traditionally underrepresented groups in clinical studies, how the inclusion and exclusion criteria effect enrollment of these populations, and a plan for the retention and reporting of said populations on the trial. If the inclusion and exclusion criteria are expected to have a negative effect on the recruitment or retention of underrepresented populations, the protocol must discuss why these criteria are necessary

m. Its study protocol explicitly discusses how the results are or are not expected to be generalizable to the Medicare population to infer whether Medicare patients may benefit from the intervention. Separate discussions in the protocol may be necessary for populations eligible for Medicare due to age, disability or Medicaid eligibility.

Note: Any clinical study in which there is coverage of extracorporeal photopheresis for this indication under this NCD must be approved by April 30, 2014 (two years from the effective date of this NCD). If there are no approved clinical studies by this date, this NCD will expire and coverage of extracorporeal photopheresis for BOS will revert to the coverage policy in effect prior to the issuance of its Final Decision Memorandum (DM) on April 30, 2012.

Billing requirements

Effective for claims with dates of service on and after April 30, 2012, your carrier, FI, or A/B MAC will accept and pay for hospital outpatient and physician claims containing Healthcare Common Procedure Coding System (HCPCS) procedure code *36522* along with one of the International Classification of Diseases (ICD-9-CM or ICD-10) diagnosis codes displayed in the following table.

ICD-9-CM	ICD-9-CM description	ICD-10	ICD-10 description
491.20	Obstructive chronic bronchitis without exacerbation	J44.9	Chronic obstructive pulmonary disease, unspecified
491.21	Obstructive chronic bronchitis with (acute) exacerbation	J44.1	Chronic obstructive pulmonary disease with (acute) exacerbation
491.9	Unspecified chronic bronchitis	J42	Unspecified chronic bronchitis
496	Chronic airway obstruction, not elsewhere classified	J44.9	Chronic obstructive pulmonary disease, unspecified
996.84	Complications of transplanted lung	T86.810	Lung transplant rejection
996.84	Complications of transplanted lung	T86.811	Lung transplant failure
996.84	Complications of transplanted lung	T86.812	Lung transplant infection (not recommended for ECP coverage)
996.84	Complications of transplanted lung	T86.818	Other complications of lung transplant
996.84	Complications of transplanted lung	T86.819	Unspecified complication of lung transplant
V70.7	Examination of participant in clinical trial	Z00.6	Encounter for examination for normal comparison and control in clinical research program (needed for CED)

Note: Any clinical study in which there is coverage of extracorporeal photopheresis for this indication under this NCD must be approved by April 30, 2014 (two years from the effective date of this NCD). If there are no approved clinical studies by this date, this NCD will expire and coverage of extracorporeal photopheresis for BOS will revert to the coverage policy in effect prior to the issuance of its final decision memorandum (DM) on April 30, 2012.

Please note that your claims will only be paid when they also contain all of the following:

- Diagnosis code V70.7 (as secondary diagnosis);
- Condition code 30 (institutional claims only);

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Photopheresis *(continued)*

- Clinical trial modifier Q0 (investigational clinical service provided in a clinical research study that is in an approved research study); and
- Value code D4 with an 8-digit clinical trial number (optional)(FIs only).

Additionally, should your Medicare contractor return your claims as unprocessable because they are missing: 1) Diagnosis code V70.7 (as secondary diagnosis), 2) Condition code 30 (institutional claims only), 3) Clinical trial modifier Q0 (institutional claims only), and 4) Value code D4 with an 8-digit clinical trial number (optional) (FIs only); they will use the following messages:

- CARC 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- RARC MA 130 – Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
- RARC M16 – Alert: Please see our website, mailings, or bulletins for more details concerning this policy/procedure/decision.

Please keep in mind that your contractor will not retroactively adjust claims from April 30, 2012, processed prior to implementation of CR 7806. However, they may adjust claims that you bring to their attention.

Additional information

The official instruction, CR 7806, was issued in two transmittals. The first updates to the *Medicare National Coverage Determinations Manual* are available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R143NCD.pdf*. The second updates the *Medicare Claims Processing Manual* and it is at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2494CP.pdf* .

If you have any questions, please contact your carrier, FI, or A/B MAC at their toll-free number, which may be found at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

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Implementation Date: October 1, 2012

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Register for free, hands-on Internet based PECOS class

Join First Coast Service Options, in Jacksonville, for a free, *interactive session* on using Internet-based PECOS to electronically create or update your Medicare enrollment. Select from the following session dates: August 21 or September 11, 2012.

Pulmonary rehabilitation (PR) services

Note: This article was revised on July 10 and 16, 2012, to add clarifying language, as contained in change request (CR) 6823, to show that the covered benefit for the comprehensive pulmonary rehabilitation (PR) program is for patients with moderate to very severe chronic obstructive pulmonary disease (COPD). All other information is the same. This information was previously published in the June 2010 *Medicare A Bulletin*, Pages 34-35.

