Medicare A Connection

medicare.fcso.com

FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction N Providers

February 2017

In this issue

What SPOT can do for you – use secure messaging to file appeals

Save time and money by corresponding electronically with First Coast

Mailing documents to First Coast Service Options Inc. (First Coast) offices in Jacksonville, FL, is no small expense, particularly when you have to submit additional documentation in support of claim appeals. Between making copies and mailing reams of paper, these costs can add up quickly.

With the availability of portable document formats (PDF) through its *secure messaging tool*, First Coast's SPOT (Secure Provider Online Tool) offers you a more convenient solution for handling correspondence. "The SPOT is the way to go. No more filling out forms and then having to fax or mail them in. By using SPOT, we also received those payments quicker than if we had faxed or mailed the request," said *Kristin Gunn, an experienced medical biller with South Florida Revenue Cycle Specialists*.

The *secure messaging feature* within SPOT allows users to select and submit appeal requests, overpayment forms, and *additional development requests (ADR)* from SPOT to First Coast's e-documentation system. In addition, it also allows users to include support documentation as required.

"I spend 30-45 minutes a day logging appeals in a spreadsheet to track where we were in the process. We handle 20-30 appeals each day. This adds up to a lot of time for me and for my team handling appeals. When SPOT added secure mail to handle appeals too, it was like, wow this is so great. SPOT just keeps getting better," *said Kristin Sierens, a University of Florida/Shands Supervisor*.

Besides *claim redeterminations*, SPOT's secure messaging feature offers access to other Medicare processes, helping to save time and money for both Medicare Part A and Part B providers.

Available secure messaging forms

- Additional claim development response - Respond to ADR requests for prepay claim
- Claim redetermination request - Level 1 appeal request

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The *Medicare A Connection* is published monthly by First Coast Service Options Inc.'s Provider Outreach & Education division to provide timely and useful information to Medicare Part A providers.

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Articles included in the *Medicare A Connection* represent formal notice of coverage policies. Policies have or will take effect on the date given. Providers are expected to read, understand, and abide by the policies outlined within to ensure compliance with Medicare coverage and payment guidelines.

SPOT

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- Claim reopening request - Clerical reopening form (**Part A**)
- Electronic Data Interchange enrollment form
- General inquiry request - Questions about Medicare program/policies
- Provider Audit & Reimbursement - Documents related to annual cost report filing.(**Part A**)
- Medicare secondary payer (MSP) overpayment form - Voluntary refund of an overpayment for an MSP claim (**Part B**)
- Non-MSP overpayment form - Voluntary refund of an overpayment for a Non-MSP claim (**Part B**)
- Overpayment redetermination request - Appeal of an overpayment decision (**Part B**)

As *one provider discovered*, SPOT allows you to quickly handle an overpayment request. "SPOT made it so easy to resolve the issue. We checked the physician's records to see if we billed an incorrect patient number among other things. Then I checked the eligibility tab on SPOT, checked the date of service. I made a screen print from SPOT and sent it through the secure mail. You hit 'send'. Boom. There it goes. No visits to the post office," said Gunn.

First Coast recently upgraded the secure messaging tool allowing Medicare providers to submit documents using the Adobe® Acrobat PDF. Prior to this improvement, SPOT account holders were required to convert some electronic documents to a tagged image file format (TIFF).

In addition to secure messaging, Medicare providers have several tools available to diagnose, correct, and prevent denied claims.

SPOT gives you the ability to view claims status and patient eligibility information online, conduct detailed data analysis at the claim and provider levels, reopen claims to make clerical corrections on multiple lines, and submit redeterminations and additional development responses (ADRs). First Coast offers SPOT to providers at no charge.

How to get your SPOT account

First Coast *provides a step-by-step guide* to assist you in establishing your SPOT account.

Updating the address for ADR letters

Did you know you can update your address for additional documentation requests (ADRs)? First Coast Service Options Inc. (First Coast) sometimes requires a clinical review of documentation to determine the medical necessity of services. It is the goal of First Coast to ensure that providers are properly reimbursed for medically reasonable and necessary services. When documentation is required, an ADR is mailed to the provider.

The ADR letter is mailed to a provider's practice address on file with Medicare. For individual providers rendering services in large facilities such as hospitals, however, the ADR letter may be misdirected and not received in time by the appropriate department or individual provider.

Providers in these situations may request First Coast to mail all correspondence (including ADRs) to the pay-to address listed on their Provider Enrollment, Chain and Ownership (PECOS) file.

How to request all correspondence to go to the pay-to address

- If the pay-to address is already on file in PECOS:
  - Submit a letter on company letterhead requesting all correspondence be sent to the pay-to address on file. The letter must be signed by a person in an official role (authorized or delegated official) for the billing provider.
- If the pay-to address is NOT already on file in PECOS:
  - Submit a change of information using the appropriate paper CMS-855 enrollment application or internet-based PECOS to update the pay-to address. Include a letter on company letterhead requesting all correspondence be sent to the pay-to address being updated with the enrollment application. The letter must be signed by a person in an official role (authorized or delegated official) for the billing provider.

Note: Please keep in mind that once completed, ALL correspondence from First Coast will be sent to this address. This includes situations where the provider has more than one practice location; all correspondence for all practice locations will be sent to the designated pay-to address you selected once First Coast makes the change.

The letter and application, if applicable, may be mailed to:

Provider Enrollment

P.O. Box 44021

Jacksonville, FL 32231-4021

CMS issues guidelines for prior authorization

Provider types affected

This *MLN Matters*® article is intended for providers ordering certain DMEPOS items and suppliers submitting claims to Medicare administrative contractors (MACs) for items furnished to Medicare beneficiaries.

What you need to know

Change request (CR) 9940 updates the Centers for Medicare & Medicaid Services (CMS) *Program Integrity Manual* to permit the MACs to conduct prior authorization processes, as so directed by CMS through individualized operational instructions. As of January 2017, prior authorization of certain durable medical equipment, prosthetic, orthotic, and supply items, frequently subject to unnecessary utilization, is the only permanent (non-demonstration) prior authorization program approved for implementation. Make sure your billing staff is aware of these changes.

Background

Prior authorization is a process through which a request for provisional affirmation of coverage is submitted to a medical review contractor for review before the item or service is furnished to the beneficiary and before the claim is submitted for processing. It is a process that permits the submitter/requester (for example, provider, supplier, beneficiary) to send in medical documentation, in advance of the item or service being rendered, and subsequently billed, in order to verify its eligibility for Medicare claim payment.

For any item or service to be covered by Medicare it must:

- Be eligible for a defined Medicare benefit category
- Be medically reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member
- Meet all other applicable Medicare coverage, coding and payment requirements

Contractors shall, at the direction of CMS or other authorizing entity, conduct prior authorizations and alert the requester/submitter of any potential issues with the information submitted.

