Medicare A Connection
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FIRST COAST SERVICE OPTIONS, INC.
A Newsletter for MAC Jurisdiction N Providers
February 2018

In this issue

NGACO year three benefit enhancements

Note: *This article was revised January 23, 2018, to reflect the revised change request (CR) 10044 issued November 22, 2017. In the article, the CR release date, transmittal number, and the web address of the CR are revised. All other information remains the same. This information was previously published in the August 2017 Medicare A Connection, page 6.*

Provider types affected

This *MLN Matters*® article is intended for providers who are participating in next generation accountable care organizations (NGACOs) and submitting claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

Provider action needed

CR 10044 provides instruction to MACs to implement two new benefit enhancements for performance year three (2018) of the NGACO model. MACs will process and pay claims for asynchronous telehealth and post-discharge home visit waiver services when those services meet the appropriate payment requirements as outlined in CR 10044. Make sure your billing staff is aware of these changes.

Background

The aim of the NGACO model is to improve the quality of care, population health outcomes, and patient experience for the beneficiaries who choose traditional Medicare fee-for-service (FFS) through greater alignment of financial incentives and greater access to tools that may aid beneficiaries and providers in achieving better health at lower costs.

In order to emphasize high-value services and support the ability of ACOs to manage the care of beneficiaries, the Centers for Medicare & Medicaid Services (CMS) is issuing the authority under Section 1115A of the Social Security Act (the Act) (Section 3021 of the Affordable Care Act) to conditionally waive certain Medicare payment requirements as part of the NGACO model.

Asynchronous telehealth

CMS is expanding the current telehealth waiver to include asynchronous (also known as “store-and-forward”) telehealth in the specialties of teledermatology and

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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.

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teleophthalmology. Asynchronous telehealth includes the transmission of recorded health history (for example, retinal scanning and digital images) through a secure electronic communications system to a practitioner, usually a specialist, who uses the information to evaluate the case or render a service outside of a real-time interaction. Asynchronous telecommunications system in single media format does not include telephone calls, images transmitted via facsimile machines, and text messages without visualization of the patient (electronic mail). Photographs must be specific to the patients' condition and adequate for rendering or confirming a diagnosis or treatment plan.

Payment will be permitted for telemedicine when asynchronous telehealth in single or multimedia formats, is used as a substitute for an interactive telecommunications system for dermatology and ophthalmology services. Distant-site practitioners will bill for these new services using new codes, and the distant-site practitioner must be an NGACO participant or preferred provider.

Asynchronous telehealth based on intra-service plus five minutes post-service time

- **Code 1:** G9868– Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation, for use under the next generation ACO model, less than 10 minutes.
- **Code 2:** G9869– Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation, for use under the next generation ACO model, 10-20 minutes.
- **Code 3**: G9870 – Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation, for use under the next generation ACO model, 20 or more minutes.

Additional information

The official instruction, CR 10044, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R187DEMO.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/MonitoringPrograms/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/*.

Document history

Date of change	Description
August 4, 2017	Initial article released
January 23, 2018	The article was revised to reflect the revised CR 10044 issued November 22, 2017. In the article, the CR release date, transmittal number, and the web address of the CR are revised. All other information is the same.

MLN Matters® Number: MM10044 *Revised*
Related Change Request (CR) Number: 10044
Related CR Release Date: November 22, 2017
Effective Date: January 1, 2018
Related CR Transmittal Number: R187DEMO
Implementation Date: January 2, 2018

New Medicare cards

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, requires the Centers for Medicare & Medicaid Services (CMS) to remove Social Security numbers (SSNs) from all Medicare cards by April 2019. A new Medicare beneficiary identifier (MBI) will replace the SSN-based health insurance claim number (HICN) on the new Medicare cards for Medicare transactions like billing, eligibility status, and claim status.

The new Medicare cards will be mailed between April 2018 and April 2019. Resources are available to prepare you for this change at *https://medicare.fcso.com/Claim_submission_guidelines/0380240.asp*.

Processing Issue

NCD 110.21 Erythropoiesis Stimulating Agents (ESAs) in cancer

Issue

Change request (CR) 10318 dated November 9, 2017, addresses edits for NCD 110.21, ESAs in cancer. Those edits are to be implemented on April 2, 2018, and are included in business requirement (BR) 10318.10.

Resolution

Medicare administrative contractors (MACs) are instructed to temporarily deactivate the shared system edits associated with NCD 110.21 from October 1, 2017, until further notice.

Status/date resolved

Open.

Provider action

None.

Current processing issues

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

Handling of claims inappropriately assigned reason code 32404

Issue

It has come to the Centers for Medicare & Medicaid Services' (CMS') attention that institutional claims are inappropriately rejecting with reason code 32404 when a revenue code between 030x-031x is submitted with a laboratory HCPCS that is not a clinical diagnostic lab code.

Resolution

A system fix is scheduled to be implemented March 5, 2018. In the interim, CMS will hold all institutional claims with reason code 32404 assigned except federally qualified health center (FQHC) and rural health clinic (RHC) claims. Held claims will be automatically released once the fix is implemented.

Status/date resolved

Open

Provider action

Until the fix is implemented, FQHC and RHC claims will be returned to provider (RTP). As a workaround, FQHC and RHC providers are advised to remove claim line(s) that have been assigned reason code 32404 and resubmit the claim. This action will not affect payment. Providers may discontinue this workaround after March 5, 2018.

Current processing issues

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

General Information

Reinstating the QMB indicator in the Medicare fee-for-service claim processing system from CR 9911

Provider type affected

This *MLN Matters*® article is intended for providers and suppliers who submit claims to Part A/B Medicare administrative contractors (MACs).

What you need to know

Effective with change request (CR) 10433, the Centers for Medicare & Medicaid Services (CMS) will reintroduce qualified Medicare beneficiary (QMB) information in the Medicare remittance advice (RA) and Medicare summary notice (MSN). CR 9911 modified the fee-for-service (FFS) systems to indicate the QMB status and zero cost-sharing liability of beneficiaries on RAs and MSNs for claims processed on or after October 2, 2017. On December 8, 2017, CMS suspended CR 9911 to address unforeseen issues preventing the processing of QMB cost-sharing claims by states and other secondary payers outside of the coordination of benefits agreement (COBA) process. CR 10433 remediates these issues by including revised "alert" remittance advice remark codes (RARC) in RAs for QMB claims without adopting other RA changes that impeded claim processing by secondary payers. CR 10433 reinstates all changes to the MSNs under CR 9911. Please make sure your billing staff is aware of these changes.

Background

Federal law bars Medicare providers and suppliers from billing an individual enrolled in the QMB program for Medicare Part A and Part B cost-sharing under any circumstances. (See Sections 1902(n)(3)(B), 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A), and 1848(g)(3)(A) of the Social Security Act.) The QMB program is a State Medicaid benefit that assists low-income Medicare beneficiaries with Medicare Part A and Part B premiums and cost-sharing, including deductibles, coinsurance, and copays. In 2015, 7.2 million individuals (more than one out of 10 beneficiaries) were enrolled in the QMB program.

Providers and suppliers may bill state Medicaid agencies for Medicare cost-sharing amounts. However, as permitted by Federal law, states may limit Medicare cost-sharing

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payments, under certain circumstances. Be aware, persons enrolled in the QMB program have no legal liability to pay Medicare providers for Medicare Part A or Part B cost-sharing.

System changes to assist providers under CR 9911

To help providers more readily identify the QMB status of their patients, CR 9911 introduced a QMB indicator in the claims processing system for the first time. CR 9911 is part of the CMS ongoing effort to give providers tools to comply with the statutory prohibition on collecting Medicare A/B cost-sharing from QMBs.

Through CR 9911, CMS indicated the QMB status and zero cost-sharing liability of beneficiaries in the RA and MSN for claims processed on or after October 2, 2017. In particular, CR 9911 changed the MSN to include new messages for QMB beneficiaries and reflect $0 cost-sharing liability for the period they are enrolled in QMB. In addition, CMS modified the RA to include new alert RARCs to notify providers to refrain from collecting Medicare cost-sharing because the patient is a QMB (N781 is associated with deductible amounts and N782 is associated with coinsurance).

Additionally, CR 9911 changed the display of patient responsibility on the RA by replacing claim adjustment group code “patient responsibility” (PR) with group code “other adjustment” (OA). CMS zeroed out the deductible and coinsurance amounts associated with claim adjustment reason code (CARC) 1 (deductible) and/or 2 (coinsurance) and used CARC 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 the patient if collected. (Use only with group code OA).”) However, the changes to the display of patient liability in the RAs for QMB claims caused unforeseen issues affecting the processing of QMB cost-sharing claims directly submitted by providers to states and other payers secondary to Medicare. Providers rely on RAs to bill state Medicaid Agencies and other secondary payers outside the Medicare COBA claims crossover process. States and other secondary payers generally require RAs that separately display the Medicare deductible and coinsurance amounts with the claim adjustment group code “PR” and associated CARC codes and could not process claims involving the RA changes from CR 9911. Barriers to the processing of secondary claims have additional implications for institutional providers that claim bad debt under the Medicare program since they must obtain a Medicaid remittance advice to seek reimbursement for unpaid deductibles and coinsurance as a Medicare bad debt for QMBs.

To address these issues, on December 8, 2017, CMS suspended the CR 9911 system changes causing the claim processing systems to suspend the RA and MSN changes for QMB claims under CR 9911.

Reintroduction of QMB information in the MA and MSN under CR 10433

Effective with CR 10433, the claim processing systems will reintroduce QMB information in the RA without impeding claim processing by secondary payers.

The RA for QMB claims will retain the display of patient liability amounts needed by secondary payers to process QMB cost-sharing claims. CMS systems shall output claim adjustment group code “PR” along with CARC 1 and/or 2, as applicable, with monetary values expressed on outbound Medicare 835 electronic remittance advices (ERAs) and on standard paper remittance advices (SPRs), as applicable. Medicare’s shared systems shall discontinue the practice of outputting claim adjustment group code OA with CARC 209 and reflecting the CARC 1 and 2 monetary amounts as zero.

The shared systems shall include the revised alert RARCs N781 and N782 in association with CARCs 1 and/or 2 on the RA. These RARCs designate that the beneficiary is enrolled in the QMB program and may not be billed for Medicare cost sharing amounts. Additionally, for QMB claims, the Part A and B shared systems shall include the revised alert RARC N781 in association with CARC 66 (blood deductible). The revised alert RARCs are as follows:

- N781 - Alert: Patient is a Medicaid/ Qualified Medicare Beneficiary. Review your records for any wrongfully collected deductible. This amount may be billed to a subsequent payer.
- N782 – Alert: Patient is a Medicaid/ Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance. This amount may be billed to a subsequent payer.