Provider types affected

This article is for physicians and providers submitting claims to Medicare contractors (Medicare administrative contractors (A/B MACs), fiscal intermediaries (FIs) and/or carriers) for pulmonary rehabilitation (PR) services provided to Medicare beneficiaries.

Provider action needed

This article is based on CR 6823 which alerts providers that the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 added payment and coverage improvements for patients with chronic obstructive pulmonary disease (COPD) and other conditions effective January 1, 2010. As a result, Medicare provides a covered benefit for a comprehensive PR program for patients with moderate to very severe COPD under Medicare Part B effective for services on or after January 1, 2010. Be certain your billing staffs are aware of these Medicare changes and of the claims processing system changes to handle claims for PR services that must be implemented no later than October 4, 2010.

Background

Pulmonary rehabilitation (PR) is a multi-disciplinary program of care for patients with chronic respiratory impairment who are symptomatic and often have decreased daily life activities. .

A PR program is individually tailored and designed to optimize physical and social performance and autonomy. The program must provide an evidence-based, multidisciplinary, and comprehensive intervention for patients with chronic respiratory impairment. In September 2007, the Centers for Medicare & Medicaid Services (CMS), in its final decision memorandum for PR services, announced there was no basis for a national coverage determination at that time. Specifically, this decision was based on a determination by CMS that the Social Security Act did not expressly define a comprehensive PR program as a Part B benefit, and the evidence was not adequate to draw conclusions on the benefit of the individual components of PR. CMS did (and still does) cover medically reasonable and necessary

respiratory treatment services in comprehensive outpatient rehabilitation facilities (CORFs), as well services to patients with respiratory impairments who are not eligible for PR but for whom local contractors determine respiratory treatment services are covered. MIPPA added payment and coverage improvements for patients with COPD and other conditions, and now provides a covered benefit for a comprehensive PR program for patients with moderate to very severe COPD under Medicare Part B effective January 1, 2010. This law authorizes a PR program, which was codified in the physician fee schedule calendar year 2010 final rule at 42 CFR 410.47.

Key points of CR 6823

Effective January 1, 2010, MIPPA provisions added a physician–supervised, comprehensive PR program for patients with moderate to very severe COPD. Medicare will pay for up to two (2) one-hour sessions per day, for up to 36 lifetime sessions (in some cases, up to 72 lifetime sessions) of PR. The PR program must include the following mandatory components:

1. Physician-prescribed exercise;
2. Education or training;
3. Psychosocial assessment;
4. Outcomes assessment; and
5. An individualized treatment plan.

The following bullet points detail Medicare claims processing requirements for PR services furnished on or after January 1, 2010:

- Effective January 1, 2010, Medicare contractors will pay claims containing Healthcare Common procedure Coding System (HCPCS) code G0424 when billing for PR services, including exercise and monitoring, as described in the *Medicare Benefit Policy Manual*, Chapter 15, section 231,

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as revised by CR 6823, and the *Medicare Claims Processing Manual*, Chapter 32, Section 140, as revised by CR 6823. These revised documents are attached to CR 6823, which is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R124BP.pdf* (*Benefit Policy Manual*) and *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1966CP.pdf* (*Claims Processing Manual*) on the CMS website.