A prior authorization request decision can be either a provisional affirmative or a non-affirmative decision.

- A provisional affirmative decision is a preliminary finding that a future claim submitted to Medicare for the item or service likely meets Medicare's coverage, coding, and payment requirements.
- A non-affirmative decision is a finding that the submitted information/ documentation does not meet Medicare's coverage, coding, and payment requirements, and if a claim associated with the prior authorization is submitted for payment, it would not be paid. MACs shall provide notification of the reason for the non-affirmation, if a request is non-affirmative, to the submitter/requester. If a prior authorization request receives a non-affirmative decision, the prior authorization request can be resubmitted an unlimited number of times.
- Prior authorization may also be a condition of payment. This means that claims submitted without an indication that the submitter/requester received a prior authorization decision (that is, unique tracking number (UTN)) will be denied payment.

Each prior authorization program will have an associated Operational Guide that will be available on the CMS website. In addition, MACs will educate stakeholders each time a new prior authorization program is launched. That education will include the requisite information and timeframes for prior authorization submissions and the vehicle to be used to submit such information to the MAC.

Prior authorization program for DME MACs

A prior authorization program for certain durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) items that are frequently subject to unnecessary utilization is described in 42 CFR 414.234. Among other things, this section establishes a Master List of certain DMEPOS items meeting inclusion criteria and potentially subject to prior authorization.

CMS will select healthcare common procedure coding system (HCPCS) codes from the prior authorization master list to be placed on the required prior authorization list, and such codes will be subject to prior authorization as a condition of payment. In selecting HCPCS codes, CMS may consider factors such as geographic location, item utilization or cost, system capabilities, administrative burden, emerging trends, vulnerabilities identified in official agency reports, or other data analysis.

- The prior authorization master list is the list of DMEPOS items that have been identified using the inclusion criteria described in 42 CFR 414.234.
- The list of required DMEPOS prior authorization items contains those items selected from the prior authorization master list to be implemented in the prior authorization program. The list of required DMEPOS

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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, 2016, must be paid before the end of business March 31, 2016.

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 2.5 percent is in effect through June 30, 2017.

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.

Source: Publication 100-04, Chapter 1, Section 80.2.2

Reprocess of some inpatient PPS claims

Issue

Some inpatient prospective payment system (IPPS) hospital and long-term care hospital (LTCH) claims with discharge dates on or after October 1, 2016, may be grouped to an incorrect Medicare severity -- diagnosis related group (MS-DRG).

Resolution

A revision to the ICD-10 MS-DRG version 34 software file was made and affected claims have been reprocessed by your Medicare administrative contractor.

Status/date resolved

Closed/February 1, 2017

Provider action

No action is required by IPPS and LTCH hospitals.

Current processing issues

Here is a link to a *table of current processing issues* for both Part A and Part B.

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prior authorization items will be updated as additional codes are selected for prior authorization.

- CMS may suspend prior authorization requirements generally or for a particular item or items at any time and without undertaking rulemaking. CMS provides notification of the suspension of the prior authorization requirements via *Federal Register* notice and posting on the CMS prior authorization website.

The master and required prior authorization lists, as well as other pertinent information and supporting documents regarding this program, are available at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Prior-Authorization-Initiatives/Prior-Authorization-Process-for-Certain-Durable-Medical-Equipment-Prosthetic-Orthotics-Supplies-Items.html*.

Additional information

The official instruction, CR 9940, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R698PI.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/*.

MLN Matters® Number: MM9940
Related Change Request (CR) #: CR 9940
Related CR Release Date: January 20, 2017
Effective Date: February 21, 2017
Related CR Transmittal #: R698PI
Implementation Date: February 21, 2017

Qualified Medicare beneficiary indicator in claims processing system

Provider types affected

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

Provider action needed

Change request (CR) 9911 modifies the Medicare claims processing systems to help providers more readily identify the Qualified Medicare Beneficiary (QMB) status of each patient and to support providers' ability to follow QMB billing requirements.

Beneficiaries enrolled in the QMB program are not liable to pay Medicare cost-sharing for all Medicare A/B claims. CR 9911 adds an indicator of QMB status to Medicare's claims processing systems.

This system enhancement will trigger notifications to providers (through the provider remittance advice) and to beneficiaries (through the Medicare summary notice) to reflect that the beneficiary is enrolled in the QMB program and has no Medicare cost-sharing liability. Make sure that your billing staffs are aware of these changes.

Background

QMB is a Medicaid program that assists low-income beneficiaries with Medicare premiums and cost-sharing. In 2015, 7.2 million persons (more than one out of every ten Medicare beneficiaries) were enrolled in the QMB program.

Under federal law, Medicare providers may not bill individuals enrolled in the QMB program for Medicare deductibles, coinsurance, or copayments, under any circumstances. (See Sections 1902(n)(3)(B); 1902(n)(3)(C); 1905(p)(3); 1866(a)(1)(A); 1848(g)(3)(A) of the Social Security Act.) State Medicaid programs may pay

providers for Medicare deductibles, coinsurance, and copayments. However, as permitted by federal law, states can limit provider reimbursement for Medicare cost-sharing under certain circumstances.

Nonetheless, Medicare providers must accept the Medicare payment and Medicaid payment (if any, and including any permissible Medicaid cost sharing from the beneficiary) as payment in full for services rendered to an individual enrolled in the QMB program.

CR 9911 aims to support Medicare providers' ability to meet these requirements by modifying the Medicare claims processing system to clearly identify the QMB status of all Medicare patients.

Currently, neither the Medicare eligibility systems (the HIPAA Eligibility Transaction System (HETS)), nor the claims processing systems (the FFS Shared Systems), notify providers about their patient's QMB status and lack of Medicare cost-sharing liability.

Similarly, Medicare summary notices (MSN) do not inform those enrolled in the QMB program that they do not owe Medicare cost-sharing for covered medical items and services.

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Quarterly provider update

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

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

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

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CR 9911 includes modifications to the FFS claims processing systems and the *Medicare Claims Processing Manual* to generate notifications to Medicare providers and beneficiaries regarding beneficiary QMB status and lack of liability for cost-sharing.

With the implementation of CR 9911, Medicare's common working file (CWF) will obtain QMB indicators so the claims processing systems will have access to this information.

CWF will provide the claims processing systems the QMB indicators if the dates of service coincide with a QMB coverage period (one of the occurrences) for the following claim types: Part B professional claims; durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) claims; and outpatient institutional types of bill (TOB) 012x, 013x, 014x, 022x, 023x, 034x, 071x, 072x, 074x, 075x, 076x, 077x, and 085x); home health claims (TOB 032x) only if the revenue code for the line item is 0274, 029x, or 060x; and skilled nursing facility (SNF) claims (based on occurrence code 50 date for revenue code 0022 lines on TOBs 018x and 021x).

