Medicare A Connection

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FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction N Providers

August 2015

In this issue

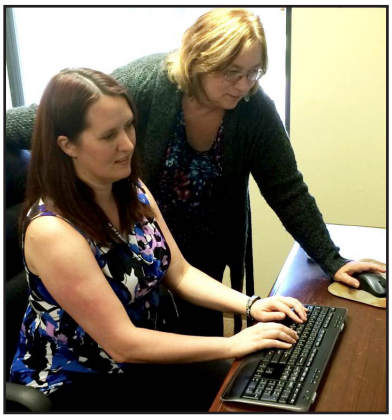
Use First Coast's Web tools to keep your provider group moving forward

Shirley Knoll knows Medicare billing like the back of hand. She's the State Director of Billing for Therapy Management Corporation, a large national rehabilitation services provider. She leads a team of 10 billing professionals who handle claims for 16 provider locations in central Florida.

Her provider group recently made the transition to Internet-based PECOS from paper in the management of provider enrollment applications and revalidations. "In the change to PECOS, we encountered some challenges with our revalidations."

PECOS (The Internet-based Provider Enrollment, Chain, and Ownership System) simplifies the enrollment process for applicants by verifying provider information online and electronically transmitting enrollment data directly to the Medicare contractor responsible for processing it.

Knoll recommends the revalidation and provider enrollment animations on the First Coast website as a way of preparing for the transition to PECOS.



"The provider enrollment animations were tremendously helpful. This to me was huge. If you are new to Medicare, I would definitely review those pages. In fact, if anyone were to establish a new provider practice in Florida, I would recommend starting off with the First Coast website."

For her practice, the move to PECOS also facilitated address changes when their group relocated several practices to different locations.

"This process can get really confusing when you open new

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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.

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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

providers sites. With the relocations, we had to re-credential to ensure compliance with the 30-mile rule. We completed the application process within 15-20 minutes using PECOS and we received approval within 60 days. When we did this on paper the entire process took up to nine months, and in one case almost a full year."

> **"The provider enrollment animations were tremendously helpful. This to me was huge. If you are new to Medicare, I would definitely review those pages. In fact, if I were establishing a new provider practice in Florida, I would recommend starting off with the First Coast website."**
>
> *– Shirley Knoll MHA, CPC*
> *Therapy Management Corporation*
> *Director of Billing*

One of the tips she offers for anyone using the online provider enrollment tools is to keep helpful notes of the information you will need to enter once you open the online application. "Keep your cheat sheets beside your computer with the practice official's name and other information and you can be done in 15 minutes versus two hours," Knoll said.

Besides the provider enrollment functions, Knoll makes use of a wide-variety of resources available through the First Coast site.

As she audits each month, Knoll often refers to the top reasons for claim denials page to diagnose any issues which pop up with her audit. "This page is so helpful. I find what I'm looking for within a few clicks." Knoll said she uses so many different functions on the site because she spent the better part of a work day and devoted the time to exploring the site.

"If you go on the First Coast site and take the better part of an afternoon, you will be amazed at what you will find. You will save so much more time by just learning and putting into practice what is available at your fingertips."

Knoll says she stays on top of her education requirements also through the First Coast site. "The education courses on First Coast University are priceless. I found them to be tremendously helpful in keeping up with the changes in Medicare," she said.

The First Coast website is my first option when I need information. Nine out of ten times I will find exactly what I am look for. In some cases, we've even used it to research information for health plans other than Medicare.

First Coast Service Options Inc. (First Coast) offers online training courses for both Part A and Part B provider offices through First Coast University.

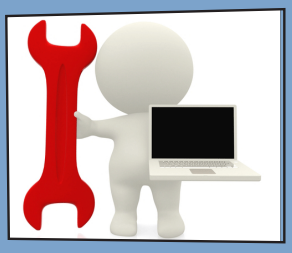
Many of the courses offer continuing education hours. The instructor-led training classes and online training (OLT) courses give Medicare billers the opportunity to stay current with Medicare policies and options for training new employees with instruction on the basics of Medicare billing.

First Coast University also offers courses in how to use several of the First Coast Web tools including the Secure Online Provider Tool (SPOT), fee schedule lookup tool among others.

"Predominantly, the two tools I used most are the fee schedule and LCD lookup tools. And, I've just started using SPOT, checking patient eligibility and claim status," Knoll said.

Got a success story using First Coast Web tools?

With its *Tools Center*, First Coast Service Options offers medical providers an abundance of self-service tools to improve Medicare billing practices.



Provider profiles - *Click here* to read how providers are making innovative use of Web tools to grow their bottom line.

Success story? - If you have a success story to share with First Coast, let us know by *clicking here*. Check the "Success Story" button on the form and let us know how First Coast's Tools Center is helping to improve your practice.

Extension of provider enrollment moratoria for home health agencies and Part B ambulance suppliers

***Note**: This article was revised on July 27, 2015, to reflect an extension of the temporary moratoria for an additional six months, as noted in the article. It was previously published in the February 2015 edition of Medicare A Connection, Pages 5-6.*

Provider types affected

This *MLN Matters*® article is intended for home health agencies, home health agency sub-units, and Part B ground ambulance suppliers in certain geographic areas of Florida, Illinois, Michigan, Texas, Pennsylvania and New Jersey that provide services to Medicare, Medicaid and CHIP beneficiaries.

Provider action needed

Stop – impact to you

Effective July 29, 2015, the temporary moratoria on new home health agencies, home health agency sub-units, and Part B ground ambulance suppliers are being extended for an additional six months in certain geographic locations.

Caution – what you need to know

During the six-month temporary moratoria, initial provider enrollment applications and change of information applications to add additional practice locations, received from home health agencies, home health agency sub-units, and Part B ground ambulance suppliers in the moratoria counties will be denied. Application fees that are paid for applications that are denied due to the temporary moratoria will be refunded.

Go – what you need to do

Effective July 29, 2015, home health agencies, home health agency sub-units, and Part B ground ambulance suppliers should not submit initial enrollment applications or change of information applications to add additional practice locations until the six-month moratoria has expired. CMS will announce in the *Federal Register* when the moratorium has been lifted, extended, or changed.

Background

In accordance with 42 CFR §424.570(c), the Centers for Medicare & Medicaid Services (CMS) may impose a moratorium on the enrollment of new Medicare providers and suppliers of a specific type or the establishment of new practice locations in a particular geographic area.

On July 28, 2015, CMS announced, in a *Federal Register* notice (*http://federalregister.gov/a/2015-18327*), the extension of temporary moratoria on the enrollment of new home health agencies, home health agency sub-units and Part B ambulance suppliers in designated geographic locations.

The moratoria initially became effective on July 30, 2013, and the implementation was announced in the *Federal Register* which may be accessed at: *http://federalregister.gov/a/2013-18394*.

The moratoria were expanded on January 30, 2014, and the expansion was announced in the *Federal Register* which may be accessed at: *http://federalregister.gov/a/2014-02166*.

Moratoria extension

Effective July 29, 2015, the temporary moratorium on new home health agencies and home health agency sub-units is being extended for an additional six months in the areas stated in Table 1, below.

