Medicare A Connection

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FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction N Providers

July 2015

In this issue

Eliminate denied claims with First Coast's Web tools

Finding a letter in the mail from a Medicare administrative contractor (MAC) might seem daunting for some health care providers. The message sealed inside could mean a number of things. But for Tracie Jones and her Medicare billing team at Simon-Med-Florida, the postman delivered an unexpected gift in March.

"We received a letter from First Coast stating that more than 10 percent of our claims were being denied," Jones said. Because Medicare beneficiaries represent about 40 percent of the patients treated at nine Simon-Med facilities in the tri-county region of Orlando, the action taken to improve its billing practices, as a result of the letter, is paying off in a big way.

Each month, First Coast Service Options (First Coast), the MAC for Florida, Puerto Rico and the U.S. Virgin Islands, contacts providers with high volumes of preventable Medicare claim errors. The letter directs providers to pages on the First Coast website, where providers can access problem-solving tools such as *First Coast Service Options' Secure Provider Online Tool (SPOT)*, *First Coast University*, and information about *avoiding return unprocessable claims (RUC)*.

"After reviewing the letter, I went to the First Coast site to get to the bottom of what was causing problems with our billing. One of the first things I did after receiving the letter was set up a SPOT account," Jones said. SPOT is a portal where medical providers can electronically view and correct Medicare claims.

"Once we had access to SPOT, I pulled two months of claims data through the PDS report," Jones said, referring to the *provider data summary (PDS)*. Most, if not all, of the denial codes were related to routine ultrasound tests and preventative exams. One procedure with an extraordinary high number of denials was DXA, a bone density test for measuring bone mineral density that is only covered by Medicare once every two years, Jones said.

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Medicare signature requirements

The Medicare requirement to authenticate the medical record is to ensure the services rendered have been thoroughly documented and authenticated by the author of the medical record entry. *Click here* for information on Medicare's signature requirements and how adhering to these requirements can prevent impacts to your claims.

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.

Publication staff:

Terri Drury
Sofia Lennie
Martin Smith
Kathleen Storey
Mark Willett
Robert Petty

Fax comments about this publication to:

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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.

TOOLS

From front page

The PDS report helps providers identify recurring billing issues through a detailed analysis of billing patterns in comparison with those of similar provider types during a specified time period.

"There were 10 message codes which made up 90 percent of the denied claims we were experiencing," Jones said "We found that our billing company had been coding tests incorrectly.

We also found that our scheduling department was scheduling DXA tests for patients sooner than Medicare coverage would otherwise allow. "We were leaking money. We had a puzzle we needed to take apart and reassemble to see where the leaks were."

> **"The PDS report was excellent. It was quite informative. It broke out what claims were sent in, those that were approved and those that were denied."**
>
> *— Tracie L. Jones MHA, CPC*
> *SimonMed-Florida*
> *Director Revenue Cycle*

The PDS includes comparisons of volumes and percentages of services in claims designated as paid, denied, duplicate, processed (subtotal), and RUCs that were submitted by the provider or the provider's peers during the specified time period. "The PDS report was excellent. It was quite informative. It broke out what claims were sent in, those that were approved and those that were denied," Jones said.

To confirm her interpretation of the data from the PDS report, Jones then called the provider relations representative phone number listed on the bottom of the letter. She reached Mary Pita Carrazana of First Coast and together they reviewed the problematic reason codes and other information from the PDS report.

Carrazana suggested they check one of the procedure codes in question, *Current Procedural Terminology* (CPT) code 77085, on the *local coverage determination lookup tool*. "I walked with Tracie through the LCD look up tool to review the procedure code and we found that the DXA procedure was covered once every two years," Carrazana said.

Using the data from the report, Jones said they educated their third party billing company about the errors and how the claims were being coded incorrectly. Then we worked with our scheduling department to make sure we were only performing the DXA test according to Medicare guidelines," said Jones.

Though they only recently implemented process improvements, Jones says she is already seeing positive results. "I've looked at our June accounts receivable report. I can already see where it's improving the bottom line."

After diagnosing the original issues with their billing, Jones says she will continue to access PDS reports on a regular basis as a part of a more robust compliance program. "Being proactive is always better. The PDS report is like a free self-audit. It's very smart. The fact that it's free shows Medicare wants you to do a good job with your billing."

Carrazana agrees the tools can be an effective part of a provider compliance program. "Providers that use vendors or third-party billing services are sometimes not aware of their claim denials. Ultimately the provider is responsible for all claims submitted under their provider number. And, use of the First Coast Web tools we emphasize in our focused education efforts can be an effective way for providers and their vendors to stay on top of any issues."

Your feedback matters

Your opinion is important to us. If you haven't already completed the MAC Satisfaction Indicator (MSI) survey, please take a moment to complete it now. Share your experience with the services we provide. It will take about 10 minutes. You can access the survey by clicking here.

Processing Issues

Claims held containing HCPCS code G0279 released July 8

Issue

Part A claims containing Healthcare Common Procedure Coding System (HCPCS) code G0279 were being held due to a previous processing issue, which was corrected with the July quarterly release. It has been determined that the scheduled fix will not fully correct the pricing problem for HCPCS G0279.

Resolution

To avoid further delays in processing claims for HCPCS code G0279 and prevent impacts to provider payments, First Coast Service Options (First Coast) has been instructed by the Centers for Medicare & Medicaid Services (CMS) to release these claims with cost pricing by July 9, 2015, and apply condition code (CC) 15 to the claims.

As the claims containing HCPCS code G0279 will price at cost, implementation of upcoming legislation or a future change request (CR) will correct the pricing to the fee schedule amount. Subsequently, the upcoming legislation will also provide First Coast with adjustment instructions to retrospectively correct the pricing for any claims processed from July 9, 2015, until the January 2016 implementation.

Status/date resolved

Closed. Claims were released on July 8, 2015, with CC15. Pricing correction will occur in January 2016, with implementation of the forthcoming legislation.

Provider action

None.

Note: Please do not contact the provider contact center (PCC) to inquire about pricing adjustments or appeals, as any necessary adjustments will occur based on the January 2016 implementation

Mass adjustment of claims containing code G0473

Issue

Due to a systems error, coinsurance and deductible are not being waived on claims containing code G0473 (intensive behavioral therapy for obesity).

Resolution

The problem was corrected April 6, 2015. For claims with dates of service of January 1, 2015, through March 31, 2015, Medicare administrative contractors mass adjusted these claims and issued corrected payments for all impacted claims.

Status/date resolved

Closed. First Coast data shows no impacted claims.

Provider action

None

Prompt payment interest rate revision

Medicare must pay interest on clean claims if payment is not made within the applicable number of calendar days (i.e., 30 days) after the date of receipt. The applicable number of days is also known as the payment ceiling. For example, a clean claim received March 1, 2015, must be paid before the end of business March 31, 2015.

The interest rate is determined by the applicable rate on the day of payment. This rate is determined by the Treasury Department on a six-month basis, effective every January and July 1.

Providers may access the Treasury Department Web page *https://www.fiscal.treasury.gov/fsservices/gov/pmt/promptPayment/rates.htm* for the correct rate. The interest period begins on the day after payment is due and ends on the day of payment.

The new rate of 2.375 percent is in effect through December 31, 2015. Interest is not paid on:

- Claims requiring external investigation or development by the Medicare contractor
- Claims on which no payment is due
- Claims denied in full
- Claims for which the provider is receiving periodic interim payment
- Claims requesting anticipated payments under the home health prospective payment system.

Note: The Medicare contractor reports the amount of interest on each claim on the remittance advice to the provider when interest payments are applicable.

