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

In this issue

Update to Medicare deductible, coinsurance and premium rates for 2019

Provider type affected

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

Provider action needed

Change request (CR) 11025 provides instruction for MACs to update the claim processing system with the new 2019 Medicare deductible, coinsurance, and premium rates. Make sure your billing staffs are aware of these changes.

Background

Beneficiaries who use covered Part A services may be subject to deductible and coinsurance requirements. A beneficiary is responsible for an inpatient hospital deductible amount, which is deducted from the amount payable by the Medicare program to the hospital, for inpatient hospital services furnished in a spell of illness. When a beneficiary receives such services for more than 60 days during a spell of illness, he or she is responsible for a coinsurance amount equal to one-fourth of the inpatient hospital deductible per-day for the 61st-90th day spent in the hospital.

An individual has 60 lifetime-reserve days of coverage, which they may elect to use after the 90th day in a spell of illness. The coinsurance amount for these days is equal to one-half of the inpatient hospital deductible. A beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible per day for the 21st through the 100th day of skilled nursing facility (SNF) services furnished during a spell of illness.

Most individuals age 65 and older, and many disabled individuals under age 65, are insured for health insurance (HI) (Part A) benefits without a premium payment. The Social Security Act provides that certain aged and disabled

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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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persons who are not insured may voluntarily enroll, but are subject to the payment of a monthly premium. Since 1994, voluntary enrollees may qualify for a reduced premium if they have 30-39 quarters of covered employment. When voluntary enrollment takes place more than 12 months after a person's initial enrollment period, a 10 percent penalty is assessed for two years for every year they could have enrolled and failed to enroll in Part A.

Under Part B of the Supplementary Medical Insurance (SMI) program, all enrollees are subject to a monthly premium. Most SMI services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay), which are set by statute. When Part B enrollment takes place more than 12 months after a person's initial enrollment period, there is a permanent 10 percent increase in the premium for each year the beneficiary could have enrolled and failed to enroll.

2019 Part A - hospital insurance (HI)

- Part A deductible: $1,364.00
- Part A coinsurance
  - $341.00 a day for 61st-90th day
  - $682.00 a day for 91st-150th day (lifetime-reserve days)
  - $170.50 a day for 21st-100th day (SNF) coinsurance
- Base premium (BP): $437.00 a month
- BP with 10 percent surcharge: $480.70 a month
- BP with 45 percent reduction: $240.00 a month (for those who have 30-39 quarters of coverage)
- BP with 45 percent reduction and 10 percent surcharge: $264.00 a month

2019 Part B - supplementary medical insurance (SMI)

- Standard premium: $135.50 a month
- Deductible: $185.00 a year
- Pro rata data amount:
  - $133.57 1st month
  - $51.43 2nd month
- Coinsurance: 20 percent

Note that the Part B premium may vary based on beneficiary income above certain levels. CR 11025 has additional information showing Part B premium rates as adjusted for income.

Additional information

The official instruction, CR 11025, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R119GI.pdf*. The updated *Medicare General Information, Eligibility, and Entitlement Manual*, Chapter 3 (Deductibles, Coinsurance Amounts, and Payment Limitations), Sections 10.3 (Basis for Determining the Part A Coinsurance Amounts), 20.2 (Part B Annual Deductible), and 20.6 (Part B Premium) is attached to that CR.

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

Document history

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A prescriber's guide to the new Medicare Part D opioid overutilization policies for 2019

Provider type affected

This *MLN Matters*® special edition article is intended for physicians and other prescribers who prescribe opioid medications to patients with a Medicare Part D prescription drug benefit.

Background

The Centers for Medicare & Medicaid Services (CMS) understands the magnitude of our nation's opioid epidemic and its impact on communities. Opioid medications are effective at treating certain types of pain, but have serious risks such as increasing tolerance, addiction, overdose, and death. Given the scope of the crisis, CMS published a *roadmap* in June 2018 outlining our efforts to address this issue. The roadmap details our three-pronged approach to combating the opioid epidemic going forward: **1**) **prevention** of new cases of opioid use disorder (OUD); **2**) **treatment** of patients who have already become dependent on or addicted to opioids; and **3**) utilization of **data** from across the country to better target prevention and treatment activities. Through our 2019 Medicare Part D opioid overutilization initiatives, CMS seeks to strengthen and broaden our partnership with providers to address the opioid crisis.

What providers need to know

CMS finalized new policies for Medicare drug plans to follow starting on January 1, 2019. These policies involve further partnership with providers and prescription drug plans. Providers are in the best position to identify and manage potential opioid overutilization in the Medicare Part D population. Medicare prescription drug plans can assist providers by alerting them about unusual utilization patterns in prescription claims.

The new policies include improved safety alerts when opioid prescriptions are dispensed at the pharmacy, and drug management programs to better coordinate care when chronic high-risk opioid use is present.

Real-time safety alerts at the time of dispensing

Part D plans commonly implement safety alerts (pharmacy claim edits) for pharmacists to review at the time of dispensing the medication to prevent the unsafe utilization of drugs. These alerts are typically for drug-drug interactions, therapeutic duplication, or a potentially incorrect drug dosage (for example, doses above the maximum dosing in the Food and Drug Administration (FDA)-approved labeling).

Specific to prescription opioids, beginning in January 2019, Medicare Part D plans will employ the following new safety alerts at the pharmacy:

- **Seven-day supply limit for opioid naïve patients**: Part D plans are expected to implement a hard safety edit to limit initial dispensing to a supply of seven days or less. A hard safety edit stops the pharmacy from processing a prescription until an override is entered or authorized by the plan. This policy will affect Medicare patients who have not filled an opioid prescription recently (for example, within the past 60 days) when they present a prescription at the pharmacy for an opioid pain medication for greater than a seven day supply.

CMS' goal with this policy is to reduce the potential for chronic opioid misuse through closer management of opioid naïve patients. Clinical evidence cited by the Centers for Disease Control and Prevention (CDC) found that opioid use for acute pain is associated with long-term opioid use and that a greater amount of early opioid exposure is associated with greater risk for long-term use.[1] Recommendation six of the CDC guideline states that opioids prescribed for acute pain should be limited to three days or fewer, and that more than a seven-day supply is rarely necessary. Limiting the amount dispensed with the first opioid prescription may reduce the risk of patients developing a future dependency or overuse of these drugs.

A pharmacist can dispense partial quantities of an opioid prescription consistent with state and federal regulations. However, if a prescriber believes that an opioid naïve patient will need more than a seven-day supply initially, the provider can proactively request a coverage determination on behalf of the patient attesting to the medical need for a supply greater than seven days. Additionally, if a provider assesses upon re-evaluation that a patient will need additional opioid therapy, subsequent prescriptions will not be subject to the seven-day supply limit, as the patient will no longer be considered opioid naive.

- **Opioid care coordination alert**: This policy will affect Medicare patients when they present an opioid prescription at the pharmacy and their cumulative morphine milligram equivalent (MME) per day across all of their opioid prescription(s) reaches or exceeds 90 MME. Regardless of whether individual prescription(s) are written below the threshold, the alert will be triggered by the fill of the prescription that reaches the cumulative threshold of 90 MME or greater. It is the prescriber who writes the prescription that triggers the alert who will be contacted by the pharmacy even if that prescription itself is below the 90 MME threshold.

