Medicare A CONNECTION
medicare.fcso.com
FIRST COAST SERVICE OPTIONS, INC.
A Newsletter for MAC Jurisdiction N Providers
September 2018

In this issue

Influenza vaccine payment allowances – annual update for 2018-2019 season

Provider type affected

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

Provider action needed

Change request (CR) 10914 informs MACs about payment allowances for influenza virus vaccines, which are updated August 1 of each year. The Centers for Medicare & Medicaid Services (CMS) will post the payment allowances for influenza vaccines that are approved after the release of CR 10914 at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html*. Make sure your billing staffs are aware that the payment allowances are being updated.

Background

The Medicare Part B payment allowance limits for influenza and pneumococcal vaccines are 95 percent of the average wholesale price (AWP), as reflected in the published compendia except where the vaccine is furnished in a hospital outpatient department, rural health clinic (RHC), or federally qualified health center (FQHC). Where the vaccine is furnished in the hospital outpatient department, RHC, or FQHC, payment for the vaccine is based on reasonable cost.

Annual Part B deductible and coinsurance amounts do not apply. All physicians, non-physician practitioners, and suppliers who administer the influenza virus vaccination and the pneumococcal vaccination must take assignment on the claim for the vaccine.

The Medicare Part B payment allowances for dates of service of August 1, 2018, through July 31, 2019, are still pending as of the date of CR 10914 for CPT® codes 90630, 90653, 90654, 90655, 90656, 90657, 90661, 90662, 90672, 90673, 90674, 90682, 90685, 90686, 90687, 90688, 90756, and HCPCS codes Q2035, Q2036, Q2037, and Q2038. Once payment allowances are available, they will be posted at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html*.

See ALLOWANCE, page 14

Contents

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

Publication staff:
Marielba Cancel
Terri Drury
Maria Murdoch
Mark Willett
Robert Petty

Fax comments about this publication to:

Medicare Publications
904-361-0723

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.

Update to Chapter 15, Pub. 100-08, Certification Statement Policies

Provider type affected

This *MLN Matters*® article is intended for physicians and providers, including home health agencies (HHAs), submitting certain internet-based applications to Medicare administrative contractors (MACs) via the Provider Enrollment Chain and Ownership System (PECOS).

Provider action needed

Change request (CR) 10845 makes modifications to certain provider enrollment certification statement policies. Specifically, you may upload provider enrollment certification statements using PECOS functionality.

CR 10845 makes these modifications via changes to the *Medicare Program Integrity Manual*, Chapter 15, Section 15.5.14.4. The revised manual section is attached to CR 10845. Make sure your billing staff is aware of these changes.

Background

PECOS functionality provides an option to upload paper certification statements. CR 10845 aligns the provider enrollment certification statement policy with this PECOS functionality.

CR 10845 and the accompanying revised portion of the manual requires your MACs to:

- Accept all handwritten signatures for paper forms CMS-855, CMS-20134, CMS-460 and CMS-588 application submissions
- Accept e-signed or uploaded signatures for web-based application submissions. MACs will no longer accept paper certification statements for web-based application submissions (CMS-855 and CMS-20134 only) via mail. If the provider chooses to submit its certification statement via paper rather than through e-signature, it shall do so via PECOS upload functionality
- Not accept stamped signatures
- Accept uploaded, faxed and emailed paper certification statements in response to a development request.
- Begin processing ALL applications upon receipt and shall develop for missing certification statements and all other missing information, including application fee, upon review
- Consider the web-based application date of receipt as the date of the web-based application submission

Note: There is no legislative or regulatory impact associated with CR 10845.

Additional information

The official instruction, CR 10845, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R824PI.pdf*.

If you have questions, your MACs may have more information. Find their website at *https://go.cms.gov/MAC-website-list*.

Document history

Date of change	Description
September 5, 2018	The article was revised to reflect a revised CR 10845 issued the same day. The revised CR did not change any substantive information in the article. Within the article, there is a revised transmittal number, CR release date, and web address for accessing the CR. All other information remains the same.
August 24, 2018	Initial article released.

MLN Matters® Number: MM10845 *Revised*
Related CR Release Date: September 5, 2018
Related CR Transmittal Number: R824PI
Related Change Request (CR) Number: 10845
Effective Date: October 1, 2018
Implementation October 1, 2018

Hurricane Maria and Medicare disaster-related U.S. Virgin Islands and Puerto Rico claims

Note: *This article was revised September 13 to advise providers that the public health emergency (PHE) declaration and Section 1135 waiver authority for the U.S. Virgin Islands were renewed again September 11. All other information is unchanged. This information was previously published in the August 2018 Medicare A Connection, pages 7-9.*

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 United States Virgin Islands and the Commonwealth of Puerto Rico who were affected by Hurricane Maria.

Provider information available

On September 18, 2017, pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, President Trump declared that, as a result of the effects of Hurricane Maria, an emergency exists in the United States Virgin Islands and the Commonwealth of Puerto Rico. Also on September 19, 2017, Secretary Price of the Department of Health & Human Services declared that a public health emergency (PHE) exists in the United States Virgin Islands and the Commonwealth of Puerto Rico and authorized waivers and modifications under Section 1135 of the Social Security Act (the Act), retroactive to September 16, 2017, for the United States Virgin Islands and retroactive to September 17, 2017, for the Commonwealth of Puerto Rico.

The PHE declaration and Section 1135 waiver authority for the U.S. Virgin Islands were renewed on December 15, 2017, renewed again on March 15, 2018, June 13, 2018, and again on September 11, 2018. The PHE and Section 1135 waiver authority for Puerto Rico were extended to March 15, 2018, and were extended again on March 16, 2018, to June 13, 2018. **The PHE and Section 1135 waiver authority for Puerto Rico expired June 13, 2018.**

On September 19, 2017, the Administrator of the Centers for Medicare & Medicaid Services (CMS) authorized waivers under Section 1812(f) of the Social Security Act for the United States Virgin Islands and the Commonwealth of Puerto Rico, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of Hurricane Maria in 2017.

Under Section 1135 or 1812(f) of the Social Security Act, the CMS has issued several blanket waivers in the impacted geographical areas of the United States Virgin Islands and the Commonwealth of Puerto Rico. 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/EPRO/Past-Emergencies/Hurricanes-and-tropical-storms.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:

1. Change request (CR) 6451 (Transmittal 1784, Publication 100-04) issued July 31, 2009, applies to items and services furnished to Medicare beneficiaries within the United States Virgin Islands from September 16, 2017, and the Commonwealth of Puerto Rico from September 17, 2017, 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.
2. The most current information can be found at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Past-Emergencies/Hurricanes-and-tropical-storms.html*. Medicare FFS Questions & Answers (Q&As) posted on that web page and also referenced below are applicable for items and services furnished to Medicare beneficiaries within the United States Virgin Islands and the Commonwealth of Puerto Rico. 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 the United States Virgin Islands and the Commonwealth of Puerto Rico.
   - 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 and are effective September 16, 2017, for the United States Virgin Islands and September 17, 2017, for the Commonwealth of Puerto Rico.

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.

See **MARIA**, page 5

MARIA

from page 4

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*.

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*.

Blanket waivers issued by CMS

Under the authority of Section 1135 (or, as noted below, Section 1812(f)), CMS has issued blanket waivers in the affected area of **the United States Virgin Islands and Commonwealth of Puerto Rico**. 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 3-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 Maria in the United States Virgin Islands and the Commonwealth of Puerto Rico 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 Maria, 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 Hurricane Maria. (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.)

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 Maria, 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.

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 Maria, 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.

Emergency durable medical equipment, prosthetics, orthotics, and supplies for Medicare beneficiaries impacted by an emergency or disaster

As a result of Hurricane Maria, 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.

For more information refer to the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies for Medicare Beneficiaries Impacted by an Emergency or

See **MARIA**, page 6

MARIA

from page 5

Disaster fact sheet at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Emergency-DME-Beneficiaries-Hurricanes.pdf*.

Appeal administrative relief for areas affected by Hurricane Maria

If you were affected by Hurricane Maria and are unable to file an appeal within 120 days from the date of receipt of the remittance advice (RA) that lists the initial determination or will have an extended period of non-receipt of remittance advices that will impact your ability to file an appeal, please contact your Medicare administrative contractor.

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.