Screening for hepatitis C – implementation of new edits

Provider types affected

This *MLN Matters*® article is intended for physicians, other providers, and suppliers submitting claims to Medicare administrative contractors (MACs) for Hepatitis C virus (HCV) screening services provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 9200 informs providers that beneficiaries born prior to 1945 or after 1965 with no risk factors for HCV are not eligible for HCV screening benefits as described in CR 8871, Transmittal 3215, dated March 11, 2015. CR 9200 also removes rural health clinics (RHCs), federally qualified health centers (FQHCs) and Method II critical access hospitals (CAHs) as valid facilities for these HCV screening services. Make sure that your billing staffs are aware of these changes.

Background

Effective June 2, 2014, the Centers for Medicare & Medicaid Services (CMS) covers screening for HCV consistent with the grade B recommendations by the United States Preventive Services Task Force for the prevention or early detection of an illness or disability, and is appropriate for individuals entitled to benefits under Medicare Part A or enrolled under Part B.

This policy was implemented in CR 8871.You may want to review the related *MLN Matters*® article MM8871 for additional claim processing instructions.

As indicated in CR 8871, and replicated in CR 9200 for ease of reference only, CMS covers screening for HCV with the appropriate U.S. Food and Drug Administration (FDA)- approved/cleared laboratory tests, and point-of-care tests (such as rapid anti-body tests that are performed in outpatient clinics and physician offices), used consistent with FDA-approved labeling and in compliance with the Clinical Laboratory Improvement Act regulations, when ordered by the beneficiary's primary care physician or practitioner within the context of a primary care setting, and performed by an eligible Medicare provider for these services, for beneficiaries who meet either of the following conditions:

1. A screening test is covered for adults at high risk for HCV infection. "High risk" is defined as persons with a current or past history of illicit injection drug use; and persons who have a history of receiving a blood transfusion prior to 1992. Repeat screening for high risk persons is covered annually only for persons who have had continued illicit injection drug use since the prior negative screening test.
2. A single screening test is covered for adults who do not meet the high risk definition as defined above, but who were born from 1945 through 1965.

The determination of "high risk for HCV" is identified by the primary care physician or practitioner who assesses the patient's history, which is part of any complete medical history, typically part of an annual wellness visit and considered in the development of a comprehensive prevention plan. The medical record should be a reflection of the service provided.

Key points

- For services provided to beneficiaries born between the years 1945 and 1965 who are not considered high risk as defined in the policy, HCV screening is limited to once per lifetime. New HCPCS code G0472 (short descriptor - Hep C screen high risk/other, and long descriptor – Hepatitis C antibody screening for individual at high risk and other covered indication(s)) will be used.
- Beneficiaries born prior to 1945 or after 1965 with no risk factors are not eligible for this benefit.
- For those beneficiaries determined to be high-risk initially as defined in the policy, regardless of birth year, ICD-9 diagnosis code V69.8, "other problems related to life style" (when ICD-10 is implemented ICD-10 diagnosis code Z72.89, "other problems related to lifestyle") is required in addition to HCPCS G0472.
- Coverage of a sub-set of the above high risk beneficiaries may occur on an annual basis if appropriate as defined in the policy, regardless of birth year, denoted by the presence of HCPCS G0472, ICD diagnosis code V69.8/Z72.89, and ICD diagnosis code 304.91, "unspecified drug dependence continuous"/ F19.20, "other psychoactive substance abuse, uncomplicated" (once ICD-10 is implemented). Annual

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HEPATITIS

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is defined as 11 full months must pass following the month of the last negative HCV screening.

- HCV screening, HCPCS code G0472, is a technical service only and there is no professional fee.
- CR 9200 also removes the following facilities as valid for HCV screening services:
- RHC, TOB 71x;
- FQHC, TOB 77x; and
- CAH Method II, professional services, TOB 85x with revenue code 096x, 097x, or 098x.
- MACs will line-item deny claims for HCV screening, HCPCS G0472, for beneficiaries born prior to 1945 and after 1965 who are not high risk with the following messages:
    - CARC 96 – Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present;
    - RARC N386 – This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.; and
    - Group code CO – assigning financial liability to the provider.

Note: Only HCPCS G0472 as noted above should be reported for this new HCV screening benefit. *CPT*® code *86803*, HCV rapid antibody test, is not appropriate for reporting screening under this policy.

Additional information

The official instruction, CR 9200 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3285CP.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html* under - How Does It Work.

MLN Matters® Number: MM9200
Related CR Release Date: June 19, 2015
Related Transmittal #: R3285CP
Change Request (CR) #: CR 9200
Effective Date: June 2, 2014
Implementation Date: For FISS shared system edits, split between October 5, 2015, and January 4, 2016, releases; July 20, 2015, - For non-shared MAC edits; October 5, 2015 - For CWF shared systems edits.

2015 MAC satisfaction indicator survey

There is still time

Your opinion is important to us.

If you haven't already completed the MAC Satisfaction Indicator (MSI) survey, please take a moment to complete it now.

Share your experience with the services we provide. It will take about 10 minutes. You can access the survey at *https://cfigroup.qualtrics.com/SE/?SID=SV_3UBxriB8PrHOZEN&MAC_BRNC=9*.

The CFI Group is conducting this survey on behalf of the Centers for Medicare & Medicaid Services (CMS).

Hurry, the survey will close soon.If you experience technical difficulties accessing or submitting the survey, please contact CFI Support at *nripberger@cfigroup.com*.

Local Coverage Determinations

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 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.

More information

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

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

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.**

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**

New LCDs

Application of skin substitute grafts for treatment of DFU and VLU of lower extremities – new LCD

LCD ID number: L36013 (Florida, Puerto Rico/U.S. Virgin Islands)

This local coverage determination (LCD) addresses the reasonable and necessary (R&N) threshold for coverage of skin replacement surgery with particular emphasis on the indications for application of skin substitute grafts for diabetic foot ulcers (DFU) and venous leg ulcers (VLU).

The definition of skin substitute grafts is addressed in AMA *CPT* Section on Skin Replacement Surgery. Evaluation of the clinical literature indicates that studies comparing the efficacy of skin substitute grafts as an adjunct to chronic wound care are limited in number, apply mainly to generally healthy patients, and examine only a small portion of the skin substitute products available in the United States.

Therefore, no individual product can be considered for payment unless the applicable skin replacement surgery code meets the requirements of this LCD. Application of skin substitute graft for indications other than for DFU or VLU are not addressed by this LCD. Such application must meet the reasonable and necessary threshold for coverage as defined in the program Integrity manual and the supply must be used per its Food and Drug Administration (FDA) label requirements.

The current LCD, "Skin Substitutes" (L29279-Florida and L29393-Puerto Rico/US Virgin Islands), will be retired effective September 6, 2015.

Effective date

This LCD revision is effective services rendered **on or after September 6, 2015**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

LCD Revisions

Treatment of lower extremity varicose veins – Part A LCD revision

LCD ID number: L28999 (Florida) LCD ID number: L29031 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for the treatment of varicose veins of the lower extremity highlights the requirement for classifying patients based on history, examination, and venous duplex scan and for outlining a plan of care before treatment of patients with significant chronic venous disease or chronic venous insufficiency. Some newer modalities for treatment and emerging technologies are addressed with the requirement for coding to specificity.

For example, MOCA (mechanical chemical ablation) (ClariVein®) remains noncovered (pending further publication of high quality evidence) and should be coded as *CPT*® code *37799* (pending assignment of a unique code by AMA/*CPT*® or CMS). Emerging modalities not addressed by the LCD that do not fit specific code descriptors addressed in the LCD should be coded with the unlisted *CPT*® code *37799* and will be addressed on a case by case basis. This LCD has been revised to update indications and limitations of coverage and/or medical necessity, documentation guidelines, coding section, references, and utilization guidelines for the treatment of varicose veins of the lower extremity.