[1] See *https://www.cdc.gov/drugoverdose/prescribing/guideline.html*.

This safety alert includes a 90 MME threshold for identifying potentially high risk patients who may benefit from closer monitoring and care coordination. 90 MME is cited in the CDC Guideline as the level above which prescribers should generally avoid. This is not a prescribing limit. In reviewing the alert, the pharmacist may

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need to consult with the prescriber to confirm medical need for the higher MME. The pharmacist can then indicate that the prescriber was consulted so the prescription claim can pay.

The care coordination safety alert is a proactive step to give prescribers more information, and if warranted, to encourage prescribers to emphasize opioid overdose risk and prevention with their patients, especially if the patient is receiving prescription opioids from multiple prescribers or pharmacies.

Drug management programs

The Comprehensive Addiction and Recovery Act of 2016 included provisions that give Part D plans important new tools to use in 2019 to address opioid overutilization. To implement this law, CMS adopted a regulation so that Part D plans may implement a drug management program that limits access to certain controlled substances that have been determined to be "frequently abused drugs" for patients who are considered to be at-risk for prescription drug abuse. Limiting access means that the patient might only be able to obtain these medications from a specified prescriber or pharmacy. For 2019, CMS has identified opioids and benzodiazepines as frequently abused drugs.

The goal of drug management programs is better care coordination for safer use. Potential at-risk patients are identified by their opioid use which involve multiple doctors and pharmacies. Therefore, these are patients who could potentially abuse or misuse prescription drugs. One of the key components of a drug management program is prescriber involvement in case management.

If a provider prescribes opioids or benzodiazepines for a patient who is identified as a potential at-risk patient, the Part D plan will contact the provider to review the patient's total utilization pattern of frequently abused drugs. The plan will ask the prescriber:

- Are the prescription opioid medications appropriate, medically necessary, and safe for the patient's medical condition and treatment;
- Is the patient at-risk for misusing or abusing opioids and benzodiazepines; and
- Would one of the drug management program tools help the prescriber better manage their patient's prescription drug use?

The potential tools include:

1. **Patient-specific point of sale (POS) claim edit**: This is an individualized POS edit for the specific patient. It limits the amount of frequently abused drugs that may be dispensed to the patient. This limitation could be a restriction on all frequently abused drugs or limitations to specific drugs and/or specific amounts, which the plan will determine on a case by case basis as a result of their review. The plan will make every effort to obtain a prescriber's agreement for this limitation, but is authorized to implement it if no prescriber responds to the plan's attempts at contacting the prescriber through case management.
2. **Pharmacy limitation (also known as "pharmacy lock-in")**: This limitation will require the patient to obtain prescriptions for frequently abused drugs at a certain pharmacy(ies). Before implementing this limitation, the plan must verify with a prescriber that the patient is at-risk, but is not required to obtain a prescriber's agreement to the limitation. Patients can choose which pharmacy(ies) they prefer to use and may update those preferences as needed.
3. **Prescriber limitation (also known as "prescriber lock-in")**: A limitation that will require the patient to obtain their prescriptions for frequently abused drugs from a certain prescriber(s). The plan must obtain the prescriber's agreement to be a prescriber and confirm the prescriber's selection for this limitation. Patients can choose which prescribers(s) they prefer to use and may update those preferences as needed.

After the Medicare drug plan conducts case management with prescribers, and before the plan implements a tool, the plan will notify the patient in writing that coverage of opioid and/or benzodiazepine medication(s) will be limited, or if the patient must obtain these prescriptions from certain prescriber(s) or pharmacy(ies). Plans are required to make reasonable efforts to send the prescriber a copy of the notice sent to the patient. The prescriber and patient will have the opportunity to provide a response to this written notice and the requested information to the Part D plan within 30 days.

After this 30 day time period, if the Part D plan determines based on its review that the patient is at-risk and implements a limitation, it must send the patient a second written notice confirming the specific limitation and its duration. The initial limitation period could be for a maximum of 12 months and extend to an additional 12 months. Alternatively, if the plan determines that the patient is not at-risk, it must send a written notice confirming that a coverage limitation will not be implemented after all.

Provider action

Why are there new Medicare Part D opioid overutilization policies for 2019?

The opioid epidemic is a top priority at CMS. We are working with multiple stakeholders to find ways to reduce the negative impacts of the opioid epidemic on the general public. These new Medicare Part D opioid overutilization policies encourage interdisciplinary collaboration as well as care coordination among Part D plans, pharmacies, prescribers, and patients in improving opioid utilization management, preventing opioid misuse,

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reducing serious adverse risks, and promoting safer prescribing practices.

Are any patients exempt from the new opioid safety alert and drug management program policies?

CMS recognizes that a "one size fits all" approach does not take into account different circumstances related to opioid use. All of the approaches are tailored to address the distinct populations of Medicare Part D prescription opioid users. Residents of long-term care facilities, those in hospice care, patients receiving palliative or end-of-life care, and patients being treated for active cancer-related pain are exempt from these interventions.

CMS would like to remind providers that access to medication-assisted treatment (MAT) such as buprenorphine will not be impacted by these initiatives. CMS recognizes the importance for patients who are on MAT drugs to continue therapy without disruption.

Will the pharmacy call the provider every time a patient has an opioid prescription that reaches or exceeds 90 MME for the care coordination safety alert?

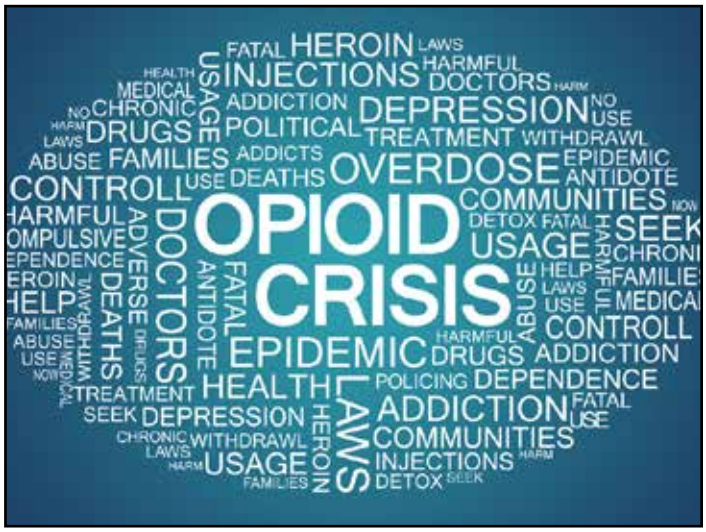
No. The provider will be initially contacted by the pharmacist if a patient presents to the pharmacy with a prescription that reaches a cumulative threshold of 90 MME or greater across all of the patient's opioid prescriptions and triggers the alert at the pharmacy. Once a pharmacist consults with a prescriber on a patient's prescription for a plan year, the pharmacist does not have to consult with the prescriber on every opioid prescription written for the same patient after that unless the plan implements further restrictions. For example, Part D plans also have the option to set an additional alert that stops a prescription from being filled at the pharmacy if the opioid threshold reaches 200 MME or greater and may additionally include prescriber and pharmacy counts.

Why is the provider contacted by the pharmacy for only certain patients?