Applicability of reporting requirements for inpatient psychiatric facilities, skilled nursing facilities, home health agencies, hospices, inpatient rehabilitation facilities, ambulatory surgical centers, and renal dialysis facilities affected by Hurricane Maria

CMS is granting exceptions under certain Medicare quality reporting and value-based purchasing programs to inpatient psychiatric facilities, skilled nursing facilities, home health agencies, hospices, inpatient rehabilitation facilities, renal dialysis facilities, and ambulatory surgical centers located in areas affected by Hurricane Maria due to the devastating impact of the storm. These providers will be granted exceptions without having to submit an Extraordinary Circumstances Exceptions (ECE) request if they are located in one of the 78 Puerto Rico municipios or one of the three U.S. Virgin Islands county-equivalents, all of which have been designated by the *Federal Emergency Management Agency (FEMA)* as a major disaster municipio or county-equivalent.

The scope and duration of the exception under each Medicare quality reporting program is described in the memorandum that CMS posted *September 25, 2017*, however, all of the exceptions are being granted to assist these providers while they direct their resources toward caring for their patients and repairing structural damages to facilities.

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 questions, your MACs may have more information. Find their website at *https://go.cms.gov/MAC-website-list*.

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

Providers may also want to review the CMS Emergency and Preparedness webpage at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/EPRO-Home.html*.

Providers may also want to view the Survey and Certification Frequently Asked Questions at *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/index.html*.

Document history

Date of change	Description
September 13, 2018	The article was revised September 13, 2018, to advise providers that the PHE declaration and Section 1135 waiver authority for the U.S. Virgin Islands were renewed again September 11, 2018. All other information is unchanged.
July 25, 2018	This article was revised to advise providers that the PHE declaration and Section 1135 waiver authority for the U.S. Virgin Islands were renewed again June 13, 2018. The PHE and Section 1135 waiver authority for Puerto Rico expired June 13, 2018. The article was updated October 2, 2017, to include the section 'Applicability of reporting requirements for inpatient psychiatric facilities, skilled nursing facilities, home health agencies, hospices, inpatient rehabilitation facilities, ambulatory surgical centers, and renal dialysis facilities affected by Hurricane Maria.' All other information remains the same.
October 2, 2017	The article was updated October 2, 2017, to include the section 'Applicability of reporting requirements for inpatient psychiatric facilities, skilled nursing facilities, home health agencies, hospices, inpatient rehabilitation facilities, ambulatory surgical centers, and renal dialysis facilities affected by Hurricane Maria.' All other information remains the same.
September 21, 2017	Initial article released.

MLN Matters® Number: SE17028 *Revised*
Related CR Release Date: September 13, 2018
Related CR Transmittal Number: N/A
Related Change Request (CR) Number: N/A
Effective Date: N/A
Implementation N/A

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.

Find fees faster: Try First Coast's fee schedule lookup

Find the fee schedule information you need fast - with First Coast's fee schedule lookup, located at *https://medicare.fcso.com/Fee_lookup/fee_schedule.asp.* This exclusive online resource features an intuitive interface that allows you to search for fee information by procedure code. Plus, you can find any associated local coverage determinations (LCDs) with just the click of a button.

Retired LCDs

Destruction of internal hemorrhoid(s) by infrared coagulation (IRC) – retired Part A and Part B LCD

LCD ID number: L33571 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on data analysis review of the local coverage determination (LCD), it was determined that the LCD is no longer required and, therefore, is being retired.

Effective date

The retirement of this LCD is effective for services rendered **on or after August 22, 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 LCDs

Cardiology — non-emergent outpatient testing: exercise stress test, stress echo, MPI SPECT, and cardiac PET – revision to the Part A and Part B LCD

LCD ID number: L36209 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for cardiology–non-emergent outpatient testing: exercise stress test, stress echo, MPI SPECT, and cardiac PET was revised to update the "CMS National Coverage Policy" section of the LCD for-*Medicare Claims Processing Manual*, Pub.100-04, Chapter 13, adding Sections 50, 60.11, and 60.9. Also, the "Limitations" section was revised as follows: "The CMS Manual System, Pub. 100-08, *Program Integrity Manual*, Chapter 13, Section 13.5.1, outlines that "reasonable and necessary" services are "ordered and furnished by qualified personnel"."

In addition, the "ICD-10 Codes that Support Medical Necessity" section of the LCD for each group of ICD-10-CM diagnosis codes was updated.

For Group 1 codes, ICD-10-CM diagnosis code Z01.810 was added for CPT® codes 93015, 93016, 93017, and 93018.

For Group 2 codes, the following ICD-10-CM diagnosis codes were added: I01.0-I01.9, I02.0, I11.0-I11.9, I13.0-I13.2, I21.01-I21.9, I21.A1-I21.A9, I22.0-I22.9, I24.1, I26.01-I26.99, I27.0-I27.9, I70.92, R01.0-R01.2, R06.00-R06.09, R06.2-R06.4, R06.81-R06.9, R55, R94.39, T36.0X5A-T36.0X5S, T36.1X5A-T36.1X5S, T36.2X5A-T36.2X5S, T36.3X5A-T36.3X5S, T36.4X5A-T36.4X5S, T36.5X5A-T36.5X5S, T36.6X5A-T36.6X5S, T36.7X5A-T36.7X5S, T36.8X5A-T36.8X5S, T36.95XA-T36.95XS, T37.0X5A-T37.0X5S, T37.1X5A-T37.1X5S, T37.2X5A-T37.2X5S, T37.3X5A-T37.3X5S, T37.4X5A-T37.4X5S, T37.5X5A-T37.5X5S, T37.8X5A-T37.8X5S, T37.95XA-T37.95XS, T38.4X5A-T38.4X5S, T38.5X5A-T38.5X5S, T39.015A-T39.015S, T39.095A-T39.095S, T39.1X5A-T39.1X5S, T39.2X5A-T39.2X5S, T39.315A-T39.315S, T39.395A-T39.395S, T39.4X5A-T39.4X5S, T39.8X5A-T39.8X5S, T39.95XA-T39.95XS, T40.0X5A-T40.0X5S, T40.2X5A-T40.2X5S, T40.3X5A-T40.3X5S, T40.4X5A-T40.4X5S, T40.5X5A-T40.5X5S, T40.605A-T40.605S, T40.695A-T40.695S, T40.7X5A-T40.7X5S, T40.905A-T40.905S, T40.995A-T40.995S, T41.5X5A-T41.5X5S, T42.0X5A-T42.0X5S, T42.1X5A-T42.1X5S, T42.2X5A-T42.2X5S, T42.3X5A-T42.3X5S, T42.4X5A-T42.4X5S, T42.5X5A-T42.5X5S, T42.6X5A-T42.6X5S, T42.75XA-T42.75XS, T42.8X5A-T42.8X5S, T43.015A-T43.015S, T43.025A-T43.025S, T43.1X5A-T43.1X5S, T43.205A-T43.205S, T43.215A-T43.215S, T43.225A-T43.225S, T43.295A-T43.295S, T43.3X5A-T43.3X5S, T43.4X5A-T43.4X5S, T43.505A-T43.505S, T43.595A-T43.595S, T43.605A-T43.605S, T43.615A-T43.615S, T43.625A-T43.625S, T43.635A-T43.635S, T43.695A-T43.695S, T43.8X5A-T43.8X5S, T43.95XA-T43.95XS, T44.0X5A-T44.0X5S, T45.0X5A-T45.0X5S, T45.1X1A-T45.1X1S, T45.2X5A-T45.2X5S, T45.3X5A-T45.3X5S, T45.4X5A-T45.4X5S, T45.515A-T45.515S, T45.525A-T45.525S, T45.605A-T45.605S, T45.615A-T45.615S, T45.625A-T45.625S, T45.695A-T45.695S, T45.7X5A-T45.7X5S, T45.8X5A-T45.8X5S, T45.95XA-T45.95XS, T47.1X5A-T47.1X5S, T47.2X5A-T47.2X5S, T47.3X5A-T47.3X5S, T47.4X5A-T47.4X5S, T47.5X5A-T47.5X5S, T47.6X5A-T47.6X5S, T47.7X5A-T47.7X5S, T47.8X5A-T47.8X5S, T47.95XA-T47.95XS, T48.0X5A-T48.0X5S, T48.1X5A-T48.1X5S, T48.205A-T48.205S, T48.295A-T48.295S, T48.3X5A-T48.3X5S, T48.4X5A-T48.4X5S, T48.5X5A-T48.5X5S, T48.6X5A-T48.6X5S, T48.905A-T48.905S, T48.995A-T48.995S, T49.0X5A-T49.0X5S, T49.1X5A-T49.1X5S, T49.2X5A-T49.2X5S, T49.3X5A-