Effective date

This LCD revision is effective for **services rendered on or after August 9, 2015**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Hemophilia clotting factors – revision to the Part A LCD

LCD ID number: L28851 (Florida)
LCD ID number: L28884 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for hemophilia clotting factors was revised to clarify that reasonable and necessary prophylaxis is covered for patients with severe hemophilia A or B who have less than one percent of normal factor (less than 0.01 IU/mL) or in persons with hemophilia A or hemophilia B that is not severe (i.e., hemophiliacs with more than 1 percent of normal factor levels) who have repeated episodes of spontaneous bleeding. Language was added to the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD. In addition, the "Sources of Information and Basis for Decision" section of the LCD was updated.

Effective date

This LCD revision is effective based for **services rendered on or after July 14, 2015**.

First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. Coding guidelines for an LCD (when present) may be found by selecting "Attachments" in the "Section Navigation" drop-down menu at the top of the LCD page.

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

Ranibizumab (Lucentis®) – revision to the Part A LCD

LCD ID number: L28977 (Florida)
LCD ID number: L29010 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for ranibizumab (Lucentis®) was revised to add a new Food and Drug Administration (FDA) approved indication for ranibizumab (Lucentis®).

The "Indications and Limitations of Coverage and/or Medical Necessity" and "ICD-9 Codes that Support Medical Necessity" sections of the LCD were revised to add the new indication for diabetic retinopathy in patients with diabetic macular edema. In addition, the "Sources of Information and Basis for Decision" section of the LCD was updated.

Effective date

This LCD revision is effective **for claims processed on or after June 23, 2015**, for services rendered on or after February 06, 2015.

First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Noncovered services – revision to the Part A LCD

LCD ID number: L28991 (Florida)
LCD ID number: L29023
(Puerto Rico/U.S. Virgin Islands)

Based on change requests (CRs) 9190 and 9205, the local coverage determination (LCD) for noncovered services was revised.

The *CPT*®/HCPCS Codes - Listed Procedure Codes – Drugs and Biologicals" section of the LCD was revised to add *CPT*® codes *90620* and *90621*.

The "*CPT*®/HCPCS Codes - Listed Procedure Codes - Procedures" section of the LCD was revised to delete HCPCS code C9737 and replace with *CPT*® code *0392T*.

Additionally, the "*CPT*®/HCPCS Codes - Listed Procedure Codes - Procedures" section of the LCD was revised to add *CPT*® code *0393T.*

Effective date

The LCD revision for *CPT*® codes *90620* and *90621* is effective for claims processed on or after July 6, 2015, for services rendered on or after February 1, 2015. The LCD revision for HCPCS code C9737 and *CPT*® codes *0392T* and *0393T* is effective for claims processed on or after July 6, 2015, for services rendered on or after July 1, 2015.

First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. Coding guidelines for an LCD (when present) may be found by selecting "Attachments" in the "Section Navigation" drop-down menu at the top of the LCD page.

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

Molecular pathology procedures – Part A LCD revision

LCD ID number: L33703
(Florida/Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for molecular pathology procedures was revised to remove specified *Current Procedural Terminology*® (*CPT*®) codes for both microbial identification using molecular pathology techniques and in situ hybridization analyses from the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD.

These molecular pathology procedure techniques describe methods in other pathology and laboratory sections of the *Current Procedural Terminology*® (*CPT*®) book. Therefore, all *CPT*® codes for the described techniques would apply.

Effective date

This LCD revision is effective for claims processed on or **on or after July 21, 2015, for services rendered on or after July 1, 2015**.

First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Investigational device exemption process change

The Centers for Medicare and Medicaid Services (CMS) made changes to the IDE regulations (42 CFR § 405 Subpart B).

CMS outlined criteria for coverage of IDE studies and changed from local Medicare administrative contractor (MAC) review and approval of IDE studies to a centralized review and approval of IDE studies (with a 2015 Food and Drug Administration (FDA) letter). *http://www.cms.gov/Medicare/Coverage/IDE/index.html.*

Assuming all applicable requirements for the program are met, an approval for a Category A (Experimental) IDE study allows coverage of routine care items and services furnished in the study, but not of the Category A device, which is statutorily excluded from coverage.

An approval for a Category B (Nonexperimental/investigational) IDE study will allow coverage of the Category B device and the routine care items and services in the trial.

The CMS review is generally a request from the principal investigator, and CMS will post the study title, sponsor name, NCT number, IDE number, and CMS approval date. *http://www.cms.gov/Medicare/Coverage/IDE/Approved-IDE-Studies.html*

The CMS approval is not a claim level coverage decision and participating providers (study sites submitting claims to A/B MAC Jurisdiction N) must be able to demonstrate if audited (pre or post payment) that all applicable requirements of the program were met, including but not limited to having an active Investigational Review Board (IRB) approval in play, documentation supporting reasonable and necessary services, and accurate billing/coding of claims to MCS/FISS.

Additionally, although it is not required, it would be beneficial to both contractor and physician/facility if the cost and coding form for CMS approved IDEs along with the CMS approval letter would be sent to First Coast before claims are submitted.

This will allow the contractor to make any necessary decisions and preparations for claims receipt especially if unlisted procedure codes are considered and/or applicable. This should not cause any delays in study participation and will help claim adjudication.

For FDA IDE approval's prior to January 1, 2015, First Coast will continue to require investigational study sites to submit for the contractor's review, all documentation that is currently required.

Please refer to the following article titled "Investigational device exemption (IDE) approval requirements" and request form for a complete list of items the contractor requires for each investigational site. Study sites should submit all of the documentation electronically to *clinicaltrials@fcso.com*.

CMS approval process:

http://www.cms.gov/Medicare/Coverage/IDE/index.html

Q&A addressing billing and coding:

http://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/Downloads/Mandatory-Clinical-Trial-Identifier-Number-QsAs.pdf

CMS *MLN*® article addressing billing and coding:

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8401.pdf

First Coast Service Options, Inc. (First Coast) cost and coding form:

http://medicare.fcso.com/Clinical_trials/138007.pdf

ICD-10 claims submission alternatives

For FROM dates of service (on professional and supplier claims) or dates of discharge/through dates (on institutional claims) on or after October 1, 2015, entities covered under the Health Insurance Portability and Accountability Act (HIPAA) are required to use the International Classification of Diseases, 10th Edition (ICD-10) code sets adopted under HIPAA.

If you will not be able to complete the necessary systems changes to submit claims with ICD-10 codes by October 1, 2015, or find that you are unable to submit claims on or after October 1, 2015, due to issues with your billing software, vendor or clearinghouse, the following claims submission alternatives are available.

Please note that these claims submission alternatives REQUIRE THE USE OF ICD-10 code sets for FROM dates of service (on professional and supplier claims) or dates of discharge/through dates (on institutional claims) on or after October 1, 2015.

Free billing software

You may download the free billing software that the Centers for Medicare & Medicaid Services (CMS) offers via our website at *http://medicare.fcso.com/PC-ACE_Pro32_software/*. **Prior to download**, you must **complete the** *EDI enrollment form*. The software has been updated to support ICD-10 codes and requires submission through a third party network service vendor (NSV) in order to transmit claims. The software download is free, but there may be fees associated with submitting claims through an NSV. Information about NSVs is available at *http://medicare.fcso.com/EDI_news/276187.asp*.

This billing software only works for submitting fee-for-service claims to Medicare. It is intended to provide submitters with an ICD-10 compliant claims submission format; it does not provide coding assistance.

Please note that submitting electronic claims to Medicare using the free billing software does not change the requirement for ICD-10 compliant claims to be submitted for FROM dates of service (on professional claims) or dates of discharge/through dates (on institutional claims) on or after October 1, 2015. Any claims containing ICD-9 codes for FROM dates of service (on professional claims) or dates of discharge/through dates (on institutional claims) on or after October 1, 2015, will be rejected by Medicare.