Prescribers may be contacted by the pharmacy for only some Medicare patients but not for all, depending on which Part D plan the patient is enrolled in because the plan sponsor has the flexibility to modify the care coordination safety alert parameters. A plan sponsor may customize this alert so that it would be triggered based on the patient's total number of opioid prescribers and/or opioid dispensing pharmacies specified in the care coordination safety alert.

What is the provider's role for a patient in the Medicare Part D drug management program?

If a patient is identified as being potentially at-risk for prescription drug abuse by his or her Part D plan, the plan will initiate case management. As part of the case management process, the Part D plan will contact the patient's providers who prescribed opioids and benzodiazepines for clinical information needed to make a decision on whether a patient is at-risk and should have his or her access to frequently abused drugs limited



through one of the available tools. The provider's role is to respond to the Part D plan if and when they contact the provider for further information about a patient's prescription use history.

How can the provider help his or her patient if their prescription triggers an opioid safety alert, such as the seven-day supply alert for opioid naïve patients or the care coordination alert?

If one of these opioid safety alerts is triggered and the prescription cannot be filled as written or cannot be resolved at the pharmacy, the pharmacist should provide a written copy of the standardized CMS pharmacy notice, *Medicare Prescription Drug Coverage and Your Rights* to the patient.

The patient, the patient's representative, or the physician or other prescriber, on the patient's behalf, has the right to request a coverage determination for a drug(s) subject to the alert, including the right to request an expedited or standard coverage determination in advance of prescribing an opioid (for example, after a surgical procedure).

The timeframe for an expedited coverage determination request applies when the prescriber indicates, or the plan decides, that applying the standard timeframe may seriously jeopardize the enrollee's life, health, or ability to regain maximum function. CMS generally expects coverage determinations related to any opioid safety alerts to meet the criteria for expedited review. If the request meets the criteria for an expedited review by the plan, the plan must make its decision and notify the patient as expeditiously as their health condition requires, but no later than 24 hours after receipt of the request.

Would the patient or the provider be able to request an appeal if the Part D plan determines a patient to be an at-risk patient under the drug management program?

A patient, a patient's representative, or the physician or other prescriber may request an appeal within 60 calendar days from the date of the second written notice, notifying the patient that he or she has been identified as an at-risk patient. At-risk determinations are subject to the existing Part D benefit appeals process. If the patient or the physician or other prescriber disagrees

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with the at-risk determination, the patient, the patient's representative, or the physician or other prescriber may request a redetermination and a change to the limitations can be made as a result of an appeal. The party may request an expedited or standard redetermination under 42 CFR § 423.580. The standard timeframe for notification of a redetermination made by the plan is as expeditiously as the patient's health condition requires, but no later than seven days from receipt of the request. The plan must notify the patient of its decision on an expedited redetermination as expeditiously as the patient's health condition requires, but no later than 72 hours from receipt of the request. In addition to the right to appeal an at-risk determination, the patient has the right to request a coverage determination, as explained in the previous response.

How else can a provider prepare for the new 2019 Medicare Part D overutilization policies?

Many patients have difficulty understanding the risk of using opioids and may underestimate their chances of overdosing. Providers may want to discuss the risks of an accidental overdose or having an adverse reaction to opioids since these risks are not necessarily associated with misuse.

As the new opioid safety alerts are implemented in 2019, on-going communication among the pharmacist, the Part D plan, and the prescriber will be critical. Physicians and other prescribers can protect their patients' access to medically necessary drugs by responding to pharmacists' or plan sponsors' telephone calls or case management notices. Providers will also want to initiate coverage determinations or exceptions, when clinically appropriate. To avoid a prescription being rejected at the pharmacy, prescribers may proactively request a coverage determination in advance of prescribing an opioid prescription if the prescriber has assessed that the patient will need the full quantity written (for example a plan may not be aware a patient is exempt based on a new exclusion such as cancer). Additionally, to resolve opioid safety alerts expeditiously and avoid withdrawal or disruption of therapy, CMS encourages prescribers to respond to pharmacists' outreach in a timely manner and give the appropriate training to on-call prescribers when necessary.

Additional information

- For additional information regarding the final 2019 Medicare Parts C&D Call Letter, please visit *https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2019.pdf*.
- For additional information regarding the 2019 Part C and D Regulation (CMS-4182-F), please visit *https://www.gpo.gov/fdsys/pkg/FR-2018-04-16/pdf/2018-07179.pdf*.

- For information on Medicare Prescription Drug Appeals and Grievances, visit *https://www.cms.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/CoverageDeterminationsandExceptions.html*.
- For additional information regarding the CDC Guideline for Prescribing Opioids for Chronic Pain, please visit *https://www.cdc.gov/drugoverdose/prescribing/guideline.html*.
- To review the CMS Roadmap to Address the Opioid Epidemic, please visit *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Opioid-epidemic-roadmap.pdf*.
- To review the Medicare Prescription Drug Coverage and Your Rights, please visit *https://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/downloads/yourrightsfactsheet.pdf*.

Document history

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Medicare cost report e-filing (MCReF)

***Note**: This article was revised November 6, 2018, to reflect revisions to change request (CR) 10611, issued October 24 and November 2. The article was revised to extend the Medicare administrative contractor (MAC) portals to be open until January 2, 2019, instead of July 2, 2018. As a result of the revision to the article, providers that wish to electronically submit their MCR must do so using MCReF on or after January 2, 2019, instead of the original date of July 2, 2018. As a result of the November 2 CR revision, an incorrect web address for new user registration is corrected. In addition, the CR release date, transmittal number, and the web address for CR 10611 are also revised. All other information remains the same. This information was previously published in the May 2018 Medicare A Connection, page 17.*

Provider type affected

This *MLN Matters*® article is intended for cost report staff submitting annual Medicare cost reports (MCRs) to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

Provider action needed

CR 10611 informs MACs and providers of the new MCR e-filing (MCReF) system available for electronic transmission of cost reports. Medicare Part A providers file an annual MCR with the Centers for Medicare & Medicaid Services (CMS). The reports are filed with a MAC assigned to each provider. The MCR is used to determine the providers' Medicare reimbursable costs. MACs may suspend payments to providers that fail to file their MCR on the due date. Make sure your cost report staffs are aware of the new MCReF system.

Background

In accordance with *Chapter 1, Section 104 of the Provider Reimbursement Manual, Part II* (PRM-II), providers that continue to participate in the Medicare program are required to submit a cost report within five months of their cost-reporting fiscal year end. For cost reports ending on a day other than the last day of the month, cost reports are due 150 days after the last day of the cost reporting period. Exceptions to this due date for "no Medicare utilization" cost reports are addressed in PRM-II, Section110.A. MACs are required to suspend payments to providers that fail to file their MCR by the due date.

Current Medicare cost report (MCR) filing and receipt process

Generally, each provider must perform the following steps to properly submit an MCR to their MAC:

- Generate an MCR consisting of a machine-readable file (ECR) and a human-readable file (PDF or equivalent, also referred to as the Print Image), using CMS-approved MCR vendor software.
- Submit the Worksheet S (certification page) signed by an officer or administrator of the provider. A "wet" signature is required for cost reports ending before December 31, 2017; an electronic signature is allowed for cost reports ending on or after December 31, 2017.
- Provide supporting cost report documentation including, but not limited to, the working trial balance, financial statements, Medicare Bad Debt Listing, Interns and Residents Information System data, and so on.
- Submit the MCR package to their MAC via mail (or hand delivery), which account for 91 percent of all MCR submissions, or a hybrid of mail and electronic submissions which account for nine percent of total submissions. The signed worksheet S must be mailed to the MAC.