CR 10433 reestablishes all CR 9911 changes to the MSN by including QMB messages and reflecting $0 cost-sharing liability for the period beneficiaries are enrolled in QMB.

Additional information

The official instruction, CR 10433, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R3965CP.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/*.

Document history

Date of change	Description
February 2, 2018	Initial article released.

MLN Matters® Number: MM10433
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Implementation Date: For claims processed on or after July 2, 2018

Hurricane Nate and Medicare disaster-related Alabama, Florida, Louisiana, and Mississippi claims

***Note**: This article was revised on January 19, 2018, to advise providers that the public health emergency declaration and Section 1135 waiver authority has expired as noted below. All other information remains the same. This information was previously published in the October 2017 Medicare A Connection, pages 5-7.*

Provider type affected

This *MLN Matters*® special edition article is intended for providers and suppliers who submit claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries in the states of Alabama, Florida, Louisiana, and Mississippi, who were affected by Hurricane Nate.

Provider information available

Pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, President Trump declared that, as a result of the effects of Hurricane Nate, an emergency exists in Alabama, Florida, Louisiana, and Mississippi.

On October 8, 2017, Acting Secretary Wright of the Department of Health & Human Services declared that a public health emergency exists in the states of Louisiana retroactive to October 5, 2017; Mississippi, and Alabama retroactive to October 6, 2017; and Florida retroactive to October 7, 2017, and authorized waivers and modifications under §1135 of the Social Security Act.

The Public Health Emergency declaration and Social Security Act waivers including the Section 1135 waiver authority expired as follows:

- The authority expired on January 2, 2018, for Louisiana.
- The authority expired on January 3, 2018, for Alabama and Mississippi.
- The authority expired on January 4, 2018, for Florida.

On October 10, 2017, the Administrator of the Centers for Medicare & Medicaid Services (CMS) authorized waivers under §1812(f) of the Social Security Act for the States of Louisiana retroactive to October 5, 2017; Mississippi, and Alabama retroactive to October 6, 2017; and Florida retroactive to October 7, 2017, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of Hurricane Nate in 2017. These waivers will prevent gaps in access to care for beneficiaries impacted by the emergency. Providers do not need to apply for an individual waiver if a blanket waiver has been issued. Providers can request an individual Section 1135 waiver, if there is no blanket waiver, by following the instructions available at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Requesting-an-1135-Waiver-Updated-11-16-2016.pdf*.

The most current waiver information can be found at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Hurricanes.html*. See the *Background* section of this article for more details.

Background

Section 1135 and Section 1812(f) Waivers

As a result of the aforementioned declaration, CMS has instructed the MACs as follows:

Change request (CR) 6451 (Transmittal 1784, Publication 100-04) issued on July 31, 2009, applies to items and services furnished to Medicare beneficiaries within the within Alabama, Florida, Louisiana and Mississippi for the duration of the emergency. In accordance with CR 6451, use of the "DR" condition code and the "CR" modifier are mandatory on claims for items and services for which Medicare payment is conditioned on the presence of a "formal waiver" including, but not necessarily limited to, waivers granted under either Section 1135 or Section 1812(f) of the Act.

The most current information can be found at *https://www.cms.gov/emergency* posted in the downloads section at the bottom of the Emergency Response and Recovery webpage.

Also referenced below are Q&As that are applicable for items and services furnished to Medicare beneficiaries within the Alabama, Florida, Louisiana, and Mississippi. These Q&As are displayed in two files:

- One file addresses policies and procedures that are applicable **without** any Section 1135 or other formal waiver. These policies are always applicable in any kind of emergency or disaster, including the current emergency in Alabama, Florida, Louisiana and Mississippi.
- Another file addresses policies and procedures that are applicable **only with** approved Section 1135 waivers or, when applicable, approved Section 1812(f) waivers. These Q&As are applicable for approved Section 1135 blanket waivers and approved individual 1135 waivers requested by providers for Alabama, Florida, Louisiana, and Mississippi.

In both cases, the links below will open the most current document. The date included in the document filename will change as new information is added, or existing information is revised.

a. Q&As applicable **without any Section 1135** or other formal waiver are available at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Consolidated_Medicare_FFS_Emergency_QsAs.pdf*.

b. Q&As applicable **only with a Section 1135** waiver or, when applicable, a Section 1812(f) waiver, are available at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/MedicareFFS-EmergencyQsAs1135Waiver.pdf*.

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Blanket waivers for Alabama, Florida, Louisiana, and Mississippi

Under the authority of Section 1135 (or, as noted below, Section 1812(f)), CMS has issued the following blanket waivers in the affected areas of Alabama, Florida, Louisiana and Mississippi. Individual facilities do not need to apply for the following approved blanket waivers.

Skilled nursing facilities

- Section 1812(f): Waiver of the requirement for a three-day prior hospitalization for coverage of a skilled nursing facility (SNF) stay provides temporary emergency coverage of SNF services without a qualifying hospital stay, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of Hurricane Nate in Alabama, Florida, Louisiana, and Mississippi in 2017. In addition, for certain beneficiaries who recently exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period. (Blanket waiver for all impacted facilities).
- 42 CFR 483.20: Waiver provides relief to skilled nursing facilities on the timeframe requirements for minimum data set assessments and transmission. (Blanket waiver for all impacted facilities)

Home health agencies

42 CFR 484.20(c)(1): This waiver provides relief to home health agencies on the timeframes related to OASIS transmission (Blanket waiver for all impacted agencies)

Critical access hospitals

This action waives the requirements that critical access hospitals limit the number of beds to 25, and that the length of stay be limited to 96 hours (Blanket waiver for all impacted hospitals).

Housing acute care patients in excluded distinct part units

CMS has determined it is appropriate to issue a blanket waiver to IPPS hospitals that, as a result of Hurricane Nate, need to house acute care inpatients in excluded distinct part units, where the distinct part unit's beds are appropriate for acute care inpatient. The IPPS hospital should bill for the care and annotate the patient's medical record to indicate the patient is an acute care inpatient being housed in the excluded unit because of capacity issues related to the hurricane. (Blanket waiver for all IPPS hospitals located in the affected areas that need to use distinct part beds for acute care patients as a result of the hurricane.)

Durable medical equipment

- As a result of Hurricane Nate, CMS has determined it is appropriate to issue a blanket waiver to suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) where DMEPOS is lost, destroyed, irreparably damaged, or otherwise rendered unusable. Under this waiver, the face-to-face requirement, a new physician's order, and new medical necessity documentation are not required for replacement. Suppliers must still include a narrative description on the claim explaining the reason why the equipment must be replaced and are reminded to maintain documentation indicating that the DMEPOS was lost, destroyed, irreparably damaged or otherwise rendered unusable as a result of the hurricane.
- As a result of Hurricane Nate, CMS is temporarily extending the 10-business day deadline to provide notification of any subcontracting arrangements. During the temporary extension period, affected contract suppliers will have 30-business days to provide notice to the competitive bidding implementation contractor of any subcontracting arrangements. CMS will notify DMEPOS competitive bidding contract suppliers via e-mail when this temporary extension expires. All other competitive bidding program requirements remain in force. **Note**: CMS will provide notice of any changes to reporting timeframes for future events.
- For more information refer to the *Durable Medical Equipment, Prosthetics, Orthotics, and Supplies for Medicare Beneficiaries Impacted by an Emergency or Disaster* fact sheet at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Emergency-DME-Beneficiaries-pdf*.

Replacement prescription fills

Medicare payment may be permitted for replacement prescription fills (for a quantity up to the amount originally dispensed) of covered Part B drugs in circumstances where dispensed medication has been lost or otherwise rendered unusable by damage due to the emergency.

Care for excluded inpatient psychiatric unit patients in the acute care unit of a hospital

CMS has determined it is appropriate to issue a blanket waiver to IPPS and other acute care hospitals with excluded distinct part inpatient psychiatric units that, as a result of Hurricane Nate, need to relocate inpatients from the excluded distinct part psychiatric unit to an acute care bed and unit. The hospital should continue to bill for inpatient psychiatric services under the inpatient psychiatric facility prospective payment system for such patients and annotate the medical record to indicate the patient is a psychiatric inpatient being cared for in an acute care bed because of capacity or other exigent circumstances related to the hurricane. This waiver may be utilized where the hospital's acute care beds are appropriate for psychiatric patients and the staff and environment are conducive to safe care. For psychiatric patients, this includes assessment of the acute care bed and unit location to ensure those patients at risk of harm to self and others are safely cared for.

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Care for excluded inpatient rehabilitation unit patients in the acute care unit of a hospital

CMS has determined it is appropriate to issue a blanket waiver to IPPS and other acute care hospitals with excluded distinct part inpatient Rehabilitation units that, as a result of Hurricane Nate, need to relocate inpatients from the excluded distinct part Rehabilitation unit to an acute care bed and unit. The hospital should continue to bill for inpatient rehabilitation services under the inpatient rehabilitation facility prospective payment system for such patients and annotate the medical record to indicate the patient is a rehabilitation inpatient being cared for in an acute care bed because of capacity or other exigent circumstances related to the hurricane. This waiver may be utilized where the hospital's acute care beds are appropriate for providing care to rehabilitation patients and such patients continue to receive intensive rehabilitation services.

These temporary emergency policies would apply to the timeframes specified in the waiver(s) issued under Section 1135 of the Act in connection with the effect of Hurricane Nate in Alabama, Florida, Louisiana, and Mississippi. More information is available in the 1135 waiver letter, which is posted in the Downloads section at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Hurricanes.html*.

Requesting an 1135 waiver

Information for requesting an 1135 waiver, when a blanket waiver hasn't been approved, can be found at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Requesting-an-1135-Waiver-Updated-11-16-2016.pdf*.

Additional information

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/*.

The Centers for Disease Control and Prevention released *ICD-10-CM coding advice* to report healthcare encounters in the hurricane aftermath.

Document history

Date of change	Description
January 19, 2018	The article was revised to include information on the expiration of the public health emergency declaration and Section 1135 waiver authority.
October 11, 2017	Initial article released.

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Non-provider entities or providers who need additional copies may purchase an annual hardcopy subscription. This subscription includes all issues published in the current fiscal year.

To order an annual subscription, complete the *Medicare A Connection Subscription Form, **located here***.