Table 1: **Home Health agencies and home health agency sub-units under temporary moratorium**

City and state	Counties
Fort Lauderdale, FL	Broward
Miami, FL	Miami-Dade Monroe
Detroit, MI	Macomb Monroe Oakland Washtenaw Wayne
Dallas, TX	Collin Dallas Denton Ellis Kaufman Rockwall Tarrant
Houston, TX	Brazoria Chambers Fort Bend Galveston Harris Liberty Montgomery Waller
Chicago, IL	Cook DuPage Kane Lake McHenry Will

In addition, the temporary moratorium on new part B ground ambulance suppliers is being extended for an additional six months in the areas stated in Table 2, below.

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Table 2: Part B Ambulance suppliers under six-month temporary moratorium

City and state	Counties
Houston, TX	Harris Brazoria Chambers Fort Bend Galveston Liberty Montgomery Waller
Philadelphia, PA	Bucks (PA) Delaware (PA) Montgomery (PA) Philadelphia (PA) Burlington (NJ) Camden (NJ) Gloucester (NJ)

Initial provider enrollment applications and change of information applications to add additional practice locations received from home health agencies, home health agency sub-units, and Part B ground ambulance suppliers in the above listed counties will be denied in accordance with 42 CFR §424.570(c). Application fees that are paid for applications that are denied due to the temporary moratoria will be refunded.

Additional information

For more information regarding CMS' use of temporary moratoria, please review *MLN Matters*® article MM7350 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7350.pdf*.

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

MLN Matters® Number: SE1425
Related Change Request (CR) #: n/a
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Effective Date: n/a
Related CR Transmittal #: n/a
Implementation Date: n/a

Temporary moratoria extended on enrollment of home health agencies and ambulance suppliers

On July 28, 2015, CMS published a notice in the *Federal Register* (CMS-6059 N3) (*go.usa.gov/37m9W*) announcing that the temporary moratoria on the enrollment of new home health agencies, home health agency sub-units, and Part B ground ambulance suppliers is being extended for an additional six months in certain geographic areas in Florida, Illinois, Michigan, Texas, Pennsylvania, and New Jersey to prevent and combat fraud, waste, and abuse. For more information see *MLN Matters*® article SE1425 *(go.usa.gov/37mnR)*, "Extension of Provider Enrollment Moratoria for Home Health Agencies and Part B Ambulance Suppliers."

Common working file rejection of claims with HCPCS C5271-C5278

The Centers for Medicare & Medicaid Services (CMS) recently identified an issue whereby the common working file (CWF) is currently rejecting outpatient claim line items containing Healthcare Common Procedure Coding System (HCPCS) values C5271-C5278.

This error is occurring because these codes were not added to the appropriate bypass lists with the 2014 skilled nursing facility (SNF) annual update.

Resolution

Beginning August 18, 2015, Medicare administrative contractors (MACs) will apply a claim level override of 'SNF CB edit C7252' for:

- HCPCS C5271 – C5278
- Type of bill 13x and 85x
- Dates of service on or after January 1, 2014
- Claims processed before August 18, 2015.

Status/date resolved: Open.

Provider action

For claims processed January 1, 2014-August 18, 2015, with dates of services on or after January 1, 2014, providers with claims fitting the above criteria may contact First Coast to request an adjustment.

National site visit verification initiative

Provider types affected

This *MLN Matters*® special edition article is intended for all providers and suppliers that enroll in the Medicare program and submit fee-for-service (FFS) claims to Medicare administrative contractors (MACs), including home health and hospice MACs, for services provided to Medicare beneficiaries.

What you need to know

This article provides the latest information about the Centers for Medicare & Medicaid Services (CMS) National Site Visit Verification (NSV) initiative. The NSV initiative is part of CMS' National Fraud Prevention Program (NFPP) and assists CMS in its efforts to prevent fraud and abuse in the Medicare program starting with the enrollment process.

Key information

National Fraud Prevention Program (NFPP)

The NFPP is an integral part of the CMS Fraud Prevention Initiative. The NFPP enables CMS to proactively identify and respond to suspicious behavior, thus making the Agency more effective at fighting health care fraud than ever before.

The NFPP focuses on two key program integrity gateways: provider enrollment and claims payment. By integrating these steps into one program, CMS can better ensure that it enrolls only qualified providers and pays only valid claims. CMS' comprehensive program integrity strategy is designed to stop fraudsters at every step of the process by:

- Identifying and preventing bad actors from enrolling in Medicare;
- Identifying and removing bad actors that are already in the program; and
- Identifying and preventing payment of fraudulent claims by responding with quick administrative action (e.g. enrollment revocations or payment suspensions).

National site visit contractor: ensuring program integrity at the provider enrollment stage

In 2011, CMS implemented a site visit verification program using a National Site Visit Contractor (NSVC). The site visit verification program is a screening mechanism to prevent questionable providers and suppliers from enrolling or maintaining enrollment in the Medicare program. The NSVC will conduct unannounced site visits for Medicare Part A/B providers and suppliers. Site visits for durable medical equipment (DMEPOS) suppliers and providers will continue to be conducted by the National Supplier Clearinghouse.

The NSVC may conduct either an observational site visit or a detailed review to verify enrollment related information and collect specific information based on pre-defined checklists and procedures determined by CMS.

During an observational visit, the inspector engages in minimal contact with the provider or supplier and does not inhibit the daily activities that occur at the facility. The inspector may take photographs of the facility as part of the site visit.

During a detailed review, the inspector will enter the facility, speak with staff, take photographs, and collect information to confirm the provider or supplier's compliance with CMS standards. MSM Security Services, LLC was awarded the national site visit contract December 20, 2011. MSM and its subcontractors, Computer Evidence Specialists, LLC (CES) and Health Integrity, LLC (HI) are authorized by CMS to conduct the provider and supplier site visits.

Inspectors performing the site visits will be employees of MSM, CES, or HI and shall possess a photo ID and a letter of authorization issued and signed by CMS that the provider or supplier may review.

If the provider and/or its staff want to verify that a site visit has been ordered by CMS, please contact the respective jurisdiction's Medicare administrative contactor (MAC). MAC contact information can be found at *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/contact_list.pdf*.

If the provider and/or its staff wish to verify that an inspector is credentialed to complete site visit verification, please call MSM Security Services, Monday through Friday from 7:00 a.m. to 8:00 p.m. ET at 1-855-220-1071. After 8 p.m., you may leave a message and the call will be returned the next business day.

Additional information

To learn more about the CMS Fraud Prevention Initiative, visit the "Fraud Prevention Toolkit" web page at *http://www.cms.gov/Partnerships/04_FraudPreventionToolkit.asp*.

MLN Matters® Number: SE1520
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

Limiting the scope of review on redeterminations and reconsiderations of certain claims

Provider types affected

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

What you need to know

This special edition article is being published by the Centers for Medicare & Medicaid Services (CMS) to inform providers of the clarification CMS has given to the MACs and qualified independent contractors (QICs) regarding the scope of review for redeterminations (Technical Direction Letter-150407). This updated instruction applies to redetermination requests received by a MAC or QIC on or after August 1, 2015, and will not be applied retroactively.

Background

CMS recently provided direction to MACs and QICs regarding the applicable scope of review for redeterminations and reconsiderations for certain claims. Generally, MACs and QICs have discretion while conducting appeals to develop new issues and review all aspects of coverage and payment related to a claim or line item. As a result, in some cases where the original denial reason is cured, this expanded review of additional evidence or issues results in an unfavorable appeal decision for a different reason.