- Medicare contractors will pay claims for HCPCS code G0424 (PR) only when services are provided in the following places of service (POS): 11 (physician's office) or 22 (hospital outpatient). Medicare will deny claims for HCPCS code G0424 performed in other than, and billed without, POS 11 or 22, using the following:
  - Claim adjustment reason code (CARC) 58 – "treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. **Note:** Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
  - Remittance advice remark code (RARC) N428 – "Service/procedure not covered when performed in this place of service."
  - Group code PR (patient responsibility) assigning financial liability to the patient if the claim was received with a GA modifier indicating a signed advance beneficiary notice (ABN) is on file or group code CO (contractual obligation) assigning financial liability to the provider if the claim is received with the GZ modifier indicating no signed ABN on file.
- Medicare contractors will pay claims for PR services containing HCPCS code G0424 and revenue code 0948 on types of bill (TOB) 13x and 85x under reasonable cost.
- Contractors will pay for PR services for hospitals in Maryland under the jurisdiction of the Health Services Cost Review Commission on an outpatient basis, TOB 13x, in accordance with the terms of the Maryland waiver.
- Contractors will deny claims for PR services provided in other than TOB 13x and 85x using the following:
  - CARC 58 – "Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. **Note:** Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
  - RARC N428 – "Service/procedure not covered when performed in this place of service."
  - Group code PR assigning financial liability to the patient if the claim was received with a GA modifier indicating a signed ABN is on file or group code CO assigning financial liability to the provider if the claim is received with the GZ modifier indicating no signed ABN on file.
- Using the Medicare physician fee schedule, Medicare contractors will also pay for PR services billed with HCPCS code G0424 and revenue code 096x, 097x, or 098x on TOB 85X from method II critical access hospitals (CAHs).
- Medicare will deny PR services that exceed two units on the same date of service and, in doing so, will use the following:
  - CARC 119 – "Benefit maximum for this time period or occurrence has been reached."
  - RARC N362 – "The number of days or units of service exceeds our acceptable maximum."
  - Group code PR assigning financial liability to the patient if the claim was received with a GA modifier indicating a signed ABN is on file or group code CO assigning financial liability to the provider if the claim is received with the GZ modifier indicating no signed ABN on file.
- Medicare will normally pay for 36 sessions of PR, but may pay up to 72 sessions when the claim(s) for sessions 37-72 includes a KX modifier. Claims for HCPCS code G0424 which exceed 36 sessions without the KX modifier will be denied using the following:
  - CARC 151 – "Payment adjusted because the payer deems the information submitted does not support this many/frequency of services."
  - Group code PR assigning financial liability to the patient if the claim was received with a GA modifier indicating a signed ABN is on file or group code CO assigning financial liability to the provider if the claim is received with the GZ modifier indicating no signed ABN on file.
- Medicare contractors will deny claims for HCPCS code G0424 when submitted for more than 72 sessions even where the KX modifier is present. In the denials, contractors will use the following:
  - CARC B5 – "Coverage/program guidelines were not met or were exceeded."

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- Group code PR assigning financial liability to the patient if the claim was received with a GA modifier indicating a signed ABN is on file or group code CO assigning financial liability to the provider if the claim is received with the GZ modifier indicating no signed ABN on file.

Additional information

If you have questions, please contact your Medicare MAC, FI, or carrier at their toll-free number which may be found at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

CR 6823 was issued to your Medicare MAC, FI, or carrier in two transmittals. One transmittal modifies the *Medicare Benefit Policy Manual* and that transmittal is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R124BP.pdf*. The second transmittal modifies the *Medicare Claims Processing Manual* and that transmittal is at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1966CP.pdf*.

For related detailed policy and claims processing instructions issued December 11, 2009, you may review MM6751 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6751.pdf.*

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Related CR Transmittal #: R124BP and R1966CP
Implementation Date: October 4, 2010

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

Quarterly provider update

The Centers for Medicare & Medicaid Services (CMS) publishes the quarterly provider update (QPU) at the beginning of each quarter to inform the public about:

- Regulations and major policies currently under development during this quarter.
- Regulations and major policies completed or canceled.
- New/revised manual instructions.

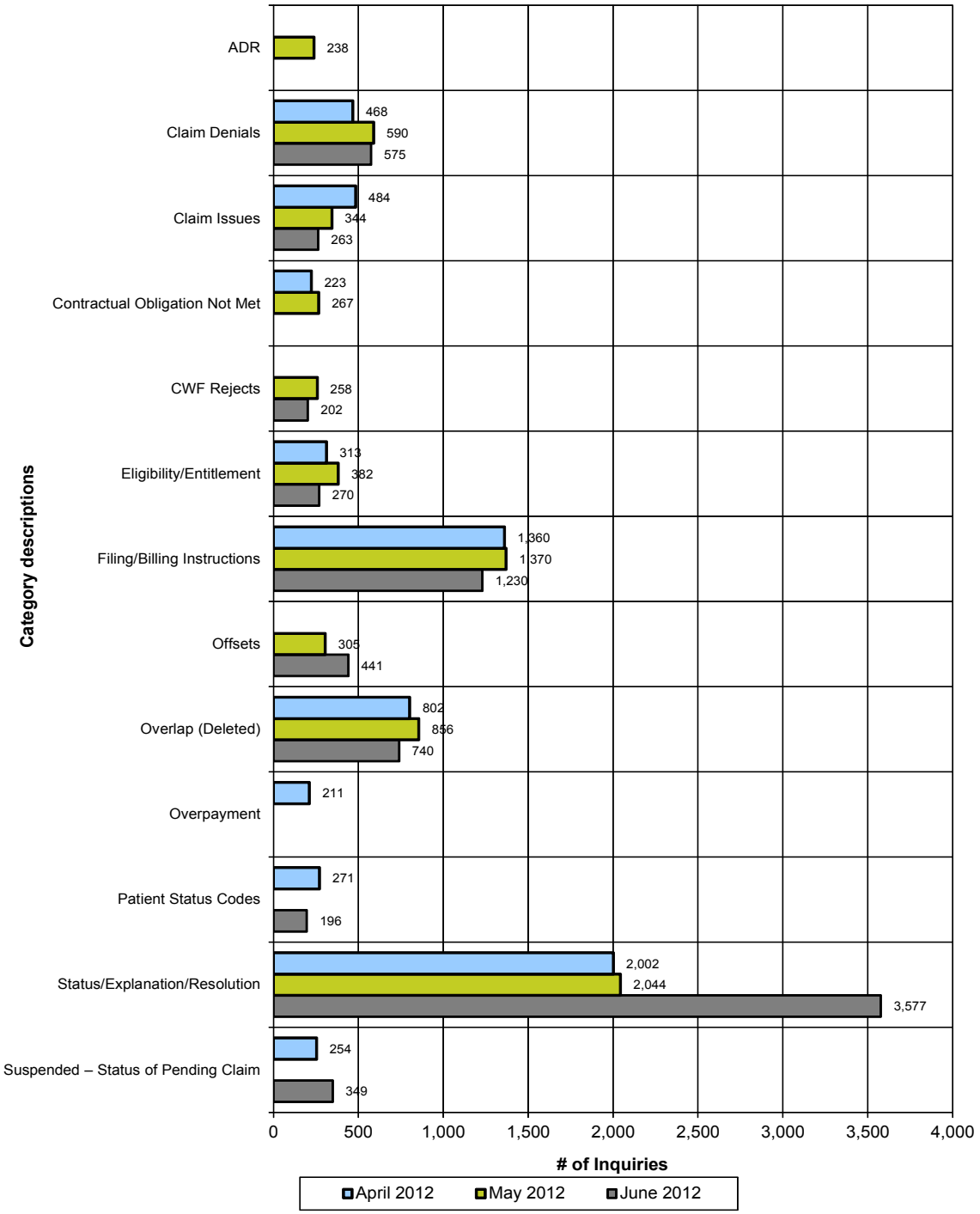
CMS regulations establish or modify the way CMS administers the Medicare program. These regulations impact providers and suppliers providing services to Medicare beneficiaries. Providers may access the QPU by going to the CMS website at *http://www.cms.gov/QuarterlyProviderUpdates/.* Providers may join the CMS-QPU electronic mail to ensure timely notification of all additions to the QPU.