This section of *Medicare A Connection* features summaries of new and revised local coverage determinations (LCDs) developed as a result of either local medical review or comprehensive data analysis initiatives. These initiatives are designed to ensure the appropriateness of medical care and to make sure that the Medicare administrative contractor (MAC) jurisdiction 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 *https://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 *https://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 *https://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.

Search capability simplifies LCD lookup

Providers in need of a quick and direct method to locate local coverage determinations (LCDs) by procedure code have a simple way to do so by using First Coast Service Options' website search functionality.

Providers can simply enter a procedure code, keyword, or ICD-10 code into the website search bar and search "LCDs only" to find the matching results. This search function replaces the multiple steps previously required by other methods, and lets providers locate the corresponding LCDs by using First Coast's own LCD data.

Click here for more information.

Retired LCDs

Multiple Part A and Part B LCDs being retired

LCD ID number: L33985, L33990, L33991, L34013 (Florida, Puerto Rico/U.S. Virgin Islands)

Based on an annual review and data analysis review of the following local coverage determinations (LCDs), it was determined that these LCDs are no longer required and, therefore, are being retired.

L33985 – Transplantation Immune Cell Function Assay (ImmuKnow®)

L33990 – Doxorubicin HCl

L33991 – Endoscopic and Percutaneous Lysis of Epidural Adhesions

L34013 – Lung Volume Reduction Surgery

Effective date

The retirement of these LCDs is effective for services rendered **on or after February 15, 2018.** LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

A coding article for an LCD (when present) may be found by selecting “Related Local Coverage Documents” 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*.

Revisions to LCD

Major joint replacement (hip and knee) – revision to the Part A and Part B LCD

LCD ID number: L33618 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for major joint replacement (hip and knee) was revised to add ICD-10-CM diagnosis code Z47.32 to the “ICD-10-CM Diagnosis Codes for Total Hip Arthroplasty” section of the LCD and ICD-10-CM diagnosis code Z47.33 to the “ICD-10-CM Diagnosis Codes for Total Knee Arthroplasty” section of the LCD. Also, the “Sources of Information and Basis for Decision” section of the LCD was updated. In addition, based on an annual review of the LCD, it was determined that some of the italicized language in the “Documentation Requirements” section of the LCD does not represent direct quotation from the Centers for Medicare & Medicaid Services (CMS) sources listed in the LCD; therefore, this LCD was revised to assure consistency with the CMS sources.

Effective date

This LCD revision is effective for services rendered **on or after February 15, 2018.** LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

A coding article for an LCD (when present) may be found by selecting “Related Local Coverage Documents” 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*.

Multiple Part A/B and Part B local coverage determination revisions

First Coast Service Options Inc. has revised the "ICD-10 Codes that Support Medical Necessity" section of multiple local coverage determinations (LCDs) to include an explanation that all the codes within an ICD-10-CM diagnosis code asterisked range from the first code to the last code apply.

The following is a list of the impacted LCDs:

Part A/B Combined LCDs

L33270 Bisphosphonates (Intravenous [IV]) and Monoclonal Antibodies in the Treatment of Osteoporosis and Their Other Indications

L36356 Bone mineral density studies

L33273 Bortezomib (Velcade®)

L33274 Botulinum Toxins

L33669 Electrocardiography

L36276 Erythropoiesis Stimulating Agents

L33661 Flow Cytometry

L33726 Gemcitabine (Gemzar®)

L34912 Genetic Testing for Lynch Syndrome

L33538 Radiation Therapy for T1 Basal Cell and Squamous Cell Carcinomas of the Skin

L34021 Sedimentation Rate, Erythrocyte

L36035 Spinal Cord Stimulation for Chronic Pain

L33410 Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiation Therapy (SBRT)

L33771 Vitamin D; 25 hydroxy, includes fraction(s), if performed

L33774 Wireless Capsule Endoscopy

Part B only LCDs

L33804 Allergen Immunotherapy

L33810 Computerized Corneal Topography

L33941 Routine Foot Care

L33963 Tympanometry

L33967 Vitamin B12 Injections

Effective date

All the LCD revisions above except for Tympanometry are effective for claims processed **on or after February 8, 2018**. The LCD revision for Tympanometry is effective for claims processed **on or after February 8, 2018**, for services rendered **on or after September 23, 2002**. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

A coding article for an LCD (when present) may be found by selecting "Related Local Coverage Documents" 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*.

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.

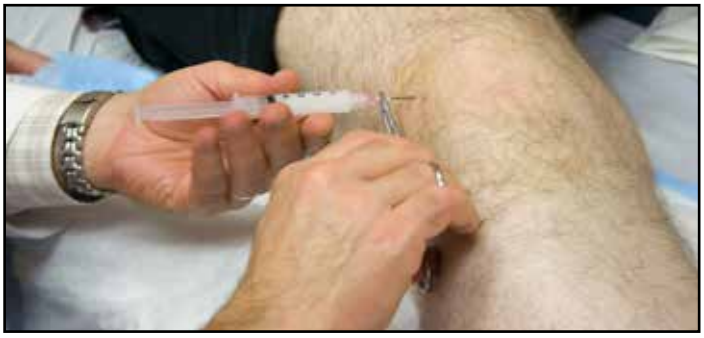
Viscosupplementation therapy for knee – revision to the Part A and Part B LCD

LCD ID number: L33767 (Florida, Puerto Rico/ U.S. Virgin Islands)

The "Utilization Guidelines" section of the local coverage determination (LCD) for viscosupplementation therapy for knee was revised to clarify the drugs that are administered as a single intra-articular injection per course of treatment and the drugs that are administered as an intra-articular injection over multiple weeks per course of treatment. In addition, a single course of treatment should be given no more than once every six months.

Effective date

This LCD revision is effective for claims processed **on or after February 8, 2018.** LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.



A coding article for an LCD (when present) may be found by selecting "Related Local Coverage Documents" 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*.

Revisions to LCD

Self-administered drug (SAD) list – revision to the Part A and Part B article

LCD ID number: A52571 (Florida, Puerto Rico/ U.S. Virgin Islands)

The Centers for Medicare & Medicaid Services (CMS) provide instructions to contractors regarding Medicare payment for drugs and biologicals incident to a physician's service. The instructions also provide contractors with a process for determining if an injectable drug is usually self-administered and therefore not covered by Medicare. Guidelines for the evaluation of drugs for the list of excluded self-administered injectable drugs incident to a physician's service are in the *Medicare Benefit Policy Manual*, Pub. 100-02, Chapter 15, Section 50.2.

Effective for services rendered **on or after April 2, 2018,** Haegarda® (c1 esterase inhibitor subcutaneous [human]) (J3490/J3590) has been added to the Medicare administrative contractor (MAC) Jurisdiction N (JN) self-administered drug (SAD) list.

The evaluation of drugs for addition to the SAD list is an ongoing process. Providers are responsible for monitoring the SAD list for the addition or deletion of drugs.

The First Coast Service Options Inc. (First Coast) SAD list is available at: *https://medicare.fcso.com/Self-administered_drugs/*.

Looking for LCDs?

Would you like to find local coverage determinations (LCD) in 10 seconds or less? First Coast's LCD lookup, available at *https://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.

Global surgical days for critical access hospital method II

Provider type affected

This *MLN Matters*® article is intended for critical access hospital (CAH) method II providers submitting claims to A/B Medicare administrative contractors (A/B MACs) for services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 10425 which discusses the global surgical days for method II CAH providers. CR 10425 contains no new policy. It improves the implementation of existing Medicare payment policies. Make sure that your billing staffs are aware of these changes.

Background

CR 10425 is for the global surgical periods for CAH method II providers to mirror the logic historically applied to physicians and non-physician practitioners that bill their own services to Medicare's multi-carrier system (MCS).

Physicians and non-physician practitioners billing on type of bill (TOB) 85x for professional services rendered in a method II CAH have the option of reassigning their billing rights to the CAH. When the billing rights are reassigned to the method II CAH, payment is made to the CAH for professional services (using revenue codes 96x, 97x, or 98x) based on the Medicare physician fee schedule (MPFS) supplemental file.

The global surgical package, also called global surgery, includes all necessary services normally furnished by a surgeon before, during, and after a procedure. Medicare payment for the surgical procedure includes the pre-operative, intra-operative, and post-operative services routinely performed by the surgeon or by members of the same group with the same specialty.

Position 13-15 of the MPFS Data Base provides the postoperative periods that apply to each surgical procedure.

The payment rules for surgical procedures apply to codes with entries of 000, 010, 090, and, sometimes, YYY, and are defined below. This field provides the postoperative time frames that apply to payment for each surgical procedure or another indicator that describes the applicability of the global concept to the service.

• 000 = Endoscopic or minor procedure with related preoperative and postoperative relative values on the day of the procedure only included in the fee schedule payment amount; evaluation and management services on the day of the procedure generally not payable.

- 010 = Minor procedure with preoperative relative values on the day of the procedure and postoperative relative values during a 10-day postoperative period included in the fee schedule amount; evaluation and management services on the day of the procedure and during this 10-day postoperative period generally not payable.
- 090 = Major surgery with a (one) 1-day preoperative period and 90-day postoperative period included in the fee schedule payment amount.
- XXX = Global concept does not apply.
- YYY = A/B MAC (Part A) determines whether global concept applies and establishes postoperative period, if appropriate, at time of pricing.

Codes with "YYY" are A/B MAC (Part B)-priced codes, for which A/B MACs (Part B) determine the global period (the global period for these codes will be 0, 10, or 90 days). Note that not all A/B MAC (Part B)-priced codes have a "YYY" global surgical indicator; sometimes the global period is specified.

CAH method II providers should follow the same guidelines as per Part B physician services that are available in the *Medicare Claims Processing Manual (Pub. 100-04, Chapter 12; (Physicians/Nonphysician Practitioners), Section 40 (Surgeons and Global Surgery))*.

Note that Medicare will reject line items that contain an E/M CPT® code (92012, 92014, 99211-99215, 99217-99223, 99231-99236, 99238, 99239, 99241-99245, 99251-99255, 99261-99263, 99271-99275, 99291, 99292, 99301-99303, 99311-99313, 99315, 99316, 99331-99333, 99347-99350, 99374, 99375, 99377, and 99378) that is covered by the global period using the following remittance codes:

- Group code of CO - contractual obligation
- Claim adjustment reason code 97 – Payment is included in the allowance for another service/procedure
- Remittance advice remark code M144 – Pre-/post-operative care payment is included in the allowance for the surgery/procedure.

MACs, however, will allow E/M services rendered during the global period when submitted with modifier 24 or 25, as appropriate.