For redeterminations and reconsiderations of claims denied following a post-payment review or audit, CMS has instructed MACs and QICs to limit their review to the reason(s) the claim or line item at issue was initially denied. Post-payment review or audit refers to claims that were initially paid by Medicare and subsequently reopened and reviewed by, for example, a zone program integrity contractor (ZPIC), recovery auditor, MAC, or comprehensive error rate testing (CERT) contractor, and revised to deny coverage, change coding, or reduce payment. If an appeal involves a claim or line item denied on a pre-payment basis, MACs and QICs may continue to develop new issues and evidence at their discretion and may issue unfavorable decisions for reasons other than those specified in the initial determination.

Please note that contractors will continue to follow existing procedures regarding claim adjustments resulting from favorable appeal decisions. These adjustments will process through CMS systems and may suspend due to system edits. Claim adjustments that do not process to payment because of additional system imposed payment limitations, conditions or restrictions (for example, frequency limits or correct coding initiative edits) will result in new denials with full appeal rights. In addition, if a MAC or QIC conducts an appeal of a claim or line item that was denied on post-payment review because a provider, supplier, or beneficiary failed to submit requested documentation, the contractor will review all applicable coverage and payment requirements for the item or service at issue, including whether the item or service was medically reasonable and necessary.

As a result, claims initially denied for insufficient documentation may be denied on appeal if additional documentation is submitted and it does not support medical necessity.

This clarification and instruction applies to redetermination and reconsideration requests received by a MAC or QIC on or after August 1, 2015. It will not be applied retroactively. Appellants will not be entitled to request a reopening of a previously issued redetermination or reconsideration for the purpose of applying this clarification on the scope of review. CMS encourages providers and suppliers to include any audit or review results letters with their appeal request. This will help alert contractors to appeals where this instruction applies.

Additional information

You can find out more about appealing claims decisions in the *Medicare Claims Processing Manual* (Publication 100-04, Chapter 29 (Appeals of Claims Decisions), Section 310.4.C.1. (Conducting the Redetermination (Overview)) at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29.pdf*.

You can also find out more about:

1. conducting a redetermination in 42 CFR 405.948, at *http://www.ecfr.gov/cgi-bin/text-idx?SID=06584dd6a5fc15094e7633ff5f6cb359&mc=true&node=pt42.2.405&rgn=div5#se42.2.405_1948*; and
2. conducting a reconsideration in 42 CFR 405.968 at *http://www.ecfr.gov/cgi-bin/text-idx?SID=06584dd6a5fc15094e7633ff5f6cb359&mc=true&node=pt42.2.405&rgn=div5#se42.2.405_1968*.

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Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Screening for hepatitis C – implementation of new edits

***Note**: This article was revised on August 10, 2015, to make clarifications regarding HCV services in rural health clinics, federally qualified health centers, and critical access hospitals. All other information remains the same. This article was previously published in the July edition of Medicare A Connection, Pages 5-6.*

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. 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 claims 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 subset 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

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304.91, “unspecified drug dependence continuous”/ F19.20, “other psychoactive substance abuse, uncomplicated” (once ICD-10 is implemented). Annual 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 types of bill (TOBs) as valid TOBs for HCV screening services:
  - * RHC, TOB 71x;
  - * FQHC, TOB 77x; and
  - ** CAH Method II, professional services, TOB 85x when submitted with revenue code 096x, 097x, or 098x. * **Note**: While RHCs and FQHCs cannot bill for HCV screening services, this does not prevent HCV screening services from being provided to patients at RHCs and FQHCs.
  - ** **Note**: CAHs, TOB 85x, are valid facilities for HCV screening services. CR 9200 removes the professional payment to CAHs for HCV screening.
- 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 *Revised*
Related CR Release Date: June 19, 2015
Related Transmittal #: R3285CP
Change Request (CR) #: CR9200
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.

Claims processing instructions for breast tomosynthesis

Provider types affected

This *MLN Matters*® article is intended for providers who bill Medicare administrative contractors (MACs) for diagnostic digital breast tomosynthesis services provided to Medicare beneficiaries.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 9191 to provide claims processing instructions for Healthcare Common Procedure Coding System (HCPCS) code G0279, defined "diagnostic digital breast tomosynthesis, unilateral or bilateral (list separately in addition to G0204 or G0206)." Make sure your billing staff is aware of this update.

Background

Effective for claims with dates of service on or after January 1, 2015, claims for HCPCS code G0279 are payable by Medicare under the following conditions:

- Payment for HCPCS code G0279 will be permitted only when billed in conjunction with HCPCS code G0204 or G0206.
- A deductible and coinsurance will be applied to claim lines with HCPCS code G0279.
- Institutional claims for HCPCS code G0279 will be paid for type of bills (TOBs) 12x, 13x, 22x, 23x, and 85x when submitted with revenue code 0401.
- Professional claims for HCPCS code G0279 will be paid for TOB 85x when submitted with revenue code 096x, 097x, or 098x.
- Your Medicare contractor will pay for HCPCS code G0279 on institutional claims TOBs 12x, 13x, 22x, and 23x based on the Medicare physician fee schedule (MPFS), and TOB 85x with revenue code other than 096x, 097x, and 098x based on reasonable cost.
- Your Medicare contractor will pay for HCPCS code G0279 on claims with TOB 85x (Method II) with revenue code 096x, 097x, or 098x based on MPFS (115 percent of the lesser of the fee schedule amount and submitted charge).

Below is a summary of the conditions and payment policies:

HCPCS	Claim type	TOB	Revenue code	Pmt based on:
G0279	Ins.	12X,13X, 22X,23X	401	MPFS
G0279	Ins.	85x	401	Reasonable costs

HCPCS	Claim type	TOB	Revenue code	Pmt based on:
G0279	Pro.	85x (Method II)	96x, 97x, 98x	MPFS (115 percent of the lesser of the fee schedule amount and submitted charge)

Note: Your MAC will adjust claims containing HCPCS code G0279 with dates of service on or after January 1, 2015 thru January 3, 2016.

Claim adjustment reason code (CARC) and remittance advice remark code (RARC) for denied claims

MACs will use the following messages when denying claim lines for HCPCS code G0279 that are not submitted with HCPCS G0204 or G0206:

- CARC 107 - The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present; and
- Group code CO (Contractual Obligation) assigning financial liability to the provider.

Claims returned to provider

- Claims for diagnostic breast tomosynthesis, HCPCS code G0279, submitted with a revenue code other than *0401*, 096x, 097x, or 098x will be return to providers.
- Claims for diagnostic breast tomosynthesis, HCPCS code G0279, submitted with a TOB other than 12x, 13x, 22x, 23x, or 85x will be return to providers.

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Additional information

The official instruction, CR 9191 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3301CP.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*?

To review the CMS online training course for Medicare Billing: 837I and Form CMS-1450 you may go to *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/WebBasedTraining.html*.

Scroll to the related links and proceed.

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Related Change Request (CR) #: CR 9191
Related CR Release Date: August 6, 2015
Effective Date: January 1, 2015
Related CR Transmittal #: R3301CP
Implementation Date: January 4, 2016

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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**

LCD Revisions

Luteinizing hormone-releasing hormone (LHRH) analogs – revision to the Part A LCD

LCD ID number: L28901 (Florida)
LCD ID number: L28923 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for luteinizing hormone-releasing hormone (LHRH) analogs was revised to add the following off-labeled indication for leuprolide acetate: malignant neoplasm of male breast.

