Medicare A Connection

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FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction 9 Providers

October 2013

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

One of the values that sets Ashford Presbyterian Community Hospital (San Juan, Puerto Rico) apart is its steadfast commitment to the promotion and provision of education for staff members. The hospital administration encourages continued professional growth and continuous quality improvement of the services they provide.

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

According to Luis Rodriguez Félix, Billing Supervisor, and Michelle Vargas, one of the members of the hospital's Medicare claims submissions staff, First Coast's provider-oriented articles allow them to be aware of major changes to the dynamic Medicare environment.

"For example, through First Coast's *eNews*, we find changes in Medicare policies and trends in medical documentation. We constantly communicate them to our Medical Records department," said Felix.

The Ashford Presbyterian Community Hospital has been at the forefront in monitoring standards and implementing quality models in compliance with all provisions of the Health Insurance Portability and Accountability Act (HIPAA). The hospital monitors the latest news, billing alerts, and information on beneficiary coverage.

For the Billing Department at Ashford Presbyterian Community Hospital, First Coast's eNews has allowed the early detection of potential problems in billing and avoid, in many cases, unnecessary claims denial.

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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.

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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.

eNews *(continued)*

The hospital monitors the latest news, billing alerts, and information on beneficiary coverage.

Michelle, who reports regulation changes from the regulations, stated "When we receive the First Coast eNews, we communicate them directly to the biller or the department that needs the information."

> **"We are aware of the changes in medical policies via First Coast eNews we receive every week. We continuously monitor eNews to identify changes and help prevent denied claims."**
>
> *– Luis Rodríguez Félix*
>
> *Billing Supervisor*

'La Escuelita' takes the hospital back to the classroom

In January 2012, Ashford Presbyterian Community Hospital created "La Escuelita," or little school, as part of their initiative for continuous improvement.

This idea was prompted by the need to establish better communication channels between their billing staff and other departments. The hospital currently has approximately 350 doctors and health care professionals, from various medical specialties and sub-specialties. It is essential to provide a unified message for all areas, given the size of the patient care and administrative staff.

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

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

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

CMS reviewing impact of partial government shutdown on Medicare fee for service regulations

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

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

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

Source: PERL 201310-03

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, located at *http://medicare.fcso.com/Fee_lookup/fee_schedule.asp.* 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.

Enrollment denials when overpayment exists

Note: This article was revised October 17, 2013, to reflect the revised change request (CR) 8039 issued August 1. Several examples and clarifying statements in bold in the *Background* section of the article have been added. In addition, the transmittal number and the Web address for accessing CR 8039 were revised. This article was previously published in the August 2013 edition of *Medicare A Connection*, Page 41.

Provider types affected

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

What you need to know

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

Background

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

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

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

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

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

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

Consider the following examples:

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

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

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

Example #4 - Jane Smith is a nurse practitioner in a solo practice. Her practice ("Smith Medicine") is set up as a closely-held corporation, of which she is the 100 percent owner. Smith Medicine is assessed a $20,000 overpayment. She terminates her Medicare

(continued on next page)

Redaction of claim numbers in Medicare redetermination notices (MRNs)

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

Provider types affected

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

What you need to know

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

Background

Medicare contractors are required to issue a notice of Medicare redetermination after an appeal is requested in accordance with 42 CFR Section 405.956. One of the elements in the MRN is the beneficiary's HICN.

To ensure that contractors protect personally identifiable information, the Centers for Medicare & Medicaid Services (CMS) is requesting that all contractors redact the HICNs in the MRNs. The HICNs will be redacted by replacing five or more values of the HICN with Xs or asterisks (*) with the last four or five digits of the HICN displayed. This applies to HICNs with both alpha and numeric digits.

Additional information

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

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

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

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.

Enrollment *(continued)*

enrollment. Nine months later, she submits a CMS-855I application to enroll Smith Medicine as a new supplier. The business will be established as a sole proprietorship. A denial is not warranted because the $20,000 overpayment was attached to Smith Medicine, not to Jane Smith.

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

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

Additional information

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

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

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

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2014 annual update for health professional shortage area bonus payments

Provider types affected

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

Provider action needed

Change request (CR) 8463, from which this article is taken, alerts you that the annual HPSA bonus payment file for 2014 will be made available by the Centers for Medicare & Medicaid Services (CMS) to your Medicare contractor and will be used for HPSA bonus payments on applicable claims with dates of service on or after January 1, 2014, through December 31, 2014.

These files will be posted to the Internet on or about December 1, 2013. You should review *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HPSAPSAPhysicianBonuses/index.html* each year to determine whether you need to add the AQ modifier to your claim in order to receive the bonus payment, or to see if the ZIP code area in which you rendered services will automatically receive the HPSA bonus payment.

Note that Medicare contractors will continue to accept the AQ modifier for partially designated HPSA claims. Please be sure that your staffs are aware of this update.

Background

Section 413(b) of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 mandated an annual update to the automated HPSA bonus payment file. CMS automated HPSA ZIP code file is populated using the latest designations as close as possible to November 1 each year.

The HPSA ZIP code file will be made available to CMS contractors in early December of each year. CMS contractors shall implement the HPSA ZIP code file and for claims with dates of service January 1 to December 31 of the following year, shall make automatic HPSA bonus payments to physicians providing eligible services in a ZIP code contained on the file.

Additional information

The official instruction, CR 8463, issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2794CP.pdf*.

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

MLN Matters® Number: MM8463
Related Change Request (CR) #: CR 8463
Related CR Release Date: September 27, 2013
Effective Date: January 1, 2014
Related CR Transmittal #: R2794CP
Implementation Date: January 6, 2014

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CMS issues new online ICD-10 implementation guide

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

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

ICD-10 allows for greater specificity and detail in describing a patient's diagnosis and in classifying inpatient procedures, so reimbursement can better reflect the intensity of the patient's condition and diagnostic needs.

The International Classification of Diseases (ICD) code set defines diseases, signs, symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or disease.

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

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

Clarification to *Benefit Policy Manual* language on 'confined to the home'

Provider types affected

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

What you need to know

This article is based on change request (CR) 8444 which requires Medicare contractors to be aware of the clarification of the definition of "confined to the home" as stated in the revised section 30.1.1 of Chapter 7 of the *Medicare Benefit Policy Manual*.

CR 8444 clarifies the definition of the patient being "confined to the home" to more accurately reflect the definition as articulated at Section 1835(a) of the Social Security Act (the Act). In addition, the Centers for Medicare & Medicaid Services (CMS) removed vague terms, such as "generally speaking", to ensure the definition is clear and specific.