CWF will provide the claims processing systems the QMB indicator if the "through date" falls within a QMB coverage period (one of the occurrences) for inpatient hospital claims (TOB 011x) and religious non-medical health care institution claims (TOB 041x).

The QMB indicators will initiate new messages on the remittance advice that reflect the beneficiary's QMB status and lack of liability for Medicare cost-sharing with three new remittance advice remark codes (RARC) that are specific to those enrolled in QMB. As appropriate, one or more of the following new codes will be returned:

N781 – No deductible may be collected as patient is a Medicaid/Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance, deductible or co-payments.

N782 – No coinsurance may be collected as patient is a Medicaid/Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance, deductible or co-payments.

N783 – No co-payment may be collected as patient is a Medicaid/Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance, deductible or co-payments.

In addition, the MACs will include a claim adjustment reason code of 209 ("Per regulatory or other agreement. The provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected. (Use only with group code OA (Other Adjustment)).

Finally, CR 9911 will modify the MSN to inform beneficiaries if they are enrolled in QMB and cannot be billed for Medicare cost-sharing for covered items and services.

Additional information

The official instruction, CR 9911, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3715CP.pdf*.

For more information regarding billing rules applicable to individuals enrolled in the QMB Program, see the *MLN Matters article*, SE1128, at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se1128.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/*.

MLN Matters® Number: MM9911
Related Change Request (CR) #: CR 9911
Related CR Release Date: February 3, 2017
Effective Date: for claims processed on or after October 2, 2017
Related CR Transmittal #: R3715CP
Implementation Date: February 21, 2017

Chronic care management services frequently asked questions

***Note**: This article was rescinded on January 19, 2017, because CMS has implemented changes to the payment policy for chronic care management (CCM) beginning January 1, 2017.*

Those changes are outlined in the 2017 physician fee schedule (PFS) final rule at https://www.gpo.gov/fdsys/pkg/FR-2016-11-15/pdf/2016-26668.pdf and the new guidance on the PFS care management web page at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Care-Management.html. This information was previously published in the May 2015 Medicare A Connection, pages 13-19.

MLN Matters® Number: SE1516 *Rescinded*

Related Change Request (CR) #: N/A
Article Release Date: January 19, 2017
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Billing clarification of procedure code 96377

The American Medical Association (AMA) issued a new Current Procedural Terminology (CPT®) code 96377 for "Application of on-body injector (includes cannula insertion) for timed subcutaneous injection," effective January 1, 2017.

According to the January 2017 Medicare physician fee schedule update, CPT® code 96377 is not a valid code for Part B providers. If reported, the service will reject as an invalid code.

To report this service, use CPT® code 96372 (Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular).

This section of *Medicare B Connection* features summaries of new and revised local coverage determinations (LCDs) developed as a result of either local medical review or comprehensive data analysis initiatives. These initiatives are designed to ensure the appropriateness of medical care and to make sure that the Medicare administrative contractor (MAC) jurisdiction N (JN) Part A LCDs and review guidelines are consistent with accepted standards of medical practice.

Refer to our LCDs/Medical Coverage 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.

Electronic notification

To receive quick, automatic notification when new and revised LCDs are posted to the website, subscribe to the First Coast eNews mailing list. Simply go to *http://medicare.fcso.com/Header/137525.asp*, enter your email address and select the subscription option that best meets your needs.

More information

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

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

Looking for LCDs?

Would you like to find local coverage determinations (LCD) in 10 seconds or less? First Coast's LCD lookup, available at *http://medicare.fcso.com/coverage_find_lcds_and_ncds/lcd_search.asp*, helps you find the coverage information you need quickly and easily. Just enter a procedure code, keyword, or the LCD's "L number," click the corresponding button, and the application will automatically display links to any LCDs applicable to the parameters you specified. Best of all, depending upon the speed of your internet connection, the LCD search process can be completed in less than 10 seconds.

Advance beneficiary notice

Modifier GZ must be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they **have not had** an advance beneficiary notification (ABN) signed by the beneficiary.

Note: Line items submitted with the modifier GZ will be automatically denied and will not be subject to complex medical review.

Modifier GA must be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny a service as not reasonable and necessary and they **do have** on file an ABN signed by the beneficiary.

All claims not meeting medical necessity of a local coverage determination must append the billed service with modifier GA or GZ.

Before you file an appeal...

Each month, thousands of medical providers send written inquiries to First Coast Service Options Inc. (First Coast) to check the status of an appealed claim. Unfortunately, many of these appeals and subsequent inquiries are submitted on claims that were ineligible for appeal.

Before you appeal a denied claim, check out *these resources*.

Revisions to LCDs

Evaluation and management services in a nursing facility – revision to the Part A and Part B LCD

LCD ID number: L36230 (Florida, Puerto Rico/U.S. Virgin Islands)

Based on change request (CR) 9754 (October 2016 Integrated Outpatient Code Editor (I/OCE) Specifications) and CR 9749 (Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - October CY 2016 Update), the local coverage determination (LCD) for evaluation and management services in a nursing facility was revised to add HCPCS code G9685 (evaluation and management of a beneficiary's acute change in condition in a nursing facility) to the "CPT®/HCPCS Codes" section of the LCD.

Effective date

This LCD revision is effective for claims processed **on or after January 17, 2017**, for services rendered **on or after October 1, 2016**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *https://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, *click here*.

Part A services denied due to laboratory NCD edit changes

Issue

Change request (CR) 9806 announces significant changes to 23 national coverage determinations outlined in *Publication 100-03, Sections 190.12 – 190.34 for Laboratory Services* involving ICD-10 diagnosis editing. These changes will be implemented December 5, 2016, for dates of service on and after October 1, 2016.

Therefore, claims submitted prior to the December 5 implementation date will be denied.

Resolution

Part A claims that denied with reason codes in the 5xNCD series with diagnosis codes updated with CR 9806 have been adjusted.

Status/date resolved

Closed/December 8, 2016

Provider action

Denied Part A claims were adjusted as brought to our attention.

Current processing issues

Here is a link to a *table of current processing issues* for both Part A and Part B.

Where do I find...

Looking for something specific and don't know where to find it? Find out how to perform routine tasks or locate information that visitors frequently visit our site to accomplish or find. Check out the "*Where do I find*" page.

Hospital requirements for making an election for a particular fiscal period covered by CMS ruling 1498-R2

Note: Transmittal 279, dated December 16, 2016, has been rescinded and replaced by Transmittal 1776, dated, January 27, 2017, to correct one of the items required to be reported by the provider in its election request; i.e., FFY based on begin date (YYYY) should be federal fiscal year (FFY) based on *change request* (CR) begin date.