Top inquiries, rejects, and return to provider claims – April-June 2012

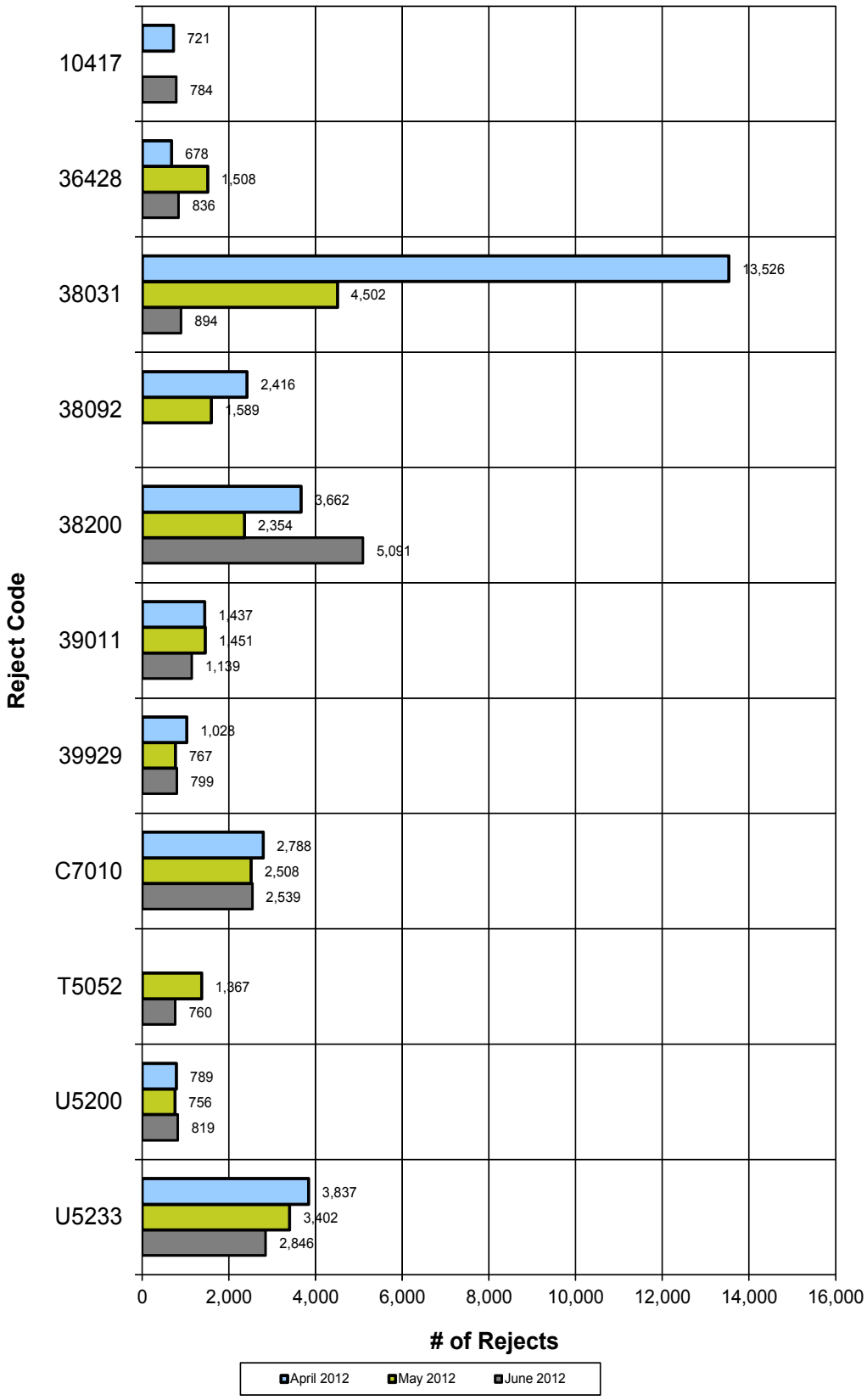
The following charts provide the most frequent inquiries and reason codes for rejected and returned to provider (RTP) claims submitted to First Coast Service Options Inc. (FCSO), by providers in Florida, Puerto Rico, and the U.S. Virgin Islands during April through June 2012.