These changes present the requirements first and more closely align the CMS policy manual with the Act. This will prevent confusion, promote a clearer enforcement of the statute, and provide more definitive guidance to HHAs in order to foster compliance.

Background

In the 2012 home health (HH) prospective payment system (PPS) proposed rule published on July 12, 2011, CMS proposed their intent to provide clarification to the *Benefit Policy Manual* language regarding the definition of "confined to the home."

In the 2012 HH PPS final rule published on November 4, 2011 (FR 76 68599-68600), CMS finalized that proposal. In order to clarify the definition, CMS is amending its policy manual as follows:

For purposes of the statute, an individual shall be considered "confined to the home" (homebound) if the following two criteria are met:

Criteria-one:

The patient must either:

- Because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence; or,

- Have a condition such that leaving his or her home is medically contraindicated.

If the patient meets one of the criteria-one conditions, then the patient must also meet two additional requirements defined in criteria-two below.

Criteria-two:

There must exist a normal inability to leave home; and, leaving home must require a considerable and taxing effort.

Additional information

The official instruction, CR 8444 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R172BP.pdf*.

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

MLN Matters® Number: MM8444
Related Change Request (CR) #: CR 8444
Related CR Release Date: October 18, 2013
Effective Date: November 19, 2013
Related CR Transmittal #: R172BP
Implementation Date: November 19, 2013

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Influenza resources for health care professionals

Provider types affected

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

What you need to know

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

Introduction

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

You can help your Medicare patients reduce their risk for contracting seasonal flu and serious complications by using every office visit as an opportunity to recommend they take advantage of Medicare's coverage of the annual flu shot. As a reminder, please help prevent the spread of flu by immunizing yourself and your staff! Know what to do about the flu!

Resources for health care professionals

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

1. MLN influenza resources for professionals

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

2. Other CMS resources

- Seasonal influenza vaccines 2013 pricing – *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/2013ASPFiles.html*
- Immunizations Web page is located at *http://www.cms.gov/Medicare/Prevention/Immunizations/index.html*
- Prevention General Information is located at *http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/index.html*
- CMS Frequently Asked Questions – *http://questions.cms.gov/faq.php*
- *Medicare Benefit Policy Manual* – Chapter 15, Section 50.4.4.2 – Immunizations - *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf*
- *Medicare Claims Processing Manual* – Chapter 18, Preventive and Screening Services *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf*

3. Other resources

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

- Advisory Committee on Immunization Practices - *http://www.cdc.gov/vaccines/acip/index.html*
- Flu Clinic Locator – *http://www.fluclinicIocator.org*

(continued on next page)

Flu *(continued)*

Other sites with helpful information include:

- Centers for Disease Control and Prevention – *http://www.cdc.gov/flu*;
- Flu.gov – *http://www.flu.gov*;
- Food and Drug Administration – *http://www.fda.gov*;
- Immunization Action Coalition – *http://www.immunize.org*;
- Indian Health Services – *http://www.ihs.gov/*;
- National Alliance for Hispanic Health – *http://www.hispanichealth.org*;
- National Foundation For Infectious Diseases – *http://www.nfid.org/influenza*;
- National Library of Medicine and NIH Medline Plus – *http://www.nlm.nih.gov/medlineplus/immunization.html*;
- National Network for Immunization Information – *http:/www.immunizationinfo.org*;
- National Vaccine Program – *http://www.hhs.gov/nvpo*;
- Office of Disease Prevention and Health Promotion – *http://odphp.osophs.dhhs.gov*;
- Partnership for Prevention – *http://www.prevent.org*;
- World Health Organization – *http://www.who.int/en*

Beneficiary information

For information to share with your Medicare patients, please visit *http://www.medicare.gov* on the Internet. Medicare provides coverage for one seasonal influenza virus vaccine per influenza season for all Medicare beneficiaries.

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

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

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

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

MLN Matters® Number: SE1336
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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Pre-approval requests for therapy services

First Coast Service Options Inc. is continuing to receive the form "**Request for pre-approval of therapy services above the $3700 threshold**" for prior authorization of therapy services.

In December 2012, First Coast notified providers that the prior authorization of therapy services ended December 17, 2012. First Coast asks that providers discontinue submitting pre-approval requests for therapy services. All fax telephone lines for that project have been discontinued.

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

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

Connolly Healthcare
Attention: Medical Record Department
555 North Lane
Suite 6125
Conshohocken, PA 19428
racinfo@connolly.com
866-360-2507 (telephone)
203-529-2995 (fax)

For additional guidance on the manual medical review process for 2013 for therapy claims above the $3,700 threshold, refer to the *May 2013 Medicare A Connection, page 12*

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 9 (J9) Part A LCDs and review guidelines are consistent with accepted standards of medical practice.

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

Effective and notice dates

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

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Revised LCDs

Psychiatric partial hospitalization program 11

Advance beneficiary notice

- **Modifier GZ** must be used when providers, physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they have not had an advance beneficiary notification (ABN) signed by the beneficiary. **Note:** Line items submitted with the modifier GZ will be automatically denied and will not be subject to complex medical review.
- **Modifier GA** must be used when providers, physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny a service as not reasonable and necessary and they **do have** on file an ABN signed by the beneficiary.
- All claims not meeting medical necessity of a local coverage determination (LCD) must append the billed service with **modifier GA or GZ.**

Revision to LCDs

Psychiatric partial hospitalization program – revision to the Part A LCD

LCD ID number: L28973 (Florida)
LCD ID number: L28975
(Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for psychiatric partial hospitalization program was most recently revised January 1, 2013.

Since that time, the LCD has been revised under the "Indications and Limitations of Coverage and /or Medical necessity" section of the LCD under "Program Criteria/Outpatient Hospital" to revise the language to include non-physician practitioner (NPP).

Effective date

This LCD revision is effective for claims processed **on or after September 5, 2013**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage databases at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

Note: To review active, future, and retired LCDs for jurisdiction (J9), please *click here.*

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

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

Claim status category and claim status codes update

Provider types affected

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

What you need to know

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

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

Background

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

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

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

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

Additional information

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

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

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

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

CMS modifies processing of post-acute transfer crossover edit 7272

Provider types affected

This *MLN Matters*® special edition article is intended for home health agencies (HHA) and hospitals submitting hospital to HHA transfer claims to Medicare contractors (fiscal intermediaries (FIs) and A/B Medicare administrative contractors (MACs) for services to Medicare beneficiaries.