In addition, a clarifying phrase was added to the third paragraph under the "Realignment" section of the CR. Also, this CR has been changed from a Pub. 100-06 to a Pub. 100-20. All other information remains the same. This information was previously published in the *December 2016 Medicare A Connection, pages 54-56*.

Effective date: January 19, 2017

*Unless otherwise specified, the effective date is the date of service.

Implementation date: January 19, 2017

I. General information

A. Background

On April 28, 2010, the Administrator of the Centers for Medicare & Medicaid Services (CMS) issued CMS ruling 1498-R. The ruling addressed administrative appeals on three different issues related to Medicare disproportionate share hospital (DSH) payment:

1) the Medicare-supplemental security income (SSI) fraction data matching process issue, and the method for recalculating the hospital's Medicare-SSI fraction by matching Medicare and SSI entitlement data;
2) the exclusion from the Medicare fraction and the numerator of the Medicaid fraction of non-covered inpatient hospital days for patients entitled to Medicare Part A, including days for which the patient's Part A inpatient hospital benefits were exhausted; and
3) the exclusion from the DSH calculation of labor/delivery room (LDR) inpatient days. On April 22, 2015, the administrator of CMS issued CMS ruling 1498-R2, which effectively amended CMS ruling 1498-R. This modification and amendment of CMS ruling 1498-R affects a change only with respect to the relief that is available for revised Medicare-SSI fractions, and the interaction between Medicare-SSI fractions suitably revised to address the data matching process issue and the issue of Medicare Part A non-covered or exhausted benefit days ("dual-eligible non-covered days") for cost reporting periods involving patient discharges before October 1, 2004.

B. Policy

Section 9105 of the Consolidated Omnibus Budget Reconciliation Act of 1985 provides that for discharges occurring on or after May 1, 1986, an additional payment must be made to inpatient prospective payment system (IPPS) hospitals serving a disproportionate share of low income patients. The additional payment is determined

by multiplying the federal portion of the diagnosis-related group (DRG) payment by the DSH adjustment factor. (See 42 CFR 412.106).

Prior to the implementation of the FY 2005 IPPS final rule, inpatient days were included in the numerator of the Medicare-SSI fraction only if the inpatient hospital days were "covered" under Medicare Part A and the patient was entitled to SSI benefits. Part A coverage of inpatient days alone was required for inclusion in the denominator of the Medicare-SSI fraction.

The FY 2005 IPPS final rule amended the DSH regulations by eliminating the requirement that Part A inpatient hospital days must be covered in order for such days to be included in the Medicare-SSI fraction and made clear that patient days were to be included in that fraction if the patient was entitled to Medicare Part A. See the FY 2005 IPPS final rule (69 FR 49246) (revising 42 CFR 412.106(b)(2)(i)).

Under our revised policy, the inpatient days of a person who was entitled to Medicare Part A are included in the numerator of the hospital's Medicare-SSI fraction (provided that the patient was also entitled to SSI at that time) and in the Medicare-SSI fraction denominator, regardless of whether the individual's inpatient hospital stay was covered under Part A or whether the patient's Part A hospital benefits were exhausted. The FY 2005 IPPS final rule revision to the DSH regulations was effective for patient discharges occurring on or after October 1, 2004 (69 FR 49099).

The CMS issued ruling 1498-R2 on April 22, 2015, and it can be found at: *https://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/CMS-Rulings-Items/CMS1498-R2.html*.

The CMS ruling 1498-R2 provided notice of CMS' determination that CMS ruling 1498-R shall be amended regarding its remedy for recalculation of certain Medicare DSH payment adjustments. CMS ruling 1498-R required the Provider Reimbursement Review Board (PRRB) and other Medicare administrative appeals tribunals to remand

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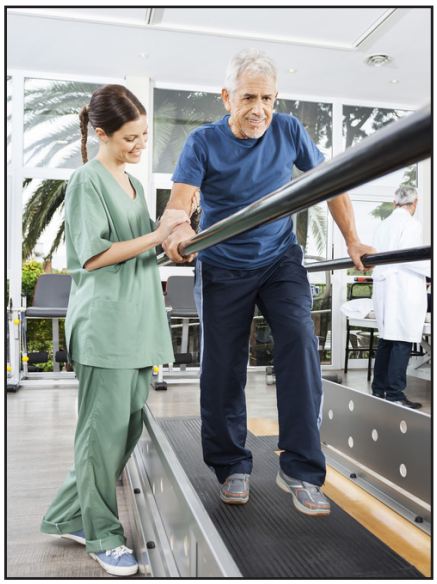
each qualifying appeal to the appropriate Medicare contractor. CMS ruling 1498-R further explained how CMS and Medicare contractors were to recalculate the provider's DSH adjustment resolving any of the three different DSH issues. CMS and the Medicare contractor also were to apply the provisions of CMS ruling 1498-R, on all three DSH issues, to each qualifying hospital cost reporting period where the contractor had not yet final settled the provider's Medicare cost report. CMS ruling 1498-R2 is a modification and amendment of CMS Ruling 1498-R, but only insofar as CMS ruling 1498-R2 requires an election with respect to the Medicare-SSI component of the DSH payment adjustment for cost reports that involve SSI ratios for FFY 2004 and earlier, or SSI ratios for hospital cost-reporting periods, but only for those patient discharges occurring before October 1, 2004.

The CMS and the Medicare contractors will resolve each Medicare-SSI and dual-eligible non-covered day appeal remanded by the PRRB to the contractor, or open hospital cost reporting period subject to CMS ruling 1498-R and the amendment in CMS ruling 1498-R2 by allowing hospitals to exercise an election.



This election is available for hospital cost reporting periods where the Medicare contractor has not yet final settled the provider's Medicare cost report, as well as appeals remanded to the contractor pursuant to CMS ruling 1498-R (assuming any such hospital cost reporting period involves SSI ratios for FFY 2004 and earlier or SSI ratios for hospital cost-reporting periods, but only for those patient discharges occurring before October 1, 2004). The election is also available for hospital cost reporting periods previously reopened specifically on the Medicare-SSI fraction issue – neither CMS ruling 1498-R nor the amendment in CMS ruling 1498-R2 required reopening. For a particular hospital cost reporting period or, as applicable, the portion of a particular cost reporting period prior to October 1, 2004, subject to CMS ruling 1498-R and the amendment in CMS ruling 1498-R2, hospitals may elect either to:

1. include inpatient days of a person entitled to Medicare Part A in the numerator of the hospital's Medicare-SSI fraction (provided that the patient was also entitled to SSI) and in that fraction's denominator, even if the inpatient stay was not covered under Part A or the patient's Part A hospital benefits were exhausted (that is, elect to have applied a suitably revised Medicare-SSI fraction calculated on the basis of "total days"); or
2. exclude such days where the patient's Part A hospital benefits were exhausted or otherwise were not in a covered Part A stay from both the numerator and denominator of the Medicare-SSI fraction (that is, elect to have applied a suitably revised Medicare-SSI fraction calculated on the basis of "covered days").