Additional information

The official instruction, CR 10425, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R2013OTN.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/*.

Document history

Date of change	Description
January 26, 2018	Initial article released.

MLN Matters® Number: MM10425
Related CR Release Date: January 26, 2018
Related CR Transmittal Number: R2013OTN
Related Change Request (CR) Number: 10425
Effective Date: July 1, 2018
Implementation Date: July 2, 2018

E/M service documentation provided by students – manual update

Provider type affected

This *MLN Matters*® article is intended for teaching physicians billing Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 10412 revises the *Medicare Claims Processing Manual* to allow the teaching physician to verify in the medical record any student documentation of components of E/M services, rather than re-documenting the work. Make sure your billing staffs are aware of the changes.

Background

The Centers for Medicare & Medicaid Services (CMS) is revising the *Medicare Claims Processing Manual*, Chapter 12, Section 100.1.1, to update policy on evaluation and management (E/M) documentation to allow the teaching physician to verify in the medical record any student documentation of components of E/M services, rather than re-documenting the work. Students may document services in the medical record. However, the teaching physician must verify in the medical record all student documentation or findings, including history, physical exam and/or medical decision making. The teaching physician must personally perform (or re-perform) the physical exam and medical decision making activities of the E/M service being billed, but may verify any student documentation of them in the medical record, rather than re-documenting this work.

Additional information

The official instruction, CR 10412, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R3971CP.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/*.

Document history

Date of change	Description
February 5, 2017	Initial article released.

MLN Matters® Number: MM10412
Related CR Release Date: February 2, 2018
Related CR Transmittal Number: R3971CP
Related Change Request (CR) Number: 10412
Effective Date: January 1, 2018
Implementation Date: March 5, 2018

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Next generation accountable care organization – implementation

***Note**: This article was revised January 23, 2018, to revise the "Telehealth expansion" portion of the article and to add Attachment A to the article. This information was previously published in the August 2016 Medicare A Connection, pages 11-13.*

Provider types affected

This *MLN Matters*® article is intended for providers who are participating in next generation accountable care organizations (NGACOs) and submitting claims to Medicare administrative contractors (MACs) for certain skilled nursing facility, telehealth, and post-discharge home visit services to Medicare beneficiaries that would not otherwise be covered by original fee-for-service (FFS) Medicare.

Provider action needed

This *MLN Matters*® special edition article provides information on the NGACO model's benefit enhancement waiver initiatives and supplemental claim processing direction. Make sure that your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) implemented the next generation ACO model (NGACO or the model) January 1, 2016. The model is the first in the next generation of ACO provider-based models that will test opportunities for increased innovation around care coordination and management through greater accountability for the total cost of care.

The aim of the model is to improve the quality of care, population health outcomes, and patient experience for the beneficiaries who choose traditional Medicare FFS through greater alignment of financial incentives and greater access to tools that may aid beneficiaries and providers in achieving better health at lower costs.

Core principles of the model are:

- Protecting Medicare FFS beneficiaries' freedom to seek the services and providers of their choice
- Creating a financial model with long-term sustainability
- Utilizing a prospectively set benchmark that:
  - Rewards quality
  - Rewards both attainment of and improvement in efficiency, and
  - Ultimately transitions away from updating benchmarks based on the ACO's recent expenditures
- Engaging beneficiaries in their care through benefit enhancements that directly improve the patient experience and incentivize coordinated care from ACOs
- Mitigating fluctuations in aligned beneficiary populations and respecting beneficiary preferences through supplementing a prospective claims-based alignment process with a voluntary process, and
- Smoothing ACO cash flow and improving investment capabilities through alternative payment mechanisms.

Additional information on NGACO is available at *https://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/*.

Participants and preferred providers

NGACO defines two categories of providers/suppliers and their respective relationships to the ACO entity: Next generation participants and next generation preferred providers. Next generation participants are the core providers/suppliers in the model. Beneficiaries are aligned to the ACO through the next generation participants and these providers/suppliers are responsible for, among other things, reporting quality through the ACO and committing to beneficiary care improvement. Preferred providers contribute to ACO goals by extending and facilitating valuable care relationships beyond the ACO. For example, preferred providers may participate in certain benefit enhancements. Services furnished by preferred providers will not be considered in alignment and preferred providers are not responsible for reporting quality through the ACO. (see Table 5.1 at end of article)

Three benefit enhancements

In order to emphasize high-value services and support the ability of ACOs to manage the care of beneficiaries, CMS uses the authority under Section 1115A of the Social Security Act (Section 3021 of the Affordable Care Act) to conditionally waive certain Medicare payment requirements as part of the NGACO model. An ACO may choose not to implement all or any of these benefit enhancements.

1. Three-day SNF rule waiver

CMS makes available to qualified NGACOs a waiver of the three-day inpatient stay requirement prior to admission to a SNF or acute-care hospital or critical access hospital (CAH) with swing-bed approval for SNF services ("swing-bed hospital"). This benefit enhancement allows beneficiaries to be admitted to qualified next generation ACO SNF participants and preferred providers either directly or with an inpatient stay of fewer than three days. The waiver will apply only to eligible aligned beneficiaries admitted to next generation ACO SNF participants and preferred providers.

An aligned beneficiary will be eligible for admission in accordance with this waiver if:

1) The beneficiary does not reside in a nursing home, SNF, or long-term nursing facility and receiving Medicaid at the time of the decision to admit to an SNF, and
2) The beneficiary meets all other CMS criteria for SNF admission, including that the beneficiary must:
   a. Be medically stable
   b. Have confirmed diagnoses (for example, does not have conditions that require further testing for

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proper diagnosis)

c. Not require inpatient hospital evaluation or treatment; and

d. Have an identical skilled nursing or rehabilitation need that cannot be provided on an outpatient basis or through home health services.

NGACOs identify the SNF participant and preferred providers with which they will partner in this waiver through the annual submission of next generation participant and preferred provider lists.

Claims

Next generation model three-day SNF rule waiver claims do not require a demo code to be manually affixed to the claim. When a qualifying stay does not exist, the fiscal intermediary standard system (FISS) checks whether 1) the beneficiary is aligned to an NGACO approved to use the SNF three-day rule waiver; 2) the SNF provider is also approved to use the waiver; and 3) the SNF is a provider for the same NGACO for which the beneficiary is aligned. Once eligibility is confirmed, demo code 74 (for the NGACO model) and indicator value 4 (for the three-day SNF rule waiver) is placed on the claim.

If an eligible NGACO SNF three-day waiver claim includes demo code 62 (for the BPCI model 2 SNF three-day rule waiver), for example, the FISS will not check to validate whether the claim is a valid NGACO SNF three-day rule waiver. CMS has instructed that FISS only validate when no demo code has been affixed and no qualifying three-day inpatient hospital stay has been met.

To assist MACs in troubleshooting provider SNF three-day rule waiver claim questions, CMS instructed the FISS and the multi-carrier system (MCS) maintainers to create screens. The FISS maintainer created a sub-menu of the 6Q – CMS demonstrations screen to allow for inquiry of both the NGACO provider file data and the NGACO beneficiary file data. The screen shows the following data value for this waiver: Three-day SNF waiver = value 4. The MCS maintainer created two screens to allow for SNF three-day rule waiver validation inquiry as listed:

- MCS created screen PROVIDER ACCOUNTABLE CARE ORGANIZATION (ACO) so that MACs would be able to see which ACO a provider is aligned with.
- MCS created screen BENEFICIARY ACCOUNTABLE CARE ORGANIZATION (ACO) so that MACs would be able to see which ACO a beneficiary is aligned with.

2. Telehealth expansion

CMS makes available to qualified NGACOs a waiver of the requirement that beneficiaries be located in a rural area and at a specified type of originating site in order to be eligible to receive telehealth services. This benefit enhancement will allow payment of claims for telehealth services delivered by Next Generation ACO Participants or Preferred Providers to aligned beneficiaries in specified facilities or at their residence regardless of the geographic location of the beneficiary.

Claims

The telehealth services originating at the beneficiary's home (in a rural or non-rural geographic setting) is billed under the Medicare physician fee schedule (MPFS) with one of nine HCPCS G-codes used for the NGACO and comprehensive joint replacement models telehealth home visits, as listed in Attachment A (see page XX). The telehealth home visit HCPCS codes are payable for beneficiaries beginning January 1, 2018. Claims submitted for telehealth home visits for the NGACO model will be accepted when the claim contains one of nine of the NGACO specific HCPCS G-Code. CMS is associating the demonstration code 74 with the NGACO initiative. Additional information on billing and payment for the telehealth home visit HCPCS G-codes are available in the MPFS. Future updates to the RVUs and payment for these HCPCS codes will be included in the MPFS final rules and recurring updates each year.

For those telehealth services originating in a non-rural area a provider does not need to insert a demonstration code in order for the claim to process successfully.

Notwithstanding these waivers, all telehealth services must be furnished in accordance with all other Medicare coverage and payment criteria, and no additional reimbursement will be made to cover set-up costs, technology purchases, training and education, or other related costs. In particular, the services allowed through telehealth are limited to those described under Section 1834(m)(4)(F) of the Social Security Act and subsequent additional services specified through regulation.

3. Post-discharge home visits

CMS makes available to qualified NGACOs waivers to allow "incident to" claims for home visits to non-homebound aligned beneficiaries by licensed clinicians under the general supervision—instead of direct supervision—of next generation participants or preferred providers.

Licensed clinicians, as defined in 42 C.F.R. § 410.26(a)(1), may be any employees, leased employees, or independent contractors who are licensed under applicable state law to perform the ordered services under physician (or other practitioner) supervision. A participant or preferred provider may contract with licensed clinicians to provide this service and the service is billed by the participant or preferred provider.

Claims for these visits will only be allowed following discharge from an inpatient facility (including, for example, inpatient prospective payment system (IPPS) hospitals, critical access hospitals (CAHs), SNFs, inpatient rehabilitation facilities (IRFs) and will be limited to no more than one visit in the first 10 days following discharge and no more than one visit in the subsequent 20 days. Payment of claims for these visits will be allowed as services and supplies that are incident to the service of a physician or other practitioner as described under 42 CFR §410.26. This provision is not generally applicable to home visits; however, for purposes of this payment waiver, CMS intends to use the same definition of general supervision as outlined in this provision.

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Claims

Post-discharge home visit service waiver claims must contain one of the following evaluation and management (E/M) CPT® codes:

- 99324-99337
- 99339-99340
- 99341-99350

Providers are not required to add a demonstration code to process these claims.