What you need to know

This article conveys updated editing requirements within the common working file (CWF) system, for which Medicare systems had edits that fired incorrectly in the past. Make sure billing staff are aware of these changes.

Background

CMS recently reexamined the post-acute transfer processing in the common working file (CWF) system of an inpatient prospective payment system (IPPS) hospital claim when a home health claim is present in claims history, and discovered a change was necessary.

CWF A/B crossover edit 7272 for transfers to home for home health services is using the home health episode start date instead of the first home health line item date of service (LIDOS) date following an IPPS hospital discharge to determine if a post-acute transfer exists. This edit has been modified to correct CWF A/B Crossover Edit 7272 to ensure that the system is following the transfer processing rules. Providers need to be aware of this change.

If you believe that your claim(s) was incorrectly processed, please contact your Medicare FI or MAC for resolution.

Additional information

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

MLN Matters® Number: SE1335 Revised
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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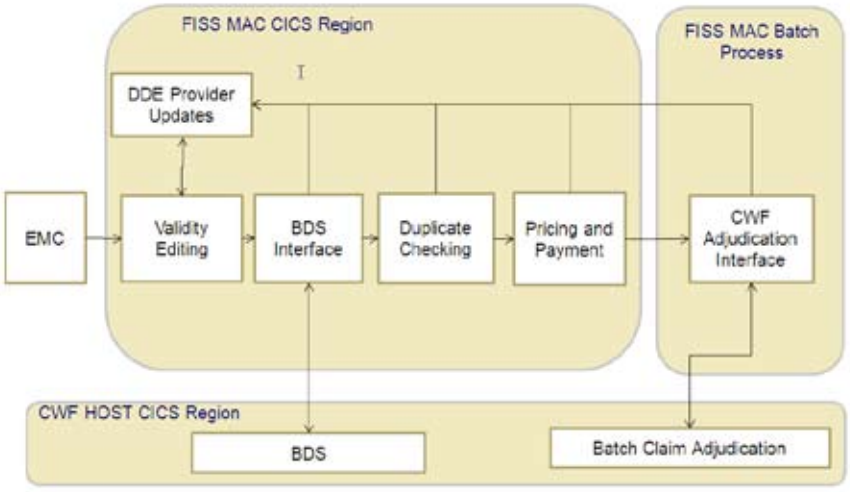
Fee-for-service beneficiary data streamlining (BDS)

To improve efficiencies in claim processing, the fee-for-service (FFS) eligibility functionality was consolidated and is accessible at the beginning of the claim adjudication process.

This eligibility check is known as the fee-for-service beneficiary data streamlining (FFS BDS). This check will be performed earlier in the claim process and as a result, claims will go through the BDS system before being sent to CWF.

Previously, the eligibility check was performed later in the claim processing. The goal of the BDS is to eliminate duplicate or unnecessary processing. The illustration to the right demonstrates how the BDS fits into the claim processing environment:



BDS will hit the existing CWF eligibility edit error codes, which are:

5050, 5052, 5053, 5054, 5055, 5056, 5057, 5058, 5059, 5200, 5210,5211, 5212, 5220, 5231, 5232, 5233, 5234, 5235, 5236, 5244, 5245, 524Z, 525Z, 538H, 538K, 538Q, 6801, 6802, 6803, 6805, 6806, 6810, 6811, 6812, 6815, 6819, 6821, 6822, 6825, 6826, 6830, 6831, 6832

Note: These error codes are not new. Check claim status in the direct data entry (DDE) screen:

S – Suspended: Eligibility check is still in progress

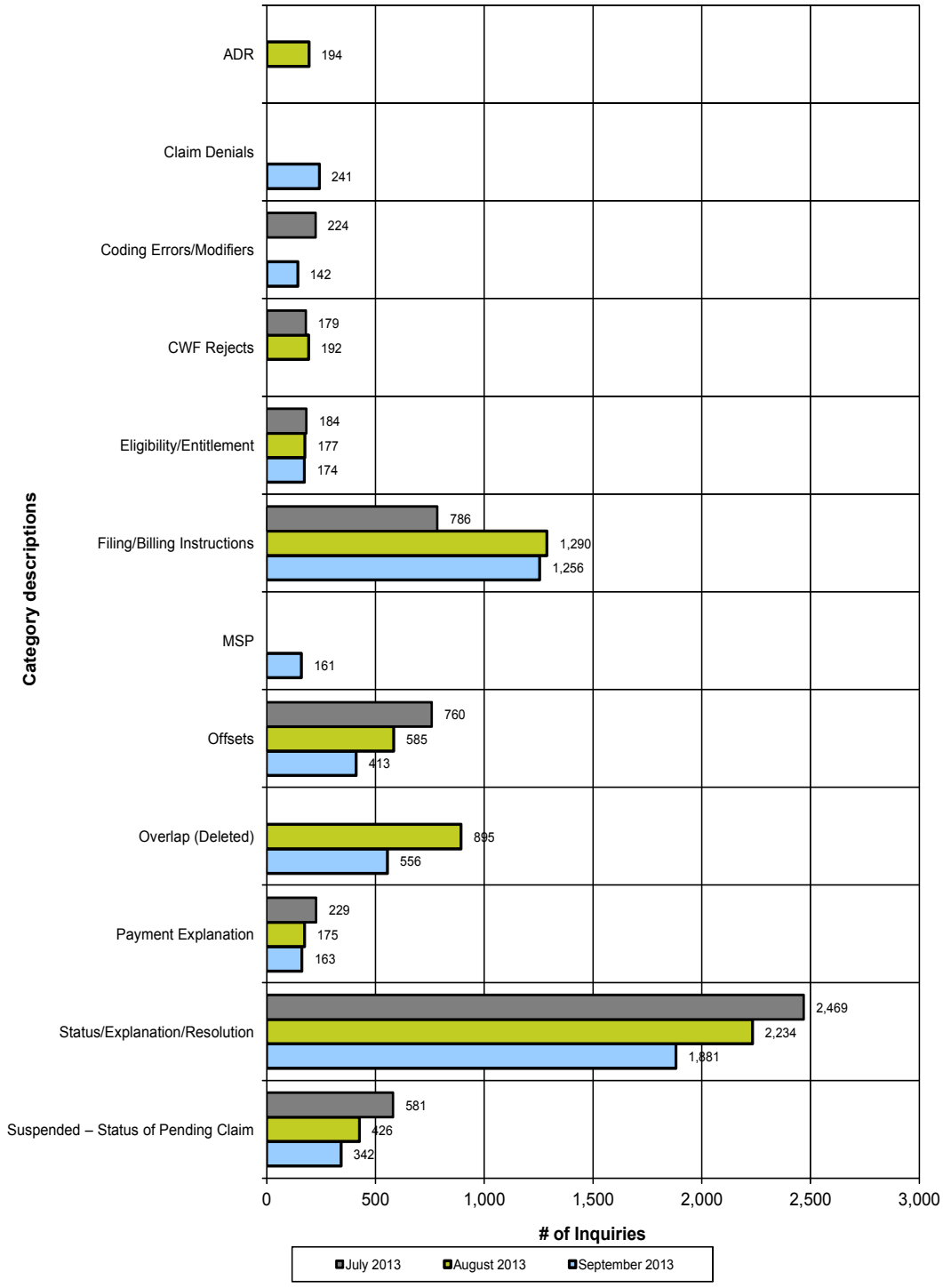
R – Reject: Adjust/correct claims and resubmit for processing