Streamlined the MCR filing process

To streamline the MCR filing process, the 2018 inpatient prospective payment system (IPPS) final rule allows for an electronic signature on the MCR Worksheet S (certification page) for cost reports ending on or after December 31, 2017. Additionally, beginning May 1, 2018, CMS will make the MCReF system available to Part A providers for electronic transmission (e-Filing) of an MCR package directly to a MAC. A CMS Enterprise Identity Management (EIDM) account is required to use MCReF, which is the same account providers use to order copies of their provider statistical and reimbursement reports (PS&R).

Upon login, providers will be able to select the fiscal year end for which they are filing, upload all corresponding MCR materials as attachments, and submit the documents directly to their MAC. The system will perform a basic review of the attached materials to determine if the MCR is "receivable" (See Attachment A of CR 10611. The web address of CR 10611 is in the *Additional information* section of this article.). If issues are identified, the provider will immediately receive an error/warning message. If no issues are identified, the provider will receive a confirmation number, as well as an electronic postmark date, which can be used in correspondence regarding the submission. Once the cost report is deemed "receivable," the MAC will perform the acceptability review within 30 days. The MAC will issue a rejection letter if the cost report is rejected.

Medicare cost report e-filing (MCReF) system access

MCReF will be hosted at the following URL: *https://mcref.cms.gov*. System access to MCReF will be controlled by the EIDM system, as previously noted. Part A provider security officials (SOs) and their backups (BSOs), already registered in EIDM for access to CMS PS&R, will inherit access to MCReF by default through their existing account.

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Providers that are not registered in EIDM, but wish to gain access to MCReF, must register in EIDM and assign an SO for their organization. New user registration is available at *https://portal.cms.gov/wps/portal/unauthportal/selfservice/newuserregistration*.

Note: It is important for providers to keep their EIDM credentials in good standing to avoid problems using MCReF to e-file cost reports and obtaining PS&R. This includes password updates per CMS policy and the timely replacement of SOs due to staffing changes. Issues with maintaining EIDM credentials will not constitute a valid reason for filing a cost report past its due date.

Starting **January 2, 2019**, providers that wish to e-file their MCR must use MCReF. MAC portals will no longer be an acceptable means of submission. Providers that wish to mail or hand deliver MCRs to MACs, may continue to do so.

Benefits of streamlined MCR processes

- Increases CMS access to MCR data as submitted by providers to assist with responding to inquiries and remove additional administrative burdens on MACs and CMS.
- Eliminates MAC processes for populating the CMS Healthcare Cost Reporting Information System (HCRIS) – including the submission of 100,000 cost reports to HCRIS and subsequent resubmission.
- Eliminates the need for MACs to enter MCR postmarked date, received date, and HCRIS sent date.
- Enables direct receipt/promotion of IRIS data to its required end-state in STAR (eliminates manually upload IRIS data).
- Large provider chain organizations will electronically submit MCRs to one system instead of transmitting their MCRs to their assigned MAC jurisdiction's portals or physical mailing addresses.
- An MCR submitted through MCReF will be directed automatically to the correct MAC eliminating the risk of submitting the MCR to an incorrect MAC.
- Providers will receive immediate feedback on whether the MCR is received.
- Providers will save time compiling the paperwork (files) needed to create electronic media and mail the MCR package;
- Providers will have until 11:59 p.m. eastern time on the due date to submit the MCR through MCReF.
- MCReF has a simple, straightforward user interface with just one screen.
- Reduces provider confusion due to conflicting MAC "receivability" rules.

Additional information

The official instruction, CR 10611, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R2194OTN.pdf*. A detailed MCReF system overview is attached to the CR. CMS encourages cost report staff to review this overview.

Chapter 1 of the *Provider Reimbursement Manual* is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021935.html*.

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
November 6, 2018	The article was revised to extend the MAC portals to be open until January 2, 2019, instead of July 2, 2018. As a result of this revision to the article, providers that wish to electronically submit their MCR must do so using MCReF on or after January 2, 2019, instead of the original date of July 2, 2018. Also, an incorrect web address for new user registration is corrected. In addition, the CR release date, transmittal number, and the web address for CR 10611 are also revised. All other information remains the same.
May 2, 2018	Initial article released.

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Implementation June 12, 2018

Hurricane Michael and Medicare disaster-related Florida and Georgia claims

***Note**: This article was revised October 12, 2018, to add information regarding the emergency declared for the state of Georgia as a result of Hurricane Michael. This information was previously published in the October 2018 Medicare A Connection, pages 3-5.*

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 Florida and Georgia who were affected by Hurricane Michael.

Provider information available

On October 9, 2018, pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, President Trump declared that, as a result of the effects of Hurricane Michael, an emergency exists in the state of Florida. On October 10, 2018, President Trump declared a similar emergency for the State of Georgia as a result of Hurricane Michael. Also, on October 9, 2018, Secretary Azar of the Department of Health & Human Services declared that a public health emergency exists in Florida and authorized waivers and modifications under Section 1135 of the Social Security Act (the Act), retroactive to October 7, 2018, for Florida. Also, on October 11, 2018, Secretary Azar declared that a public health emergency exists in the state of Georgia, retroactive to October 9, 2018, and authorized the same waivers and modifications for Georgia.

On October 9, 2018, the Administrator of the Centers for Medicare & Medicaid Services (CMS) authorized waivers under Section 1812(f) of the Social Security Act for the state of Florida for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of Hurricane Michael in 2018, retroactive to October 7, 2018. On October 11, 2018, the CMS Administrator authorized the same waivers for the state of Georgia, retroactive to October 9, 2018.

Under Section 1135 or 1812(f) of the Social Security Act, CMS has issued several blanket waivers in the impacted geographical areas of the states of Florida and Georgia. 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 is available at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page.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 on July 31, 2009, applies to items and services furnished to Medicare beneficiaries within the state of Florida from October 7, 2018, for the duration of the emergency and for the state of Georgia from October 9, 2018, 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 is available at *https://www.cms.gov/About-CMS/Agency- Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page.html*. Medicare FFS Questions & Answers (Q&As) posted on the waivers and flexibilities page at *https://www.cms.gov/About-CMS/Agency- Information/Emergency/EPRO/Resources/Waivers-and-flexibilities.html*, and also referenced below are applicable for items and services furnished to Medicare beneficiaries within the states of Florida and Georgia. 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 Florida and Georgia.
   - 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 October 7, 2018, for Florida and October 9, 2018, for Georgia.

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

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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 **Florida and Georgia**. Individual facilities do not need to apply for the following approved blanket waivers:

Skilled nursing facilities (SNFs)

- Section 1812(f): This waiver of the requirement for a three-day prior hospitalization for coverage of a 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 Michael in the states of Florida and Georgia. 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 SNFs 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).
- To ensure the correct processing of home health disaster related claims, Medicare administrative contractors (MACs) are allowed to extend the auto-cancellation date of requests for anticipated payment (RAPs).

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 Michael, 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 Michael. (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 Michael, 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 Michael, 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 Michael, CMS has determined it is appropriate to issue a blanket waiver to suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) where DMEPOS are 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 were lost, destroyed, irreparably damaged or otherwise rendered unusable as a result of the hurricane.