Additional information

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

Additional information about the next generation ACO model is available at: *https://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/*.

Date of change	Description
January 23, 2018	Article revised to revise the telehealth expansion information and to add Attachment A.
November 7, 2017	Article revised to provide a link to MM10044 that provides instruction to MACs to implement two new benefit enhancements for performance year three (calendar year 2018) of the NGACO model.
August 4, 2017	Initial article released

Attachment A

HCPCS code	Long descriptor	Short descriptor	RVUs Equal to those of the corresponding office/ outpatient E/M visit CPT® code under the MPFS
G9481	Remote in-home visit for the evaluation and management of a new patient for use only in the Medicare-approved comprehensive joint replacement and next generation accountable care organization models, which requires these three key components: ▪ A problem focused history; ▪ A problem focused examination; and ▪ Straightforward medical decision making, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are self-limited or minor. Typically, 10 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology	Remote E/M new pt 10mins.	99201
G9482	Remote in-home visit for the evaluation and management of a new patient for use only in the Medicare-approved comprehensive joint replacement and next generation accountable care organization models, which requires these three key components: ▪ An expanded problem focused history; ▪ An expanded problem focused examination; ▪ Straightforward medical decision making, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology.	Remote E/M new pt 20 mins.	99202

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HCPCS code	Long descriptor	Short descriptor	RVUs Equal to those of the corresponding office/ outpatient E/M visit CPT® code under the MPFS
G9483	Remote in-home visit for the evaluation and management of a new patient for use only in the Medicare-approved comprehensive joint replacement and next generation accountable care organization models, which requires these three key components: ▪ A detailed history; ▪ A detailed examination; ▪ Medical decision making of low complexity, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology	Remote E/M new pt 30 mins	99203
G9484	Remote in-home visit for the evaluation and management of a new patient for use only in the Medicare-approved comprehensive joint replacement and next generation accountable care organization models, which requires these three key components: ▪ A comprehensive history; ▪ A comprehensive examination; ▪ Medical decision making of moderate complexity, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology.	Remote E/M new pt 45 mins	99204
G9485	Remote in-home visit for the evaluation and management of a new patient for use only in the Medicare-approved comprehensive joint replacement and next generation accountable care organization models, which requires these three key components: ▪ A comprehensive history; ▪ A comprehensive examination; ▪ • Medical decision making of high complexity, furnished in real time using interactive audio and video technology	Remote E/M new pt 60 mins	99205

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HCPCS code	Long descriptor	Short descriptor	RVUs Equal to those of the corresponding office/ outpatient E/M visit CPT® code under the MPFS
G9486	Remote in-home visit for the evaluation and management of an established patient for use only in the Medicare-approved CJR model, which requires at least two of the following three key components: ▪ A problem focused history; ▪ A problem focused examination; ▪ Straightforward medical decision making, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are self-limited or minor. Typically, 10 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology.	Remote E/M new pt 10 mins	99212
G9487	Remote in-home visit for the evaluation and management of an established patient for use only in the Medicare-approved comprehensive joint replacement and next generation accountable care organization models, which requires at least two of the following three key components: • An expanded problem focused history; • An expanded problem focused examination; • Medical decision making of low complexity, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology	Remote E/M new pt 15 mins	99213
G9488	Remote in-home visit for the evaluation and management of an established patient for use only in the Medicare-approved comprehensive joint replacement and next generation accountable care organization models, which requires at least two of the following three key components: • A detailed history; • A detailed examination; • Medical decision making of moderate complexity, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology.	Remote E/M new pt 25 mins	99214

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HCPCS code	Long descriptor	Short descriptor	RVUs Equal to those of the corresponding office/ outpatient E/M visit CPT® code under the MPFS
G9489	Remote in-home visit for the evaluation and management of an established patient for use only in the Medicare-approved comprehensive joint replacement and next generation accountable care organization models, which requires at least two of the following three key components: ▪ A comprehensive history; ▪ A comprehensive examination; ▪ Medical decision making of high complexity, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology.	Remote E/M new pt 40 mins	99215

MLN Matters® Number: SE1613
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: January 1, 2016
Related CR Transmittal #: N/A
Implementation Date: January 1, 2016

Table 5.1 Types of providers/suppliers and associated functions[1]

Provider type	Alignment	Quality reporting through ACO	Eligible for ACO shared savings	PBP	All-inclusive PBP	Coordinated care reward	Telehealth	Three-day SNF rule	Post-discharge home visit
Next generation participant	X	X	X	X	X	X	X	X	X
Preferred provider			X	X	X	X	X	X	X

[1] This table is a simplified depiction of key design elements with respect to next generation participant and preferred provider roles. It does not necessarily imply that this list is exhaustive with regards to possible ACO relationships and activities.

Update to the 'Medicare Benefit Policy Manual' Chapter 11 – ESRD

Provider type affected

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

Provider action needed

Change request (CR) 10366 updates the *Medicare Benefit Policy Manual* (Publication 100-02, Chapter 11 (End Stage Renal Disease (ESRD)), Section 100 (Payment for Renal Dialysis Services Furnished to Individuals with Acute Kidney Injury (AKI)). Note that CR 10366 contains no policy changes. Make sure that your billing staffs are aware of these updates.

Background

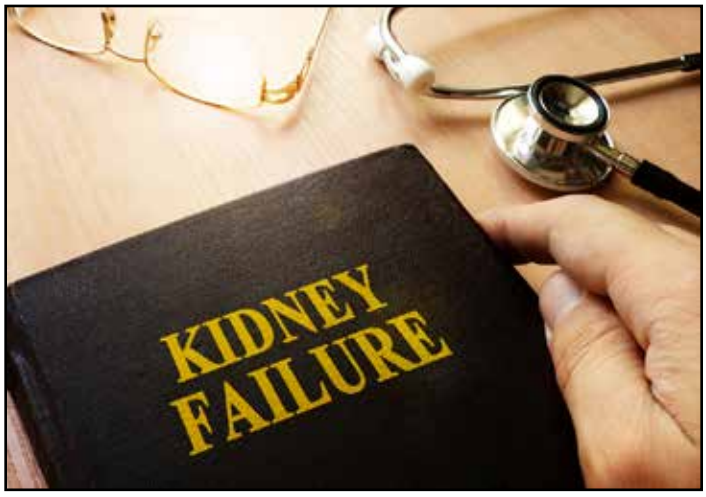
On June 29, 2015, the Trade Preferences Extension Act of 2015, available at *https://www.gpo.gov/fdsys/pkg/PLAW-114publ27/pdf/PLAW-114publ27.pdf* was enacted in which Section 808 amended Section 1861(s)(2)(F) of the Social Security Act (42 U.S.C. 1395x(s)(2)(F)) by extending renal dialysis services paid under the Social Security Act (Section 1881(b)(14)) to beneficiaries with acute kidney injury, effective January 1, 2017.

As previously stated, CR 10366 presents no new policy. It only updates the *Medicare Benefit Policy Manual* to include information communicated previously in other CRs regarding Medicare coverage or renal dialysis furnished to individuals with AKI. The updated manual section is attached to CR 10366.

Additional information

The official instruction, CR 10366, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R240BP.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/*.



Document history

Date of change	Description
January 19, 2018	Initial article released.

MLN Matters® Number: MM10366
Related CR Release Date: January 19, 2018
Related CR Transmittal Number: R240BP
Related Change Request (CR) Number: CR 10366
Effective Date: January 1, 2017
Implementation Date: February 20, 2018

April update to the FQHC PPS for 2018 – recurring file update

Provider type affected

This *MLN Matters*® article is intended for federally qualified health centers (FQHCs) billing Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 10480 updates the FQHC prospective payment system (FQHC PPS) grandfathered tribal FQHC base payment rate in the FQHC pricer. Make sure your billing staffs are aware of these changes.

Background

Effective for dates of service on or after January 1, 2016, Indian Health Service (IHS) and tribal facilities and organizations may seek to become certified as grandfathered tribal FQHCs, if they:

1. Met the conditions of 42 CFR Section 413.65(m), which is available at *https://www.ecfr.gov/cgi-bin/text-idx?SID=19dd7fa703112dee60510c39b8c4c2ae&mc=true&node=pt42.2.413&rgn=div5#se42.2.413_165*,on or before April 7, 2000, and
2. Have
   - A change in their status on or after April 7, 2000, from IHS to tribal operation, or vice versa, or
   - The realignment of a facility from one IHS or tribal hospital to another IHS or tribal hospital such that the organization no longer meets the conditions of participation (CoPs).

These grandfathered tribal FQHCs would be required to meet all FQHC certification and payment requirements. The grandfathered PPS rate equals the Medicare outpatient per visit payment rate paid to them as a provider-based department, as set annually by the IHS.

Grandfathered tribal FQHCs are paid the lesser of their charges or a grandfathered tribal FQHC PPS rate for all FQHC services furnished to a beneficiary during a medically-necessary, face-to-face FQHC visit. Note that:

- From January 1, 2018, through December 31, 2018, the grandfathered tribal FQHC PPS rate is $383.
- FQHC claims (TOB 77x) for grandfathered tribal FQHCs submitted with dates of service on or after January 1, 2018, through March 31, 2018, paid at the 2017 rate of $349 must be adjusted and paid at the 2018 rate of $383.
- Grandfathered tribal FQHC claims with dates of service on or after January 1, 2019, through December 31, 2019, should be paid at the 2018 rate of $383 until the Centers for Medicare & Medicaid Services (CMS) provides an updated payment rate for 2019.

The grandfathered tribal FQHC PPS rate will not be adjusted by the FQHC PPS geographic adjustment factors (GAFs) or be eligible for the special payment adjustments under the FQHC PPS for new patients, patients receiving an initial preventive physical examination (IPPE) or an annual wellness visit (AWV). The rate is also ineligible for exceptions to the single per diem payment that is available to FQHCs paid under the FQHC PPS. In addition, the FQHC market basket adjustment that is applied annually to the FQHC PPS base rate will not apply to the grandfathered tribal FQHC PPS rate.

Additional information

The official instruction, CR 10480, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R3972CP.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/*.

Document history

Date of change	Description
February 9, 2018	Initial article released.

MLN Matters® Number: MM10480
Related CR Release Date: February 8, 2018
Related CR Transmittal Number: R3972CP
Related Change Request (CR) Number: 10480
Effective Date: April 1, 2018
Implementation Date: April 2, 2018

April 2018 update of drug and biological code changes

Note: Editorial corrections made May 23, 2018, to the related CR transmittal number.