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

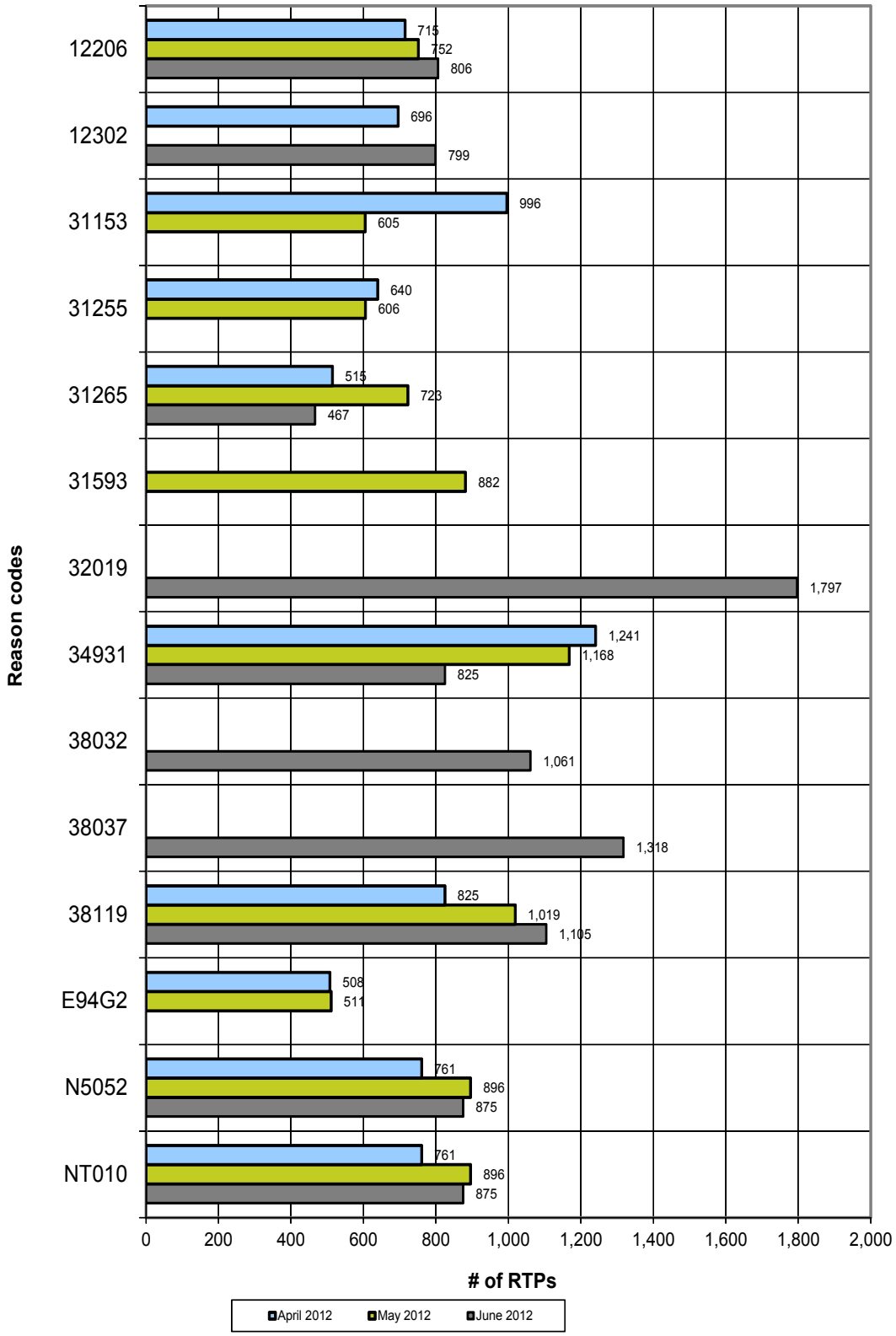
Part A top inquiries for April-June 2012