See **CARDIOLOGY**, page 9

CARDIOLOGY

from page 8

T49.3X5S, T49.4X5A-T49.4X5S, T49.5X5A-T49.5X5S, T49.6X5A-T49.6X5S, T49.7X5A-T49.7X5S, T49.8X5A-T49.8X5S, T49.95XA-T49.95XS, T50.3X5A-T50.3X5S, T50.4X5A-T50.4X5S, T50.5X5A-T50.5X5S, T50.6X5A-T50.6X5S, T50.7X5A-T50.7X5S, T50.8X5A-T50.8X5S, T50.A15A-T50.A15S, T50.A25A-T50.A25S, T50.A95A-T50.A95S, T50.B15A-T50.B15S, T50.B95A-T50.B95S, T50.Z15A-T50.Z15S, T50.Z95A-T50.Z95S, T50.905A-T50.905S, T50.995A-T50.995S, T88.52XA-T88.52XS, and Z01.810 for CPT codes 93350, 93351 and 93352 . ICD-10-CM diagnosis codes I25.10-I25.799, I25.811-I25.812, I25.84, I25.89, and I25.9 were removed and replaced with ICD-10-CM diagnosis code range I25.10-I25.9 for CPT® codes 93350, 93351 and 93352.

For Group 3 codes, the following ICD-10 CM diagnoses codes were added: I11.0-I11.9, I13.0-I13.2, I21.01-I21.9, I21.A1-I21.A9, I22.0-I22.9, and R55 for CPT® codes 78451, 78452, 78453, and 78454.

For Group 4 codes, the following ICD-10-M diagnosis codes were added: I11.0-I11.9, I13.0-I13.2, I21.01-I21.9, I21.A1-I21.A9, I22.0-I22.9, I24.8, I24.9, I70.211-I70.269, I70.92, R55, R94.31, R94.39, T36.0X5A-T36.0X5S, T36.1X5A-T36.1X5S, T36.2X5A-T36.2X5S, T36.3X5A-T36.3X5S, T36.4X5A-T36.4X5S, T36.5X5A-T36.5X5S, T36.6X5A-T36.6X5S, T36.7X5A-T36.7X5S, T36.8X5A-T36.8X5S, T36.95XA-T36.95XS, T37.0X5A-T37.0X5S, T37.1X5A-T37.1X5S, T37.2X5A-T37.2X5S, T37.3X5A-T37.3X5S, T37.4X5A-T37.4X5S, T37.5X5A-T37.5X5S, T37.8X5A-T37.8X5S, T37.95XA-T37.95XS, T38.0X5A-T38.0X5S, T38.1X5A-T38.1X5S, T38.2X5A-T38.2X5S, T38.4X5A-T38.4X5S, T38.5X5A-T38.5X5S, T38.6X5A-T38.6X5S, T38.7X5A-T38.7X5S, T38.805A-T38.805S, T38.815A-T38.815S, T38.895A-T38.895S, T38.905A-T38.905S, T38.995A-T38.995S, T39.015A-T39.015S, T39.095A-T39.095S, T39.1X5A-T39.1X5S, T39.2X5A-T39.2X5S, T39.315A-T39.315S, T39.395A-T39.395S, T39.4X5A-T39.4X5S, T39.8X5A-T39.8X5S, T39.95XA-T39.95XS, T40.0X5A-T40.0X5S, T40.2X5A-T40.2X5S, T40.3X5A-T40.3X5S, T40.4X5A-T40.4X5S, T40.5X5A-T40.5X5S, T40.605A-T40.605S, T40.695A-T40.695S, T40.7X5A-T40.7X5S, T40.905A-T40.905S, T40.995A-T40.995S, T41.5X5A-T41.5X5S, T42.0X5A-T42.0X5S, T42.1X5A-T42.1X5S, T42.2X5A-T42.2X5S, T42.3X5A-T42.3X5S, T42.4X5A-T42.4X5S, T42.5X5A-T42.5X5S, T42.6X5A-T42.6X5S, T42.75XA-T42.75XS, T42.8X5A-T42.8X5S, T43.015A-T43.015S, T43.025A-T43.025S, T43.1X5A-T43.1X5S, T43.205A-T43.205S, T43.215A-T43.215S, T43.225A-T43.225S, T43.295A-T43.295S, T43.3X5A-T43.3X5S, T43.4X5A-T43.4X5S, T43.505A-T43.505S, T43.595A-T43.595S, T43.605A-T43.605S, T43.615A-T43.615S, T43.625A-T43.625S, T43.635A-T43.635S, T43.695A-T43.695S, T43.8X5A-T43.8X5S, T43.95XA-T43.95XS, T44.0X5A-T44.0X5S, T44.1X5A-T44.1X5S, T44.2X5A-T44.2X5S, T44.3X5A-T44.3X5S, T44.4X5A-T44.4X5S, T44.5X5A-T44.5X5S, T44.6X5A-T44.6X5S, T44.7X5A-T44.7X5S, T44.8X5A-T44.8X5S, T44.905A-T44.905S, T44.995A-T44.995S, T45.0X5A-T45.0X5S, T45.1X1A-T45.1X1S, T45.1X5A-T45.1X5S, T45.2X5A-T45.2X5S, T45.3X5A-T45.3X5S, T45.4X5A-T45.4X5S, T45.515A-T45.515S, T45.525A-T45.525S, T45.605A-T45.605S, T45.615A-T45.615S, T45.625A-T45.625S, T45.695A-T45.695S, T45.7X5A-T45.7X5S, T45.8X5A-T45.8X5S, T45.95XA-T45.95XS, T46.0X5A-T46.0X5S, T46.1X5A-T46.1X5S, T46.2X5A-T46.2X5S, T46.3X5A-T46.3X5S, T46.4X5A-T46.4X5S, T46.5X5A-T46.5X5S, T46.6X5A-T46.6X5S, T46.7X5A-T46.7X5S, T46.8X5A-T46.8X5S, T46.905A-T46.905S, T46.995A-T46.995S, T47.0X5A-T47.0X5S, T47.1X5A-T47.1X5S, T47.2X5A-T47.2X5S, T47.3X5A-T47.3X5S, T47.4X5A-T47.4X5S, T47.5X5A-T47.5X5S, T47.6X5A-T47.6X5S, T47.7X5A-T47.7X5S, T47.8X5A-T47.8X5S, T47.95XA-T47.95XS, T48.0X5A-T48.0X5S, T48.1X5A-T48.1X5S, T48.205A-T48.205S, T48.295A-T48.295S, T48.3X5A-T48.3X5S, T48.4X5A-T48.4X5S, T48.5X5A-T48.5X5S, T48.6X5A-T48.6X5S, T48.905A-T48.905S, T48.995A-T48.995S, T49.0X5A-T49.0X5S, T49.1X5A-T49.1X5S, T49.2X5A-T49.2X5S, T49.3X5A-T49.3X5S, T49.4X5A-T49.4X5S, T49.5X5A-T49.5X5S, T49.6X5A-T49.6X5S, T49.7X5A-T49.7X5S, T49.8X5A-T49.8X5S, T49.95XA-T49.95XS, T50.0X5A-T50.0X5S, T50.1X5A-T50.1X5S, T50.2X5A-T50.2X5S, T50.3X5A-T50.3X5S, T50.4X5A-T50.4X5S, T50.5X5A-T50.5X5S, T50.6X5A-T50.6X5S, T50.7X5A-T50.7X5S, T50.8X5A-T50.8X5S, T50.A15A-T50.A15S, T50.A25A-T50.A25S, T50.A95A-T50.A95S, T50.B15A-T50.B15S, T50.B95A-T50.B95S, T50.Z15A-T50.Z15S, T50.Z95A-T50.Z95S, T50.905A-T50.905S, T50.995A-T50.995S, T88.52XA-T88.52XS, Z01.810, Z08 and Z09 for CPT® codes 78459, 78491, and 78492. ICD-10-CM diagnosis codes I25.10-I25.119, I25.3-I25.42, and I25.700-I25.812 were removed and replaced with ICD-10-CM diagnosis code range I25.10-I25.9 for CPT® codes 78459, 78491, and 78492. ICD-10-CM diagnosis code range I44.30-I45.5 was removed and replaced with ICD-10-CM diagnosis code range I44.30-I45.6 for CPT® codes 78459, 78491, and 78492.