In summary, a provider may elect whether to receive a suitably revised Medicare-SSI fraction on the basis of "covered days" or "total days" for hospital cost reporting periods that involve SSI ratios for FFY 2004 and earlier, or SSI ratios for hospital cost reporting periods, but only for those patient discharges occurring before October 1, 2004. CMS ruling 1498-R2 does not effect any change with respect to the Medicaid fraction of the Medicare DSH payment calculation. The amendment to CMS ruling 1498-R only allows providers to exercise a choice with respect to the Medicare-SSI fraction, and nothing in the amended ruling or these instructions shall be interpreted to affect a hospital's Medicaid fraction of its DSH payment calculation.

The CMS has published on its web site suitably revised Medicare-SSI fractions that display Medicare-SSI fractions calculated on the basis of "covered days," as well as "total days." Before an initial notice of program reimbursement (NPR) or revised NPR pursuant to the amendment to CMS ruling 1498-R is issued by its Medicare contractor, a hospital's designated representative should submit to its Medicare contractor a written request that reflects the hospital's election of whether, for a particular fiscal period, the hospital's suitably revised Medicare-SSI fraction will be calculated on the basis of "total days" or "covered days." The written request must be received by the Medicare contractor within 180 calendar days of the date instructions are posted on the contractor's web site. The request to the Medicare contractor must include the following information:

Provider number
Hospital name
PRRB case number and PRRB remand date (if applicable)
Case name, docket number (if applicable)
Hospital's designated representative (if applicable)
Cost report begin date (YYYYMMDD)
Cost report end date (YYYYMMDD)
FFY based on CR begin date (YYYY)
Provider election ("total" or "covered")
SSI ratio selected (numerical value from CMS website)

If the hospital's request does not contain all of the required information or if the hospital does not make an election for a particular fiscal period covered by CMS ruling 1498-R (as modified by CMS ruling 1498-R2) in this time frame, the Medicare contractor shall contact the hospital via letter, using a method that tracks delivery and receipt, to obtain the required information and if the provider does not respond within 30 days of the date of the letter, the

See **ELECTION**, next page

ELECTION

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Medicare contractor shall recalculate the provider's DSH adjustment using the higher of the two revised Medicare-SSI fractions.

Realignment

42 CFR 412.106(b)(3) allows the hospital the opportunity to request to have their Medicare-SSI fraction realigned based on its cost reporting period (as opposed to the FFY).

For cost reporting periods subject to CMS ruling 1498-R and the amendment in CMS ruling 1498-R2, CMS will furnish (at the hospital's written request and at no cost to the hospital) patient-level data concerning the number of the hospital's "covered" and "total" Medicare-SSI days, and the number of the hospital's "covered" and "total" Medicare days. Hospitals with cost reporting periods that ended before December 8, 2004, that did not receive an initial NPR, must appeal the issue of the calculation of their Medicare-SSI days to the PRRB subsequent to receipt of an initial NPR in order to receive their data at no cost. Such data will be provided on the FFY basis for the relevant cost reporting period, or, if the hospital does not report on the FFY basis, the two FFYs in which the hospital's cost reporting period falls.

If a provider previously submitted a realignment request for an open cost report, or for a cost report with an SSI appeal or SSI remand that uses a federal fiscal year 2004 or earlier Medicare-SSI fraction, the contractor shall send a notice to the provider to inform them that the realignment request no longer applies since the provider will first receive an initial/revised NPR with a revised Medicare-SSI fraction calculated based on the federal fiscal year. After receiving its revised Medicare-SSI fraction, the provider may request realignment, based on the revised Medicare-SSI fraction, within the normal timeframes.

The hospital must submit a written request to its contractor if it elects to receive the suitably revised Medicare-SSI fractions on the basis of its cost reporting period. The request must be on provider letterhead and signed by authorized hospital personnel. The request must specify whether the provider elects to have its realigned Medicare-SSI fraction generated on the basis of "total days" or "covered days." Hospitals requesting that CMS recalculate their SSI ratios on the basis of their cost reporting period shall send their Medicare contractor the following information:

Provider number
Hospital name
PRRB case number and PRRB remand date (if applicable)
Case name, docket number (if applicable)
Hospital's designated representative (if applicable)
Cost report begin date (YYYYMMDD)
Cost report end date (YYYYMMDD)
FFY based on CR begin date (YYYY)
Provider election ("total" or "covered")

If the hospital's realignment request does not contain all of the required information, notably if the request does not contain an election of "total" or "covered" with regard to the SSI ratio, the Medicare contractor shall contact the hospital via letter, using a method that tracks delivery and receipt, to obtain the required information and if the provider does not respond within 30 days of the date of the letter, the Medicare contractor shall inform CMS that no election was provided. In this instance, CMS will provide a realigned Medicare SSI ratio using the higher of the two revised Medicare-SSI fractions for the hospital's cost reporting period.

If a provider submitted a realignment request within three years of the NPR where there is no SSI appeal or SSI remand, the provider will receive its requested realignment using the original SSI ratio.

Change request: 9896 (*View here*.)
Transmittal: 1776
Effective date: January 19, 2017
Implementation date: January 19, 2017

ICD-10 update for severe wound discharges from long-term care hospitals

Provider types affected

This *MLN Matters*® article is intended for hospitals, including certain long-term care hospitals (LTCHs) submitting claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 9872 which informs MACs about an update to include additional ICD-10 codes for the implementation of the temporary exception for certain wound care discharges from the site neutral payment rate for certain LTCH hospitals within hospitals (HwHs). Make sure that your billing staffs are aware of these changes.

Background

Under the LTCH prospective payment system (PPS), for LTCH discharges in cost reporting periods beginning on or after October 1, 2015, Medicare established two separate payment categories for LTCH patients upon discharge. LTCH cases meeting specific clinical criteria are paid the LTCH PPS standard federal rate payment and those cases not meeting specific clinical criteria are paid the site neutral rate payment (the lesser of an "Inpatient Prospective Payment System (IPPS)-comparable" payment amount or 100 percent of the estimated cost of the case).