Top inquiries, rejects, and return to provider claims July 2013 through September 2013

The following charts provide the most frequent inquiries and reason codes for rejected and returned to provider (RTP) claims submitted to First Coast Service Options Inc. (First Coast), by providers in Florida, Puerto Rico, and the U.S. Virgin Islands during July 2013 through September 2013.

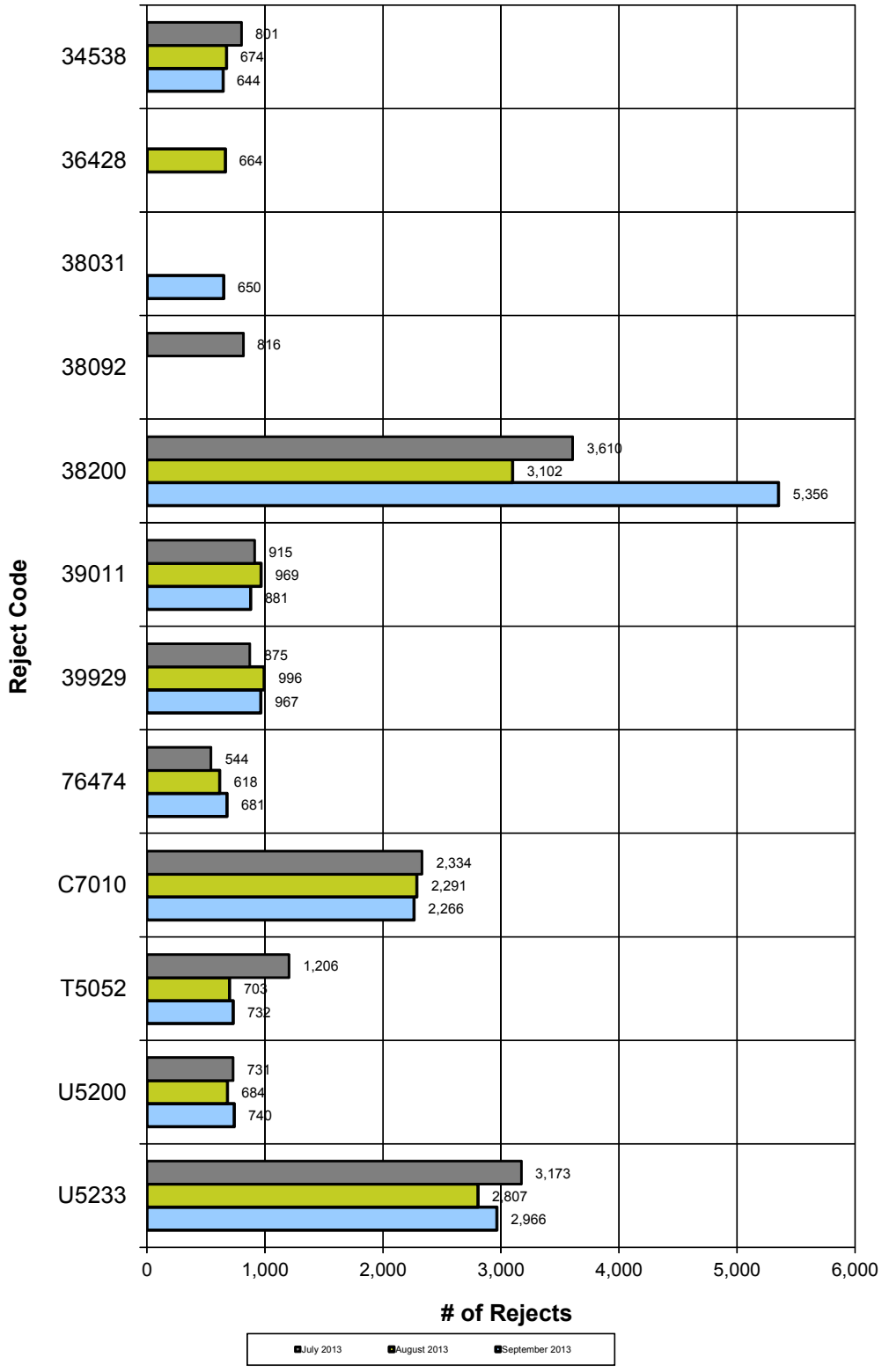
For tips and resources to help providers to avoid or reduce the amount of time spent on many of these issues, refer to the *Inquiries and Denials* section of our website at *http://medicare.fcso.com/Inquiries_and_denials/index.asp*.