Provider type affected

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

What you need to know

The HCPCS code set is updated on a quarterly basis. Change request (CR) 10454 informs MACs of the April 2018 updates of specific biosimilar biological product HCPCS code, modifiers used with these biosimilar biologic products and an autologous cellular immunotherapy treatment. Be sure your staffs are aware of these updates.

Background

CR 10454 describes updates associated with the following biosimilar biological product HCPCS codes and modifiers. The April 2018 HCPCS file includes three new HCPCS codes: Q5103, Q5104, and Q2041 Also, the April 2018 HCPCS file includes a revision to the descriptor for HCPCS code Q5101.

Effective for services as of April 1, 2018, The April 2018 HCPCS file includes these revised/new HCPCS codes:

- HCPCS code: Q5101
  - Short description: Injection, zarxio
  - Long description: Injection, filgrastim-sndz, biosimilar, (zarxio), 1 microgram
- HCPCS code: Q5103
  - Short description: Injection, inflectra
  - Long description: Injection, infliximab-dyyb, biosimilar, (inflectra), 10 mg
  - Type of service (TOS) code: 1,P
  - Medicare physician fee schedule database (MPFSDB) status indicator: E
- HCPCS code: Q5104
  - Short description: Injection, renflexis
  - Long description: Injection, infliximab-abda, biosimilar, (renflexis), 10 mg
  - TOS code: 1, P
  - MPFSDB status indicator: E
- HCPCS code:Q2041
  - Short description: Axicabtagene ciloleucel car+
  - Long description: Axicabtagene Ciloleucel, up to 200 million autologous Anti-CD19 CAR T Cells, Including leukapheresis and dose preparation procedures, per infusion
  - TOS code: 1
  - MPFSDB status indicator: E

Effective for claims with dates of service on or after April 1, 2018, HCPCS code Q5102 (which describes both currently available versions of infliximab biosimilars) will be replaced with two codes, Q5103 and Q5104. Thus, Q5102 Injection, infliximab, biosimilar, 10 mg, will be discontinued, effective March 31, 2018.

Also, beginning on April 1, 2018, modifiers that describe the manufacturer of a biosimilar product (for example, ZA, ZB and ZC) will no longer be required on Medicare claims for HCPCS codes for biosimilars. However, please note that HCPCS code Q5102 and the requirement to use biosimilar modifiers remain in effect for dates of service prior to April 1, 2018.

Medicare Part B policy changes for biosimilar biological products were discussed in the 2018 physician fee schedule (PFS) final rule at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1676-F.html*. Effective January 1, 2018, newly approved biosimilar biological products with a common reference product will no longer be grouped into the same billing code. The rule also stated that instructions for new codes for biosimilars that are currently grouped into a common payment code and the use of modifiers would be issued.

Additional information

The official instruction, CR 10454, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R3966CP.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/*.

Document history

Date of change	Description
February 2, 2018	Initial article released.

MLN Matters® Number: MM10454
Related CR Release Date: February 8, 2018
Related CR Transmittal Number: R3966CP
Related Change Request (CR) Number: 10454
Effective Date: April 1, 2018
Implementation Date: April 2, 2018

Supervised exercise therapy for symptomatic peripheral artery disease

Provider type affected

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

Provider action needed

Change request (CR) 10295 informs MACs that effective May 25, 2017, the Centers for Medicare & Medicaid Services (CMS) issued a national coverage determination (NCD) to cover supervised exercise therapy (SET) for beneficiaries with intermittent claudication (IC) for the treatment of symptomatic peripheral artery disease (PAD). Make sure your billing staffs are aware of these changes.

Background

SET involves the use of intermittent walking exercise, which alternates periods of walking to moderate-to-maximum claudication, with rest. SET has been recommended as the initial treatment for patients suffering from IC, the most common symptom experienced by people with PAD.

Despite years of high-quality research illustrating the effectiveness of SET, more invasive treatment options (such as, endovascular revascularization) have continued to increase. This has been partly attributed to patients having limited access to SET programs. There is currently no NCD in effect.

CMS issued the NCD to cover SET for beneficiaries with IC for the treatment of symptomatic PAD. Up to 36 sessions over a 12-week period are covered if all of the following components of a SET program are met:

The SET program must:

- Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication
- Be conducted in a hospital outpatient setting, or a physician's office
- Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD
- Be under the direct supervision of a physician (as defined in Section 1861(r)(1)) of the Social Security Act (the Act), physician assistant, or nurse practitioner/ clinical nurse specialist (as identified in Section 1861(aa)(5) of the Act)) who must be trained in both basic and advanced life support techniques.

Beneficiaries must have a face-to-face visit with the physician responsible for PAD treatment to obtain the referral for SET. At this visit, the beneficiary must receive information regarding cardiovascular disease and PAD risk factor reduction, which could include education, counseling, behavioral interventions, and outcome assessments.

MACs have the discretion to cover SET beyond 36 sessions over 12 weeks and may cover an additional 36 sessions over an extended period of time. MACs shall accept the inclusion of the KX modifier on the claim line(s) as an attestation by the provider of the services that documentation is on file verifying that further treatment beyond the 36 sessions of SET over a 12-week period meets the requirements of the medical policy. SET is non-covered for beneficiaries with absolute contraindications to exercise as determined by their primary attending physician.

Coding requirements for SET

Providers should use *Current Procedural Terminology* (CPT®) 93668 (under peripheral arterial disease rehabilitation) to bill for these services with appropriate International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10) code as follows:

- I70.211 – right leg
- I70.212 – left leg
- I70.213 – bilateral legs
- I70.218 – other extremity
- I70.311 – right leg
- I70.312 – left leg
- I70.313 – bilateral legs
- I70.318 – other extremity
- I70.611 – right leg
- I70.612 – left leg
- I70.613 – bilateral legs
- I70.618 – other extremity
- I70.711 – right leg
- I70.712 – left leg
- I70.713 – bilateral legs
- I70.718 – other extremity

Medicare will deny claim line items for SET services when they do not contain one of the above ICD-10 codes using the following messages:

- Claim adjustment reason code (CARC) 167 – This (these) diagnosis (es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- Remittance advice remark code (RARC) N386: This decision was based on a National Coverage Determination 20.35 (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.
- Group code CO (contractual obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

MACs will accept claims for CPT® 93668 only when services are provided in Place of Service (POS) code 11, 19, or 22. MACs will deny claims for SET if services are not provided in POS 11, 19, or 22, using the following remittance messages:

See **PAD**, page 25

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- CARC 58: Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. **NOTE**: Refer to the 832 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present.
- RARC N386: This decision was based on a National Coverage Determination 20.35 (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.
- Group code CO (contractual obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

Institutional claims for SET must be submitted on type of bills (TOB) 13x or 85x. MACs will deny line items on institutional claims that are not submitted on TOB 13x or 85x using the following messages:

- CARC 58: "Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. NOTE: Refer to the 832 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present.
- RARC N386: "This decision was based on a National Coverage Determination 20.35 (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.
- Group code CO (contractual obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

Medicare will pay claims for SET services containing CPT® code 93668 on types of bill (TOBs) 13x under OPPS and 85x on reasonable cost, except it will pay claims for SET services containing CPT® 93668 with revenue codes 096x, 097x, or 098x when billed on TOB 85x method II critical access hospitals (CAHs) based on 115 percent of the lesser of the fee schedule amount or the submitted charge.

Medicare will reject claims with CPT® 93668 which exceed 36 sessions within 84 days from the date of the first session when the KX modifier is not included on the claim line OR any SET session provided after 84 days from the date of the first session and the KX modifier is not included on the claim and use 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 N640: Exceeds number/frequency approved/ allowed within time period.
- Group code CO (contractual obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.
- Group code PR (patient responsibility) assigning financial liability to the beneficiary if a claim is received with a GA modifier indicating a signed ABN is on file.

MACs will deny/reject claim lines for SET exceeding 73 sessions using the following codes:

- CARC 119: Benefit maximum for this time period or occurrence has been reached.
- RARC N386: "This decision was based on a National Coverage Determination 20.35 (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.
- Group code CO (contractual obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.
- Group code PR (patient responsibility) assigning financial liability to the beneficiary if a claim is received with a GA modifier indicating a signed ABN is on file.

Medicare's common working file (CWF) will display remaining SET sessions on all CWF provider query screens (HIQA, HIQH, ELGH, ELGA, and HUQA). The multi-carrier system desktop tool will also display remaining SET sessions in a format equivalent to the CWF HIMR screen(s).

Additional information

The official instruction, CR 10295, was issued to your MAC via two transmittals. The first updates the *Medicare Claims Processing Manual* and it is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R3969CP.pdf*. The second updates the *NCD Manual* and it is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R204NCD.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/*.

Document history

Date of change	Description
January 12, 2018	Initial article released.

MLN Matters® Number: MM10295
Related CR Release Date: February 2, 2018
Related CR Transmittal Number: R204NCD and R3969CP
Related Change Request (CR) Number: 10298
Effective Date: May 25, 2017
Implementation Date: April 3, 2018 – MAC edits; July 2, 2018 – full implementation

Quarterly update for clinical laboratory fee schedule and services subject to reasonable charge payment

Provider type affected

This *MLN Matters*® article is intended for clinical diagnostic laboratories submitting claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 10445 which informs the MACs about the changes in the April 2018 quarterly update to the clinical laboratory fee schedule (CLFS). Make sure that your billing staffs are aware of these changes.

Background

Effective January 1, 2018, CLFS rates will be based on weighted median private payor rates as required by the Protecting Access to Medicare Act (PAMA) of 2014. For more details, visit PAMA Regulations, at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/PAMA-Regulations.html*. Part B deductible and coinsurance do not apply for services paid under the CLFS.

Access to data file

Internet access to the quarterly CLFS data file will be available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html*. Interested parties, such as the Medicaid State agencies, the Indian Health Service, the United Mine Workers, and the Railroad Retirement Board, should use the Internet to retrieve the quarterly clinical laboratory fee schedule. The file will be available in multiple formats: Excel, text, and comma delimited.

Pricing information

The CLFS includes separately payable fees for certain specimen collection methods (codes 36415, P9612, and P9615). The fees are established in accordance with Section 1833(h)(4)(B) of the Social Security Act.