Effective date

This revision to the LCD is effective for claims processed **on or after September 13, 2018**, for services rendered **on or after November 9, 2017.** 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, *click here*.

Duplex scan of lower extremity arteries – revision to the Part A and Part B LCD

LCD ID number: L33667 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for duplex scan of lower extremity arteries was revised to change diagnosis code range S85.001A-S85.999S to diagnosis code ranges S85.001A-S85.299S and S85.801A-S85.999S. Diagnosis code range S85.301A-S85.599S was added in error. In addition, the LCD was revised to add the following language "<0.9 at rest), it must be accompanied by another appropriate indication before proceeding to more sophisticated or complete studies, except in patients with severely elevated ankle blood pressure" to the "Coverage Indications, Limitations and/or Medical Necessity" section of the LCD, in the second paragraph under "Limitations", as it was omitted in error.

Effective date

The LCD revision related to diagnosis is effective for claims processed **on or after September 18, 2018**, for services rendered **on or after October 1, 2015**. 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*.

Electrocardiography – revision to the Part A and Part B LCD

LCD ID number: L33669 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for electrocardiography was revised to change diagnosis code T36.4X5A to diagnosis code range T36.4X5A-T36.4X5S, diagnosis code T45.515A to diagnosis code range T45.515A-T45.515S, and diagnosis code T50.B95A to diagnosis code range T50.B95A-T50.B95S, as they were omitted in error.

Effective date

The LCD revision related to diagnosis is effective for claims processed **on or after October 1, 2018**, for services rendered **on or after October 1, 2015**. 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*.

Emergency and non-emergency ground ambulance services – revision to the Part A and Part B LCD

LCD ID number: L37697 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for emergency and non-emergency ground ambulance services was revised in the "Coverage Indications, Limitations, and/ or Medical Necessity" section of the LCD under "The Destination" to add "site of transfer (e.g. airport or helicopter pad) between modes of ambulance transport" as a covered destination for emergency ambulance services.

Effective date

This LCD revision is effective for claims processed **on or after September 19, 2018,** for services rendered **on or after June 28, 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*.

Erythropoiesis stimulating agents – revision to the Part A and Part B LCD

LCD ID number: L36276 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 10859 (International Code of Diseases, Tenth Revision [ICD-10] and Other Coding revisions to National Coverage Determinations [NCDs]), the local coverage determination (LCD) for erythropoiesis stimulating agents was revised to remove ICD-10-CM diagnosis code D64.9 from the "ICD-10 Codes that Support Medical Necessity" "Group 3 Codes:" section of the LCD for Healthcare Common Procedure Coding System (HCPCS) codes J0885 and Q5106, as it is on the list of national non-covered diagnoses.

In addition, the LCD was revised to remove revenue code 045X based on updated language in the Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual (IOM).

Effective date

The LCD revision related to CR 10859 is effective for claims processed **on or after September 28, 2018**, for services rendered **on or after January 1, 2017**.

The LCD revision related to revenue code 045X is for claims processed **on or after October 1, 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*.

Humanitarian use device (HUD) and humanitarian device exemption (HDE) process – revision to the Part A and Part B LCD

LCD ID number: L36238 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on an annual review, the local coverage determination (LCD) for humanitarian use device (HUD) and humanitarian device exemption (HDE) process was revised to add language taken from the 21 CFR Parts 814 to reflect changes recently enacted into law by the 21st Century Cures Act. The phrase "fewer than 4,000" has been replaced with "not more than 8,000" in the first paragraph under "Background" in the "Coverage Indications, Limitations, and/or Medical Necessity" section of the LCD.

Effective date

This LCD revision is effective for claims processed **on or after August 23, 2018**, for services rendered **on or after June 7, 2017.** 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, *click here*.

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 remove diagnosis codes M96.65, T84.020A, T84.020D, T84.020S, T84.021A, T84.021D, T84.021S, Z89.621, and Z89.622, that were included in the "ICD-10 Codes that Support Medical Necessity/Group 2 Codes:/Total Knee Arthroplasty" section of the LCD in error.

Effective date

The LCD revision is effective for claims processed **on or after October 1, 2018**, for services rendered **on or after March 2, 2016**. 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*.

Pegfilgrastim (Neulasta®) – revision to the Part A and Part B LCD

LCD ID number: L33747 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 10834, CR 10898, CR 10900, CR 10923, and CR 10932 (October 2018 Quarterly Updates), the pegfilgrastim (Neulasta®) local coverage determination (LCD) was revised to add Healthcare Common Procedure Coding System (HCPCS) code Q5108 to the "CPT®/HCPCS Codes" section of the LCD.

Effective date

This LCD revision is effective for claims processed **on or after October 1, 2018**, for services rendered **on or after July 12, 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*.

Additional Information

2019 ICD-10-CM Coding Changes (Part A/B, Part A and Part B)

The 2019 update to the ICD-10-CM diagnosis coding structure is effective for services rendered **on or after October 1, 2018.** First Coast Service Options Inc. (First Coast) medical policy team has evaluated all active local coverage determinations (LCDs) for diagnosis criteria that are impacted by the 2019 ICD-10-CM update. As a reminder, diagnosis codes included in an LCD are surrogate to the indications addressed within the LCD and providers are required to bill the highest level of specificity for the applicable diagnosis code when reporting services. ICD-10-CM diagnosis codes have been added, revised, and deleted. The following is a list of the impacted LCDs. **Note:** The LCDs will be viewable to the public in Medicare Coverage Database **October 11, 2018.**

Part A/B Combined LCDs

L33256 3D Interpretation and Reporting of Imaging Studies

L36767 Aortography and peripheral angiography

L33274 Botulinum Toxins

L33275 Carboplatin (Paraplatin®, Paraplatin-AQ®)

L33278 Cetuximab (Erbitux®)

L36393 Controlled Substance Monitoring and Drugs of Abuse Testing

L33989 Docetaxel (Taxotere®)

L33669 Electrocardiography

L36276 Erythropoiesis Stimulating Agents

L33723 Etoposide (Etopophos®, Toposar®, Vepesid®, VP-16)

L34003 Hepatitis B Surface Antibody and Surface Antigen

L36773 Intensity Modulated Radiation Therapy (IMRT)

L33382 Lumbar Spinal Fusion for Instability and Degenerative Disc Conditions

L33618 Major Joint Replacement (Hip and Knee)

L33689 Mohs Micrographic Surgery (MMS)

L34859 Nerve Conduction Studies and Electromyography

L33695 Non-invasive Extracranial Arterial Studies

L33730 Paclitaxel (Taxol®)

L33747 Pegfilgratim (Neulasta®)

L33252 Psychiatric Diagnostic Evaluation and Psychotherapy Services

L34520 Psychological and Neuropsychological Tests

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

L36342 Screening and Diagnostic Mammography

See **ICD-10**, page 13

ICD-10

from page 12

L34021 Sedimentation Rate, Erythrocyte

L34022 Serum Phosphorus

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

L33411 Surgical Management of Morbid Obesity

L34031 Total Calcium

L33768 Transthoracic Echocardiography (TTE)

L33766 Visual Field Examination

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

Part A only LCD

L33972 Psychiatric Partial Hospitalization Program

Part B only LCDS

L33904 B-Scan

L33813 Destruction of Malignant Skin Lesions

L33906 Epidural

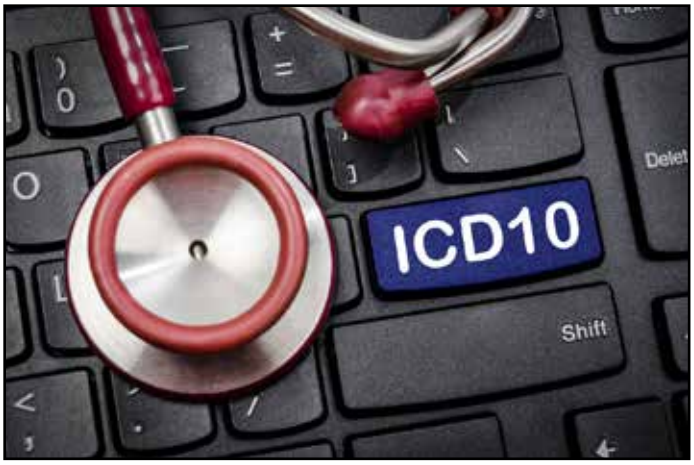
L33818 Excision of Malignant Skin Lesions

L33907 Hepatic (Liver) Function Panel

L33908 High Sensitivity C-Reactive Protein (hsCRP)

L33912 Injection of Trigger Points

L33933 Peripheral Nerve Blocks



L33937 Proton Beam Radiotherapy

L33977 Transcranial Doppler Studies

Effective date

These LCD revisions are effective for services rendered **on or after October 1, 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, *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.