Top inquiries for July-September 2013



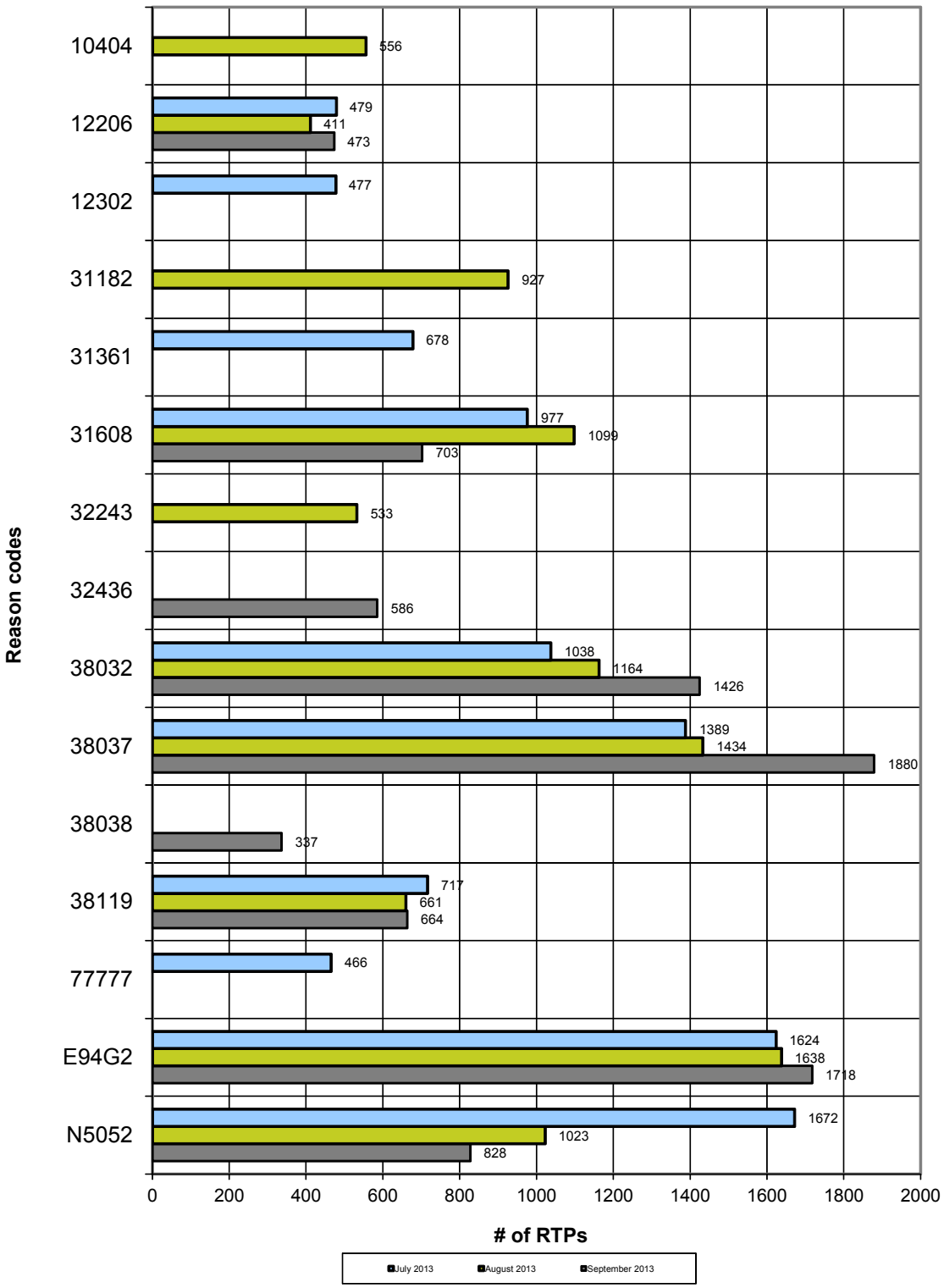
Part A top rejects for July 2013 through September 2013

Top rejects for July-September 2013



Part A top return to providers (RTPs) for July 2013 through September 2013

Top RTPs for July-September 2013



Affordable Care Act's Model 4 bundled payments for care improvement

Note: This article was revised September 23, 2013, to add clarifying language in the Model 4 Bundled Payment Provision section; and, July 26, 2013, to reflect a revised change request (CR). The CR added Part B MAC responsibility to the CR's business requirement 18.3. The release date, transmittal number and link to the CR were also changed. All other information remains the same. This article was previously published in the August 2013 edition of Medicare A Connection, Pages 45-49.

Provider types affected

This *MLN Matters*® article is intended for hospitals, physicians, and non-physician providers participating in the Model 4 Bundled Payments for Care Improvement (BPCI) initiative and submitting claims to Medicare contractors (fiscal intermediaries (FIs) and A/B Medicare administrative contractors (MACs)) for services to Medicare beneficiaries.

What you need to know

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

Background

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

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

Information in this article is based on the change requests implemented for Bundled Payments for Care

Improvement Model 4, including CRs 7887, 8070, and 8196.

General BPCI Model 4 Information

Beneficiary eligibility

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

- Beneficiary is eligible for Part A and enrolled in Part B;
- At the time of admission, beneficiary either (a) has at least one day of utilization left and that day is also a day of entitlement or (b) has at least one lifetime reserve day remaining;
- Beneficiary does not have end-stage renal disease;
- Beneficiary is not enrolled in any managed care plans;
- Beneficiary must not be covered under the United Mine Workers; and
- Medicare must be the primary payer.
- If the beneficiary does not meet all of these requirements, the following codes will be assigned to rejected or cancelled NOAs:
- Claims adjustment reason code (CARC) B5: Coverage/program guidelines were not met or were exceeded.
- Remittance advice remarks code (RARC) N564: This patient did not meet the inclusion criteria for the demonstration project or pilot program.

Model 4 bundled payment provision

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

- This will not apply to claims that are paid on a

(continued on next page)

Bundle *(continued)*

transfer per-diem basis.

- This payment will include both the DRG payment for the hospital and a fixed amount for the Part B services anticipated to be rendered during the admission. Separate payment for providers' professional services rendered during the inpatient hospital stay will not be made.
- Participating Model 4 hospitals will receive a Model 4 payment and will be responsible for payment to providers who would otherwise be paid for professional services under the physician fee schedule (PFS). As such, physicians and non-physician practitioners should seek payment for professional provider services from the Model 4 hospital.
- Per the conditions of the agreement between CMS and the Model 4 hospital, payment to physicians and non-physician practitioners must be made at a rate that is equivalent to the amount that would otherwise apply under the PFS, unless a different amount has been agreed to in writing by the Model 4 hospital and the physician.
- Claims from physicians will be processed as no-pay claims if they occur between the inpatient hospital admission and discharge date in order to prevent duplicate payment of physicians under the bundled payment.