Part A top rejects for April-June 2012



Part A top return to providers (RTPs) for April-June 2012



SSI ratios for FY 2006-2009 for IPPS hospitals, IRFs, and LTCHs

Provider types affected

This *MLN Matters*® special edition article is intended for inpatient prospective payment system (IPPS) hospitals, inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCHs) submitting claims to Medicare contractors (fiscal intermediaries (FIs) and A/B Medicare administrative contractors (MACs)) for services provided to Medicare beneficiaries.

What you need to know

The Centers for Medicare & Medicaid Services (CMS) has posted the Supplemental Security Income (SSI) ratios for fiscal years (FYs) 2006, 2007, 2008, and 2009 to the CMS website. These SSI ratios include Medicare Advantage (MA) patient days and are calculated in the manner prescribed by CMS-1498-R. Providers who are interested in obtaining the data used to calculate their FY 2006 – FY 2009 SSI ratios are encouraged to submit a letter of request along with a disproportionate share (DSH) data use agreement. See the *Background* and *Additional information* sections of this special edition article for further details.

Background

The Centers for Medicare & Medicaid Services (CMS) has posted the SSI ratios for FYs 2006, 2007, 2008, and 2009 to the CMS website.

- The IPPS SSI ratios are located at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html* ;
- The IRF SSI ratios are located at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/SSIData.html*; and
- The LTCH SSI ratios are located at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/download.html*.
- These SSI ratios include Medicare Advantage (MA) patient days and are calculated in the manner prescribed by CMS-1498-R, available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/Downloads/CMS1498R.pdf*.

Obtaining data

Providers who are interested in obtaining the data used to calculate their FY 2006-2009 SSI ratios are encouraged to submit a letter of request along with a DSH data use agreement. These data will display MA patient days separately. If you submitted a request when CMS was not accepting requests because these data were not available, you must submit a new request. In order to obtain this data, you should follow the data request process outlined at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Privacy/-_DSH_Privacy.html*.

SSI ratios

The SSI ratios are used for settlement purposes for IPPS and IRFs eligible for a Medicare DSH payment or low income payment adjustment, respectively.

- The FY 2006 SSI ratios will be used to settle cost reports with cost reporting periods beginning on or after October 1, 2005, and before October 1, 2006;
- The FY 2007 SSI ratios will be used to settle cost reports with cost reporting periods beginning on or after October 1, 2006, and before October 1, 2007;
- The FY 2008 SSI ratios will be used to settle cost reports with cost reporting periods beginning on or after October 1, 2007, and before October 1, 2008; and
- The FY 2009 SSI ratios will be used to settle cost reports with cost reporting periods beginning on or after October 1, 2008, and before October 1, 2009.

Under the LTCH PPS, the payment adjustment for short-stay outlier (SSO) cases at 42 *Code of Federal Regulations* (CFR) Section 412.529 requires the calculation of an amount comparable to the amount that would otherwise be paid under the IPPS (i.e., the "IPPS comparable amount."). This calculation includes the Medicare DSH adjustment where applicable, using the best available SSI ratios at the time of claim payment (See 42 CFR Section 412.529(d)(4), available at *http://edocket.access.gpo.gov/cfr_2008/octqtr/pdf/42cfr412.529.pdf*.) The latest published SSI ratios will be included in the provider specific file and will be used to calculate interim Medicare DSH payments and low income patient (LIP) payments.

Realignment and requests

Previous requests for realignment:

42 CFR Section 412.106(b)(3) allows you to request to have your SSI ratio recomputed/realigned based on your cost reporting period for IPPS payment. You may have requested that your cost reports for cost years 2006 - 2009 be settled using SSI ratios based on your cost reporting periods rather than the federal fiscal year (i.e., that your SSI ratios be realigned for 2006 - 2009) prior to the release of the revised SSI ratios on March 16, 2012. Since CMS has published revised SSI ratios, the previous requests for these cost report years are no longer valid. (See 42 CFR Section 106(b)(3), available at *http://www.gpo.gov/fdsys/pkg/CFR-2003-title42-vol2/pdf/CFR-2003-title42-vol2-sec412-106.pdf.*)

Current settlement actions and requests for realignment:

- All cost reports for cost years 2006 - 2009 will be

(continued on next page)

Outpatient *(continued)*

settled using revised SSI ratios that are based on the federal fiscal year.