Direct data entry

Providers that bill institutional claims are also permitted to submit claims electronically via direct data entry (DDE) screens. For more information about DDE, go to *http://medicare.fcso.com/Direct_data_entry/*.

Please **submit a request to submit claims** via DDE by **September 16, 2015**, to ensure access by October 1, 2015.

Please note that claims submitted via DDE must contain ICD-10 codes for dates of discharge/through dates on or after October 1, 2015. Those submitted containing ICD-9 codes for dates of discharge/through dates on or after October 1, 2015, will be returned to provider (RTP).

Paper claims

In limited situations, you may submit paper claims with ICD-10 codes to Medicare. To find more information on when you may submit paper claims, visit *http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/ASCAWaiver.html* on the CMS website. Please note that to submit paper claims, a provider must meet the requirements to qualify for a waiver of the Administrative Simplification Compliance Act (ASCA) provisions.

Practitioners (physicians and non-physicians) and suppliers use Form CMS-1500 to bill MACs and DME MACs. You can order Form CMS-1500 from printing companies, office supply stores, and the U.S. Government Printing Office (GPO), U.S. Government Bookstore. U.S. Government Bookstore orders can be placed by calling (866) 512-1800 or visiting *http://bookstore.gpo.gov/agency/346*.

Institutional providers use Form CMS-1450, also known as the UB-04, to bill MACs. You can order UB-04 claim forms from the National Uniform Billing Committee (NUBC) at *http://www.nubc.org* on the NUBC website. Also see *http://medicare.fcso.com/Claim_submission_guidelines/268048.asp* for more information about submitting paper claims.

Please note that submitting paper claims to Medicare, even if approved for an ASCA waiver, does not change the requirement for ICD-10 compliant claims to be submitted for FROM dates of service (on professional and supplier claims) or dates of discharge/through dates (on institutional claims) on or after October 1, 2015 .

Any paper claims containing ICD-9 codes for FROM dates of service (on professional and supplier claims) or dates of discharge/through dates (on institutional claims) on or after October 1, 2015, will be returned as unprocessable by Medicare.

Please submit a request for an ASCA waiver by **September 16, 2015**, to ensure a response by October 1, 2015.

If you have questions, *please contact us*.

Fee-for-service claim guidance for implementing ICD-10

***Note**: This article was revised June 27, 2015, to clarify language under "Claims that span the ICD-10 implementation date." All other information remains the same. This information was previously published in the March 2015 Medicare A Connection, Pages 30-36.*

Provider types affected

This article is intended for all physicians, providers, and suppliers submitting claims to Medicare administrative contractors (MACs), including home health & hospice MACs (HH&H MACs), and durable medical equipment MACs (DME MACs) for services provided to Medicare beneficiaries.

Provider action needed

For dates of service on and after October 1, 2015, entities covered under the Health Insurance Portability and Accountability Act (HIPAA) are required to use the ICD-10 code sets in standard transactions adopted under HIPAA. The HIPAA standard health care claim transactions are among those for which ICD-10 codes must be used for dates of service on and after October 1, 2015. As a result of change request (CR) 7492 (and related *MLN Matters*® article MM7492), guidance was provided on processing certain claims for dates of service near the original October 1, 2013, implementation date for ICD-10. **This article updates MM7492 to reflect the October 1, 2015, implementation date**. Make sure your billing and coding staffs are aware of these changes.

Key points of SE1408

General reporting of ICD-10

As with ICD-9 codes today, providers and suppliers are still required to report all characters of a valid ICD-10 code on claims. ICD-10 diagnosis codes have different rules regarding specificity and providers/suppliers are required to submit the most specific diagnosis codes based upon the information that is available at the time. Please refer to *http://www.cms.gov/Medicare/Coding/ICD10/index.html* for more information on the format of ICD-10 codes. In addition, ICD-10 procedure codes (PCs) will only be utilized by inpatient hospital claims as is currently the case with ICD-9 procedure codes.

General claim submissions information

ICD-9 codes will no longer be accepted on claims (including electronic and paper) with FROM dates of service (on professional and supplier claims) or dates of discharge/through dates (on institutional claims) on or after October 1, 2015. Institutional claims containing ICD-9 codes for services on or after October 1, 2015, will be returned to provider (RTP) as unprocessable. Likewise, professional and supplier claims containing ICD-9 codes for dates of services on or after October 1, 2015, will also be returned as unprocessable. You will be required to re-submit these claims with the appropriate ICD-10 code. A claim cannot contain both ICD-9 codes and ICD-10 codes. Medicare will RTP all claims that are billed with both ICD-9 and ICD-10 **diagnosis codes** on the same claim. For dates of service prior to October 1, 2015, submit claims with the appropriate ICD-9 diagnosis code. For dates of service on or after October 1, 2015, submit with the appropriate ICD-10 diagnosis code. Likewise, Medicare will also RTP all claims that are billed with **both** ICD-9 and ICD-10 **procedure codes** on the same claim. For claims with dates of service **prior to** October 1, 2015, submit with the appropriate ICD-9 procedure code. For claims with dates of service on or after October 1, 2015, submit with the appropriate ICD-10 procedure code. Remember that ICD-10 codes may only be used for services provided on or after October 1, 2015. Institutional claims containing ICD-10 codes for services prior to October 1, 2015, will be returned to provider (RTP). Likewise, professional and supplier claims containing ICD-10 codes for services prior to October 1, 2015, will be returned as unprocessable. Please submit these claims with the appropriate ICD-9 code.

Will the Centers for Medicare & Medicaid Services (CMS) allow for dual processing of ICD-9 and ICD-10 codes (accept and process both ICD-9 and ICD-10 codes for dates of service on and after October 1, 2015)?

No, CMS will not allow for dual processing of ICD-9 and ICD-10 codes after ICD-10 implementation October 1, 2015. Many providers and payers, including Medicare have already coded their systems to only allow ICD-10 codes beginning October 1, 2015. The scope of systems changes and testing needed to allow for dual processing would require significant resources and could not be accomplished by the October 1, 2015, implementation date. Should CMS allow for dual processing, it would force all entities with which we share data, including our trading partners, to also allow for dual processing. In addition, having a mix of ICD-9 and ICD-10 codes in the same year would have major ramifications for CMS quality, demonstration, and risk adjustment programs.

Claims that span the ICD-10 implementation date

There may be times when a claim spans the ICD-10 implementation date for institutional, professional, and supplier claims. For example, the beneficiary is admitted as an inpatient in late September 2015 and is discharged after October 1, 2015. Another example is a DME claim for monthly billing that spans between September and October, 2015 (that is, the monthly billing dates are September 15 – October 14, 2015). The following tables

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provide further guidance to providers for claims that span the periods where ICD-9 and ICD-10 codes may both be applicable.