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Certifying patients for the Medicare home health benefit

***Note**: This article was revised November 5, 2018, to reflect policies finalized in the 2019 home health PPS final rule (CMS-1689-FC). Specifically, the regulation at 42 CFR 424.22(b)(2) has been revised to remove the requirement that the recertification statement must include an estimate of how much longer the services will be required. This change is effective January 1, 2019. All other information remains the same. This information was previously published in the January 2015 Medicare A Connection, pages 15-18.*

Provider type affected

This *MLN Matters*® special edition (SE) 1436 is intended for Medicare-enrolled physicians who certify patient eligibility for home health care services and submit claims to Medicare administrative contractors (MACs) for those services provided to Medicare beneficiaries.

What you need to know

This *MLN Matters*® SE1436 article gives Medicare-enrolled providers an overview of the Medicare home health services benefit, including patient eligibility requirements and certification/recertification requirements of covered Medicare home health services.

Key points

To be eligible for Medicare home health services a patient must have Medicare Part A and/or Part B per Section1814(a)(2)(C) and Section 1835(a)(2)(A) of the Social Security Act (the Act):

- Be confined to the home;
- Need skilled services;
- Be under the care of a physician;
- Receive services under a plan of care established and reviewed by a physician; and
- Have had a face-to-face encounter with a physician or allowed non-physician practitioner (NPP).

- Care must be furnished by or under arrangements made by a Medicare-participating home health agency (HHA).

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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-Hurricanes.pdf*.

Medicare advantage plan or other Medicare health plan beneficiaries

CMS reminds suppliers that Medicare beneficiaries enrolled in a Medicare advantage or other Medicare health plans should contact their plan directly to find out how it replaces DMEPOS damaged or lost in an emergency or disaster. Beneficiaries who do not have their plan's contact information can contact 1-800-MEDICARE (1-800-633-4227) for assistance.

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 disaster or emergency.

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 web page 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
October 12, 2018	The article was revised to add information regarding the emergency declared for the state of Georgia as a result of Hurricane Michael.
October 11, 2018	Initial article released.

MLN Matters® Number: SE18021 *Revised*
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Effective Date: N/A
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Patient eligibility—confined to home

Section 1814(a) and Section 1835(a) of the Act specify that an individual is considered "confined to the home" (homebound) if the following two criteria are met:

First criteria One of the Following must be met:	Second criteria Both of the following must be met:
1. Because of illness or injury, the individual needs the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person to leave their place of residence.	1. There must exist a normal inability to leave home.
2. Have a condition such that leaving his or her home is medically contraindicated.	2. Leaving home must require a considerable and taxing effort.

The patient may be considered homebound (that is, confined to the home) if absences from the home are:

Infrequent;

- For periods of relatively short duration;
- For the need to receive health care treatment;
- For religious services;
- To attend adult daycare programs; or
- For other unique or infrequent events (for example, funeral, graduation, trip to the barber).

Some examples of persons confined to the home are:

- A patient who is blind or senile and requires the assistance of another person in leaving their place of residence;
- A patient who has just returned from a hospital stay involving surgery, who may be suffering from resultant weakness and pain and therefore their actions may be restricted by their physician to certain specified and limited activities such as getting out of bed only for a specified period of time or walking stairs only once a day; and
- A patient with a psychiatric illness that is manifested, in part, by a refusal to leave home or is of such a nature that it would not be considered safe for the patient to leave home unattended, even if they have no physical limitations.

Patient eligibility—need skilled services

According to Section 1814(a)(2)(C) and Section1835(a)(2)(A) of the Act, the patient must be in need of one of the following services:

- Skilled nursing care on an intermittent basis (furnished or needed on fewer than seven days each week or less than eight hours each day for periods of 21 days or less, with extensions in exceptional circumstances when the need for additional care is finite and predictable per Section 1861(m) of the Act);
- Physical therapy (PT);
- Speech-language pathology (SLP) services; or
- Continuing occupational therapy (OT).

Patient eligibility—under the care of a physician and receiving services under a plan of care

Section 1814(a)(2)(C) and Section 1835(a)(2)(A) of the Act require that the patient must be under the care of a Medicare-enrolled physician, defined at 42 CFR 424.22(a)(1)(iii) as follows:

- Doctor of medicine;
- Doctor of osteopathy; or
- Doctor of podiatric medicine (may perform only plan of treatment functions that are consistent with the functions he or she is authorized to perform under state law).

According to Section 1814(a)(2)(C) and Section 1835(a)(2)(A) of the Act, the patient must receive home health services under a plan of care established and periodically reviewed by a physician. Based on 42 CFR 424.22(d)(1) a plan of care may not be established and reviewed by any physician who has a financial relationship with the HHA.

Physician certification of patient eligibility

As a condition for payment, according to the regulations at 42 CFR 424.22(a)(1):

- A physician must certify that a patient is eligible for Medicare home health services according to 42 CFR 424.22(a)(1)(i)(v); and
- The physician who establishes the plan of care must sign and date the certification.

The Centers for Medicare & Medicaid Services (CMS) does not require a specific form or format for the certification as long as a physician certifies that the following five requirements, outlined in 42 CFR Section 424.22(a)(1), are met:

1. The patient needs intermittent SN care, PT, and/or SLP services;
2. The patient is confined to the home (that is, homebound);
3. A plan of care has been established and will be periodically reviewed by a physician;
4. Services will be furnished while the individual was or is under the care of a physician; and
5. A face-to-face encounter:
   a. Occurred no more than 90 days prior to the home health start of care date or within 30 days of the start of the home health care;
   b. Was related to the primary reason the patient requires home health services; and

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c. Was performed by a physician or allowed non-physician practitioner.

Note: The certifying physician must also document the date of the face-to-face encounter.

According to the regulations at 42 CFR 424.22(a)(2) physicians should complete the certification when the plan of care is established or as soon as possible thereafter. The certification must be complete prior to when an HHA bills Medicare for reimbursement.

Certification requirements: Who can perform a face-to-face encounter

According to 42 CFR 424.22(a)(1)(v)(A), the face-to-face encounter can be performed by:

- The certifying physician;
- The physician who cared for the patient in an acute or post-acute care facility (from which the patient was directly admitted to home health);
- A nurse practitioner or a clinical nurse specialist who is working in collaboration with the certifying physician or the acute/post-acute care physician; or
- A certified nurse midwife or physician assistant under the supervision of the certifying physician or the acute/post-acute care physician.

According to 42 CFR 424.22(d)(2), the face-to-face encounter cannot be performed by any physician or allowed NPP (listed above) who has a financial relationship with the HHA.

Certification requirements: Management and evaluation narrative

According to 42 CFR 424.22(a)(1)(i) if a patient's underlying condition or complication requires a registered nurse (RN) to ensure that essential **non-skilled** care is achieving its purpose and a RN needs to be involved in the development, management and evaluation of a patient's care plan, the physician will include a brief narrative describing the clinical justification of this need.

If the narrative is part of the certification form then the narrative must be located immediately prior to the physician's signature. If the narrative exists as an addendum to the certification form in addition to the physician's signature on the certification form, the physician must sign immediately following the narrative in the addendum.