Quarterly influenza virus vaccine code update – January 2019

***Note**: This article was revised September 6, 2018 to reflect the revised change request (CR) 10871 issued September 5. In the article, the CR release date, transmittal number, and the web address for accessing CR 10871 are revised. All other information remains the same. This information was previously published in the August 2018 Medicare A Connection, page 1.*

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

CR 10871 provides instructions for payment and edits for Medicare's common working file (CWF) and fiscal intermediary shared system (FISS) to include and update new or existing influenza virus vaccine codes. This update includes one new influenza virus vaccine code: 90689. Please make certain your billing staffs are aware of this update.

Background

Effective for claims processed with dates of service (DOS) on or after January 1, 2019, influenza virus vaccine code 90689 (*Influenza virus vaccine quadrivalent (IIV4), inactivated, adjuvanted, preservative free, 0.25mL dosage, for intramuscular use)* will be payable by Medicare. The short descriptor is VACC IIV4 NO PRSRV 0.25ML IM. This new code will be included on the 2019 Medicare physician fee schedule database file update and the annual Healthcare Common Procedure Coding System (HCPCS) update.

Except as noted below, MACs will use the Centers for Medicare & Medicaid Services (CMS) Seasonal Influenza Vaccines Pricing webpage: *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html* to obtain the payment rate for 90689.The new influenza virus vaccine code 90689 is not retroactive to August 1, 2018. No claims should be accepted for influenza virus vaccine code 90689 between the DOS August 1, 2018, and December 31, 2018. If claims are received in January 2019 with code 90689 for DOS between August 1, 2018, and December 31, 2018, MACs will follow their normal course of action for codes billed prior to their effective date.

Payment basis for institutional claims

MACs will pay for influenza virus vaccine code 90689 with a type of service (TOS) of V based on reasonable cost to

- Hospitals (type of bill 12x and 13x)
- Skilled nursing facilities (22x and 23x)
- Home health agencies (34x)
- Hospital-based renal dialysis facilities (72x)

See **CODE**, page 15

ALLOWANCE

from page 1

Payment allowances for codes for which products have not yet been approved will be provided when the products have been approved and pricing information becomes available to CMS.

The payment allowances for pneumococcal vaccines are based on 95 percent of the AWP and are updated on a quarterly basis via the quarterly average sales price (ASP) drug pricing files.

Note: MACs will reprocess any previously processed and paid claims for the current flu season that were paid using influenza vaccine payment allowances other than the allowances published in the influenza vaccine pricing website for the 2018/2019 season, that began August 1, 2018. This reprocessing should occur by November 1, 2018.

Additional information

The official instruction, CR 10914, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4124CP.pdf*.

If you have questions, your MACs may have more information. Find their website at *https://go.cms.gov/MAC-website-list*.

Document history

Date of change	Description
September 4, 2018	Initial article released.

MLN Matters® Number: MM10914
Related CR Release Date: August 31, 2018
Related CR Transmittal Number: R4124CP
Related Change Request (CR) Number: 10914
Effective Date: August 1, 2018
Implementation No later than October 1, 2018

Reminder on billing requirements implemented for non-OPPS providers

Provider type affected

This *MLN Matters*® special edition article is intended for non-outpatient prospective payment system (OPPS) hospital providers (for example, Maryland waiver hospitals, critical access hospitals (CAH)) and other non-OPPS provider types (for example, outpatient rehabilitation facility (ORF), comprehensive outpatient rehabilitation facility (CORF), skilled nursing facility (SNF), end-stage renal disease (ESRD) facility, home health agency (HHA)).

What you need to know

This article conveys enforcement editing requirements for the *Medicare Claims Processing Manual*, Chapter 12, Section 30 which describes Correct Coding Policy, Section D. Coding Services Supplemental to Principal Procedure (Add-On Codes) Code and Chapter 23, Section 20.9 which describes the Correct Coding Initiative. These requirements are not new requirements. Previously, these requirements were discussed in CRs 10504 and 10699, which were effective April 1, 2018, and July 1, 2018. *MLN Matters*® article for CR 10699 is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10699.pdf*. CR 10504 is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R2044OTN.pdf*. Make sure your billing staff is aware of these instructions.

Background

Correct Coding Initiative (CCI) edits history

The Centers for Medicare & Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims. CMS developed its coding policies based on coding conventions defined in the *American Medical Association's CPT® Manual*, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices.

Since 1996 the Medicare NCCI procedure to procedure (PTP) edits have been assigned to either the column one/column two correct coding edit file or the mutually exclusive edit file based on the criterion for each edit. The mutually exclusive edit file included edits where two procedures could not be performed at the same patient encounter because the two procedures were mutually exclusive based on anatomic, temporal, or gender considerations. All other edits were assigned to the column one/column two correct coding edit file.

In order to simplify the use of PTP edit files, CMS consolidated the two edit files into the column one/column two correct coding edit file. This change occurred for PTP edits in NCCI version 18.1 scheduled for April 1, 2012.

See **REMINDER**, page 16

CODE

from page 14

- Critical access hospitals (85x)

MACs will pay for influenza virus vaccine code 90689 with a TOS of V based on the lower of the actual charge or 95 percent of the average wholesale price (AWP), to:

- Indian Service Hospitals (IHS) (12x and 13x)
- Hospices (81x and 82x)
- IHS critical access hospitals (85x)
- Comprehensive outpatient rehabilitation facilities (CORFs) (75x)
- Independent renal dialysis facilities (72x)

Note: In all cases, coinsurance and deductible do not apply.

Additional information

The official instruction, CR 10871, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4127CP.pdf*.

If you have questions, your MACs may have more information. Find its website at *https://go.cms.gov/MAC-website-list*.

Document history

Date of change	Description
September 6, 2018	The article was revised to reflect the revised CR 10871 issued September 5. In the article, the CR release date, transmittal number, and the web address for accessing CR 10871 are revised. All other information remains the same.
August 6, 2018	Initial article released.

MLN Matters® Number: MM10871 *Revised*
Related CR Release Date: September 5, 2018
Related CR Transmittal Number: R4127CP
Related Change Request (CR) Number: 10871
Effective Date: January 1, 2019
Implementation January 7, 2019

REMINDER

from page 15

After this date, it will only be necessary to search the column one/column two correct coding edit file for active or previously deleted edits.

NCCI PTP edits are used by Medicare administrative contractors (MACs) to adjudicate provider claims for physician services, outpatient hospital services, and outpatient therapy services. They are not applied to facility claims for inpatient services.

Although the NCCI was initially developed for use by Medicare carriers (A/B MACs processing practitioner service claims) to process Part B claims, many of the edits were added to the outpatient code editor (OCE) in August, 2000, for use by fiscal intermediaries (A/B MACs processing outpatient hospital service claims) to process claims for Part B outpatient hospital services. Some of the edits applied to outpatient hospital claims through OCE differ from the comparable edits in NCCI. Effective January 2006, all therapy claims at most sites of service paid by A/B MACs processing facility claims (fiscal intermediaries) were also subject to NCCI PTP edits in the OCE. These include, but are not limited to, therapy services reported by SNFs, CORFs, HHAs, and outpatient rehabilitation agencies (OPTs - outpatient physical therapy and speech pathology services). NCCI PTP edits used for practitioner claims are also used for ambulatory surgical center claims.

Prior to January 1, 2012, NCCI PTP edits incorporated into OCE appeared in OCE one calendar quarter after they appear in NCCI. Effective January 1, 2012, NCCI PTP edits in OCE appear synchronously with NCCI PTP edits for practitioners. Hospitals, like physicians and other providers, must code correctly even in the absence of NCCI or OCE edits. For example, new category I CPT® codes are generally effective on January 1 each year, and many new edits for these codes appear in NCCI January 1. Prior to January 1, 2012, the new edits for these codes did not appear in OCE until the following April 1. Hospitals were required to code correctly during the three month delay.

OCE will generate CCI edit dispositions. All current CCI edits will be incorporated in the OCE.