Table A – Institutional providers

Bill type(s)	Facility type/ services	Claim processing requirement	Use FROM or THROUGH date
11x	Inpatient hospitals (incl. TERFHA hospitals, prospective payment system hospitals, long term care hospitals, critical access hospitals CAHs)	If the hospital claim has a discharge and/or through date on or after 10/1/15, then the entire claim is billed using ICD-10.	THROUGH
12x	Inpatient Part B hospital services	Split claims - require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM
13x	Outpatient hospital	Split claims - require providers split the claim so all ICD-9 codes remain on one claim with DOS through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM
14x	Non-patient laboratory services	Split claims - require providers split the claim so all ICD-9 codes remain on one claim with DOS through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM
18x	Swing beds	If the [swing bed or skilled nursing facility (SNF)] claim has a discharge and/or through date on or after 10/1/2015, then the entire claim is billed using ICD-10.	THROUGH
21x	Skilled nursing (inpatient Part A)	If the [swing bed or SNF] claim has a discharge and/or through date on or after 10/1/2015, then the entire claim is billed using ICD-10.	THROUGH

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Bill type(s)	Facility type/ services	Claim processing requirement	Use FROM or THROUGH date
22x	SNF (Inpatient Part B)	Split claims - require providers split the claim so all ICD-9 codes remain on one claim with DOS through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM
23x	SNFs (outpatient)	Split claims - require providers split the claim so all ICD-9 codes remain on one claim with DOS through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM
32x	Home health (inpatient Part B)	Allow HHAs to use the payment group code derived from ICD-9 codes on claims which span 10/1/2015, but require those claims to be submitted using ICD-10 codes.	THROUGH
3x2	Home health – request for anticipated payment (RAPs)*	* **Note** - RAPs can report either an ICD-9 code or an ICD-10 code based on the one (1) date reported. Since these dates will be equal to each other, there is no requirement needed. The corresponding final claim, however, will need to use an ICD-10 code if the HH episode spans beyond 10/1/2015.	*See Note
34x	Home health – (outpatient)	Split claims - require providers split the claim so all ICD-9 codes remain on one claim with DOS through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM

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Bill type(s)	Facility type/ services	Claim processing requirement	Use FROM or THROUGH date
71x	Rural health clinics	Split claims - require providers split the claim so all ICD-9 codes remain on one claim with DOS through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM
72x	End-stage renal disease (ESRD)	Split claims - require providers split the claim so all ICD-9 codes remain on one claim with DOS through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM
73x	Federally qualified health clinics (prior to 4/1/10) N/A – Always ICD-9 code set.	N/A – Always ICD-9 code set.	N/A
74x	Outpatient therapy	Split claims - require providers split the claim so all ICD-9 codes remain on one claim with DOS through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM
75x	Comprehensive outpatient rehab facilities	Split claims - require providers split the claim so all ICD-9 codes remain on one claim with DOS through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM

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Bill type(s)	Facility type/ services	Claim processing requirement	Use FROM or THROUGH date
76x	Community mental health clinics	Split claims - require providers split the claim so all ICD-9 codes remain on one claim with DOS through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM
77x	Federally qualified health clinics (effective 4/4/10)	Split claims - require providers split the claim so all ICD-9 codes remain on one claim with DOS through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM
81x	Hospice-hospital	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with DOS through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM
82x	Hospice – non-hospital	Split claims - require providers split the claim so all ICD-9 codes remain on one claim with DOS through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM
83x	Hospice – hospital-based	N/A	N/A
85x	Critical access hospital	Split claims - require providers split the claim so all ICD-9 codes remain on one claim with DOS through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM

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Table B - Special outpatient claim processing circumstances

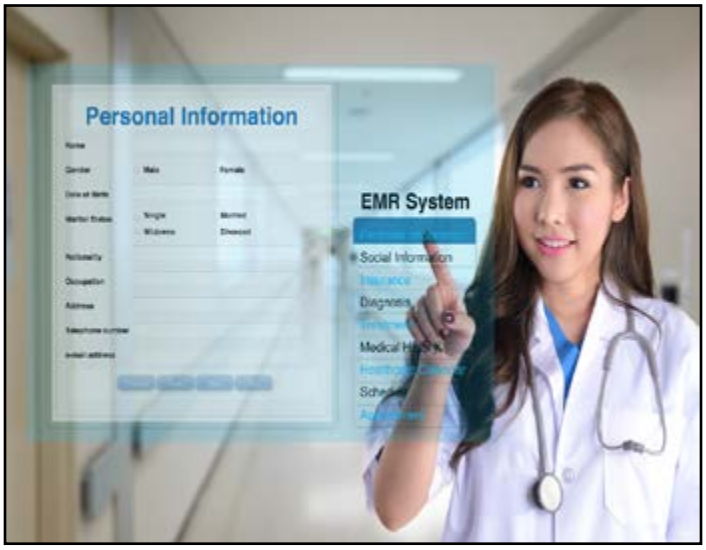
Scenario	Claim processing requirement	Use FROM or THROUGH date
3-day /1-day payment window	Since all outpatient services (with a few exceptions) are required to be bundled on the inpatient bill if rendered within three (3) days of an inpatient stay; if the inpatient hospital discharge is on or after 10/1/2015, the claim must be billed with ICD-10 for those bundled outpatient services.	THROUGH

Table C – Professional claims

Type of claim	Claim processing requirement	Use FROM or THROUGH date
All anesthesia claims	Anesthesia procedures that begin on 9/30/2015, but end 10/1/2015, are to be billed with ICD-9 diagnosis codes and use 9/30/2015, as both the FROM and THROUGH date.	FROM

Table D –Supplier claims

Supplier type	Claim processing requirement	Use FROM or THROUGH/ TO date
DMEPOS	Billing for certain items or supplies (such as capped rentals or monthly supplies) may span the ICD-10 compliance date of 10/1/2015, (i.e., the FROM date of service occurs prior to 10/1/2015, and the TO date of service occurs after 10/1/2015).	FROM



Additional information

You may also want to review SE1239 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1239.pdf*. SE1239 announces the revised ICD-10 implementation date of October 1, 2015.

You may also want to review SE1410 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1410.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html* under - *How Does It Work*.

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Effective Date: October 1, 2014
Related CR Transmittal #: N/A
Implementation Date: N/A

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Non-specific procedure code description requirement for HIPAA version 5010 claims

***Note**: This article was revised June 22, 2015, to delete the last two sentences of the Background section. All other information remains the same. This information was previously published in the June 2015 Medicare A Connection, Page 17.*

Provider types affected

This *MLN Matters*® special edition article is intended for all physicians, providers, and suppliers who bill Medicare contractors (carriers, fiscal intermediaries (FIs), Medicare administrative contractors (A/B MACs), home health and hospice MACs (HH+H MACs), and durable medical equipment MACs (DME MACs)) for services provided to Medicare beneficiaries.

What you need to know

The Office of E-Health Standards and Services (OESS) announced November 17, 2011, that although the 5010/D.0 compliance date of January 1, 2012, will not change, HIPAA enforcement of compliance with the standards will be deferred until March 31, 2012.

The 5010 versions of the institutional and professional claim implementation guides mandate that when claims use non-specific procedure codes a corresponding description of the service is now required. Please make certain your billing and coding staff follow these requirements for submitting a HIPAA compliant claim when non-specific procedure codes are used. Please ensure these implementation guide requirements are followed when submitting a HIPAA compliant claim for all non-specific procedure codes.

Background

The HIPAA version 5010 implementation guide describes non-specific procedure codes as codes that may include, in their descriptor, terms such as: “not otherwise classified (NOC); unlisted; unspecified; unclassified; other; miscellaneous; prescription drug generic; or prescription drug, brand name”.

If a procedure code containing any of these descriptor terms is billed, a corresponding description of that procedure is required; otherwise, the claim is not HIPAA compliant. Note that there is no crosswalk of non-specified procedure codes with corresponding descriptions.

Detailed information regarding this requirement can be found in the 837I and 837P implementation guides (837I – 005010X223A2 and 837P – 005010X222A1). If the corresponding non-specific procedure code description is not submitted, the transaction does not comply with the implementation guide and is not, therefore, HIPAA compliant.

Additional information

For 5010/D.O implementation information and deadlines, refer to *MLN Matters*® special edition article SE1131, which is available at *http://www.cms.gov/MLNMattersArticles/downloads/SE1131.pdf*.

If you are not ready, consider contacting your Medicare contractor to receive the free version 5010 software (PC-Ace Pro32) and begin testing now. Or, consider contracting with a version 5010 compliant clearinghouse who can translate the non-compliant transactions into compliant 5010 transactions.