For skilled nursing care to be reasonable and necessary for management and evaluation of the patient's plan of care, the complexity of the necessary unskilled services that are a necessary part of the medical treatment must require the involvement of a registered nurse to promote the patient's recovery and medical safety in view of the patient's overall condition.

For more information about SN for management and evaluation refer to Section 40.1.2.2, Chapter 7 of the *Medicare Benefit Policy Manual* at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf*.

Certification requirements: Supporting documentation

- Documentation in the certifying physician's medical records and/or the acute/post-acute care facility's medical records (if the patient was directly admitted to home health) shall be used as the basis for certification of home health eligibility. If the documentation used as the basis for the certification of eligibility is not sufficient to demonstrate that the patient is or was eligible to receive services under the Medicare home health benefit, payment will not be rendered for home health services provided.
- According to the regulations at 42 CFR 424.22(c), Certifying physicians and acute/post-acute care facilities must provide, upon request, the medical record documentation that supports the certification of patient eligibility for the Medicare home health benefit to the home health agency, review entities, and/or CMS. Certifying physicians who show patterns of non-compliance with this requirement, including those physicians whose records are inadequate or incomplete for this purpose, may be subject to increased reviews, such as provider-specific probe reviews.
- Information from the HHA, such as the patient's comprehensive assessment, can be incorporated into the certifying physician's and/or the acute/post-acute care facility's medical record for the patient.
  - Information from the HHA must be corroborated by other medical record entries and align with the time period in which services were rendered**.**
  - The certifying physician must review and sign off on anything incorporated into the patient's medical record that is used to support the certification of patient eligibility (that is, agree with the material by signing and dating the entry).
- The certifying physician's and/or the acute/post-acute care facility's medical record for the patient must contain information that **justifies the referral** for Medicare home health services. This includes documentation that substantiates the patient's:
  1. Need for the skilled services; and
  2. Homebound status.
- The certifying physician's and/or the acute/post-acute care facility's medical record for the patient must contain the **actual clinical note for the face-to-face encounter visit** that demonstrates that the encounter:
  1. Occurred within the required timeframe;
  2. Was related to the primary reason the patient requires home health services; and
  3. Was performed by an allowed provider type.

This information can be found most often in, but is not

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limited to, clinical and progress notes and discharge summaries.

Please review the following examples included at the end of this article:

1. Discharge summary;
2. Progress note;
3. Progress note and problem list; or
4. Discharge summary and comprehensive assessment.

Recertification

At the end of the initial 60-day episode, a decision must be made as to whether or not to recertify the patient for a subsequent 60-day episode. According to the regulations at 424.22(b)(1) recertification is required at least every 60 days when there is a need for continuous home health care after an initial 60-day episode and unless there is a:

- Patient-elected transfer; or
- Discharge with goals met and/or no expectation of a return to home health care.

(These situations trigger a new certification, rather than a recertification)

Medicare does not limit the number of continuous episodes of recertification for patients who continue to be eligible for the home health benefit.

Recertification requirements

1. Must be signed and dated by the physician who reviews the plan of care; and
2. Indicate the continuing need for skilled services (the need for OT may be the basis for continuing services that were initiated because the individual needed SN, PT or SLP services).

Physician billing for /certification/recertification

Certifying/recertifying patient eligibility can include contacting the home health agency and reviewing of reports of patient status required by physicians to affirm the implementation of the plan of care that meets patient's needs.

1. Healthcare Common Procedure Coding System (HCPCS) code G0180 − Physician certification home health patient for Medicare-covered home health service under a home health plan of care (patient not present).
2. HCPCS code G0179 −Physician recertification home health patient for Medicare-covered home health services under a home health plan of care (patient not present)

Physician claims for certification/recertification of eligibility for home health services (G0180 and G0179 respectively) are not considered to be for "Medicare-covered" home health services if the HHA claim itself was non-covered because the certification/recertification of eligibility was not complete or because there was insufficient documentation to support that the patient was eligible for the Medicare home health benefit.

Additional information

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

More information is available at the Medicare Home Health Agency website at *https://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html*.

Document history

Date of change	Description
November 5, 2018	This article was revised to reflect policies finalized in the 2019 home health PPS final rule (CMS-1689-FC). Specifically, the regulation at 42 CFR 424.22(b)(2) has been revised to remove the requirement that the recertification statement must include an estimate of how much longer the services will be required. This change is effective January 1, 2019.
December 23, 2014	Initial article released.

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Example 1

AAA HOSPITAL DISCHARGE SUMMARY
-DEPARTMENT OF SURGERY-

Date of Encounter

DOE, JANE	00000123	02-13-2014	02-17-2014
Patient Name	Med Rec No.	Admit Date	Discharge Date

Physician: John A. Doe, M.D.
Dictated By: John A. Doe, M.D.

Allowed Provider Type

ADMISSION DIAGNOSIS:
Right knee osteoarthritis.

DISCHARGE DIAGNOSIS:
Right knee osteoarthritis.

CONSULTATIONS:
1. Physical Therapy
2. Occupational Therapy

PROCEDURES:
02/14/2014: Total Right knee arthroplasty.

HISTORY OF PRESENT ILLNESS:
Mrs. Doe is a pleasant 60-year old female who has had a longstanding history of right knee arthritis. She has complained of right sided knee pain since January 2013. Since then, her ambulation has been limited by pain and she has pain at night that interrupts sleep. Pain medication, ibuprofen and hydrocodone, have been unsuccessful in relieving her pain for the last 6 months. Workup did show reduction in the right knee joint space. She initially failed conservative treatment and has elected to proceed with surgical treatment.

PAST MEDICAL HISTORY:
Hypertension, Gout.

PAST SURGICAL HISTORY:
Hysterectomy.

Meets the requirements for documenting: (1) the need for skilled services; (2) the patient was/is confined to the home [homebound]; and (3) that the encounter was related to the primary reason the patient requires home health services.

DISCHARGE MEDICATIONS:
Colace 100 mg daily, Percocet 5/325 every 4 hours as needed for pain, Lisinopril 10 mg daily, Coumadin 4 mg daily; blood draw for INR ordered for 2/20/2014.

DISCHARGE CONDITION:
Upon discharge Mrs. Doe is stable status post right total knee replacement and has made good progress with her therapies and rehabilitation. Mrs. Doe is to be discharged to home with home health services, physical therapy and nursing visits, ordered. The patient is temporarily homebound secondary to status post total knee replacement and currently walker dependent with painful ambulation. PT is needed to restore the ability to walk without support. Short-term skilled nursing is needed to monitor for signs of decompensation or adverse events from the new Coumadin medical regimen.

PATIENT INSTRUCTION:
The patient is discharged to home in the care of her son. Diet is regular. Activity, weight bear as tolerated right lower extremity. The patient prescribed Coumadin 4 mg a day as the INR was 1.9 on discharge with twice weekly lab checks. Resume home medications. Call the office or return to the emergency room for any concerns including increased redness, swelling, drainage, fever, or any concerns regarding operation or site of incision. The patient is to follow up with Dr. Doe in two weeks.

Transcribed by: A.M 02/17/2014
Electronically signed by: John A. Doe, M.D. 02/17/2014 17:52

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Example 2

Progress Notes
Patient: Smith, Jane
DOB: 04/13/1941
Address: 1714 Main Street, Plano TX 15432

Provider: John Doe, M.D.
Date: 05/03/2013

Allowed Provider Type

Date of Encounter

Subjective:
CC:
1. Wound on left heel.