Co-payments, co-insurance, and deductibles

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

Appeals

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

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

Information for hospitals

Notification of admission (NOA)

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

- Hospitals will be paid a $500 payment upon submission of the NOA and will receive the balance of the prospectively established bundled payment when the hospital claim is processed.
- RARC N568: Initial payment based on the NOA under the Bundled Payment Model IV initiative.
- If the patient ultimately does not qualify for a Model 4 prospective payment based on the MSDRG ultimately assigned to their inpatient stay, or if the NOA is cancelled, the $500 NOA payment will be recouped.
- Medicare systems will initiate a "look back" into the claims history records upon receipt of a canceled NOA to identify Model 4 BPCI claims – i.e., Part B physician or other professional claims – which were processed as "no pay" as a result of the NOA being opened. If such claims were processed, the Medicare contractor will adjust the claims automatically and remit payment for services rendered based on regular Medicare fee-for-service claims processing rules.
- Hospitals must submit the final claim within 60 days of the beneficiary's hospital admission or submit an interim claim during that time period to demonstrate that the beneficiary is still an inpatient. Otherwise, the beneficiary will be considered not subject to episode payment and the $500 will be recouped.
- The following codes will be assigned when a Model 4 claim matches an NOA for admission date and beneficiary, but not provider.
- CARC 208: National provider identifier – not matched
- RARC N562: The provider number of your incoming claim does not match the processed

(continued on next page)

Bundle *(continued)*

notice of admission (NOA) for this bundled payment

- The following codes shall be assigned when an NOA is cancelled because a matching claim is not received within 60 days. A match consists of beneficiary, admit date, and provider.
- CARC 226: Information requested from the billing/rendering provider was not provided or not provided timely or was insufficient/incomplete
- RARC N560: This pilot program requires an interim or final claim within 60 days of the Notice of Admission. A claim was not received

Readmissions

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

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

Payment rate updates and adjustors

Payment rates may be updated as often as quarterly to allow for ongoing updates to Medicare payment rates, including regular recurring changes made to

the physicians fee schedule (PFS) and inpatient prospective payment system (IPPS). indirect medical education (IME) and disproportionate share hospital (DSH) payments, as well as outlier payments and hospital capital payments to Model 4 hospitals will be calculated based on the non-discounted base DRG payment that would have been made in the absence of the model. This is true for both anchor admissions and related readmissions to the Model 4 hospital. In the case of readmissions, these payments will be denoted by the following:

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

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

Information for physicians and non-physician providers

Claims submission and processing

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

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

For those Part B services rendered during a Model 4 admission or a related readmission to that Model 4 hospital, Medicare will process claims as no-pay. In processing no-pay professional claims, Medicare will assign the following:

- CARC 234: This procedure is not paid separately.
- RARC N67: Professional provider services not

(continued on next page)

Bundle *(continued)*

paid separately. Included in facility payment under a demonstration project. Apply to that facility for payment, or resubmit your claim if: the facility notifies you the patient was excluded from this demonstration; or, if you furnished these services in another location on the date of admission or discharge from a demonstration hospital.

If services furnished in a facility not involved in the demonstration on the same date the patient was discharged from or admitted to a demonstration facility, you must report the provider ID number for the non-demonstration facility on the new claim.

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

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

Incentive payments

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

Participation declination

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

Readmissions

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

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

Claims crossover

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

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

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

Additional information

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

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

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

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

2014 ambulance inflation factor and productivity adjustment

Provider types affected

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

What you need to know

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

Background

CR 8452 furnishes the 2014 AIF for determining the payment limit for ambulance services required by section 1834(l)(3)(B) of the Social Security Act (the Act), and updates the *Medicare Claims Processing Manual*, Chapter 15, Section 20.4, which contains a chart tracking the history of the AIF.

Section 1834(l)(3)(B) of the Act provides the basis for an update to the payment limits for ambulance services that is equal to the percentage increase in the consumer price index for all urban consumers (CPI-U) for the 12-month period ending with June of the previous year. Section 3401 of the Affordable Care Act amended Section 1834(l)(3) of the Act to apply a productivity adjustment to this update equal to the 10-year moving average of changes in economy-wide private non-farm business multi-factor productivity (MFP) beginning January 1, 2011. The resulting update percentage is referred to as the AIF.

The MFP for calendar year 2014 is 0.80 percent and the CPI-U for 2014 is 1.80 percent. According to the Affordable Care Act, the CPI-U is reduced by the MFP, even if this reduction results in a negative AIF update. Therefore, the AIF for 2014 is 1.00 percent.

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

Additional information

The official instruction, CR 8452 issued to your MAC regarding this change may be viewed at *http://cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2788CP.pdf.*

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

MLN Matters® Number: MM8452
Related Change Request (CR) #: CR 8452
Related CR Release Date: September 20, 2013
Effective Date: January 1, 2014
Related CR Transmittal #: R2788CP
Implementation Date: January 6, 2014

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Temporary instructions for implementation of final rule 1599-F for Part A to Part B billing of denied hospital inpatient claims

Note: This article was revised October 23, 2013, to make some adjustments to the table in the *Inpatient Part B hospital services* on page 24. It was previously published in the September 2013 edition of *Medicare A Connection*, Pages 54-56. All other information remains the same.

Provider types affected

This *MLN Matters*® special edition article is intended for hospitals submitting claims to Medicare contractors (fiscal intermediaries (FIs and A/B Medicare administrative contractors (MACs) for services to Medicare beneficiaries.

What you need to know

For admissions on or after October 1, 2013

When an inpatient admission is found to be not reasonable and necessary, the Centers for Medicare & Medicaid Services (CMS) will allow payment of all hospital services that were furnished and would have been reasonable and necessary if the beneficiary had been treated as an outpatient, rather than admitted to the hospital as an inpatient, except for those services that specifically require an outpatient status such as outpatient visits, emergency department visits, and observation services, that are, by definition, provided to hospital outpatients and not inpatients.

Hospitals are required to maintain documentation to support the services billed on a Part B inpatient claim for services rendered during the inpatient stay.

A hospital may also be paid for Part B inpatient services if it determines under Medicare's utilization review requirements that a beneficiary should have received hospital outpatient rather than hospital inpatient services, and the beneficiary has already been discharged from the hospital (commonly referred to as hospital self-audit). If the hospital already submitted a claim to Medicare for payment under Part A, the hospital would be required to cancel its Part A claim prior to submitting a claim for payment of Part B inpatient services.

Any coinsurance or deductible collected for the Part A claim must be refunded. Whether or not the hospital had submitted a claim to Part A for payment, Medicare requires the hospital to submit a Part A claim indicating that the provider is liable under section 1879 of the Act for the cost of the Part A services. The hospital would indicate provider liability period on the Part A claim by including the occurrence span code "M1" and the inpatient admission dates of service.

The hospital could then submit an inpatient claim for payment under Part B on a type of bill (TOB) 12x for inpatient services that would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient rather than admitted as a hospital inpatient, except where those services specifically require an outpatient status.

For Part B inpatient services furnished by the hospital that are not paid under the outpatient prospective payment system (OPPS), but rather under some other Part B payment mechanism, Part B inpatient payment would be made pursuant to the Part B fee schedules or prospectively determined rates for which payment is made for these services when provided to hospital outpatients.