If you are billing Part B and DME claims, you may download the free Medicare remit easy print (MREP) software to view and print compliant HIPAA 5010 835 remittance advices. This software is available at *http://www.cms.gov/AccesstoDataApplication/02_MedicareRemitEasyPrint.asp*.

Contact your respective professional associations and other payers for guidance and resources in order to meet their deadlines. Part A billers may download the free PC-Print software to view and print a compliant HIPAA 5010 835 remittance advice from their A/B MACs website.

Please note, change request (CR) 7392, “Common Edits and Enhancements Module (CEM) and Receipt, Control, and Balancing Updates,” dated July 21, 2011, established the requirements that all procedures shall comply with the HIPAA 5010 version claim process. CR 7392 was implemented by Medicare contractors October 1, 2011, and does not override any previous claim processing instructions.

MLN Matters® Number: SE1138
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
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Related CR Transmittal #: N/A
Implementation Date: N/A

CMS begins implementation of key payment legislation

Proposed Update to Physician Fee Schedule is First Since Repeal of SGR

On July 8, CMS released the first proposed update to the physician payment schedule since the repeal of the Sustainable Growth Rate through the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The proposal includes a number of provisions focused on person-centered care, and continues the Administration's commitment to transform the Medicare program to a system based on quality and healthy outcomes.

"CMS is building on the important work of Congress to shift the Medicare program toward a system that rewards physicians for providing high quality care," said Andy Slavitt, Administrator of CMS. "Thanks to the recent landmark Medicare and children's health insurance program legislation, CMS and Congress are working together to achieve a better Medicare payment system for physicians and the American people."

In the proposed 2016 Physician Fee Schedule rule, CMS is also seeking comment from the public on implementation of certain provisions of the MACRA, including the new Merit-based Incentive payment system (MIPS). This is part of a broader effort at the Department to move the Medicare program to a health care system focused on the delivery of quality care and value.

The proposed rule includes updates to payment policies, proposals to implement statutory adjustments to physician payments based on misvalued codes, updates to the Physician Quality Reporting System, which measures the quality performance of physicians participating in Medicare, and updates to the Physician Value-Based Payment Modifier, which ties a portion of physician payments to performance on measures of quality and cost.

CMS is also seeking comment on the potential expansion of the Comprehensive Primary Care Initiative, a CMS Innovation Center initiative designed to improve the coordination of care for Medicare beneficiaries.

The proposed rule also seeks comment on a proposal that supports patient- and family-centered care for seniors and other Medicare beneficiaries by enabling them to discuss advance care planning with their providers. The proposal follows the American Medical Association's recommendation to make advance care planning services a separately payable service under Medicare.

The release of the rule triggers a 60-day comment period, during which time CMS welcomes the input of stakeholders and the public. A final rule will be published this fall.

For More Information:

Proposed Rule

Fact Sheet

New application for physician-owned hospital reporting

The Centers for Medicare & Medicaid Services (CMS) CMS has released the *CMS-855POH*, a new Office of Management and Budget (OMB) approved application for physician-owned hospitals to report ownership and/or investment interest upon initial enrollment, revalidation, or when requested by CMS.

This form has replaced Attachment 1 of the CMS-855A application.

For more information, visit the *Physician-Owned Hospital Web page*.

The A/B Medicare administrative contractors (MACs) will continue to accept the CMS 855A with Attachment 1 through December 9, 2015. Beginning December 10, the *CMS-855A* (without Attachment 1), as well as the *CMS-855-POH* must be submitted. Both forms are available on the *CMS Forms List*.

Changes to the opt-out law for physicians and practitioners

Prior to enactment of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), physician/practitioner opt-out affidavits were only effective for two years. As a result of changes made by MACRA, valid opt-out affidavits signed *on or after June 16, 2015*, will automatically renew every two years.

If physicians and practitioners that file affidavits effective on or after June 16, 2015, do not want their opt-out to automatically renew at the end of a two year opt-out period, they may cancel the renewal by notifying all Medicare administrative contractors with which they filed an affidavit in writing at least 30 days prior to the start of the next opt-out period.

Valid opt-out affidavits signed before June 16, 2015, will expire two years after the effective date of the opt-out.

If physicians and practitioners that filed affidavits effective before June 16, 2015, want to extend their opt out, they must submit a renewal affidavit within 30 days after the current opt-out period expires to all Medicare administrative contractors with which they would have filed claims absent the opt-out.

October 2015 ASP drug pricing files and revisions

Provider types affected

This *MLN Matters*® article is intended for physicians, other providers, and suppliers submitting claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 9248 which instructs MACs to download and implement the October 2015 average sales price (ASP) drug pricing files and, if released by CMS, the July 2015, April 2015, January 2015, and October 2014, ASP drug pricing files for Medicare Part B drugs.

Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after October 5, 2015, with dates of service October 1, 2015, through December 31, 2015. MACs will not search and adjust claims that have already been processed unless brought to their attention. Make sure your billing staffs are aware of these changes.

Background

The average sales price (ASP) methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply Medicare contractors with the ASP and not otherwise classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis.

Payment allowance limits under the OPPS are incorporated into the outpatient code editor (OCE) through separate instructions that can be located in the *Medicare Claims Processing Manual* (Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)), Section 50 (Outpatient PRICER). The following table shows how the quarterly payment files will be applied:

Files	Effective dates of service
October 2015 ASP and ASP NOC	October 1, 2015, through December 31, 2015
July 2015 ASP and ASP NOC	July 1, 2015, through September 30, 2015
April 2015 ASP and ASP NOC	April 1, 2015, through June 30, 2015
January 2015 ASP and ASP NOC	January 1, 2015, through March 31, 2015

Files	Effective dates of service
October 2014 ASP and ASP NOC	October 1, 2014, through December 31, 2014

Note: The absence or presence of a HCPCS code and its associated payment limit does not indicate Medicare coverage of the drug or biological. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. The local MAC processing the claim shall make these determinations.

Additional information

The official instruction, CR 9248 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3290CP.pdf*

If you have any questions, please contact your MAC at their toll-free number. That number is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html* under - *How Does It Work*?

MLN Matters® Number: MM9248
Related Change Request (CR) #: CR 9248
Related CR Release Date: July 10, 2015
Effective Date: October 1, 2015
Related CR Transmittal #: R3290CP
Implementation Date: October 5, 2015

Medicare Part A skilled nursing facility prospective payment system pricer update

Provider types affected

This *MLN Matters*® article is intended for skilled nursing facilities (SNFs) submitting claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries paid under the skilled nursing facility (SNF) prospective payment system (PPS).

Provider action needed

Change request (CR) 9222 describes the updates to the payment rates used under the PPS for SNFs, for fiscal year (FY) 2016, as required by statute. Make sure that your billing staffs are aware of these changes.

Background

Annual updates to the SNF PPS rates are required by the Social Security Act (Section 1888(e); see *http://www.ssa.gov/OP_Home/ssact/title18/1888.htm*), as amended by the Medicare, Medicaid, and the State Children's Health Insurance Plan (SCHIP) Balanced Budget Refinement Act of 1999 (the BBRA), the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (the BIPA), and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (the MMA), relating to Medicare payments and consolidated billing for SNFs.

Each July, the Centers for Medicare & Medicaid Services (CMS) publishes the SNF payment rates for the upcoming fiscal year (October 1, 2015 through September 30, 2016) in the *Federal Register*, available online at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/List-of-SNF-Federal-Regulations.html*.

The update methodology is identical to that used in the previous year, which includes a forecast error adjustment whenever the difference between the forecasted and actual change in the SNF market basket exceeds 0.5 percentage point.

The statute mandates an update to the federal rates using the latest SNF full market basket adjusted for productivity. The payment rates will be effective October 1, 2015.

Additional information

The official instruction, CR 9222 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3289CP.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html* under - *How Does It Work*?