The CCI edits are applicable to claims submitted on behalf of the same beneficiary, provided by the same provider and on the same date of service. The edits are of two major types of coding situations. One type, referred to as the comprehensive/component edits, are those edits which are applied to code combinations where one of the codes is a component of the more comprehensive code. In this instance only the comprehensive code is paid. The other type, referred to as the mutually exclusive edits, are those edits which are applied to code combinations where one of the codes is considered to be either impossible or improbable to be performed with the other code. Other unacceptable code combinations are also included. One such code combination consists of one code that represents a service “with” something and the other is “without” the something. The edit is set to pay the lesser priced service.

OCE / OPPS OCE /non-OPPS OCE / IOCE history

OCE

Prior to OPPS implementation in August 2000, all outpatient claims processed through the OCE for basic editing. The software focused solely on editing claims without specifying any action to take when an edit occurred. It also did not compute any information for payment purposes. With the implementation of the OPPS in August 2000, CMS planned to apply CCI edits within the OCE, with the exception of anesthesiology, to hospital outpatient claims. The purpose of the CCI edits is to ensure the most comprehensive groups of codes are billed rather than the component parts. Additionally, CCI edits check for mutually exclusive code pairs. These edits were being implemented to ensure that only appropriate codes are grouped and priced. All of this editing was maintained by a single OCE

While the software maintained the editing logic of previous versions, assignment of APC numbers for services has been added to meet Medicare’s mandated OPPS implementation. The revised program indicates what actions to take when an edit occurs, and the reason(s) why the actions are necessary. For example, an edit can cause a line item to be denied payment while still allowing the claim to be processed for payment. In this case, the line item cannot be resubmitted but can be appealed.

A major change was the processing of claims with service dates that span more than one day. Each claim is represented by a collection of data, consisting of all necessary demographic (header) data, plus all services provided (line items).

Note: It is the user’s responsibility to organize all applicable services into a single claim record and pass them as a unit to the software.

The OCE only functions on a single claim and does not have any cross claim capabilities. The software can accept up to 450 line items per claim.

Certain services (for example, physical therapy, diagnostic clinical laboratory) are excluded from Medicare’s prospective payment system for hospital outpatient departments. These services are exceptions paid under fee schedules and other prospectively determined rates.

OPPS OCE versus non-OPPS OCE

Due to the uniqueness of some institutional claim processing and payment methodologies, it was necessary to separate the OCE into two separate software packages (an OPPS OCE and a non-OPPS OCE until the differences could be addressed. This separation began in January 1, 2001. It continued until January 2008. Many of the specific editing with dispositions had to be abandoned for the non-OPPS hospital claims.

The ‘integrated’ outpatient code editor (I/OCE)

Finally in July 2007, the OCE logic could be updated and implemented with an “Integrated” approach. The I/OCE program processes claims for all outpatient institutional providers including hospitals that are subject to the OPPS

See **REMINDER**, page 17

REMINDER

from page 16

as well as hospitals that are NOT (Non-OPPS). Claim will be identified as "OPPS" or "non-OPPS" by passing a flag to the OCE in the claim record, 1=OPPS, 2=Non-OPPS; a blank, zero, or any other value is defaulted to 1. The I/OCE software combines editing logic to disposition with the new ambulatory payment classification (APC) assignment program designed to meet the mandated OPPS implementation. The software performs the following functions when processing a claim:

- Edit a claim for accuracy of submitted data
- Assign APC
- Assign CMS-designated status indicator
- Assign payment indicator
- Compute discounts, if applicable
- Determine a claim disposition based on generated edits
- Determine if packaging is applicable
- Determine payment adjustment, if applicable

This integration does not change current logic that is applied to outpatient bill types that already pass through the OPPS OCE software.

Editing that only applied to OPPS hospitals (for example, blood, drug, partial hospitalization logic) in the past will not be applied to non-OPPS hospitals at this time. However, with the I/OCE, line items on claims from non-OPPS hospitals will be assigned specific edit numbers and dispositions, where in the past; this type of detail was not provided.

Addition of specific edit numbers and dispositions for non-OPPS hospitals

With the implementation of the July 2018 release of the I/OCE, CMS was able to revisit and re-instate NCCI PTP editing, along with additional editing with disposition into the system logic for non-OPPS hospitals and other non-OPPS provider types.

- NCCI add-on code editing with edits 106, 107, and 108
- Invalid procedure code editing with edit 6
- Invalid modifier editing with edit 22
- NCCI PTP editing with edits 20 and 40

As indicated by the development of the NCCI program, it has always been CMS's intent that all providers code correctly as we continue to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims regardless of our ability to edit on a pre-payment basis.

Tables 6.3 and 6.4 were updated in the I/OCE CMS Specifications V19.2.R1 Effective 07/01/2018 as found on our website on the OCE Quarterly Release Files July 2018 Quarterly Data file zip file link at *https://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/OCEQtrReleaseSpecs.html*.

6.3 OCE edits applied by OPPS bill type table [OPPS flag =1]

Row #	Provider/ bill types	Edits applied (by edit number)	APC buffer
1	12x or 14x with condition code 41	46	Buffer not completed
2	12x or 14x without condition code 41	1-9, 11-18, 20-23, 25-28, 35-38, 40-45, 47-50, 52-54, 56-58, 60-79, 81-85, 87, 92, 93, 94, 98, 99, 100, 102, 103, 105	Buffer completed
3	13x with condition code 41	1-9, 11-18, 20-23, 25-28, 29-34, 37, 38, 40-45, 47-50, 52, 54, 56-58, 60-62, 65-80, 82–85, 87, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 105	Buffer completed
4	13x without condition code 41	1-9, 11-18, 20-23, 25-28, 35-38, 40-45, 47-50, 52, 54, 56-58, 60-79, 81, 82-85, 87, 92, 93, 94, 98, 99, 100, 101, 102, 103, 105	Buffer completed
5	76x (CMHC)	1-9, 11-13, 15, 18, 20, 22, 23, 25, 26, 29-34, 38, 40, 41, 43-45, 47-50, 53-55, 61, 65, 69, 71-73, 75, 77- 80, 82, 84, 85, 87, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 105	Buffer completed
6	34x (HHA) with vaccine	1-5, 7-9, 11-13, 15, 18, 20, 25-26, 28, 38, 40, 41, 43-45, 47, 49-50, 53-55, 62, 65, 69, 71, 73, 75, 77-79, 82, 84, 85, 87, 92, 93, 94, 98, 99, 100, 105	Buffer completed
7	34x (HHA) without vaccine	1-5, 7-9, 11-13, 20, 25, 26, 40-41, 44, 50, 53-55, 65, 69, 94	Buffer not completed
8	43x (RNHCI)	25, 26, 41, 44, 46, 55, 65	Buffer not completed

See **REMINDER**, page 18

REMINDER

from page 17

Row #	Provider/ bill types	Edits applied (by edit number)	APC buffer
9	71x (RHC), 77x (FQHC through v15.2)	1-5, 6, 25, 26, 41, 61, 65, 72, 91, 94, 104	Buffer not completed
10	77x (FQHC PPS) [v15.3 -]	1-6, 25, 26, 41, 65, 72, 84, 88, 89, 90, 91, 94	Buffer not completed
11	Any bill type except 12x, 13x, 14x, 34x, 43x, 71x, 73x/77x, 76x, with CC 07, with antigen, splint, or cast	1-9, 11-13, 18, 20, 23, 25, 26, 28, 38, 40, 41, 43-45, 47, 49, 50, 53-55, 62, 65, 69, 71, 73, 75, 77 -79, 82, 84, 85, 87, 92, 93, 94, 98, 99, 100, 105, 106, 107, 108	Buffer completed
12	75x (CORF)	1-9, 11-13, 15, 20, 22, 23, 25, 26, 40, 41, 44, 48, 50, 53-55, 61, 65, 69, 72, 94, 106, 107, 108	Buffer not completed
13	22x, 23x (SNF)	1-9, 11-13, 20, 23, 25, 26, 28, 40-41, 44, 50, 53, 54, 55, 61, 62, 65, 69, 72, 94, 106, 107, 108	Buffer not completed
14	32x, (HHA)	1-9, 11, 12, 20, 22, 25, 26, 40, 41, 44, 50, 53-55, 65, 69, 86, 94, 106,107, 108	Buffer not completed
15	72x (ESRD)	1-9, 11, 12, 20, 22, 25, 26, 40, 41, 44, 50, 53, 54, 55, 61, 65, 69, 72, 94, 106, 107, 108	Buffer not completed
16	74x (ORF)	1-9, 11-13, 20, 22, 25, 26, 40-41, 44, 48, 50, 53, 54, 55, 61, 65, 69, 72, 94, 106, 107, 108	Buffer not completed
17	81x (Hospice), 82x	1-9, 11, 12, 20, 22, 25, 26, 40, 41, 44, 50, 53-55, 65, 69, 86, 94, 106, 107, 108	Buffer not completed