The "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD was updated to include malignant neoplasm of male breast as an off-labeled indication for leuprolide acetate. Under the "ICD-9 Codes that Support Medical Necessity" section of the LCD, diagnosis codes 175.0-175.9 and descriptors were added for HCPCS code J1950. In addition, the "Sources of Information and Basis for Decision" section of the LCD has also been updated.

Effective date

This LCD revision is effective for **services rendered on or after August 13, 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*.

Spinal cord stimulation for chronic pain – revision to the Part A/B LCD

LCD ID number: L35648
(Florida, Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for spinal cord stimulation for chronic pain was revised based on a reconsideration request to include diagnosis codes that support medical necessity for *CPT*® codes *63661-63664*, *63685*, and *63688* when the device has complications and requires removal, revision, or replacement.

The "ICD-9 Codes that Support Medical Necessity" section was updated to add ICD-9 diagnosis codes 996.2, 996.63, and 996.75.

Effective date

This LCD revision is effective for **services provided on or after August 13, 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*.

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.

Update of remittance advice remark and claims adjustment reason code lists

Provider types affected

This *MLN Matters*® article is intended for providers who submit claims to Medicare administrative contractors (MACs), including home health and hospice MACs (HHH MACs), and durable medical equipment MACS (DME MACs) for services provided to Medicare beneficiaries.

Provider action needed

Stop – impact to you

If you do not have a valid, current, Clinical Laboratory Improvement Amendments of 1998 (CLIA) certificate and submit a claim to your MAC for a *Current Procedural Terminology* (*CPT*®) code that is considered to be a laboratory test requiring a CLIA certificate, your Medicare payment may be impacted.

Caution – what you need to know

Change request (CR) 9278 updates the claim adjustment reason code (CARC) and remittance advice remark code (RARC) lists and also instructs Medicare system maintainers to update Medicare Remit Easy Print (MREP) and PC Print software used by some providers.

Go – what you need to do

Make sure that your billing staffs are aware of these updates.

Background

The Health Insurance Portability and Accountability Act (HIPAA) of 1996, instructs health plans to be able to conduct standard electronic transactions adopted under HIPAA using valid standard codes.

Medicare policy states that CARCs and appropriate RARCs that provide either supplemental explanation for a monetary adjustment or policy information that generally applies to the monetary adjustment are required in the remittance advice and coordination of benefits transactions.

The CARC and RARC changes that impact Medicare are usually requested by staff of the Centers for Medicare & Medicaid Services (CMS), in conjunction with a policy change. MACs are notified about these changes in the corresponding instructions from the specific CMS component that implements the policy change, in addition to the regular code update notification.

If a modification has been initiated by an entity other than CMS for a code currently used by Medicare, MACs must either use the modified code or another code if the modification makes the modified code inappropriate to explain the specific reason for adjustment.

If any new or modified code has an effective date past the implementation date specified in CR 9278, MACs must implement on the effective date found at the WPC website.

The discrepancy between the dates may arise because the Washington Publishing Company (WPC) website gets updated only three times per year and may not match the CMS release schedule. CR 9278 lists only the changes that have been approved since the last code update by CR 9125 (*https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3242CP.pdf*), issued April 13, 2015, and does not provide a complete list of codes for these two code sets.

The WPC website has four listings available for both CARC and RARC. Those listings are available at *http://www.wpc-edi.com/Reference*.

Changes in RARC list since CR 9125

New codes – RARC

Code	Modified narrative	Effective date
N753	Missing/Incomplete/Invalid Attachment Control Number.	7/1/15
N754	Missing/Incomplete/Invalid Referring Provider or Other Source Qualifier on the 1500 Claim Form.	7/1/15
N755	Missing/Incomplete/Invalid ICD Indicator on the 1500 Claim Form.	7/1/15
N756	Missing/Incomplete/Invalid point of drop-off address,	7/1/15
N757	Adjusted based on the Federal Indian Fees schedule (MLR).	7/1/15
N758	Adjusted based on the prior authorization decision.	7/1/15
N759	Payment adjusted based on the National Electrical Manufacturers Association (NEMA) Standard XR-29-2013.	7/1/15

Modified codes – RARC

Code	Modified narrative	Effective date
M47	Missing/Incomplete/Invalid Payer Claim Control Number. Other terms exist for this element including, but not limited to, Internal Control Number (ICN), Claim Control Number (CCN), Document Control Number (DCN).	7/1/15

See **RARC**, next page

RARC

From previous page

Code	Modified narrative	Effective date
MA74	**ALERT**: This payment replaces an earlier payment for this claim that was either lost, damaged or returned.	7/1/15
N432	**ALERT**: Adjustment based on a Recovery Audit.	7/1/15
N22	**ALERT**: This procedure code was added/changed because it more accurately describes the services rendered.	7/1/15
M39	**ALERT**: The patient is not liable for payment of this service as the advance notice of non-coverage you provided the patient did not comply with program requirements.	7/1/15
M109	**ALERT**: This claim/service was chosen for complex review.	7/1/15
M38	**ALERT**: The patient is liable for the charges for this service as they were informed in writing before the service was furnished that we would not pay for it and the patient agreed to be responsible for the charges.	7/1/15
N381	**ALERT**: Consult our contractual agreement for restrictions/billing/ payment information related to these charges.	7/1/15
MA91	**ALERT**: This determination is the result of the appeal you filed.	7/1/15

Deactivated codes - RARC

Code	Current narrative	Effective date
N102	This claim has been denied without reviewing the medical/ dental record because the requested records were not received or were not received timely.	7/1/16

***N735** - This RARC is not included in the list of deactivated codes because CMS did not add this code during the previous release when it was included on the WPC website. The RARC was previously added to the WPC website erroneously.

Changes in CARC list since CR 9125

New code – CARC

Code	Modified narrative	Effective date
270	Claim received by the medical plan, but benefits not available under this plan. Submit these services to the patient's dental plan for further consideration.	7/1/15

Modified code – CARC

Code	Modified narrative	Effective date
45	Charge exceeds fee schedule/ maximum allowable or contracted/ legislated fee arrangement. **Note**: This must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability.)	11/1/15

There have been no deactivated CARC codes since CR 9125.

In case of any discrepancy in the code text as posted on the WPC website and as reported in any CR, the WPC version should be implemented.

Additional information

The official instruction, CR 9278, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3298CP.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: MM9278
Related CR Release Date: August 6, 2015
Related Transmittal #: R3298CP
Change Request (CR) #: CR 9278
Effective Date: October 1, 2015
Implementation Date: October 5, 2015

July 2015 healthcare common procedure coding system drug/biological code changes – update

***Note**: This article was revised July 20 and July 22 to reflect the revised change request (CR) 9167 issued July 10. In the article, language has been modified to clarify the use of Q9977. Also, the CR release date, transmittal number, and the Web address for accessing CR 9167 are revised. All other information remains the same. This article was previously published in the May 2015 edition of Medicare A Connection, Page 12.*

Provider types affected

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

Provider action needed

This article is based on CR 9167 and informs Medicare providers about the updating of specific drug and biological HCPCS codes that occur quarterly. It alerts providers that the July file includes new HCPCS codes.

Background

CR 9167 also updates Chapter 17, Section 20.1.2 (Average Sales Price (ASP) Payment Methodology) in the *Claims Processing Manual* to address the use of a compounded drug not otherwise classified (NOC) code on claims for compounded drugs. Make sure that your billing staffs are aware of these changes.