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Related Change Request (CR) #: CR 9222
Related CR Release Date: July 2, 2015
Effective Date: October 1, 2015
Related CR Transmittal #: R3289CP
Implementation Date: October 5, 2015

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Online Medicare refreshers

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These WBT courses provide information on a broad range of Medicare topics for health care professionals and their staff. Many of these courses offer continuing education credits.

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Quarterly update to the end-stage renal disease prospective payment system

Provider types affected

This *MLN Matters*® article is intended for end-stage renal disease (ESRD) facilities that submit claims to Medicare administrative contractors MACs) for ESRD services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 9127 which provides instructions for new codes added to the Healthcare Common Procedure Coding System (HCPCS) file for anemia management. These new codes will be added to the list of items and services subject to the ESRD PPS consolidated billing requirements. Make sure that your billing staff is aware of these changes.

Background

The Medicare Improvements for Patients and Providers Act (MIPPA; Section 153(b)) required the implementation of an ESRD PPS effective January 1, 2011. The ESRD PPS provides a single payment to ESRD facilities that covers all of the resources used in furnishing an outpatient dialysis treatment.

The ESRD PPS includes consolidated billing (CB) requirements for limited Part B services included in the ESRD facility's bundled payment. The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of items and services that are subject to Part B CB and are therefore no longer separately payable when provided to ESRD beneficiaries by providers other than ESRD facilities. The ESRD PPS provides outlier payments, if applicable, for high-cost patients due to unusual variations in the type or amount of medically necessary care. Anemia management is a category of drugs and biologicals that are always considered to be used for the treatment of ESRD.

CR 9127 updates

- ESRD facilities will not receive separate payment for J0887, J1439, or Q9976 with or without the AY modifier, and the claims will process the line item as covered with no separate payment under the ESRD PPS. Effective July 1, 2015, these new codes will be added to the list of items and services subject to the ESRD PPS CB requirements:
  - J0887 - Injection, Epoetin Beta (For ESRD On Dialysis), 1 microgram
  - J1439 - Injection, ferric carboxymaltose, 1mg
  - Q9976 - Injection ferric pyrophosphate citrate solution; 0.1 mg of iron
  - Q9976 is administered via dialysate. Therefore, when billing for Q9976, it should be accompanied by the JE modifier as discussed in CR 8256 issued April 26, 2013. You can review the MLN Matters® article (MM8256) corresponding to CR 8256 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8256.pdf*.
- In accordance with 42 CFR 413.237(a)(1), HCPCS J0887, J1439, and Q9976 are considered to be eligible outlier services and will be included in the outlier calculation when CMS provides a fee amount on the average sales price fee schedule.
- There is a new HCPCS J0888 for epoetin beta for non-ESRD use. This code will not be permitted on the ESRD type of bill 072x. HCPCS J0888 replaces HCPCS Q9973; and
- Q2047 (Peginesatide) was terminated effective January 1, 2013. Therefore, it is no longer subject to the ESRD PPS consolidated billing requirements.
- In addition, J0890 (Peginesatide) is a recalled drug and should not be furnished to ESRD patients. Therefore effective July 1, 2015, this code will be removed from the list of items and services that are subject to CB requirements.

You can find the updated list of renal dialysis services that are subject to the ESRD PPS CB requirements at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/Consolidated_Billing.html*.

Additional information

The official instruction, CR 9127, issued to your MAC regarding this change is available at *http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3260CP.pdf.*

If you have any questions, please contact your MAC at their toll-free number. That number is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html* under - *How Does It Work*?

MLN Matters® Number: MM9127
Related Change Request (CR) #: CR 9127
Related CR Release Date: May 15, 2015
Effective Date: July 1, 2015
Related CR Transmittal #: R3260CP
Implementation Date: July 6, 2015

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. CPT only copyright 2014 American Medical Association.

Educational Events

Provider outreach and educational events – August/ September 2015

Internet-based PECOS class

When: Thursday, August 13
Time: 1:00 p.m. -5:00 p.m. ET – Delivery language: English
Type of Event: Conference/Seminar
http://medicare.fcso.com/Events/0293487.asp

Medicare Speaks - Tampa

When: September 15-16
Time: 7:30 a.m. - 4:15 p.m. ET – Delivery language: English
Type of Event: Seminar
Location: Tampa, Fl
http://medicare.fcso.com/Medicare_Speaks/278356.pdf

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*.

MLN Connects®

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.

MLN Connects® Provider eNews for June 18, 2015

MLN Connects® Provider eNews for June 18, 2015
View this edition as a PDF

In this edition:

MLN Connects® National Provider Calls

- ESRD QIP System Training — Save the Date
- ESRD QIP: Reviewing Your Facility's PY 2016 Performance Data — Register Now
- 2016 PFS Proposed Rule: Medicare Quality Reporting Programs — Registration Now Open
- ESRD QIP: Proposed Rule for Payment Year 2019 — Register Now
- New MLN Connects® National Provider Call Audio Recording and Transcript

CMS Events

- Medicare Learning Network® Webinar: Medicare Basics for New Providers Part Two: Billing, Reimbursement, and Appeals
- PERM Cycle 1 Provider Education Sessions

Announcements

- Medicare Provides Coverage of HIV Screening
- Medicare and Medicaid 50th Anniversary Count Down
- Use New Interactive Case Studies to Explore ICD-10 Concepts
- Corrections to eCQM Measures for 2016 Reporting
- 2015 PQRS GPRO: 1 Week Left to Register by June 30 Deadline

Claims, Pricers, and Codes

- CY 2015 Home Health PPS Mainframe Pricer Software Available

Medicare Learning Network® Educational Products

- "Using the ICD-10-PCS New Technology Section X Codes" *MLN Matters®* Article — Released
- "Reminder to Billing Procedures Related to the Department of Veterans Affairs (VA) – Companion Information to CR8198" MLN Matters® Article — Released
- "FAQs – International Classification of Diseases, 10th Edition (ICD-10) End-to-End Testing" *MLN Matters®* Article — Revised
- "General Equivalence Mappings Frequently Asked Questions" Booklet — Revised
- "ICD-10-CM/PCS Myths and Facts" Fact Sheet — Revised
- "ICD-10-CM Classification Enhancements" Fact Sheet — Revised
- "ICD-10-CM/PCS The Next Generation of Coding" Fact Sheet — Revised
- *Medicare Learning Network®* Product Available In Electronic Publication Format

Take the time to 'chat' with the website team

You now have the opportunity to save your valuable time by asking your website-related questions online – with First Coast's Live Chat service.

Live chat is available Monday-Friday, from 10 a.m.-2 p.m. ET.

MLN Connects® Provider eNews for June 25, 2015

MLN Connects® Provider eNews for June 25, 2015
View this edition as a PDF

Editor's Note:

The October 1, 2015, compliance date for ICD-10 will be here in less than 100 days. Starting this week, your eNews has a new "Countdown to ICD-10" section, which groups all related information in one place to help you prepare.