6.4 OCE edits applied by non-OPPS hospital bill type table [OPPS flag=2]

Row #	Provider/ bill types	Edits applied (by edit number)	APC buffer
1	12x or 14x with condition code 41, and OPPS flag=2	46	Buffer not completed
2	12x or 14x without condition code 41, and OPPS flag=2	1-3, 5, 6, 8, 9, 11, 12, 15, 17, 20, 22, 23, 24, 25, 26, 28, 40, 41, 50, 53, 54, 61, 65, 67-69, 72, 83, 94, 103, 106, 107, 108	Buffer not completed
3	13x with condition code 41, and OPPS flag=2	1-3, 5, 6, 8, 9, 11, 12, 15, 17, 20, 22, 23, 24, 25, 26, 28, 40, 41, 50, 54, 61, 65, 67-69, 72, 83, 94, 103, 106, 107, 108	Buffer not completed
4	13x without condition code 41, and OPPS flag=2	1-3, 5, 6, 8, 9, 11, 12, 15, 17, 20, 22, 23, 24, 25, 26, 28, 40, 41, 50, 54, 61, 65, 67-69, 72, 83, 94, 103, 106, 107, 108	Buffer not completed
5	85x and OPPS flag=2	1-3, 5, 6, 8, 9, 11, 12, 15, 20, 22, 23, 24, 25, 26, 28, 40, 41, 50, 54, 61, 65, 67-69, 72, 74, 83, 94, 106, 107, 108	Buffer not completed

Additional information

If you have questions, your MACs may have more information. Find their website at *https://go.cms.gov/MAC-website-list*.

Document history

Date of change	Description
September 4, 2018	Initial article released.

MLN Matters® Number: SE18012
Related CR Release Date: March 16, 2018; June 15, 2018
Related CR Transmittal Number: R2044OTN and R4074CP
Related Change Request (CR) Number: 10504; 10699
Effective Date: April 1, 2018; July 1, 2018
Implementation: April 2, 2018, for CR 10504 and July 2, 2018, for CR 10699

Upcoming provider outreach and educational events

Topic: Medicare outpatient physical therapy services (A/B)

Date: Tuesday, October 30
Time: 11:30 a.m.-1:00 p.m.
Type of Event: Webcast

https://medicare.fcso.com/Events/0414762.asp

Topic: Medicare Speaks 2018 Panama City

Date: Wednesday-Thursday, November 7-8
Time: 8:00 a.m.-4:30 p.m. CT
Type of Event: Face-to-face

https://medicare.fcso.com/medicare_speaks/0404329.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.

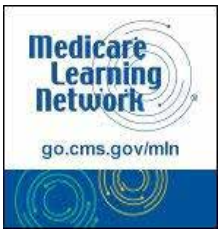
Never miss a training opportunity

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® – Special Edition for August 20, 2018

New Medicare Card Mailing Update – Wave 5 Begins, Wave 3 Ends

We started mailing new Medicare cards to people with Medicare who live in Wave 5 states: Alabama, Florida, Georgia, North Carolina, and South Carolina. We continue to mail new cards to people who live in Wave 4 states, as well as nationwide to people who are new to Medicare.

We finished mailing cards to people with Medicare who live in Wave 1, 2 and 3 states and territories. If your Medicare patients say they did not get a card, instruct them to:

- Sign into *MyMedicare.gov* to see if we mailed their card. If so, they can print an official card. They must create an account if they do not already have one.
- Call 1-800-MEDICARE (1-800-633-4227). There might be something that needs to be corrected, such as updating their mailing address.

You can also print out and give them a copy of "*Still Waiting for Your New Card?*" or you can *order* copies to hand out.

To ensure your Medicare patients continue to get care, you can use either the former Social Security number-based Health Insurance Claim Number or the new alpha-numeric Medicare Beneficiary Identifier (MBI) for all Medicare transactions through December 31, 2019.

Check this *website* as the mailings progress. Continue to direct your Medicare patients to *Medicare.gov/NewCard* for information about the mailings and to sign up to get email about the status of card mailings in their state.

Information on the transition to the new MBI:

- *New MBI Get It, Use It* MLN Matters® Article
- *Transition to New Medicare Numbers and Cards* MLN Fact Sheet
- *New Medicare Card information* website

The Medicare Learning Network®, MLN Connects®, and MLN Matters® are registered trademarks of the U.S. Department of Health and Human Services (HHS).

MLN Connects®for August 23, 2018

MLN Connects® for August 23, 2018
View this edition as a PDF

News & Announcements

- New Medicare Card: 0 not O
- Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier
- 2016 PQRS and 2018 Value Modifier Experience Reports
- Patients Over Paperwork: Medicare Physician Fee Schedule Proposed Rule Presentation
- 2019 MIPS Performance Year Virtual Groups Toolkit
- Hospice Compare Quarterly Refresh
- 2016 Inpatient Hospital Utilization and Payment Data
- Hospices: Second Quarter HQRP Update

Provider Compliance

- Medicare Hospital Claims: Avoid Coding Errors — Reminder

Claims, Pricers & Codes

- 2019 MS-DRG Definitions Manual and Software
- Hospice: NOE information in the HETS Transaction

Upcoming Events

- Quality Payment Program Virtual Groups Webinar — August 27
- Person-Centered Approaches to Support Dual Eligibles for Medicare & Medicaid- September 6
- Dementia Care: Opioid Use & Impact for Persons Living with Dementia Call — September 18

Medicare Learning Network Publications & Multimedia

- Additional Search Features on FISS Provider DDE Screen MLN Matters Article — New
- ICD-10 and Other Coding Revisions to NCDs MLN Matters Article — New
- Clarifying Language for Chapters 3 and 5 of the MSP Manual MLN Matters Article — New
- Medicare Coverage of Diabetes Supplies MLN Matters Article — New
- Improvements in Hospice Billing and Claims Processing MLN Matters Article — Revised

The Medicare Learning Network®, MLN Connects®, and MLN Matters® are registered trademarks of the U.S. Department of Health and Human Services (HHS).

MLN Connects® for August 30, 2018

MLN Connects® for August 30, 2018
View this edition as a PDF

News & Announcements

- New Medicare Card: 0 not O
- Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier
- 2016 PQRS and 2018 Value Modifier Experience Reports
- Patients Over Paperwork: Medicare Physician Fee Schedule Proposed Rule Presentation
- 2019 MIPS Performance Year Virtual Groups Toolkit
- Hospice Compare Quarterly Refresh
- 2016 Inpatient Hospital Utilization and Payment Data
- Hospices: Second Quarter HQRP Update

Provider Compliance

- Medicare Hospital Claims: Avoid Coding Errors — Reminder

Claims, Pricers & Codes

- 2019 MS-DRG Definitions Manual and Software
- Hospice: NOE information in the HETS Transaction

Upcoming Events

- Quality Payment Program Virtual Groups Webinar — August 27
- Person-Centered Approaches to Support Dual Eligibles for Medicare & Medicaid- September 6
- Dementia Care: Opioid Use & Impact for Persons Living with Dementia Call — September 18

Medicare Learning Network Publications & Multimedia

- Additional Search Features on FISS Provider DDE Screen MLN Matters Article — New
- ICD-10 and Other Coding Revisions to NCDs MLN Matters Article — New
- Clarifying Language for Chapters 3 and 5 of the MSP Manual MLN Matters Article — New
- Medicare Coverage of Diabetes Supplies MLN Matters Article — New
- Improvements in Hospice Billing and Claims Processing MLN Matters Article — Revised

The Medicare Learning Network®, MLN Connects®, and MLN Matters® are registered trademarks of the U.S. Department of Health and Human Services (HHS).