Summary of new HCPCS codes in CR 9167

CR 9167 adds the following HCPCS codes with the effective dates noted.

Note: The Medicare physician fee schedule status indicator for all four codes below in Table 1 is 'E.' CR 9167 also updates Section 20.1.2 average sales price (ASP) Payment Methodology in Chapter 17 of the *Medicare Claims Processing Manual* to address the use of a compounded drug NOC code on claims for compounded drugs.

Please note: The new compounded drug code, Q9977 - Compounded Drug, Not Otherwise Classified, is not a replacement for existing codes. It is intended to distinguish compounded drugs (which may include biologicals) from other "not otherwise classified" codes such as J3490, J3590, J7799, J9999 and existing specific codes for compounded nebulized drugs. The implementation of Q9977 as a means of identifying compounded drug claims does not affect existing payment policy for compounded drugs as outlined in the *Medicare Claims Processing Manual*, Chapter 17, Section 20.1.2..

Additional information

The official instruction, CR 9167 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3292CP.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: MM9167
Related Change Request #: CR 9167
Related CR Release Date: July 10, 2015
Effective Date: July 1, 2015
Related CR Transmittal #: R3292CP
Implementation Date: July 6, 2015

Table 1 - New HCPCS codes in CR 9167

Effective for claims with dates of service on or after:	HCPCS code	Long description	Short description	Type of service (TOS)
March 6, 2015	Q5101	Injection, Filgrastim (GCSF), Biosimilar, 1 microgram	Inj filgrastim g-csf biosim	1, P
July 1, 2015	Q9976	Injection, Ferric Pyrophosphate Citrate Solution, 0.1 mg of iron	Inj Ferric Pyrophosphate Cit	1,L
July 1, 2015	Q9978	Netupitant 300 mg and Palonosetron 0.5 mg, oral	Netupitant Palonosetron oral	1
July 1, 2015	Q9977	Compounded Drug, Not Otherwise Classified	Compounded Drug NOC	1, P

October 2015 update to the Medicare physician fee schedule database

Provider types affected

This *MLN Matters*® article is intended for physicians, other providers, and suppliers who submit claims to Medicare administrative contractors (MACs) for services subject to the Medicare physician fee schedule database (MPFSDB) that are provided to Medicare beneficiaries.

What you need to know

Changes included in the October update to the 2015 MPFSDB are effective for dates of service on and after January 1 (unless otherwise stated).

The key change is to the malpractice relative value units (RVU) of the following *CPT*®/HCPCS codes: *33471, 33606, 33611, 33619, 33676, 33677, 33692, 33737, 33755, 33762, 33764, 33768, 33770, 33771, 33775, 33776, 33777, 33778, 33779, 33780, 33781, 33783, 33786, 33803, 33813, 33822, 33840*, and *33851*. The RVU changes for these codes are retroactive to January 1, 2015.

Also, effective October 1, 2015, *CPT*®/HCPCS code Q9979 is assigned a procedure status indicator of E (Excluded from the PFS by regulation.

These codes are for items and services that CMS has excluded from the PFS by regulation. No payment may be made under the PFS for these codes and generally, no RVUs are shown.).

Background

The Social Security Act (Section 1848(c)(4); see *http://www.ssa.gov/OP_Home/ssact/title18/1848.htm*) authorizes the Centers for Medicare & Medicaid Services (CMS) to establish ancillary policies necessary to implement relative values for physicians' services.

Payment files were issued to the MACs based upon the 2015 Medicare physician fee schedule (MPFS) final rule, published in the *Federal Register* on December 19, 2014, to be effective for services furnished between January 1, 2015, and December 31, 2015.

Additional information

The official instruction, CR 9266 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3317CP.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: MM9266
Change Request (CR) #: CR 9266
Related CR Release Date: August 6, 2015
Implementation Date: January 1, 2015
Related Transmittal #: R3317CP
Effective Date: October 5, 2015

CMS issues October 2015 HCPCS update

Provider types affected

This *MLN Matters*® article is intended for physicians, other providers, and suppliers who submit claims to Medicare administrative contractors (MACs), including home health and hospice MACs (HH+H MACs) and durable medical equipment MACs (DME MACs), for services provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 9273 informs the MACs that, effective for claims with dates of service on or after October 1, 2015, new Healthcare Common Procedure Coding System (HCPCS) code Q9979 (INJECTION, ALEMTUZUMAB, 1 MG) will be payable for Medicare. Make sure that your billing staff is aware of these changes.

Background

The Healthcare Common Procedure Coding System (HCPCS) code set is updated on a quarterly basis. Change request (CR) 9273 instructs that, effective for claims with dates of service on or after October 1, 2015, HCPCS code Q9979 will be established for alemtuzumab (Lemtrada) and will be payable for Medicare.

See the following table for details regarding this temporary HCPCS code:

HCPCS code	Short description	Long description	Type of serv. (TOS) code	Medicare phy. fee sch. database status indicator
Q9979	Injection, alemtuzumab	Injection, alemtuzumab, 1 mg	1, P	E

Additional information

The official instruction, CR 9273, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3304CP.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: MM9273
Related Change Request (CR) #: CR 9273
Related CR Release Date: August 6, 2015
Effective Date: October 1, 2015
Related CR Transmittal #: R3304CP
Implementation Date: October 5, 2015

October update to DMEPOS fee schedule

Provider types affected

This *MLN Matters*® article is intended for physicians, other providers, and suppliers submitting claims to Medicare administrative contractors (MACs), including home health and hospice MACs and durable medical equipment (DME MACs), for DMEPOS items or services paid under the DMEPOS fee schedule.

Provider action needed

Change request (CR) 9279 alerts providers and suppliers that the Centers for Medicare & Medicaid Services (CMS) issued instructions updating the DMEPOS fee schedule payment amounts, effective October 1, 2015. Make sure your billing staffs are aware of the changes.

Background

The DMEPOS fee schedule are updated on a quarterly basis, when necessary, in order to implement fee schedule amounts for new and existing codes, as applicable, and apply changes in payment policies.

The quarterly update process for the DMEPOS fee schedule is located in Pub.100-04, *Medicare Claims Processing Manual*, Chapter 23, Section 60, found here *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf*.

The recurring update notification provides instructions regarding the October quarterly update for the 2015 DMEPOS fee schedule. Payment on a fee schedule basis is required for DME, prosthetic devices, orthotics, prosthetics and surgical dressings by §1834(a), (h), and (i) of the Social Security Act. Payment on a fee schedule basis is a regulatory requirement at 42 CFR §414.102 for parenteral and enteral nutrition (PEN), splints and casts, and intraocular lenses (IOLs) inserted in a physician's office.

As part of the October 2015 update, fee schedules are established for the following two Healthcare Common Procedure Coding System (HCPCS) codes added to the HCPCS file effective January 1, 2005:

- **E0639** – Patient lift, moveable from room to room with disassembly and reassembly, includes all components/accessories, and
- **E0640** – Patient lift, fixed system includes all components/accessories.

The fee schedule amounts for both codes were established using fees for comparable items in accordance with the instructions found in the *Medicare Claims Processing Manual*, Chapter 23, Section 60.3. An average of the existing hydraulic or mechanical patient lift code E0630 and the electric patient code E0635 were used to establish the fee schedules for the hydraulic or electric patient lifts described under E0639 and E0640. The fee schedules for E0639 and E0640 are effective for dates of service on or after January 1, 2015. This update also revises the type of service code for HCPCS codes E0639 and E0640 from "9" to type of service code "R".