In general, in order to be paid at the LTCH PPS standard federal rate payment amount, an LTCH discharge must either:

1. Have been admitted directly from an IPPS hospital during which at least 3 days were spent in an intensive care unit (ICU) or coronary care unit (CCU), but the discharge must not have a principal diagnosis in the LTCH of a psychiatric or rehabilitation diagnosis or
2. Have been admitted directly from an IPPS hospital and the LTCH discharge is assigned to an MS-LTC-DRG based on the receipt of ventilator services of at least 96 hours, but must not have a principal diagnosis in the LTCH of a psychiatric or rehabilitation diagnosis.

Section 231 of the Consolidated Appropriations Act of 2016 established an additional temporary exception from the site neutral payment rate for patients discharged from certain LTCHs with a severe wound, effective for discharges occurring before January 1, 2017. In a final rule published in the *Federal Register* August 22, 2016 (81 FR 57068 through 57075), the Centers for Medicare & Medicaid Services (CMS) updated the list of ICD-10 codes that qualify as severe wounds under the categories:

- Stage 3 wound
- Stage 4 wound
- Unstageable wound
- Non-healing surgical wound

• Fistula

• Osteomyelitis

The complete list of ICD-10 codes for this provision is available for download at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/download.htm*.

CR 9872 adds ICD-10 codes L97.112-L97.114, L97.122-L97.124, L97.912-L97.914, L97.921-L97.924, T81.30XA, T81.30XD, T81.31XA, T81.31XD, T81.32XA, T81.32XD, T81.4XX, T81.4XXA, T81.4XXD, T81.89XA, T81.89XD to this list.

As noted in CR 9599, only grandfathered LTCH HwHs are eligible to qualify for this temporary exception. MACs shall verify such status upon request from a hospital.

MACs will reprocess claims with a through date (for interim claims) or a discharge date (for final claims) on or after April 21, 2016, through December 31, 2016, containing one of the above ICD-10 codes and which are eligible for this temporary exception. Such claims will be reprocessed within 60 days of the implementation date of CR 9872.

Additional information

The official instruction, CR 9872, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1786OTN.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/*.

MLN Matters® Number: MM9872
Related Change Request (CR) #: CR 9872
Related CR Release Date: February 3, 2017
Effective Date: April 21, 2016
Related CR Transmittal #: R1786OTN
Implementation Date: July 3, 2017

Change to beneficiary liability and cost report days for long term care hospitals

Provider types affected

This *MLN Matters*® article is intended for subclause (II) long term care hospitals (LTCHs) submitting claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 9912 announces that, effective with cost reporting periods beginning on or after October 1, 2016, for a subclause (II) LTCH, the Medicare payment would only apply to the LTCH's costs incurred for the days used to calculate the Medicare payment (that is, days for which the patient has a benefit day available). Make sure that your billing staffs are aware of these changes.

Background

In the Fiscal Year (FY) 2015 Inpatient Prospective Payment System (IPPS)/Long-Term Care Hospital Prospective Payment System (LTCH PPS) Final Rule, CMS-1607-F, the Centers for Medicare & Medicaid Services (CMS) established a payment adjustment under the LTCH PPS for hospitals "classified under subclause (II) of subsection (d)(1)(B)(iv)" of the Social Security Act (the Act) (referred to as "subclause (II) LTCHs), effective for cost reporting periods beginning in FY 2015 and beyond.

Under this payment adjustment, payments to subclause (II) LTCHs are adjusted so that their LTCH PPS payments are generally equivalent to an amount determined under the reasonable cost-based reimbursement rules for both operating and capital-related costs under 42 CFR Part 413. In the FY 2017 IPPS/LTCH PPS Final Rule, CMS revised the policy concerning beneficiary liability, which results in corresponding changes relating to cost report days, for subclause (II) LTCHs (see §412.507).

Section 15008 of the 21st Century Cures Act, enacted December 13, 2016, reclassifies hospitals which had previously been classified as "subclause (II) LTCHs" as their own category of IPPS-excluded hospitals (at section 1886(d)(1)(B)(vi) of the Act). Also, this provision codifies, effective January 1, 2015, the reasonable cost-based payment adjustment CMS implemented in 42 CFR 412.526, and requires Medicare claims be processed as paid on a reasonable cost basis for discharge occurring on or after January 1, 2017.

Under the current policy, for a subclause (II) LTCH, the Medicare payment applies to the LTCH's costs incurred for all days in the "inlier" period regardless of whether the beneficiary has a benefit day available. This policy, which was implemented in CR9401, will continue to apply for utilization days in cost reporting periods beginning before October 1, 2016, that is, through December 31, 2016, for a subclause (II) LTCH with a calendar year cost reporting period.

Under the revisions in the FY 2017 final rule and consistent with Section 15008 of the 21st Century Cures Act, effective with cost reporting periods beginning on or after October 1, 2016, for a subclause (II) LTCH, the Medicare payment would only apply to the LTCH's costs incurred for the days used to calculate the Medicare payment (that is, days for which the patient has a benefit day available). For a subclause (II) LTCH with a calendar year cost reporting period, the revised policy will become effective for utilization days beginning January 1, 2017.

Note: Under this revised policy, whether the LTCH discharge would qualify for a high-cost outlier payment will no longer effect beneficiary liability.

Additional information

The official instruction, CR 9912, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1791OTN.pdf*.

CR 9401 is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3394CP.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/*.

MLN Matters® Number: MM9912
Related Change Request (CR) #: CR 9912
Related CR Release Date: February 3, 2017
Effective Date: January 1, 2017
Related CR Transmittal #: R1791OTN
Implementation Date: July 3, 2017

Medicare outpatient observation notice instructions

Provider types affected

This *MLN Matters*® article is intended for hospitals, including critical access hospitals (CAHs) submitting claims to Medicare administrative contractors (MACs) for outpatient observation services provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 9935 updates Chapter 30 of the *Medicare Claims Processing Manual* to include the Medicare outpatient observation notice (MOON), CMS-10611, and related instructions. Providers should use the MOON to inform Medicare beneficiaries when they are an outpatient receiving observation services, and are not an inpatient of the hospital or a critical access hospital (CAH). The instructions included in Chapter 30 provide guidance for proper issuance of the MOON. The updated Chapter 30 is attached to CR 9935.

Background

The MOON is mandated by the Federal Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act), passed August 6, 2015. This law amended Section 1866(a)(1) of the Social Security Act by adding new subparagraph (Y) that requires hospitals and CAHs to provide written notification and an oral explanation of such notification to individuals receiving observation services as outpatients for more than 24 hours at the hospitals or CAHs.

Scope

Hospitals and CAHs must provide the MOON to beneficiaries in original Medicare (fee-for-service) who receive observation services as outpatients for more than 24 hours. (**Note**: MA plans are to follow MOON instructions outlined in CR 9935/Section 400 of Chapter 30 of the *Medicare Claims Processing Manual*.