MLN Connects® for September 6, 2018

MLN Connects® for September 6, 2018
View this edition as a PDF

News & Announcements

- Physician Fee Schedule Year 3 Proposed Rule: Comments due September 10
- QRDA III Implementation Guide: Submit Comments by September 21
- PEPPERs for Short-term Acute Care Hospitals
- Hospice Quality Reporting Program: Training Materials from August Webinar
- Healthy Aging® Month: Discuss Preventive Services with your Patients

Provider Compliance

- CMS Provider Minute Video: The Importance of Proper Documentation — Reminder

Claims, Pricers & Codes

- Average Sales Price Files: October 2018

Upcoming Events

- Quality Payment Program All-Payer Combination Option Overview Webinar — September 12
- New Medicare Card Open Door Forum — September 13
- Dementia Care: Opioid Use & Impact for Persons Living with Dementia Call — September 18
- Medicare Diabetes Prevention Program: New Covered Service Call — September 26

Medicare Learning Network Publications & Multimedia

- Review of Opioid Use during the IPPE and AWV MLN Matters® Article — New
- Update of the Hospital OPPS: October 2018 MLN Matters Article — New
- Physician Fee Schedule Listening Session: Audio Recording and Transcript — New
- Next Generation ACO Model 2019 Benefit Enhancement MLN Matters Article — Revised
- Mass Immunizers and Roster Billing Booklet — Revised

The Medicare Learning Network®, MLN Connects®, and MLN Matters® are registered trademarks of the U.S. Department of Health and Human Services (HHS).

MLN Connects® for September 13, 2018

MLN Connects® for September 13, 2018
View this edition as a PDF

News & Announcements

- Help Your Medicare Patients Avoid and Report Scams
- Hospice Provider Preview Reports: Review Your Data by October 5
- IRF Provider Preview Reports: Review Your Data by October 8
- LTCH Provider Preview Reports: Review Your Data by October 8
- Open Payments: Key Thresholds for Program Year 2019 Reporting
- Open Payments: Program Year 2019 Teaching Hospital List
- Hand in Hand: A Training Series for Nursing Homes
- Quality Payment Program: Other Payer Advanced APM Resources
- Mapping Medicare Disparities Tool: Hospital View
- Physician Compare: Public Reporting Webinar Materials
- Prostate Cancer Awareness Month

Provider Compliance

- Bill Correctly for Device Replacement Procedures - Reminder

Upcoming Events

- Dementia Care: Opioid Use & Impact for Persons Living with Dementia Call — September 18
- Medicare Diabetes Prevention Program: New Covered Service Call — September 26
- Final Modifications to the Quality of Patient Care Star Rating Algorithm Call — October 3
- Comparative Billing Report on Psychologists Webinar — October 17

Medicare Learning Network Publications & Multimedia

- Billing Requirements Implemented for non-OPPS Providers MLN Matters® Article — New
- Annual Clotting Factor Furnishing Fee: 2019 Update MLN Matters Article — New
- ASC Payment System: October 2018 Update MLN Matters Article — New
- Influenza Vaccine Payment Allowances: Annual Update MLN Matters Article — New
- Influenza Virus Vaccine Code: January 2019 Update MLN Matters Article — Revised
- Certification Statement Policies MLN Matters Article — Revised
- Telehealth Billing Requirements for Distant Site Services MLN Matters Article — Revised
- Complying with Documentation Requirements for Laboratory Services Fact Sheet — Revised
- Global Surgery Booklet— Revised
- Medicare Provider-Supplier Enrollment National Educational Products — Reminder

MLN Connects® – Special Edition for September 17, 2018

New Medicare Card Mailing Update – Wave 6 Begins, Wave 4 Ends

CMS started mailing new Medicare cards to people with Medicare who live in Wave 6 states: Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Texas, Utah, Washington and Wyoming.

We finished mailing cards to people with Medicare who live in *Waves 1, 2, 3, and now Wave 4 states and territories*. If your Medicare patients say they did not get a card, ask them to:

Sign into *MyMedicare.gov* to see if we mailed their card. If so, they can print an official card. They must create an account if they do not already have one.

Call 1-800-MEDICARE (1-800-633-4227). There might be something that needs to be corrected, such as updating their mailing address.

You can also print out and give them a copy of *Still Waiting for Your New Card?*, or you can order *copies* to hand out.

To ensure your Medicare patients continue to get care, you can use either the former Social Security number-based Health Insurance Claim Number or the new alpha-numeric Medicare Beneficiary Identifier (MBI) for all Medicare transactions through December 31, 2019.

Check this *website* as the mailings progress. Continue to direct your Medicare patients to *Medicare.gov/NewCard* for information about the mailings and to sign up to get email about the status of card mailings in their state.

We are committed to mailing new cards to all people with Medicare by April 2019.

Information on the transition to the new MBI:

New MBI Get It, Use It MLN Matters® Article

Transition to New Medicare Numbers and Cards Fact Sheet

New Medicare Card information website

MLN Connects® – Special Edition for September 19, 2018

New Medicare Card – Progress Updates

CMS continues to successfully mail newly-designed Medicare cards with the new Medicare number and we are excited to share important progress updates with you.

As of August 31, we mailed nearly 35 million cards and continue to mail more every day. We are processing claims and eligibility requests with the Medicare Beneficiary Identifier (MBI), showing that providers are successfully using the new number.

We started mailing new cards to people with Medicare who live in Wave 6 states this week and finished mailing cards to people who live in Waves 1, 2, 3 and 4 states. Because card mailing is progressing so well, we updated the *mailing schedule* to include an approximate start date for the last wave, and we are on track to finish mailing new cards to all people with Medicare before April 2019.

With our ongoing focus on fraud and protecting the identities of people with Medicare, we are continuously adjusting and improving our mailing strategy to make sure we are mailing new cards to accurate addresses and using the highest levels of fraud protection throughout the mailing. To do this, we are:

- Using trusted industry tools and standards to verify addresses
- Comparing each address against multiple information sources to ensure we are mailing to the right person and the right address
- Mailing cards to people with Medicare when we have high confidence in their identity and address

If your Medicare patients say they did not get a card after their mailing wave ends, ask them to:

- Call 1-800-MEDICARE (1-800-633-4227) where we can verify their identity, check their address, and help them get their new card
- Continue to use their current card to get health care services until they get their new card

Your Medicare patients should continue to protect their new number to prevent medical identity theft and health care fraud. We will continue to raise awareness about potential scams and how they can prevent fraud through our outreach and launched a national fraud prevention campaign in September before Medicare Open Enrollment.

The Medicare Learning Network®, MLN Connects®, and MLN Matters® are registered trademarks of the U.S. Department of Health and Human Services (HHS).

MLN Connects® for September 20, 2018

MLN Connects® for September 20, 2018
View this edition as a PDF

News & Announcements

- CMS Proposes to Lift Unnecessary Regulations and Ease Burden on Providers
- Hospital Quality Reporting System Open for CY 2018 eCQM Data
- eCQM Value Sets: Updates for 2019 Reporting and Performance Periods
- MIPS Targeted Review Request: Deadline Extended to October 15
- Quality Payment Program: MIPS Resources
- Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier

Provider Compliance

- Billing for Stem Cell Transplants — Reminder

Claims, Pricers & Codes

- ASP Pricing Files and Coverage for Drugs

Upcoming Events

- Medicare Diabetes Prevention Program: New Covered Service Call — September 26
- FY 2019 IPPS/LTCH PPS Final Rule Webinar— September 26
- Final Modifications to the Quality of Patient Care Star Rating Algorithm Call — October 3
- Provider Compliance Focus Group Meeting — October 5
- Submitting Your Medicare Part A Cost Report Electronically Webcast — October 15
- Home Health Quality Reporting Program In-Person Training Event — November 6 and 7

Medicare Learning Network Publications & Multimedia

- IMRT Planning Services Editing MLN Matters Article — New
- Payment Policy Changes Affecting Hospice Aggregate Cap Calculation and Designation of Hospice Attending Physicians MLN Matters Article — New
- Medicare Claims Processing Manual, Chapter 23: Update MLN Matters Article — New
- Procedure Coding: Using the ICD-10-PCS Web-Based Training — New
- ICD-10 and Other Coding Revisions to NCDs MLN Matters Article — Revised
- HCPCS Drug/Biological Code Changes: October 2018 Update MLN Matters Article — Revised
- Hurricane Maria and Medicare Disaster Related U.S Virgin Islands and Commonwealth of Puerto Rico Claims MLN Matters Article — Revised
- Preventive Services Poster Educational Tool — Revised
- Medicare Fraud & Abuse Poster — Revised

The Medicare Learning Network®, MLN Connects®, and MLN Matters® are registered trademarks of the U.S. Department of Health and Human Services (HHS).

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

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 3409
Mechanicsburg, PA 17055-1849

Special or overnight deliveries
Provider Enrollment
2020 Technology Parkway Suite 100
Mechanicsburg, PA 17055-1849

Redetermination
Florida:
Medicare Part A Redetermination/Appeals
P. O. Box 3409
Jacksonville, FL 32232-5053

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