New codes

The following new codes will be MAC priced, until they are addressed at the annual Clinical Laboratory Public Meeting, which will take place in July, 2018. The following "U" codes shall have HCPCS pricing indicator code - 22 = Price established by A/B MACs Part B (e.G., gap-fills, A/B MACs Part B established panels) instead of pricing indicator - 21 = Price subject to national limitation amount. (code, long descriptor, short descriptor, effective date, type of service (TOS))

0024U Glycosylated acute phase proteins (GlycA), nuclear magnetic resonance spectroscopy, quantitative GLYCA NUC MR SPECTRSC QUAN 1/1/2018 5

0025U Tenofovir, by liquid chromatography with tandem mass spectrometry (LC-MS/MS), urine, quantitative TENOFOVIR LIQ CHROM UR QUAN 1/1/2018 5

0026U Oncology (thyroid), DNA and mRNA of 112 genes, next-generation sequencing, fine needle aspirate of thyroid nodule, algorithmic analysis reported as a categorical result ("Positive, high probability of malignancy" or "Negative, low probability of malignancy") ONC THYR DNA&MRNA 112 GENES 1/1/18 5

0027U JAK2 (Janus kinase 2) (eg, myeloproliferative disorder) gene analysis, targeted sequence analysis exons 12-15 JAK2 GENE TRGT SEQ ALYS 1/1/18 5

0028U CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism) gene analysis, copy number variants, common variants with reflex to targeted sequence analysis CYP2D6 GENE CPY NMR CMN VRNT 1/1/18 5

0029U Drug metabolism (adverse drug reactions and drug response), targeted sequence analysis (ie, CYP1A2, CYP2C19, CYP2C9, CYP2D6, CYP3A4, CYP3A5, CYP4F2, SLCO1B1, VKORC1 and rs12777823) RX METAB ADVRS TRGT SEQ ALYS 1/1/18 5

0030U Drug metabolism (warfarin drug response), targeted sequence analysis (ie, CYP2C9, CYP4F2, VKORC1, rs12777823) RX METAB WARF TRGT SEQ ALYS 1/1/18 5

0031U CYP1A2 (cytochrome P450 family 1, subfamily A, member 2)(eg, drug metabolism) gene analysis, common variants (ie, *1F, *1K, *6, *7) CYP1A2 GENE 1/1/18 5

0032U COMT (catechol-O-methyltransferase)(drug metabolism) gene analysis, c.472G>A (rs4680) variant COMT GENE 1/1/18 5

0033U HTR2A (5-hydroxytryptamine receptor 2A), HTR2C (5-hydroxytryptamine receptor 2C) (eg, citalopram metabolism) gene analysis, common variants (ie, HTR2A rs7997012 [c.614-2211T>C], HTR2C rs3813929 [c.-759C>T] and rs1414334 [c.551-3008C>G]) HTR2A HTR2C GENES 1/1/18 5

0034U TPMT (thiopurine S-methyltransferase), NUDT15 (nudix hydroxylase 15)(eg, thiopurine metabolism), gene analysis, common variants (ie, TPMT *2, *3A, *3B, *3C, *4, *5, *6, *8, *12; NUDT15 *3, *4, *5) TPMT NUDT15 GENES 1/1/18 5

The following new code is effective January 1, 2018:

New code 87634QW is priced at the same rate as code 87634.

The following new codes are effective April 1, 2018:

New code 0001UQW is priced at the same rate as 0001U.

New code 0002UQW is priced at the same rate as 0002U.

New code 0003UQW is priced at the same rate as 0003U.

New code 0005UQW is priced at the same rate as 0005U.

New code 0006UQW is priced at the same rate as 0006U.

New code 0007UQW is priced at the same rate as 0007U.

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New code 0008UQW is priced at the same rate as 0008U.
New code 0009UQW is priced at the same rate as 0009U.
New code 0010UQW is priced at the same rate as 0010U
New code 0011UQW is priced at the same rate as 0011U
New code 0012UQW is priced at the same rate as 0012U
New code 0013UQW is priced at the same rate as 0013U
New code 0014UQW is priced at the same rate as 0014U
New code 0016UQW is priced at the same rate as 0016U
New code 0017UQW is priced at the same rate as 0017U
New code 81105QW is priced at the same rate as 81105
New code 81106QW is priced at the same rate as 81106
New code 81107QW is priced at the same rate as 81107
New code 81108QW is priced at the same rate as 81108
New code 81109QW is priced at the same rate as 81109
New code 81110QW is priced at the same rate as 81110
New code 81111QW is priced at the same rate as 81111
New code 81112QW is priced at the same rate as 81112
New code 81120QW is priced at the same rate as 81120
New code 81121QW is priced at the same rate as 81121
New code 81175QW is priced at the same rate as 81175
New code 81176QW is priced at the same rate as 81176
New code 81230QW is priced at the same rate as 81230
New code 81231QW is priced at the same rate as 81231
New code 81232QW is priced at the same rate as 81232
New code 81238QW is priced at the same rate as 81238
New code 81247QW is priced at the same rate as 81247
New code 81248QW is priced at the same rate as 81248
New code 81249QW is priced at the same rate as 81249
New code 81258QW is priced at the same rate as 81258
New code 81259QW is priced at the same rate as 81259
New code 81269QW is priced at the same rate as 81269
New code 81283QW is priced at the same rate as 81283
New code 81328QW is priced at the same rate as 81328
New code 81334QW is priced at the same rate as 81334
New code 81335QW is priced at the same rate as 81335
New code 81346QW is priced at the same rate as 81346
New code 81361QW is priced at the same rate as 81361
New code 81362QW is priced at the same rate as 81362
New code 81363QW is priced at the same rate as 81363
New code 81364QW is priced at the same rate as 81364
New code 81448QW is priced at the same rate as 81448
New code 81520QW is priced at the same rate as 81520
New code 81521QW is priced at the same rate as 81521
New code 81541QW is priced at the same rate as 81541
New code 81551QW is priced at the same rate as 81551
New code 86008QW is priced at the same rate as 86008
New code 86794QW is priced at the same rate as 86794
New code 87662QW is priced at the same rate as 87662

Deleted codes

The following codes are deleted effective January 1, 2018:

Existing code 0004U is to be deleted
Existing code 0015U is to be deleted
Existing code 81280 is to be deleted
Existing code 81281 is to be deleted
Existing code 81282 is to be deleted

Code update

Existing code 80410 had an incorrect crosswalk (multiplier of 1 instead of 3) in the annual CLFS file, and is corrected with this CR in the quarterly file, effective January 1, 2018.

Additional information

The official instruction, CR 10445, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R3973CP.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/*.

Document history

Date of change	Description
January 12, 2018	Initial article released.

MLN Matters® Number: MM10445
Related CR Release Date: February 8, 2018
Related CR Transmittal Number: R3973CP
Related Change Request (CR) Number: 10445
Effective Date: January 1, 2018, for new HCPCS codes, otherwise April 1, 2018
Implementation Date: April 2, 2018

Diagnosis code update for add-on payments for blood clotting factor administered to hemophilia inpatients

Provider type affected

This *MLN Matters*® article is intended for providers who submit claims to Medicare administration contractors (MACs) for inpatient services to Medicare beneficiaries with hemophilia.

What you need to know

Change request (CR) 10474 provides updates to diagnosis codes required in order to allow add-on payments under the inpatient prospective payment system (IPPS) for blood clotting factor administered to hemophilia inpatients. The add-on payment criteria for blood clotting factors administered to hemophilia inpatients will be updated July 1, 2018, by terminating International Classification of Diseases, Clinical Modification (ICD-CM) code D68.32, effective with that date. The list of ICD-CM codes that will continue to receive the add-on payment can be found in Section 20.7.3, of Chapter 3 of the *Medicare Claims Processing Manual*. Make sure your billing staffs are aware of this update.

Background

The September 1, 1993, IPPS final rule (58 FR 46304) states that payment will be made for the blood clotting factor only if an ICD-CM dia

gnosis code for hemophilia is included on the bill.

Effective July 1, 2018, code D68.32 (Antiphospholipid antibody with hemorrhagic disorder) is **terminated**. Therefore, providers that include diagnosis code D68.32 on inpatient claims with discharge dates after July 1, 2018, will not receive the add-on payment.

Additional information

The official instruction, CR 10474, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R3974CP.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/*.

Document history

Date of change	Description
February 9, 2018	Initial article released.

MLN Matters® Number: MM10474
Related CR Release Date: February 8, 2018
Related CR Transmittal Number: R3974CP
Related Change Request (CR) Number: 10474
Effective Date: July 1, 2018
Implementation Date: July 2, 2018

Replacement of mammography codes, waiver of coinsurance and deductible for preventive and other services, and addition of anesthesia and prolonged preventive services

***Note**: This article was revised February 9, 2018, to reposition text under different headers on page 2. All other information is unchanged. This information was previously published in the December 2017 Medicare A Connection, pages 47-48.*

Provider type affected

This *MLN Matters*® article is intended for providers submitting claims to Part A & B Medicare administrative contractors (MACs) for services furnished to Medicare beneficiaries.

Provider action needed

Change request (CR) 10181 provides for the replacement of HCPCS codes G0202, G0204, and G0206 with *Current Procedural Terminology* (CPT®) codes 77067, 77066, and 77065, effective January 1, 2018. CR 10181 also applies the waiver of deductible and coinsurance to 76706, 77067, prolonged preventive services, and anesthesia services furnished in conjunction with and in support of colorectal cancer services. Make sure your billing staffs are aware of these changes.

The language and policy referred to in this article are included in Chapter 18, Sections 20 and 240 (new) of the *Medicare Claims Processing Manual*, which is included as an attachment to CR 10181.

Background

Replacement of mammography HCPCS codes

Effective for claims with dates of service on or after January 1, 2018, the following HCPCS codes are being replaced:

- G0202 - “screening mammography, bilateral (2-view study of each breast), including computer-aided detection Computer-Aided Detection (CAD) when performed”
- G0204 - “diagnostic mammography, including when performed; bilateral” and

See **PREVENTIVE**, page 29

PREVENTIVE

from page 28

- G0206 - “diagnostic mammography, including CAD when performed; unilateral”

These codes are being replaced by the following CPT® codes:

- 77067 - “screening mammography, bilateral (2-view study of each breast), including CAD when performed”
- 77066 - “diagnostic mammography, including (CAD) when performed; bilateral” and
- 77065 - “diagnostic mammography, including CAD when performed; unilateral”.

As part of the January 2017 HCPCS code update, code G0389 was replaced by CPT® code 76706. Type of service (TOS) “5” was assigned to 76706, and the coinsurance and deductible were waived.

Effective January 1, 2018, the TOS for 76706 will be changed to “4” as part of the 2018 HCPCS update; the coinsurance and deductible will continue to be waived.