All beneficiaries receiving services in hospitals and CAHs must receive a MOON no later than 36 hours after observation services as an outpatient begin. For purposes of these instructions, the term “beneficiary,” means either beneficiary or representative, when a representative is acting for a beneficiary.

This also includes beneficiaries in the following circumstances:

- Beneficiaries who do not have Part B coverage
- Beneficiaries who are subsequently admitted as an inpatient prior to the required delivery of the MOON
- Beneficiaries for whom Medicare is either the primary or secondary payer

The statute expressly provides that the MOON be delivered to beneficiaries receiving observation services as an outpatient for more than 24 hours. In other words, the MOON should not be delivered to all beneficiaries receiving outpatient services. The MOON is intended to inform beneficiaries who receive observation services for more than 24 hours that they are outpatients receiving observation services and not inpatients, and the reasons for such status, and must be delivered no later than 36 hours after observation services begin.

However, hospitals and CAHs may deliver the MOON to an individual receiving observation services as an outpatient before such individual has received more than 24 hours of observation services.

Allowing delivery of the MOON before an individual has received 24 hours of observation services affords hospitals and CAHs the flexibility to deliver the MOON consistent with any applicable state law that requires notice to outpatients receiving observation services within 24 hours after observation services begin.

The flexibility to deliver the MOON any time up to, but no later than, 36 hours after observation services begin also allows hospitals and CAHs to spread out the delivery of the notice and other hospital paperwork in an effort to avoid overwhelming and confusing beneficiaries.

Hospitals affected by these instructions

These instructions apply to hospitals as well as CAHs per Section 1861(e) and Section 1861(mm) of the Social Security Act.

Medicare outpatient observation notice

The MOON is subject to the Paperwork Reduction Act (PRA) process and approved by the Office of Management and Budget (OMB). OMB-approved notices may only be modified as per its accompanying form instructions, as well as per guidance in this section of the manual.

Unapproved modifications cannot be made to the OMB-approved, standardized MOON. The notice and accompanying form instructions are available at *https://www.cms.gov/Medicare/Medicare-General-Information/BNI*.

Alterations to the notice

In general, the MOON must remain two pages, except as needed for the additional information field discussed below or to include state-specific information below. Hospitals and CAHs subject to state law observation notice requirements may attach an additional page to the MOON to supplement the *Additional information* section in order to communicate additional content required under state law, or may attach the notice required under state law to the MOON. The pages of the notice can be two sides of one page or one side of separate pages, but must not be condensed to one page.

Hospitals may include its business logo and contact information on the top of the MOON. Text may not be shifted from page 1 to page 2 to accommodate large logos, address headers, or any other information.

Completing the MOON

Hospitals must use the OMB-approved MOON (CMS-10611). Hospitals must type or write the following

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information in the corresponding blanks of the MOON:

- Patient name
- Patient number
- Reason patient is an outpatient

Hospital delivery of the MOON

Hospitals and CAHs must provide both the standardized written MOON, as well as oral notification. Oral notification must consist of an explanation of the standardized written MOON. The format of such oral notification is at the discretion of the hospital or CAH, and may include, but is not limited to, a video format. However, a staff person must always be available to answer questions related to the MOON, both in its written and oral delivery formats.

The hospital or CAH must ensure that the beneficiary or representative signs and dates the MOON to demonstrate that the beneficiary or representative received the notice and understands its contents. Use of assistive devices may be used to obtain a signature.

Electronic issuance of the MOON is permitted. If a hospital or CAH elects to issue a MOON viewed on an electronic screen before signing, the beneficiary must be given the option of requesting paper issuance over electronic issuance if that is what the beneficiary prefers. Regardless of whether a paper or electronic version is issued and regardless of whether the signature is digitally captured or manually penned, the beneficiary must be given a paper copy of the MOON with the required beneficiary specific information inserted, at the time of notice delivery.

Refusal to sign the MOON

If the beneficiary refuses to sign the MOON, and there is no representative to sign on behalf of the beneficiary, the notice must be signed by the staff member of the hospital/CAH who presented the written notification. The staff member's signature must include the name and title of the staff member, a certification that the notification was presented, and the date and time the notification was presented. The staff member annotates the *Additional information* section of the MOON to include the staff member's signature and certification of delivery. The date and time of refusal is considered to be the date of notice receipt.

MOON delivery to representatives

The MOON may be delivered to a beneficiary's appointed representative. A beneficiary may designate an appointed representative via the "Appointment of Representative" form, the CMS-1696, which can be found at *https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf*. See Chapter 29, Section 270.1 of the *Medicare Claims Processing Manual* at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c29.pdf* for more information on appointed representatives.

The MOON may also be delivered to an authorized representative. Generally, an authorized representative is an individual who, under state or other applicable law, may make health care decisions on a beneficiary's behalf (for example, the beneficiary's legal guardian, or someone appointed in accordance with a properly executed durable medical power of attorney).

Notification to a beneficiary who has been deemed legally incompetent is typically made to an authorized representative of the beneficiary.

However, if a beneficiary is temporarily incapacitated, a person (typically, a family member or close friend) whom the hospital or CAH has determined could reasonably represent the beneficiary, but who has not been named in any legally binding document, may be a representative for the purpose of receiving the MOON.

Such a representative should act in the beneficiary's best interests and in a manner that is protective of the beneficiary and the beneficiary's rights. Therefore, a representative should have no relevant conflict of interest with the beneficiary.

In instances where the notice is delivered to a representative who has not been named in a legally binding document, the hospital or CAH should annotate the MOON with the name of the staff person initiating the contact, the name of the person contacted, and the date, time, and method (in person or telephone) of the contact.

Note: There is an exception to the in-person notice delivery requirement. If the MOON must be delivered to a representative who is not physically present to receive delivery of the notice, the hospital/CAH is not required to make an off-site delivery to the representative. The hospital/CAH must complete the MOON as required and telephone the representative.

- The information provided telephonically should include all contents of the MOON.
- Note the date and time the hospital or CAH communicates (or makes a good faith attempt to communicate) this information telephonically to the representative is considered the receipt date of the MOON.
- Annotate the *Additional information* section to reflect that all of the information indicated above was communicated to the representative.
- Annotate the *Additional information* section with the name of the staff person initiating the contact, the name of the representative contacted by phone, the date and time of the telephone contact, and the telephone number called.

A copy of the annotated MOON should be mailed to the representative the day telephone contact is made.

A hard copy of the MOON must be sent to the representative by certified mail, return receipt requested, or any other delivery method that can provide signed verification of delivery (for example: FedEx or UPS). The burden is on the hospital or CAH to demonstrate that timely contact was attempted with the representative and

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that the notice was delivered.