CR 9279 also provides revised fee schedules for speech generating device (SGD) HCPCS codes E2500, E2502, E2504, E2506, E2508, E2510 and E2351 per the recent amendments to Section 1834(a)(2)(A) of the Social Security Act.

The "Steve Gleason Act of 2015" was signed by the President on July 30, 2015, and changes the DME payment category for SGDs and accessories essential for the effective use of the SGD furnished between October 1, 2015, and September 30, 2018, from capped rental (CR) to inexpensive or routinely purchased (IN). Instructions relating to the implementation of the SGD amendments to Section 1834(a)(2)(A) were issued in CR 9179, dated June 12, 2015. The NU, UE, and RR fee schedule amounts for codes E2500, E2502, E2504, E2506, E2508, E2510 and E2351 are being added to the fee schedule file as part of this update.

The *MLN Matters*® article related to CR 9179 is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9179.pdf*.

Additional information

The official instruction, CR 9279, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3323CP.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: MM9279
Related CR Release Date: August 14, 2015
Related Transmittal #: R3323CP
Change Request (CR) #: CR 9279
Effective Date: January 1, 2015 (for implementation of fee schedule amounts for codes in effect on January 1, 2015; October 1, 2015 for all other changes)
Implementation Date: October 5, 2015

Common payment errors for ambulance emergency transport HCPCS code A0427

Provider types affected

One of the top contributors to First Coast Service Options' (First Coast's) claims payment error rate, as measured by the comprehensive error rate testing (CERT) program, is improper billing of Healthcare Common Procedure Coding System (HCPCS) code A0427. HCPCS code A0427 is defined as an ambulance service, advanced life support (ALS), emergency transport, level 1.

Recent CERT error findings demonstrate the beneficiary did not meet coverage guidelines for the following reasons:

- Insufficient documentation to support medical necessity of the service or the level of service billed;
- Documentation did not include the beneficiary's signature (or the signature of his or her authorized representative).

Ambulance suppliers are encouraged to review the following article regarding Medicare's ambulance benefit and ensure that they meet documentation requirements for services that are medically reasonable and necessary.

Medical necessity

One common CERT error for HCPCS code A0427 is the clinical documentation submitted for review did not support the level of emergency ambulance transport billed. For example, submitted documentation for one claim indicated that the beneficiary was "weak, having nausea/vomiting, and severe back pain from surgery. Beneficiary was able to walk to stretcher for transportation."

To be covered, ambulance services must be medically necessary and reasonable. According to *CMS Publication 100-02, Chapter 10 Ambulance Services, Section 10.2.1 Necessity for the Service*, medical necessity is established when the patient's condition is such that use of any other method of transportation is contraindicated.

In any case in which some means of transportation other than an ambulance could be used without endangering the individual's health, whether or not such other transportation is actually available, no payment may be made for ambulance services.

The manual also states that the reasons for the ambulance transport must be medically necessary. That is, the transport must be to obtain a Medicare covered service, or to return from such a service.

Furthermore, *Section 10.2.2 Reasonableness of the Ambulance Trip* states that under the fee schedule (FS), payment is made according to the level of medically necessary services actually furnished. That is, payment is based on the level of service furnished (provided they were medically necessary), not simply on the vehicle used.

Even if a local government requires an ALS response for all calls, payment under the FS is made only for the level of service furnished, and then only when the service is medically necessary.

Other common CERT errors is that although an ICD-9 code(s) was submitted on the claim, the clinical documentation submitted regarding the beneficiary's condition was either insufficient or missing. According to *CMS Publication 100-04, Chapter 15 Ambulance, Section 40 Medical Conditions and Instructions*, Medicare contractors will rely on medical record documentation to justify coverage, not simply the HCPCS code or the condition code by themselves.

Documentation

In all cases, the appropriate documentation must be kept on file and, upon request, presented to the carrier/intermediary. Appropriate documentation includes:

- Dispatch instructions;
- Patient's condition;
- Other on-scene information; and
- Details of the transport (e.g., medications administered, changes in the patient's condition, and miles traveled)
- Proper and legible signatures

Missing signatures

Another common CERT error for HCPCS code A0427 is the documentation submitted did not include the beneficiary's signature or the signature of his or her authorized representative.

As outlined in *CMS Publication 100-02, Chapter 10, Section 20.1.2*, Medicare requires the signature of the beneficiary, or that of his or her representative, for both the purpose of accepting assignment and submitting a claim to Medicare.

See **AMBULANCE**, next page

AMBULANCE

From previous page

If the beneficiary is unable to sign because of a mental or physical condition, the following individuals may sign the claim form on behalf of the beneficiary:

- The beneficiary's legal guardian.
- A relative or other person who receives Social Security or other governmental benefits on behalf of the beneficiary.
- A relative or other person who arranges for the beneficiary's treatment or exercises other responsibility for his or her affairs.
- A representative of an agency or institution that did not furnish the services for which payment is claimed, but furnished other care, services, or assistance to the beneficiary.
- A representative of the provider or of the nonparticipating hospital claiming payment for services it has furnished, if the provider or nonparticipating hospital is unable to have the claim signed in accordance with 42 CFR 424.36(b) (1-4)
- A representative of the ambulance provider or supplier who is present during an emergency and/or nonemergency transport, provided that the ambulance provider or supplier maintains certain documentation in its records for at least four years from the date of service. A provider/supplier (or his/her employee) cannot request payment for services furnished except under circumstances fully documented to show that the beneficiary is unable to sign and that there is no other person who could sign.

Medicare does not require that the signature to authorize claim submission be obtained at the time of transport for the purpose of accepting assignment of Medicare payment for ambulance benefits.

When a provider/supplier is unable to obtain the signature of the beneficiary, or that of his or her representative, at the time of transport, it may obtain this signature any time prior to submitting the claim to Medicare for payment.

Additional educational resources

CMS ambulance service center

http://www.cms.gov/Center/Provider-Type/Ambulances-Services-Center.html

First Coast checklist for ambulance transports documentation at *http://medicare.fcso.com/Medical_documentation/192607.pdf*

CMS issues notification of final FY 2017 wage index PUF availability and timeline

For fiscal year (FY) 2017, the Centers for Medicare & Medicaid Services have changed the wage index development timetable.

The wage index development process started in May with the posting of the preliminary worksheet S-3 PUF. The following are links to the final FY 2017 wage index PUF availability and timeline.

Final FY 2017 Hospital Wage Index Development Timetable

Letter to hospitals on the "Availability of the Final FY 2017 Wage Index Development Timetable"

Wage Index PUFs

Applying therapy caps to Maryland hospitals

Provider types affected

This *MLN Matters*® article is intended for Maryland hospitals that provide therapy services and submit claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries.

Provider action needed

Stop – impact to you

Change request (CR) 9223 revises original Medicare systems to ensure therapy services provided in Maryland hospitals are subject to the outpatient therapy per-beneficiary caps.

Caution – what you need to know

In earlier CRs, the therapy cap provisions were inadvertently not applied to Maryland hospitals when Section 3005 of the Middle Class Tax Relief and Job Creation of 2012 (MCTRJCA) applied them to other outpatient hospitals described in Section 1833(a)(8)(B) of the Social Security Act. CR 9223 corrects this oversight. It also includes corrections and clarifications to various sections of Chapter 5 of the *Medicare Claims Processing Manual*.