All hospitals billing Part A services are eligible to bill the Part B inpatient services, including short term acute care hospitals paid under the inpatient prospective payment system (IPPS), hospitals paid under the OPPS, long term care hospitals (LTCHs), inpatient psychiatric facilities (IPFs) and IPF hospital units, inpatient rehabilitation facilities (IRFs) and IRF hospital units, critical access hospitals (CAHs), children's hospitals, cancer hospitals, and Maryland waiver hospitals. Hospitals paid under the OPPS would continue billing the OPPS for Part B inpatient services. Hospitals that are excluded from payment under the OPPS in 42 CFR 419.20(b) would be eligible to bill Part B inpatient services under their non-OPPS Part B payment methodologies.

Beneficiaries are liable for their usual Part B financial liability. For example, beneficiaries would be liable for Part B copayments for each hospital Part B inpatient service and for the full cost of drugs that are usually self-administered. Timely filing restrictions will apply for Part B inpatient services. Claims that are filed beyond 12 months from the date of service will be rejected as untimely and will not be paid.

When beneficiaries treated as hospital inpatients are either not entitled to Part A, or are entitled to Part A but have exhausted Part A benefits, hospitals may only bill for the limited set of Part B inpatient services specified in the *Medicare Benefit Policy Manual* (Chapter 6, Section 10), which is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c06.pdf*.

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Temporary *(continued)*

Hospitals may continue to bill Part B for outpatient services provided to the beneficiary prior to the point of inpatient admission in the 3 calendar day (or 1 calendar day for a non-IPPS hospital) payment window prior to the admission, including those services that require an outpatient status (see the *Medicare Claims Processing Manual* Chapter 4, Section 10.12, at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c02.pdf*).

These services should be billed on a 131 Part B outpatient TOB and must be filed timely (within 1 calendar year of date of service) in order to be paid.

Services provided prior to the point of inpatient admission are outpatient services and may not be included on the 121 Part B inpatient claim; services provided after the point of admission are inpatient services and may not be included on the 131 Part B outpatient claim. Two complementary claims are therefore necessary if some services are provided before admission and others are provided after admission.

In placing services on the appropriate claim, hospitals should use the same billing and coding rules used for assigning dates of service to services that cross midnight, using the start of the service to determine correct claim placement unless other specific instructions are provided, and ensuring that services are not double billed.

If inpatient only services, such as procedures on the inpatient only list, were delivered prior to the point of admission, they cannot be paid because they were provided as outpatient services; they may not be reported on the 121 Part B inpatient claim because they were provided prior to the point of admission.

If outpatient only services, such as outpatient observation, were continued after the point of admission, the post admission services cannot be paid because they were provided as inpatient services; the time may not be included on the 131 Part B outpatient claim because it was provided after the point of admission.

Appeals

If a hospital chooses to submit a Part B claim for payment following the denial of an inpatient admission on a Part A claim, the hospital cannot also maintain its request for payment for the same services on the Part A claim (including an appeal of the Part A claim). In this situation, before the hospital submits a Part B claim, it must ensure that there is no pending appeal request on the Part A claim.

In addition, if a beneficiary files an appeal of a Part A inpatient admission denial, a hospital cannot submit a Part B claim in order to extinguish a beneficiary's appeal rights. Therefore, the hospital's submission of a Part B claim does not affect a beneficiary's pending appeal or right to appeal the Part A claim.

If a beneficiary has a pending Part A appeal for an inpatient admission denial, any claims re-billed under Part B by the hospital will be denied as duplicates by the Medicare contractor. Once a Part B claim is filed, there are no further appeal rights available with respect to the Part A claim. However, the hospital and beneficiary have appeal rights with respect to an initial determination made on the Part B claim under existing policies set forth at 42 CFR Part 405, Subpart I.

Billing tips

For "self-audit" claims, providers shall submit a Part A provider liable claim. The inpatient claim must indicate the following information on the UB-04 claim form when billed to Medicare:

- Type of bill (TOB) 110 in form locator (FL) 4.
- Non-covered days.
- The services from admission through discharge.
- The appropriate patient status.
- Occurrence span code "M1" and dates of service.
- Non-covered charges for all services rendered.
- All diagnosis codes.
- All procedures codes.

After the inpatient claim has processed and a remittance advice (RA) has been issued, a Part B inpatient claim (TOB 12x) can be submitted. For Part A inpatient admissions denied as not reasonable and necessary, providers shall submit a qualifying Part B inpatient claim (TOB 12x) with:

1. A treatment authorization code of A/B rebilling submitted by a provider.

Note: Providers billing an 837I shall place the appropriate prior authorization code above into Loop 2300 REF02 (REF01 = G1) as follows:

REF*G1*A/B Rebilling~

2. A condition code "W2" attesting that this is a rebilling and no appeal is in process; and

3. The original, denied inpatient claim (CCN/DCN/ICN) number

Note: Providers billing an 837I shall place DCN in the billing notes loop 2300/NTE in the format:

NTE*ADD*ABREBILL12345678901234~

For DDE or paper claims, providers shall place the word "ABREBILL" plus the denied inpatient DCN/CCN/ICN shall be added to the remarks field (form locator #80) on the claim using the following format: "ABREBILL12345678901234".

Note: The numeric string above (12345678901234) is meant to represent original claim DCN/ICN numbers from the inpatient denial.

(continued on next page)

Temporary *(continued)*

Inpatient Part B hospital services

Inpatient Part B services include services which are not strictly provided in an outpatient setting. Examples of services that are strictly provided in an outpatient setting include services such as diabetes self-management training (DSMT), clinic visits, emergency department, and observation services (this is not a complete listing). Inpatient routine services in a hospital generally are those services included by the provider in a daily service charge – sometimes referred to as the "room and board" charge.

Routine services are the regular room, dietary and nursing services, minor medical and surgical supplies, medical social services, psychiatric social services, and the use of certain equipment and facilities for which a separate charge is not customarily made. Examples of routine nursing services that are captured in the room and board rate include patients that receive from the floor nurse IV infusions and injections, blood administration, and nebulizer treatments. These services are not separately billable inpatient Part B services. Medicare pays under inpatient Part B for the non-physician medical and other health services listed in the *Medicare Benefit Policy Manual*, Chapter 6, Section 10.1.

The revenue codes listed in the table below are a guide for providers to use when a service is non-covered at the revenue code level. Some revenue codes allow many services, some of which are covered and some of which are non-covered by Medicare inpatient Part B for inpatients. When a revenue code can be sometimes covered, sometime not covered, providers should use the HCPCS to determine if the service is covered (i.e., revenue code 0942 is not listed below. However, when DSMT services are billed with this revenue code, the DSMT service remains non-covered under Medicare inpatient Part B).