If the hospital or CAH and the representative both agree, the hospital or CAH may send the notice by fax or e-mail; however, the hospital or CAH's fax and e-mail systems must meet the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy and security requirements.

Ensuring beneficiary comprehension

The OMB-approved standardized MOON is available in English and Spanish. If the individual receiving the notice is unable to read its written contents and/or comprehend the required oral explanation, hospitals and CAHs must employ their usual procedures to ensure notice comprehension. Usual procedures may include, but are not limited to, the use of translators, interpreters, and assistive technologies.

Hospitals and CAHs are reminded that recipients of federal financial assistance have an independent obligation to provide language assistance services to individuals with Limited English Proficiency (LEP) consistent with Section 1557 of the Affordable Care Act and Title VI of the Civil Rights Act of 1964. In addition, recipients of federal financial assistance have an independent obligation to provide auxiliary aids and services to individuals with disabilities free of charge, consistent with Section 1557 of the Affordable Care Act and Section 504 of the Rehabilitation Act of 1973.

Completing the additional information field of the MOON

This section may be populated with any additional information a hospital wishes to convey to a beneficiary. Such information may include, but is not limited to:

- Contact information for specific hospital departments or staff members
- Additional content required under applicable state law related to notice of observation services
- Part A cost-sharing responsibilities if a beneficiary is admitted as an inpatient before 36 hours following initiation of observation services
- The date and time of the inpatient admission if a patient is admitted as an inpatient prior to delivery of the MOON
- Medicare accountable care organization information
- Hospital waivers of the beneficiary's responsibility for the cost of self-administered drugs
- Any other information pertaining to the unique circumstances regarding the particular beneficiary

If a hospital or CAH wishes to add information that cannot be fully included in the *Additional information* section, an additional page may be attached to the MOON.

Notice retention for the MOON

The hospital or CAH must retain the original signed MOON in the beneficiary's medical record. The beneficiary should receive a paper copy of the MOON that includes all of the required information. Electronic notice retention is permitted.

Intersection with state observation notices

Hospitals and CAHs in states that have state-specific observation notice requirements may add state-required information to the *Additional information* field, attach an additional page, or attach the notice required under state law to the MOON.

Additional information

The official instruction, CR 9935, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3698CP.pdf*. As mentioned earlier, the notice and accompanying instructions are available at *https://www.cms.gov/Medicare/Medicare-General-Information/BNI*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/*.

Document history

- **January 24, 2017:** Initial issuance
- **February 2, 2017:** The article was revised to reflect a revised CR 9935 issued January 27, 2017. In the article, the CR release date, transmittal number, and the web address for accessing the CR were revised. All other information remains the same.

MLN Matters® Number: MM9935
Related Change Request (CR) #: CR 9935
Related CR Release Date: January 27, 2017
Effective Date: February 21, 2017
Related CR Transmittal #: R3698CP
Implementation Date: February 21, 2017

Upcoming provider outreach and educational events

Medicare Part A changes and regulations

Date: Tuesday, March 14
Time: 10:00 a.m.-11:30 a.m.
Type of Event: Webcast
https://medicare.fcso.com/Events/0366070.asp

Medicare Part A/B changes and regulations

Date: Wednesday, March 28
Time: 2:00-3:30 p.m.
Type of Event: Webcast
https://medicare.fcso.com/Events/0366056.asp

Note: Unless otherwise indicated, designated times for educational events are stated as ET, and the focus is to Florida, Puerto Rico, and the U.S. Virgin Islands.

Two easy ways to register

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

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

Fax – Providers without internet access may request a fax registration form through our Registration Hotline at 1-904-791-8103. Class materials will be faxed to you the day of the event.

Please Note:

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

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Provider Address: _____

City, State, ZIP Code: _____

Keep checking our website, *medicare.fcso.com*, for details and newly scheduled educational events (teleconferences, webcasts, etc.) or call the First Coast Provider Education Registration Hotline at 1-904-791-8103 to learn more about the about our newest training opportunities for providers.

Never miss a training opportunity

If you or your colleagues were unable to attend one of our past Medicare educational webcasts, you still have the opportunity to learn about the topics covered during the training session. Visit the First Coast Medicare training website, download the recording of the event, and listen to the webcast when you have the time.

Take advantage of 24-hour access to free online training

In addition to live training events, we also offer you the advantage of self-paced, free online courses that will allow you and your staff to train when and where it is most convenient for you. In addition, our comprehensive course catalog allows you to find the Medicare training that fits your specific needs, and several of our online courses offer CEUs. Learn more on the First Coast Medicare training website and explore our catalog of online courses.

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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® for February 2, 2017

MLN Connects® for February 2, 2017

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News & Announcements

- Clinical Laboratories: Prepare Now to Report Lab Data through March 31
- Updated Clinical Laboratory Fee Schedule Website
- Teaching Hospitals Receiving FTE Resident Caps Due to Hospital Closures
- February is American Heart Month

Provider Compliance

- Hospital Discharge Day Management Services

Upcoming Events

- Understanding and Promoting the Value of Chronic Care Management Services Call — February 21
- Looking Ahead: The IMPACT Act in 2017 Call — February 23

Medicare Learning Network® Publications & Multimedia

- Telehealth Services Fact Sheet — Revised
- Inpatient Rehabilitation Facility Prospective Payment System Fact Sheet — Revised
- Home Oxygen Therapy Booklet — Revised
- MLN Suite of Products & Resources for Rural Health Providers Educational Tool — Revised

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MLN Connects® for February 9, 2017

MLN Connects® for February 9, 2017

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News & Announcements

- Clinical Laboratories: Easier to Report Lab Data

Claims, Pricers & Codes

- January 2017 OPPS Pricer File

Upcoming Events

- Understanding and Promoting the Value of Chronic Care Management Services Call — February 21
- Looking Ahead: The IMPACT Act in 2017 Call — February 23

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MLN Connects® for February 16, 2017

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News & Announcements

Influenza Activity Continues: Are Your Patients Protected?

Upcoming Events

- Understanding and Promoting the Value of Chronic Care Management Services Call — February 21
- What's New with Physician Compare Webinar — February 21 and 23
- Looking Ahead: The IMPACT Act in 2017 Call — February 23

Medicare Learning Network® Publications & Multimedia

- Medicare Home Health Benefit Booklet — Revised
- Medicare Costs at a Glance: 2017 Educational Tool — Revised
- CMS Provider Minute Video: Nasal Endoscopy — Reminder

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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
904-791-8123

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

Reconsideration
C2C Innovative Solutions, Inc.
QIC Part A East Appeals
P. O. Box 45305
Jacksonville, FL 32232-5305

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)
(https://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)

Beneficiary customer service
1-800-MEDICARE (1-800-633-4227)

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