Go – what you need to do

Make sure that your billing staffs are aware of these system revisions related to therapy services provided in Maryland hospitals.

Background

Section 3005 of the Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA) required Original Medicare to temporarily apply the therapy caps (and related provisions) to the therapy services furnished in an outpatient hospital.

These provisions have been extended several times by additional legislation. They were implemented by CR 7785, effective October 1, 2012. (MM7785 can be viewed at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7785.pdf.)*

To account for future extensions of the effective dates, in January 2013, CR 7881 created a mechanism that MACs use to update a screen of 'legislation effective' indicators in their claims processing systems. (MM7881 can be viewed at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7881.pdf.)*

In those earlier CRs, the therapy cap provisions were inadvertently not applied to Maryland hospitals when MCTRJCA applied them to other outpatient hospitals described at section 1833(a)(8)(B) of the Social Security Act. CR 9223 corrects that oversight.

Key points

CR 9223 implements the following policies:

- Original Medicare pays outpatient therapy services furnished in Maryland hospitals at rates established under the Maryland all-payer model.
- The therapy caps and related provisions described at Section 1833(g) apply to hospitals paid under the Maryland all-payer model.
- Medicare will use the rates established under the all-payer model to count the therapy services of Maryland hospitals toward the therapy caps and threshold total of beneficiaries.

Additional information

The official instruction, CR 9223 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3309CP.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: MM9223
Related Change Request (CR) #: CR 9223
Related CR Release Date: August 6, 2015
Effective Date: January 4, 2016
Related CR Transmittal #: R3309CP
Implementation Date: January 1, 2016

CMS releases October 2015 integrated outpatient code editor specifications

Provider types affected

This *MLN Matters*® article is intended for providers who submit claims to Medicare administrative contractors (MACs), including home health and hospice MACS (HH+H MACs) for services provided to Medicare beneficiaries.

Provider action needed

Stop – impact to You

Be aware that the integrated/outpatient code editor (I/OCE) is being updated for October 1, 2015. change request (CR) 9290 details those changes.

Caution – what you need to know

CR 9290 provides the instructions and specifications for the I/OCE to be used under the outpatient prospective payment system (OPPS) and non-OPPS for hospital outpatient departments, community mental health centers, all non-OPPS providers, and for limited services when provided in a home health agency not under the home health prospective payment system (PPS) or to a hospice patient for the treatment of a non-terminal illness. This notification applies to Chapter 4, Section 40.1 of the *Medicare Claims Processing Manual*, which is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf* on the Centers for Medicare & Medicaid Services (CMS) website.

Go – what you need to do

Make sure that your billing staffs are aware of the updated I/OCE for October 1, 2015.

Background

CR 9290 provides the I/OCE instructions and specifications for the Integrated OCE that will be utilized under the OPPS and non-OPPS for hospital outpatient departments, community mental health centers, all non-OPPS providers, and for limited services when provided in a home health agency not under the home health PPS or to a hospice patient for the treatment of a non-terminal illness. The I/OCE specifications will be posted online and can be found at *http://www.cms.gov/OutpatientCodeEdit/*.

The modifications of the I/OCE for the October 2015 release (V16.3) are summarized in the table below. Some I/OCE modifications in this update may be retroactively added to prior releases. If so, the retroactive date appears in the "Effective date" column.

Effective date	Edits affected	Modification
10/1/2015	87	Modify the program logic to not ignore skin substitute product code(s) present with line item action flag 2 in order to process edit 87.
10/1/2015	87	Update to the skin substitute product list (move HCPCS Q4151 from List A to List B – Appendix P, list E of CR 9290).
10/1/2015	88, 89	Modify the program logic to not assign edits 88 and 89 for federally qualified health center (FQHC) PPS claims when only FQHC non-covered services are present with edit 91 (page 11; Appendix M processing steps and flowchart).
10/1/2015	2, 3, 86	Update the diagnosis/age and diagnosis/sex conflict, and manifestation edits based on the official ICD-10-CM diagnosis code editing content for the MCE.

See **OUTPATIENT**, next page

OUTPATIENT

From previous page

Effective date	Edits affected	Modification
10/1/2015		Modify the diagnosis code content to replace all preliminary ICD-10-CM content with the official ICD-10-CM code content effective for 10/1/2015; restrict the use of ICD-9-CM code content for historical claims with from dates through 9/30/2015.
10/1/2015		Updates to FQHC non-covered procedures and flu/PPV vaccine lists (see quarterly data file changes).
10/1/2015		Make Healthcare Common Procedure Coding System (HCPCS)/ Ambulatory Payment Classification (APC)/Status Indicator (SI) changes as specified by CMS (data change files).
10/1/2015	20, 40	Implement version 21.3 of the NCCI (as modified for applicable institutional providers).
10/1/2015		Update the IOCE PC product User and Installation Manual for removal of support for Microsoft® Windows® versions 2000, XP and Vista; add support for Microsoft® Windows® version 8.1.
10/1/2015		Update page 3 and Table 1 (OCE Control Block) to indicate ICD-10-CM diagnosis codes as the primary diagnosis code set with ICD-9-CM diagnosis codes remaining for historical claims.

Note: Readers should also read through the entire CR 9290 document and note the highlighted sections, which also indicate changes from the prior release of the software. A full summary of data changes in I/OCE V16.3, including diagnosis, HCPCS, *Current Procedural Terminology* (*CPT*®) and APC codes, is attached to the CR.

Additional information

The official instruction, CR 9290 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3328CP.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: MM9290
Related Change Request (CR) #: CR 9290
Related CR Release Date: August 14, 2015
Effective Date: October 1, 2015
Related CR Transmittal #: R3328CP
Implementation Date: October 5, 2015

Educational Events

Provider outreach and educational events – September 2015

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

Medicare Part A changes and regulations

When: Tuesday, September 22
Time: 10:00 a.m. -11:30 a.m. ET – Delivery language: English
Type of Event: Webcast
http://medicare.fcso.com/Events/0299001.asp

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

Medicare Learning Network®
Official Information Health Care Professionals Can Trust

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 July 23, 2015

MLN Connects® Provider eNews for July 23, 2015

View this edition as a PDF

In this edition:

Countdown to ICD-10

- ICD-10 Is Less than 70 Days Away: Get Ready
- Are Non-HIPPA Covered Entities Required to Transition to ICD-10?
- MLN Connects National Provider Call: Countdown to ICD-10
- Video: 10 Facts about ICD-10

MLN Connects® National Provider Calls and Events

- ESRD QIP: Proposed Rule for Payment Year 2019 Call — Last Chance to Register
- Proposed Reform of Requirements for Long-Term Care Facilities Call — Registration Now Open
- Hospital Compare Overall Star Ratings Methodology Call — Register Now
- New MLN Connects National Provider Call Audio Recordings and Transcripts
- Associations and Organizations Providing Credit for MLN Connects Events

Announcements

- CMS Releases First Round of Home Health Compare Quality of Patient Care Star Ratings
- CMS Announces Medicare Care Choices Model Awards
- LTCH QRP Data Submission Deadline: August 15
- IRF QRP Data Submission Deadline: August 15
- Updated Open Payments CME Guidance
- eCQM: 2016 QRDA Implementation Guide Now Available