- Providers receiving the revised federal fiscal year SSI ratios may then exercise their one-time ability to request realignment to the SSI ratios based on their cost reporting period using the revised SSI ratios, but any previous requests will not be implemented since the SSI ratios have changed.

Open or reopened cost reports:

If you have a realignment request for an open cost report, or a cost report that was previously final settled and was properly reopened to use the revised SSI ratio, you will receive a notice from your Medicare contractor that the realignment request no longer applies, since you will receive a revised SSI ratio. You may request realignment, based on the revised SSI ratio, within the normal timeframes.

FYs 2006-2009 cost report final settlement

Medicare contractors will be working to final settle the backlog of cost reports that have been held, awaiting revised SSI ratios. CMS anticipates that most of the 2006-2009 cost reports will be final settled (issuance of the notice of program reimbursement - NPR) over the next year. In addition, contractors will issue revised NPRs for any 2006 or 2007 cost reports that were previously final settled, and properly reopened for the SSI ratio issue. You should address any specific questions with your Medicare contractor.

Additional information

If you have any questions, please contact your FI or A/B MAC at their toll-free number, which may be found at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: SE1225
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

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Hospice *(continued)*

Key points of CR 7857

The annual hospice payment updates will be implemented through the hospice Pricer software found in the fiscal intermediary standard systems. The new Pricer module will not contain any new calculation logic, but will simply apply the existing calculation to the updated payment rates in the table on the next page. An updated table will be installed in the module, to reflect the FY 2013 hospice wage index.

The FY 2013 payment rates will be the FY 2012 payment rates increased by 1.6 percentage points, which is the final hospital market basket update for FY 2013 (2.6 percent) less a productivity adjustment of 0.7 percent, less 0.3 percent per the Affordable Care Act. The FY 2013 hospice payment rates are effective for care and services furnished on or after October 1, 2012, through September 30, 2013.

FY 2013 hospice payment rates

The hospice payment rate is discussed further in the *Medicare Claims Processing Manual*, Chapter 11, Processing Hospice Claims, Section 30.2, which is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c11.pdf*.

Code	Description	Rate	Wage component subject to index	Non-weighted amount
651	Routine home care	$153.45	$105.44	$48.01
652	Continuous home care full rate = 24 hours of care $37.32= hourly rate	$895.56	$615.34	$280.22
655	Inpatient respite care	$158.72	$85.92	$72.80
656	General inpatient care	$682.59	$436.93	$245.66

(continued on next page)

Hospice *(continued)*

Hospice cap

The latest hospice cap amount for the cap year ending October 31, 2012, is $25,377.01. In computing the cap, we used the medical care expenditure category of the March 2012 Consumer Price Index for all Urban consumers, which was 411.498. This index is published by the Bureau of Labor Statistics and is available at *http://www.bls.gov/cpi/home.htm*. The hospice cap is discussed further in the *Medicare Benefit Policy Manual*, Chapter 9, "Coverage of Hospice Services Under Hospital Insurance," Section 90, which is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c09.pdf*.

Hospice wage index

The FY 2013 hospice wage index notice will be effective October 1, 2012, and will be published in the *Federal Register* before that date. The revised wage index and payment rates will be incorporated in the hospice Pricer and forwarded to the intermediaries following publication of the wage index notice.

Note: Hospice providers are encouraged to split claims if dates of service span separate fiscal years, e.g., September/October billing. Medicare contractors will use the FY 2012 rates if the hospice chooses not to split the claim; the contractor will perform no subsequent adjustments to these claims.

Additional information

The official instruction, CR 7857, issued to your FI, RHHI and A/B MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2497CP.pdf*.

If you have any questions, please contact your FI, RHHI or A/B MAC at their toll-free number, which may be found at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM7857
Related Change Request (CR) #: CR 7857
Related CR Release Date: July 20, 2012
Effective Date: October 1, 2012
Related CR Transmittal #: R2497CP
Implementation Date: October 1, 2012

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Reporting of recoupment for overpayment on the remittance advice with patient control number

Note: This article was revised July 25, 2012, to reflect a revised change request (CR) 7499 issued on July 19, 2012. The article was also revised July 2, 2012, to reflect a revised CR 7499 issued on June 28, 2012. The article was revised to show a financial control number in PLB 03-2 of the remittance advice. The article was revised to show a revised transmittal number, CR release date, and Web address for accessing CR 7499. All other information is the same. This information was previously published in the May 2012 *Medicare A Connection*, Page 39.

Provider types affected

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

Provider action needed

This article is based on CR 7499 which instructs Medicare's claims processing systems maintainers to replace the health insurance claim (HIC) number being sent on the ASC X12 transaction 835) with the patient control number received on the original claim, whenever the electronic remittance advice (ERA) is reporting the recovery of an overpayment.