In this edition:

Countdown to ICD-10

- ICD-10 Deadline: October 1, 2015
- ICD-10 Training Series for Small and Rural Practices
- Claims that Span the ICD-10 Implementation Date
- ICD-10 FAQs: CMNs, Prescriptions, and Orders
- Coding for ICD-10-CM: Continue to Report CPT/HCPCS Modifiers for Laterality
- Transition to ICD-10 for Home Health

MLN Connects® National Provider Calls

- ESRD QIP System Training — Registration Now Open
- ESRD QIP: Reviewing Your Facility's PY 2016 Performance Data — Register Now
- 2016 PFS Proposed Rule: Medicare Quality Reporting Programs — Register Now
- ESRD QIP: Proposed Rule for Payment Year 2019 — Register Now

MLN Connects® Events

- IQCP for CLIA Laboratory Non-waived Testing: Workbook Tool — Webcast

Announcements

- Are You Providing an Annual Wellness Visit to Your Medicare Patients?
- Affordable Care Act Payment Model Saves More than $25 Million in First Performance Year
- National Medicare Fraud Takedown Results in Charges against 243 Individuals for Approximately $712 Million in False Billing
- Changes to the Medicare Opt-Out Law for Physicians and Practitioners
- Corrections to eCQM Measures for 2016 Reporting

Claims, Pricers, and Codes

- July 2015 Outpatient Prospective Payment System Pricer File Update
- CY 2015 Home Health PPS Mainframe Pricer Software Available

Medicare Learning Network® Educational Products

- Medicare Learning Network® Products Available In Electronic Publication Format
- New Medicare Learning Network® Educational Web Guides Fast Fact

Expand your knowledge of Medicare

Visit the *Medicare Learning Network®* (MLN) Educational Web Guides Overview page, for educational and informational resources to improve your knowledge of Medicare billing and policies.

The *MLN Educational Web Guides* provides information on evaluation and management (E/M) services; guided pathways to resources and topics of interest; lists of health care management products; as well as easy-to-understand billing and coding products.

Click here to explore educational Web guides.

MLN Connects® Provider eNews for July 2, 2015

MLN Connects® Provider eNews for July 2, 2015
View this edition as a PDF

In this edition:

Countdown to ICD-10

- Results From June 2015 ICD-10 Acknowledgement Testing Week
- "ICD-10-CM/PCS Billing and Payment Frequently Asked Questions" Fact Sheet — Revised
- Prepare for ICD-10 with MLN Connects Videos

MLN Connects® National Provider Calls

- ESRD QIP System Training — Last Chance to Register
- ESRD QIP: Reviewing Your Facility's PY 2016 Performance Data — Last Chance to Register
- 2016 PFS Proposed Rule: Medicare Quality Reporting Programs — Register Now
- ESRD QIP: Proposed Rule for Payment Year 2019 — Register Now
- New MLN Connects National Provider Call Audio Recordings and Transcripts

MLN Connects® Events

- IQCP for CLIA Laboratory Nonwaived Testing: Workbook Tool — Webcast

Announcements

- Open Payments Posts Full Year of 2014 Financial Data
- Proposed CY 2016 Updates to Policies and Payment Rates for ESRD Facilities
- ACO Investment Model
- DMEPOS Competitive Bidding: Common Ownership and Control
- Physician-Owned Hospital Ownership Reporting: Release of the CMS 855POH
- AHRQ Ambulatory Surgery Center Survey on Patient Safety Culture
- EHR Incentive Program: Discontinuation of EHR-Randomizer Application Effective July 1
- PQRS: Transition from IACS to EIDM—Action Needed by July 2

Claims, Pricers, and Codes

- Modifications to HCPCS Code Set

Medicare Learning Network® Educational Products

- "Medicare Costs at a Glance: 2015" Fact Sheet — Released
- "Provider Compliance Tips for Computed Tomography (CT Scans)" Fact Sheet — Revised
- "Medicare Remit Easy Print Software" Fact Sheet — Revised
- "Mass Immunizers and Roster Billing" Fact Sheet — Revised
- "Medicare Preventive Services" Educational Tool — Reminder
- "Medicare Basics Commonly Used Acronyms" Educational Tool — Reminder
- Medicare Learning Network Product Available In Electronic Publication Format
- Upgraded Learning Management System — Coming Soon

MLN Connects® Provider eNews for July 9, 2015

MLN Connects® Provider eNews for July 9, 2015
View this edition as a PDF

In this edition:

Countdown to ICD-10

- CMS and AMA Announce Efforts to Help Providers Get Ready For ICD-10
- MLN Connects National Provider Call: Countdown to ICD-10
- "ICD-10 Website Wheel" Educational Tool — Released
- "Medicare FFS Claims Processing Guidance for Implementing ICD-10 — A Re-Issue of MM7492" *MLN Matters*® Article — Revised
- *Medicare Learning Network* ICD-10 Products Available In Electronic Publication Format
- Get Ready for ICD-10 with the CMS Infographic
- ICD-10 Resources for Medicare Providers

MLN Connects® National Provider Calls

- IQCP for CLIA Laboratory Nonwaived Testing: Workbook Tool Webcast — Last Chance to Register
- 2016 PFS Proposed Rule: Medicare Quality Reporting Programs Call — Last Chance to Register
- ESRD QIP: Proposed Rule for Payment Year 2019 Call — Register Now
- Check Out the MLN Connects Call Program Collection of Provider Resources

CMS Events

- PERM Cycle 1 Provider Education Sessions

Announcements

- Proposed Hospital Outpatient and ASC Policy and Payment Changes for 2016, including Two-Midnight Rule
- New Initiative to Promote Value-Based Home Health Care
- PV-PQRS Users: Do Not Log into the Portal until Further Notice
- IRF-PAI Training Manual Updated with Information on New Items Effective October 1, 2015
- EHR Incentive Programs: Reporting CQMs with a Zero Numerator and/or Denominator

MLN Connects® Provider eNews for July 16, 2015

MLN Connects® Provider eNews for July 16, 2015
View this edition as a PDF

In this edition:

Countdown to ICD-10

- CMS and AMA Announce Efforts to Help Providers Get Ready For ICD-10
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- EHR Incentive Programs: Reporting CQMs with a Zero Numerator and/or Denominator

First Coast Service Options Phone Numbers

***(Note:** Specific geographic contact information is noted when phone numbers and addresses are different for providers in Florida, U.S. Virgin Islands or Puerto Rico.)*

Customer service
Monday to Friday
8:00 a.m. to 4:00 p.m
888-664-4112 (FL/USVI)
877-908-8433 (Puerto Rico)
877-660-1759 (TDD-FL/USVI)
888-216-8261 (TDD-Puerto Rico)

Electronic data interchange
888-670-0940 (FL/USVI)
888-875-9779 (Puerto Rico)

Interactive Voice Response
877-602-8816

Provider education/outreach
Event registration hotline
904-791-8103

Overpayments
904-791-6281

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

Websites
medicare.fcso.com
medicareespanol.fcso.com

First Coast Service Options Addresses

Claims/correspondence
Florida/ U.S. Virgin Islands

Medicare Part A Customer Service
P. O. Box 2711
Jacksonville, FL 32231-0021

Puerto Rico

First Coast Service Options Inc.
P.O. Box 45003
Jacksonville, FL 32232-5003

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

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

FOIA requests
Provider audit/reimbursement
(relative to cost reports and audits)
Attn: FOIA PARD – 16T
P. O. Box 45268
Jacksonville, FL 32232-5268

General Inquiries

Online Form (Click here)

Email: *AskFloridaA@fcso.com*

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

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

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

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

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

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

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

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

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

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

Redetermination (cont'd)
U.S. Virgin Islands:
First Coast Service Options Inc
P. O. Box 45097
Jacksonville, FL 32232-5097

Puerto Rico

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

Special delivery/courier services

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

Other Medicare carriers and intermediaries

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

CGS Administrators, LLC
P. O. Box 20010
Nashville, Tennessee 37202

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

Regional home health/hospice intermediary
Palmetto GBA
Medicare Part A
34650 US HWY 19N
Palm Harbor, FL 34684

Contact CMS

Centers for Medicare & Medicaid Services (CMS) *(www.cms.gov)*

Centers for Medicare & Medicaid Services, Division of Financial Management and Fee for Service Operations

ROATLFM@CMS.HHS.GOV

Office of Inspector General (OIG)
Medicare fraud hotline
800-HHS-TIPS (800-447-8477)

Medicare beneficiary customer service
1-800-MEDICARE
1-800-633-4227

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