HPI:
Pt is here for evaluation of wound on left heel. Patient reports her daughter noticed the wound on patient's heel when she was washing her feet. Patient states she has difficulty with reaching her feet and her daughter will sometimes clean them for her. She reports she uses a shoe horn to put on her shoes.

ROS:
General_____:
No weight change, no fever, no weakness, no fatigue.
Cardiology_____:
No chest pain, no palpitations, no dizziness, no shortness of breath.
Skin ____:
Wound on left lower heel, no pain.

Medical History: HTN, hyperlipidemia, hypothryroidism, DJD.

Medications: zolpidem 10 mg tablet 1 tab once a day (at bedtime), Diovan HCl 12.5 mg-320 mg tablet 1 tab once a day, Lipitor 10 mg tablet 1 tab once a day.

Allergies: NKDA

Objective:
Vitals: Temp 96.8, BP 156/86, HR 81, RR 19, Wt 225, Ht 5'4"
Examination: General appearance pleasant. HEENT normal. Heart rate regular rate and rhythm, lungs clear, BS present, pulses 2+ bilaterally radial and pedal. Diminished pinprick sensation on bilateral lower extremities from toes to knees. Left heel wound measures 3 cm by 2 cm and 0.4 cm deep. Wound bed is red, without slough. Minimal amount of yellow drainage noted on removed bandage.

Assessment:
1. Open wound left heel

Plan:
1. **OPEN WOUND** Begin hydrocolloid with silver dressing changes. Minimal weight bear on left leg with a surgical boot on left foot. Begin home health for wound care, family teaching on wound care, and patient education on signs and symptoms of infection. The patient is now homebound due to minimal weight bearing on left foot and restrictions on walking to promote wound healing, she is currently using a wheelchair. Short-term nursing is needed for wound care, monitor for signs of infection, and education on wound care for family to perform dressing changes.

Follow Up: Return office visit in 2 weeks.

Provider: John Doe, M.D.
Patient: Smith, Jane **DOB**: 04/13/1941 **Date**: 05/03/2013
Electronically signed by John Doe, M.D. on 05/03/2013 at 10:15 AM
Sign off status: Completed

Meets the requirements for documenting: (1) the need for skilled services; (2) why the patient was/is confined to the home (homebound); and (3) that the encounter was related to the primary reason the patient requires home health services.

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Example 3 – Part 1 of 2

Progress Notes
Patient: Rogers, Buck
DOB: 08/13/1925
Address: 234 Happy Lane, Teamwork, MD 12345

Provider: Jane Doe, M.D.
Date: 09/01/2014

Allowed provider type

Date of Encounter

Subjective:
CC:
Weakness
HPI:
Pt was hospitalized 2 weeks ago for pneumonia. He was treated with IV antibiotics for 5 days and discharged on oral antibiotics for 10 days. His caregiver is present with him for the visit. The patient reports that his appetite has been decreased since the hospitalization and he has noticed increasing weakness and difficulty walking. The patient has lost 2 lbs. since his last visit. He has stayed in bed for most of the time since his hospitalization. He used a wheelchair to move from the front of the office building to the exam room. The patient has not needed a wheel chair previously. The patient denies any fever, chills, cough, rhinorrhea, sore throat, ear pain, difficulty drinking liquids, nausea, vomiting or diarrhea.
ROS:
General:
2 lb weight change, positive for weakness, positive for fatigue.
Pulmonary: As per the HPI
Cardiology:
No chest pain, no palpitations, no dizziness, no shortness of breath.

Medical History: HTN; hyperlipidemia; Diabetes Mellitus

Medications: ASA 325 mg once a day, Diovan HCl 12.5 mg-320 mg tablet 1 tab once a day, Lipitor 10 mg tablet 1 tab once a day. Metformin 1000 mg once a day.

Allergies: NKDA

Objective:
Vitals: Temp 98.6, BP 120/80, HR 71, RR 12, Wt 200, Ht 5'9" pulse ox 99% on room air
Examination: The patient is awake and alert and in no acute distress. He is in a wheelchair. HEENT: Pupils do not react to light. Heart rate regular rate and rhythm, lungs clear, BS present, Extremities: pulses 2+ bilaterally radial and pedal. Diminished pinprick sensation on bilateral lower extremities from toes to knees ; Muscle Strength 3/5 in all 4 extremities(normal 5/5). The patient's get up and go test was 35 seconds(normal <10)

Assessment:
1. Muscle Weakness secondary to deconditioning due to pneumonia

Plan:
1. Prior to the patient's hospitalization for pneumonia, the patient could ambulate in his residence with assistance and was able to rise from a chair without difficulty. The patient requires a home health PT program for gait training and increasing muscle strength to restore the patient's ability to walk in his residence.

Follow Up: Return office visit in 6 weeks.

Provider: Jane Doe, M.D.
Electronically signed by Jane Doe, M.D. on 09/02/2014 at 10:15 AM
Sign off status: Completed

Meets the requirements for documenting: (1) the need for skilled services; and (2) that the encounter was related to the primary reason the patient requires home health services.

Please see problem list (Part 2 of 2) for homebound status.

See **CERTIFYING**, page 19

CERTIFYING

from page18

Example 3 – Part 2 of 2

Problem List*

Patient: Rogers, Buck
DOB: 08/13/1925
Address: 234 Happy Lane, Teamwork, MD 12345

401.1 HTN - 1999
272.2 Hyperlipidemia -1999
250.5 Diabetes Mellitus with ophthalmic manifestations -2000
369.22 Blindness - 2002 (requires caregiver assistance in order to leave the home)

482.31 Pneumonia- Streptococcus- 2014

In conjunction with the progress note, this meets the requirements for documenting why the patient was/is confined to the home (homebound).

***A problem list would not be acceptable by itself to demonstrate skilled need and/or homebound status.**

See **CERTIFYING**, page 20

CERTIFYING

from page 19

Example 4 – Part 1 of 2

Date of Encounter

AAA HOSPITAL DISCHARGE SUMMARY
-DEPARTMENT OF SURGERY-

Smith, John	00000124	04-14-2014	04-18-2014
Patient Name	Med Rec No.	Admit Date	Discharge Date

Physician: Sam Bone, M.D.
Dictated By: Sam Bone, M.D.

Allowed Provider Type

ADMISSION DIAGNOSIS:
Left knee osteoarthritis.

DISCHARGE DIAGNOSIS:
Left knee osteoarthritis.

CONSULTATIONS:
1. Physical Therapy
2. Occupational Therapy

PROCEDURES:
04/14/2014: Left knee arthroplasty.

HISTORY OF PRESENT ILLNESS:
Mr. Smith is 70 y.o. male who presents with left knee osteoarthritis for 10 years. Over the past three years the pain has steadily increased. It was initially controlled by ibuprofen and steroid injections. In the last year he has required ibuprofen and Percocet to ambulate and this treatment has been unsuccessful in relieving pain for the last 6 months. His ambulation has been limited by pain and he has pain at night that interrupts sleep. Workup did show reduction in the left knee joint space. He has failed conservative treatment and has elected to proceed with surgical treatment.