Background

The Centers for Medicare & Medicaid Services (CMS) generates Health Insurance Portability and Accountability Act (HIPAA) compliant remittance advice that includes enough information to providers so that manual intervention is not needed on a regular basis. CMS changed reporting of recoupment for overpayment on the ERA) as a response to provider request per CR 6870 and CR 7068. The *MLN Matters* article corresponding to CR 6870 can be reviewed at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6870.pdf* and CR 7068 can be reviewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R812OTN.pdf*.

It has been brought to the attention of CMS that providing the patient control number as received on the original claim rather than the health insurance claim (HIC) number would:

- Enhance provider ability to automate payment posting, and
- Reduce the need for additional communication (via telephone calls, etc.) that would subsequently reduce the costs for providers as well as Medicare.

CR 7499 instructs the shared systems to replace the HIC number being sent on the ERA with the patient control number, received on the original claim. The ERA will continue to report the HIC number if the patient control number is not available. This would appear in positions 20-39 of PLB 03-2. A demand letter is also sent to the provider when the accounts receivable (A/R) is created. This document contains a claim control number for tracking purposes that is also reported in positions 1-19 of PLB 03-2 on the ERA. (DME ERAs (835's) will show a financial control number in positions 1-14 of PLB 03-2 and the adjustment claim control number in positions 15-29 of PLB 03-2.)

Note: Instructions in CR 7499 apply to the 005010A1 version of ASC X12 transaction 835 only and do not apply to the standard paper remit or the 004010A1 version of ASC X12 transaction 835.

Additional information

The official instruction, CR 7499, issued to your carrier, FI, A/B MAC, DME MAC, or RHHI regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1101OTN.pdf*.

If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM7499 Revised
Related Change Request (CR) #: CR 7499
Related CR Release Date: July 19, 2012
Effective Date: January 1, 2012
Related CR Transmittal #: R1101OTN
Implementation Date: January 3, 2012 for professional claims billed to carriers or B MACs; April 2, 2012 for institutional claims billed to Fiscal intermediaries or A MACs; October 1, 2012 for supplier claims submitted to DME MACs

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Educational Events

Upcoming provider outreach and educational events – August 2012

Internet-based PECOS class (A/B)
When: Tuesday, August 21
Time: 8 a.m. – noon ET **Delivery language:** English
Type of Event: Face-to-face **Focus:** Florida, Puerto Rico, and U.S. Virgin Islands

Two easy ways to register

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

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

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

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

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Provider Address: _____

City, State, ZIP Code: _____

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

Never miss a training opportunity

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

Take advantage of 24-hour access to free online training

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

Addresses

First Coast Service Options

American Diabetes Association certificates
Medicare Provider Enrollment – ADA
P. O. Box 2078
Jacksonville, FL 32231-0048

Claims/correspondence
Florida:
Medicare Part A Customer Service
P. O. Box 2711
Jacksonville, FL 32231-0021

U.S. Virgin Islands:
First Coast Service Options Inc.
P. O. Box 45071
Jacksonville, FL 32232-5071

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

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

Freedom of Information Act requests
(relative to cost reports and audits)

Provider Audit and Reimbursement (PARD)
Attn: FOIA PARD – 16T
P. O. Box 45268
Jacksonville, FL 32232-5268

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

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

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

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

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

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

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

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

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

U.S. Virgin Islands:
First Coast Service Options Inc
P. O. Box 45097
Jacksonville, FL 32232-5097

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

Other Medicare carriers and intermediaries

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

CIGNA Government Services
P. O. Box 20010
Nashville, Tennessee 37202

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

Regional home health and hospice intermediary
Palmetto Government Benefit Administrators
Medicare Part A
P.O. Box 100238
Columbia, SC 29202-3238

Phone numbers

Customer service/IVR
Providers:
888-664-4112
Speech and hearing impaired
877-660-1759

Beneficiaries:
800-MEDICARE (800-633-4227)
Speech and hearing impaired
800-754-7820

Credit balance report
Debt recovery
904-791-6281
Fax
904-361-0359

Electronic data interchange
888-670-0940

Option 1 – Transaction support

Option 2 – PC-ACE support

Option 3 – Direct data entry (DDE)

Option 4 – Enrollment support

Option 5 – 5010 testing

Option 6 – Automated response line

Provider audit and reimbursement
904-791-8430

Provider education and outreach
Seminar registration hotline
904-791-8103
Seminar registration fax
904-361-0407

Provider enrollment
877-602-8816

Websites

First Coast Service Options Inc. (Florida and U.S. Virgin Islands Medicare contractor)
medicare.fcso.com

Centers for Medicare & Medicaid Services
Providers:
www.cms.gov

Beneficiaries:
www.medicare.gov

Medicare A *Connection*

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