Claims, Pricers, and Codes

- July 2015 OPPS Pricer File Update

Medicare Learning Network® Educational Products

- "Medicare Quarterly Provider Compliance Newsletter [Volume 5, Issue 4]" Educational Tool — Released
- "Home Oxygen Therapy" Booklet — Released
- "The Basics of DMEPOS Accreditation" Fact Sheet — Revised
- "Medical Privacy of Protected Health Information" Fact Sheet — Reminder
- "Avoiding Medicare Fraud and Abuse: A Roadmap for Physicians" Web-Based Training Course — Reminder
- Medicare Learning Network Products Available In Electronic Publication Format
    - New Continuing Education Organization Now Accepting Medicare Learning Network Web-Based Training Courses

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 July 30, 2015

MLN Connects® Provider eNews for July 30, 2015

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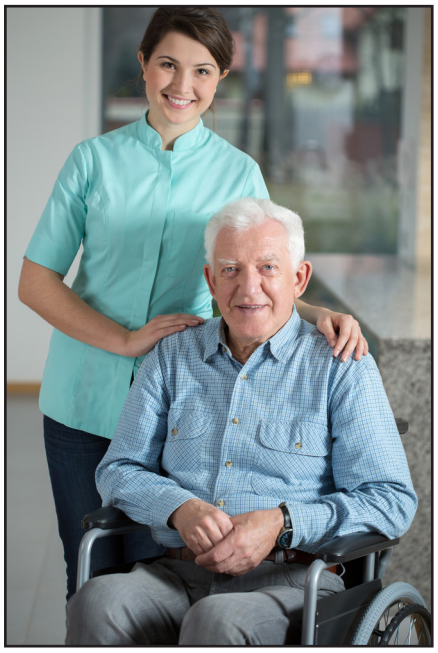
In This Edition

Countdown to ICD-10

- Clarifying Questions and Answers Related to CMS/AMA Joint Announcement and Guidance Regarding ICD-10 Flexibilities
- MLN Connects National Provider Call: Countdown to ICD-10
- List of Valid ICD-10-CM Codes
- Use of Unspecified Codes in ICD-10-CM
- Coding for ICD-10-CM: Continue to Report CPT/HCPCS Modifiers for Laterality
- Transition to ICD-10 for Home Health
- Claims that Span the ICD-10 Implementation Date



MLN Connects® National Provider Calls and Events

- Proposed Reform of Requirements for Long-Term Care Facilities Call — Register Now
- Hospital Compare Overall Star Ratings Methodology Call — Register Now
- New MLN Connects National Provider Call Audio Recording and Transcript

Announcements

- On Its 50th Anniversary, More than 55 Million Americans Covered by Medicare
- Temporary Moratoria Extended on Enrollment of Home Health Agencies and Ambulance Suppliers
- eCQM: Version 2 Schematron Rules for 2016 QRDA Implementation Guide Now Available

Medicare Learning Network® Educational Products

- July 2015 Version of the Medicare Learning Network Catalog — Released
- "Medicare Claim Review Programs" Booklet — Revised
- Medicare Learning Network Products Available in Electronic Publication Format
- New Medicare Learning Network Educational Web Guides Fast Fact

Online Medicare refreshers

The *Medicare Learning Network®* (MLN) Products Web-Based Training (WBT) courses are designed for self-paced training via the Internet.

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.

Click here to explore the wide away of training opportunities.

MLN Connects® Provider eNews for August 6, 2015

MLN Connects® Provider eNews for August 6, 2015
View this edition as a PDF

In this edition:

Countdown to ICD-10

- Clarifying Questions and Answers Related to CMS/AMA Joint Announcement and Guidance Regarding ICD-10 Flexibilities — Update
- MLN Connects National Provider Call: Countdown to ICD-10
- Prepare for ICD-10 with MLN Connects Videos

MLN Connects® National Provider Calls and Events

- Proposed Reform of Requirements for Long-Term Care Facilities Call — Last Chance to Register
- Hospital Compare Overall Star Ratings Methodology Call — Last Chance to Register
- National Partnership to Improve Dementia Care and QAPI Call — Registration Now Open
- New MLN Connects National Provider Event Audio Recording and Transcript

MLN Connects Videos

- New Videos on HIS Manual for Hospice Quality Reporting Program

Announcements

- Inpatient and Long-term Care Hospital PPS: Final FY 2016 Payment and Policy Changes
- Skilled Nursing Facilities: Final FY 2016 Payment and Policy Changes
- Inpatient Rehabilitation Facilities: Final FY 2016 Payment and Policy Changes
- Inpatient Psychiatric Facilities: Final FY 2016 Payment and Policy Changes
- Hospice: Final FY 2016 Payment Rates
- Immunizations – Not Just for Kids
- Technical Correction to ESRD PPS Proposed Rule

- Decision Memorandum and Revised Scope of Benefit NCD for Speech Generating Devices
- Hospice Providers: Review HIS Reports to Confirm Successful Submission
- PEPPERs Available for SNFs, HHAs, Hospices, CAHs, LTCHs, IPFs, IRFs, and PHPs
- Antipsychotic Drug use in Nursing Homes: Trend Update
- EHR Incentive Programs: Determine Broadband Speed in Your Area

Claims, Pricers, and Codes

- FY 2015 Inpatient PPS PC Pricer Update Available

Medicare Learning Network® Educational Products

- Upgraded Learning Management and Product Ordering System — Going Live August 12
- "HIPAA Basics for Providers: Privacy, Security, and Breach Notification Rules" Fact Sheet — Released
- "Extension of Provider Enrollment Moratoria for Home Health Agencies and Part B Ambulance Suppliers" MLN Matters® Article — Revised
- Medicare Learning Network Products Available in Electronic Publication Format

MLN Connects® Provider eNews for August 13, 2015

Your responses to our eNews feedback tool help us improve our service. Each week, we offer an *online version* of the eNews, as well as a PDF version, located below the table of contents on the web page. If you are having trouble viewing the eNews, please *let us know* through our updated feedback tool. If you have a question about Medicare, please contact your *Medicare administrative contractor*.

MLN Connects® Provider eNews for August 13, 2015
View this edition as a PDF

In this edition:

Countdown to ICD-10

- MLN Connects National Provider Call: Countdown to ICD-10
- Finding ICD-10 Information Online Just Got Easier
- Five Ways to Check Your Claim Status
- Home Health Episodes that Span October 1, 2015
- New CMS Infographic: Get the Facts About ICD-10

MLN Connects® National Provider Calls and Events

- National Partnership to Improve Dementia Care and QAPI Call — Register Now
- New MLN Connects® National Provider Event Audio Recording and Transcript

MLN Connects Videos

- New Videos on HIS Manual for Hospice Quality Reporting Program

Announcements

- DMEPOS Competitive Bidding: Timeline for Round 1 2017

Medicare Learning Network® Educational Products

- Upgraded Learning Management and Product Ordering System — Now Live

Get ready for ICD-10

On October 1, 2015, the health care industry will transition from ICD-9 to ICD-10 codes for diagnoses and inpatient procedures.

This transition is going to change how you do business—from registration and referrals to superbills and software upgrades. But that change doesn't have to be overwhelming.

The Centers for Medicare & Medicaid Services has the following resources to help your practice prepare for the transition.

Online ICD-10 guide

ICD-10 basics for large medical practices

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