Summary of changes: For claims with dates of service January 1, 2017, through December 31, 2017, report HCPCS codes G0202, G0204, and G0206. For claims with dates of service on or after January 1, 2018, report CPT® codes 77067, 77066, and 77065 respectively.

Prolonged preventive services

Effective for claims with dates of service on or after January 1, 2018, prolonged preventive services will be payable by Medicare when billed as an add-on to an applicable preventive service that is payable from the Medicare physician fee schedule, and both deductible and coinsurance do not apply.G0513 and G0514 for prolonged preventive services will be added as part of January1, 2018, HCPCS update and the coinsurance and deductible will be waived.

Anesthesia services

Section 4104 of the Affordable Care Act defined the term “preventive services” to include “colorectal cancer screening tests,” and as a result, it waives any coinsurance that would otherwise apply under Section 1833(a)(1) of the Social Security Act (the Act) for screening colonoscopies.

In addition, the Affordable Care Act amended Section 1833(b)(1) of the Act to waive the Part B deductible for screening colonoscopies, which includes anesthesia services as an inherent part of the screening colonoscopy procedural service. These provisions are effective for services furnished on or after January 1, 2011.

In the 2018 physician fee schedule (PFS) final rule, the Centers for Medicare & Medicaid Services (CMS) modified reporting and payment for anesthesia services furnished in conjunction with and in support of colorectal cancer screening services.

Anesthesia services furnished in conjunction with and in support of a screening colonoscopy are reported with CPT® code 00812 (Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy). CPT® code 00812 will be added as part of January 1, 2018, HCPCS update. Effective for claims with dates of service on or after January 1, 2018, Medicare will pay claim lines with new CPT® 00812 and waive the deductible and coinsurance.

When a screening colonoscopy becomes a diagnostic colonoscopy, anesthesia services are reported with CPT® 00811 (Anesthesia for lower intestinal endoscopic procedures, endoscopy introduced distal to duodenum; not otherwise specified) and with the PT modifier. CPT® 00811 will be added as part of the January 1, 2018, HCPCS update. Effective for claims with dates of service on or after January 1, 2018, Medicare will pay claim lines with new CPT® 00811 and waive only the deductible when submitted with the PT modifier.

Additional information

The official instruction, CR 10181, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3844CP.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/*.

Document history

Date of change	Description
February 9, 2018	Article was revised to reposition text under different headers in the *Background* section (under *Prolonged preventive services* and *Anesthesia services*.
November 24, 2017	Initial article released.

MLN Matters® Number: MM10181
Related CR Release Date: August 18, 2017
Related CR Transmittal Number: R3844CP
Related Change Request (CR) Number: 10181
Effective Date: January 1, 2018
Implementation Date: January 2, 2018

Upcoming provider outreach and educational events

Topic: Medicare Part A changes and regulations

Date: Wednesday, March 14
Time: 10:00 a.m.-11:30 a.m.
Type of Event: Webcast

https://medicare.fcso.com/Events/0396640.asp

Topic: Ask-the-contractor teleconference (ACT): Medicare provider enrollment process (A/B)

Date: Thursday, March 22
Time: 11:30 a.m.-1:00 p.m.
Type of Event: Webcast

https://medicare.fcso.com/Events/0399040.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 *https://gm1.geolearning.com/geonext/fcso/opensite.geo*, 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.

CMS MLN Connects®

The Centers for Medicare & Medicaid Services (CMS) *MLN Connects*® 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 *MLN Connects*® to its membership as appropriate.

MLN Connects® for January 25, 2018

MLN Connects® for January 25, 2018

View this edition as a PDF

News & Announcements

- VA, HHS Announce Partnership to Strengthen Prevention of Fraud, Waste and Abuse Efforts
- CMS Updates Open Payments Data
- Improved Open Payments Data Website
- IRF and LTCH Quality Reporting Programs: Submission Deadline February 15
- Panel on Development of Potentially Preventable Hospitalization Measures for HHAs: Nominations due February 22
- SNF Quality Reporting Program: Submission Deadline Extended to May 15
- Hospice Quality Reporting Program: Quality Measure User's Manual Version 2
- Continue Seasonal Influenza Vaccination through January and Beyond

Provider Compliance

- Reporting Changes in Ownership — Reminder

Upcoming Events

- Low Volume Appeals Settlement Option Call – February 13
- Home Health Review and Correct Reports Webinar — March 6

Medicare Learning Network Publications & Multimedia

- Low Volume Appeals Settlement Call: Video Presentation — New
- Hurricane Nate and Medicare Disaster Related Alabama, Florida, Louisiana and Mississippi Claims *MLN Matters*® Article — Updated
- Swing Bed Services Fact Sheet — Revised

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MLN Connects® – Special Edition for January 26, 2018

In this Edition:

- Therapy Cap Claims Rolling Hold
- New Medicare Card: Web Updates
- New Medicare Card: When Will My Medicare Patients Receive Their Cards?

Therapy Cap Claims Rolling Hold

CMS is immediately releasing for processing *held therapy claims* with the KX modifier with dates of receipt beginning January 1-10; CMS will also implement a "rolling hold" to minimize impact if legislation to extend the outpatient therapy caps exceptions process is enacted.

New Medicare Card: Web Updates

To help you prepare for the transition to the Medicare Beneficiary Identifier (MBI) on Medicare cards beginning April 1, 2018, review the new information about remittance advices.

Beginning in October 2018, through the *transition period*, when providers submit a claim using a patient's valid and active Health Insurance Claim Number (HICN), CMS will return both the HICN and the MBI on every remittance advice. Here are examples of different remittance advices:

- *Medicare Remit Easy Print* (Medicare Part B providers and suppliers)
- *PC Print for Institutions*
- Standard Paper Remits: *FISS (Medicare Part A/ Institutions)*, *MCS (Medicare Part B/Professionals)*, *VMS (Durable Medicare Equipment)*

Find more new information on the New Medicare Card provider webpage.

New Medicare Card: When Will My Medicare Patients Receive Their Cards?

Starting April 2018, CMS will begin mailing new Medicare cards to all people with Medicare on a flow basis, based on geographic location and other factors. Learn more about the *Mailing Strategy*. Also starting April 2018, your patients will be able to check the status of card mailings in their area on *Medicare.gov*.

For More Information:

- *Mailing Strategy*
- Questions from Patients? *Guidelines*
- New Medicare Card *overview* and *provider* web pages

MLN Connects® for February 1, 2018

MLN Connects® for February 1, 2018
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News & Announcements

- Medicare Diabetes Prevention Program: Supplier Enrollment Open
- Targeted Probe and Educate: New Resources
- MIPS Clinicians: 2017 Extreme and Uncontrollable Circumstances Policy
- Quality Payment Program: Patient-facing Encounters Resources
- Eligible Hospitals and CAHs: Get Help with Attestation on QNet
- Find Medicare FFS Payment Regulations
- February is American Heart Month

Provider Compliance

- Cochlear Devices Replaced Without Cost: Bill Correctly — Reminder

Upcoming Events

- Low Volume Appeals Settlement Option Call – February 13
- Home Health Review and Correct Reports Webinar — March 6

Medicare Learning Network Publications & Multimedia

- Next Generation Accountable Care Organization - Implementation MLN Matters® Article — Revised
- DMEPOS Quality Standards Educational Tool — Revised
- Home Oxygen Therapy Booklet — Revised
- Looking for Educational Materials?

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MLN Connects® for February 8, 2018

MLN Connects® for February 8, 2018
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News & Announcements

- Patients over Paperwork: January Newsletter
- Open Payments Registration
- MIPS: Call for Advancing Care Information Measures and Improvement Activities
- Quality Payment Program: Advanced APM Table
- Hospice Quality Reporting Program Resources
- LTCH Quality Reporting Program: Materials from December Training
- SNF QRP Quality Measure and Review and Correct Report: Calculation Error
- Home Health Review and Correct Report: Correction
- Influenza Activity Continues: Are Your Patients Protected?

Provider Compliance

- Medicare Hospital Claims: Avoid Coding Errors — Reminder

Upcoming Events

- Low Volume Appeals Settlement Option Call — February 13
- What's New with Physician Compare Webinar — February 21 or 22
- Comparative Billing Report on Opioid Prescribers Webinar — February 21 or March 7
- ESRD QIP: Final Rule for CY 2018 Call — February 22

Medicare Learning Network Publications & Multimedia

- E/M Service Documentation Provided by Students MLN Matters Article — New
- Medicare Enrollment Resources Educational Tool — Revised
- Medicare Part B Immunization Billing Educational Tool — Reminder

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MLN Connects® for February 15, 2018

MLN Connects® for February 15, 2018

View this edition as a PDF

News & Announcements

- MIPS Reporting Deadlines Fast Approaching: 10 Things to Do and Know
- Quality Payment Program: Performance Scores for 2017 Claims Data
- Diabetic Self-Management Training Accreditation Program: New Webpage and Helpdesk
- Measures of Hospital Harm: Comment by February 16
- EHR Incentive Program: Accepting Proposals for New Measures by June 29
- New Option for Submission of Medicare Cost Reports

Provider Compliance

- Home Health Care: Proper Certification Required — Reminder

Claims, Pricers & Codes

- January 2018 OPPS Pricer File

Upcoming Events

- Improving Accessibility of Provider Settings Webinar — February 21
- ESRD QIP: Final Rule for CY 2018 Call — February 22
- 2018 QCDR Measures Workgroup Webinar — February 27
- Serving Adults with Disabilities on the Autism Spectrum Webinar — February 28
- MIPS Quality Data Submission Webinar – February 28
- Palliative and Hospice Care for Adults with Disabilities Webinar — March 7
- Low Volume Appeals Settlement Option Update Call — March 13
- Open Payments: The Program and Your Role Call — March 14
- MIPS Attestation for Advancing Care Information and Improvement Activities Webinar — March 14

Medicare Learning Network Publications & Multimedia

- Medicare Enrollment Resources Educational Tool — Revised
- PECOS FAQs Booklet — Revised
- PECOS for DMEPOS Suppliers Booklet — Revised
- Safeguard Your Identity and Privacy Using PECOS Booklet —Revised
- PECOS for Provider and Supplier Organizations Booklet — Revised
- PECOS Technical Assistance Contact Information Fact Sheet — Revised
- Health Professional Shortage Area Physician Bonus Program Fact Sheet — Revised
- Medicare Secondary Payer Booklet – Reminder
- Beneficiaries in Custody under a Penal Authority Fact Sheet — Reminder

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.

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: *EDOC-CS-FLINQA@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)
(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