Revenue codes not covered under inpatient Part B medical necessity denials					
010x	011x	012x	013x	014x	015x
016x	017x	018x	019x	020x	021x
022x	023x	024x	029x	0390	0391
0399	045x	050x	051x	052x	054x
055x	056x	057x	058x	059x	060x
0630	0631	0632	0633	0637	064x
065x	066x	067x	068x	072x	0762
082x	083x	084x	085x	088x	089x
0905	0906	0907	0912	0913	093x
0941	0943	0944	0945	0946	0947
0948	095x	0960	0961	0962	0963
0964*	0969	097x	098x	099x	100x
210x	310x				

* In the case of revenue code 0964, this is used by hospitals that have a CRNA exception.

Implantable prosthetic devices

When a hospital that is not paid under the OPPS furnishes an implantable prosthetic device that meets the criteria for coverage in *Medicare Benefit Policy Manual*, Chapter 6, Section 10, to an inpatient who has coverage under Part B, payment for the implantable prosthetic device is made under the payment mechanism that applies to other hospital outpatient services (e.g., reasonable cost, all inclusive rate, waiver).

When a hospital that is paid under the OPPS furnishes an implantable prosthetic device to an inpatient who has coverage under Part B due to Part A medical necessity denial, the hospital should report the HCPCS that describes the device as outlined under OPPS rules. The OPPS hospital should not report HCPCS code, C9899, implanted prosthetic device, payable only for inpatients who do not have inpatient coverage, when the Part A claim has been medically denied. The OPPS hospital should only report HCPCS code, C9899, implanted prosthetic device, payable only for inpatients who do not have inpatient coverage, due to no Part A coverage or Part A benefits exhausted.

Additional information

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

MLN Matters® Number: SE1333 Revised
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

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.

Hospitals must attest by November 30 to receive EHR incentive payment

Eligible hospitals and critical access hospitals (CAHs) face a critical deadline of November 30, 2013, for participation in the Medicare electronic health record incentive (EHR) program.

Eligible hospitals and CAHs that have yet to register for the EHR program must do so by November 30, 2013 to avoid a negative payment adjustment for fiscal year 2015. Those hospitals, which register this year, will need to demonstrate significant use of electronic health records for a 90-day period in 2014 to avoid the adjustment.

Payment adjustments will be applied beginning October 1, 2014, to Medicare-eligible hospitals that have not registered or successfully demonstrated meaningful use. The Centers for Medicare & Medicaid Services (CMS) bases the adjustment on the hospital's reporting period in a prior year. Read the *eligible hospital payment adjustment tipsheet* to learn more.

Hospitals that registered in prior years for the Medicare EHR program need to attest they have met the meaningful use standard by the respective date in order to receive incentive payments in 2015. Once hospitals begin participation in the Medicare EHR incentive program, they must continue to demonstrate meaningful use every year to avoid payment adjustments in subsequent years.

Review *this CMS health information technology timeline* to see all critical deadlines for health providers participating in Medicare EHR incentive programs.

For more information visit the *Medicare EHR incentive program Web page here*.

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

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

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

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

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

See *http://medicare.fcso.com/Landing/256747.asp*

Medicare Learning Network® – resources for inpatient hospitals

The *Medicare Learning Network®* (MLN) suite of products and resources for inpatient hospitals gives Medicare Part A providers and business management professionals with an understanding of payment systems, fee schedules, and reimbursement assistance resources.

It includes information and direct links to Medicare payment policies and procedures, provider enrollment, streamlining claims review and submission requirements, and payment rates and classification criterion for reimbursement.

Click here for more information.

Educational Events

Provider outreach and educational events – November 2013

E/M issues: Does your documentation justify 99215?

When: Wednesday, November 20
Time: 11:30 a.m. -12:30 p.m. ET – Delivery language: English
Type of Event: Webcast

Provider enrollment process

When: Thursday, November 21
Time: 11:30 a.m. -1:00 p.m. ET – Delivery language: English
Type of Event: Webcast

Two easy ways to register

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

Please note:

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

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Provider Address: _____

City, State, ZIP Code: _____

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

Never miss a training opportunity

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

Take advantage of 24-hour access to free online training

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

CMS MLN Connects™ Provider eNews

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

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

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

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

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

CGS Administrators, LLC
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

Contact CMS

The Region 4 office of the Centers for Medicare & Medicaid Services is located in Atlanta. The feedback email address is:
ROATLFM@CMS.HHS.GOV

Puerto Rico Contact Information

Addresses

Claims

Additional documentation
General mailing
Congressmen mailing
First Coast Service Options Inc.
P.O. Box 45003
Jacksonville, FL 32232-5003

Redeterminations

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

Debt recovery (except for MSP)

First Coast Service Options Inc.
P.O. Box 45096
Jacksonville, FL 32232-5096

Post-payment medical exams

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

Freedom of Information Act (FOIA*) related requests

First Coast Service Options Inc.
Attn: FOIA PARD 16T
P.O. Box 45268
Jacksonville, FL 32232-5268

Medicare fraud and abuse

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

Provider enrollment

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

Electronic Data Interchange (EDI*)

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

MSPRC DPP debt collection – Part A

First Coast Service Options Inc.
P.O. Box 44179
Jacksonville, FL 32231-4179

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

Audit and reimbursement department

Reporte de costo, auditoría, apelación de reporte de costo, porcentaje tentativo, rama de PS &R
First Coast Service Options Inc.
P.O. Box 45268
Jacksonville, FL 32231-0048

Overnight mail and other special handling postal services

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

Other Medicare carriers and intermediaries

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

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

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

Phone Numbers

Providers

Customer service – free of charge
Monday to Friday
8:00 a.m. to 4:00 p.m.
1-877-908-8433

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

Interactive voice response (IVR)
1-877-602-8816

Beneficiary

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

For the hearing and speech impaired (TDD)
1-800-754-7820

Electronic Data Interchange

1-888-875-9779

Educational Events Enrollment

1-904-791-8103

Fax number
1-904-361-0407

Audit And Reimbursement Department

Fax number
1-904-361-0407

Websites

Providers

First Coast – MAC J9
medicare.fcso.com

medicareespanol.fcso.com

Centers for Medicare & Medicaid Services
www.cms.gov

Beneficiary

Centers for Medicare & Medicaid Services
www.medicare.gov