PAST MEDICAL HISTORY:
Hypertension

PAST SURGICAL HISTORY:
Inguinal hernia repair

DISCHARGE MEDICATIONS:
Colace 100 mg daily, Percocet 5/325 every 4 hours as needed for pain, Lisinopril 10 mg daily, Lovenox 30mg sq every 12hours for 6 more days.

Meets the requirements for documenting: (1) the need for skilled services; and (2) that the encounter was related to the primary reason the patient requires home health services.

Please see OASIS (Part 2 of 2) for homebound status.

DISCHARGE CONDITION:
Upon discharge Mr. Smith is stable status post left total knee replacement and has made good progress with his therapies and rehabilitation. Mr. Smith is to be discharged to home with home health services, physical therapy and nursing visits, ordered. PT is needed to restore the ability to walk without support. Short-term skilled nursing is needed to monitor for signs of decompensation and teaching of Lovenox injections.

PATIENT INSTRUCTION:
The patient is discharged to home in the care of his wife. Diet is regular. Activity, weight bear as tolerated left lower extremity. Call the office or return to the emergency room for any concerns including increased redness, swelling, drainage, fever, or any concerns regarding operation or site of incision. The patient is to follow up with Dr. Bone in two weeks.
Transcribed by: A.M 04/18/2014
Electronically signed by: Sam Bone, M.D. 04/18/2014 18:31

See **CERTIFYING**, page 21

CERTIFYING

from page 20

Example 4 – Part 2 of 2

Generic Home Health Agency
Excerpt from Comprehensive Assessment (OASIS-C)

Patient Name: John Smith
HH Record Number: 4433225

ADL/IADLs continued

(M1845) Toileting Hygiene: Current ability to maintain perineal hygiene safely, adjust clothes and/or incontinence pads before and after using toilet, commode, bedpan, urinal. If managing ostomy, includes cleaning area around stoma, but not managing equipment.

☐ 0 - Able to manage toileting hygiene and clothing management without assistance.

X 1 - Able to manage toileting hygiene and clothing management without assistance if supplies/implements are laid out for the patient.

☐ 2 - Someone must help the patient to maintain toileting hygiene and/or adjust clothing.

☐ 3 - Patient depends entirely upon another person to maintain toileting hygiene.

Comments: *Patient requires clothes to be laid out on bed. He is able to dress himself from a seated position at foot of bed.*

(M1850) Transferring: Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.

☐ 0 - Able to independently transfer.

X 1 - Able to transfer with minimal human assistance or with use of an assistive device.

☐ 2 - Able to bear weight and pivot during the transfer process but unable to transfer self.

☐ 3 - Unable to transfer self and is unable to bear weight or pivot when transferred by another person.

☐ 4 - Bedfast, unable to transfer but is able to turn and position self in bed.

☐ 5 - Bedfast, unable to transfer and is unable to turn and position self.

Comments: *Patient requires one-arm assistance to transfer from bed to chair.*

(M1860) Ambulation/Locomotion: Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.

☐ 0 - Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (i.e., needs no human assistance or assistive device).

☐ 1 - With the use of a one-handed device (e.g. cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.

X 2 - Requires use of a two-handed device (e.g., walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.

☐ 3 - Able to walk only with the supervision or assistance of another person at all times.

☐ 4 - Chairfast, unable to ambulate but is able to wheel self independently.

See **CERTIFYING**, page 22

CERTIFYING

from page 21

Example 4 – Part 2 of 2

☐ 5 - Chairfast, unable to ambulate and is unable to wheel self.

☐ 6 - Bedfast, unable to ambulate or be up in a chair.

Comments: *Pt. with a shuffling gait and frequently trips while ambulating. Pt. requires a wheeled walker and requires frequent cueing to remind him to not shuffle when he walks and to look up to avoid environmental hazards. Unable to go up and down stairs without his daughter assisting him. Daughter states that patient needs 24/7 supervision and is only able to leave his home for doctor appointments and only when she and her husband assist him. Patient is an increased fall risk because of inability to safely navigate stairs, uneven sidewalks and curbs.*

In conjunction with the discharge summary, this meets the requirements for documenting why the patient was/is confined to the home (homebound).

Sam Bone, M.D. 4/20/2014

Signed and dated by certifying physician indicating review and incorporation into the patient's medical record.

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 *http://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

Implantable infusion pump for the treatment of chronic intractable pain – retired Part A and Part B LCD

LCD ID number: L33593 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on data analysis and annual review of the local coverage determination (LCD) for implantable infusion pump for the treatment of chronic intractable pain, 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 November 13, 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

Botulinum toxins – revision to the Part A and Part B LCD

LCD ID number: L33274 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on a reconsideration request, the local coverage determination (LCD) for botulinum toxins was revised to add the new Food and Drug Administration (FDA) approved indication for Xeomin® in the "Coverage Indications, Limitations, and/or Medical Necessity" section of the LCD. Also, ICD-10-CM diagnosis code K11.7 was added to the "ICD-10 Codes that Support Medical Necessity" section of the LCD under "Group 4 Codes:" for Healthcare Common Procedure Coding System (HCPCS) code J0588. In addition, the "Sources of Information" section of the LCD was updated.

Effective date

This LCD revision is effective for services rendered **on or after November 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*.

Lumbar spinal fusion for instability and degenerative disc conditions – revision to the Part A and Part B LCD

LCD ID number: L33382 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on review, the local coverage determination (LCD) for lumbar spinal fusion for instability and degenerative disc conditions was revised to include the descriptors for the ICD-10-PCS codes listed in the "ICD-10 Codes that Support Medical Necessity/Group 1 Paragraph:/Inpatient only ICD-10 CM Procedure Codes" section of the LCD. Also, the inactive links were removed from the "Sources of Information" section of the LCD.

Effective date

This LCD revision is effective for claims processed **on or after October 23, 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*.

Prostatic urethral lift (PUL) – revision to the Part A and Part B LCD

LCD ID number: L36775 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on a reconsideration request of the prostatic urethral lift (PUL) local coverage determination (LCD), the "Coverage Indications, Limitations, and/or Medical Necessity" section of the LCD was revised to reflect a change of age from "50 years of age and older" to "45 years of age or older." In addition, the "Sources of Information" section of the LCD was updated to include multiple published sources from a reconsideration request. Furthermore, grammatical errors were corrected throughout the LCD.

Effective date

The revision to the LCD related to the age change is effective for claims processed **on or after October 30, 2018,** for services rendered **on or after December 28, 2017.**

The revision to the LCD related to updating the "Sources of Information" is effective for services rendered **on or after October 30, 2018**.

The revision to the LCD related to correcting grammatical errors is effective for claims processed **on or after October 30, 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*.

Pulmonary diagnostic services – revision to the Part A and Part B LCD

LCD ID number: L33707 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on a reconsideration request of the pulmonary diagnostic services local coverage determination (LCD), the "Sources of Information" section of the LCD was updated to include multiple published sources. The content of the LCD has not been changed in response to the reconsideration request. In addition, grammatical errors were corrected throughout the LCD.

Effective date

The LCD revision related to updating the "Sources of Information" is effective for services rendered **on or after November 13, 2018.**

The LCD revision related to correcting grammatical errors is effective for claims processed **on or after November 13, 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*.

Surgical management of morbid obesity – revision to the Part A and Part B LCD

LCD ID number: L33411 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on an annual review of the surgical management of morbid obesity local coverage determination (LCD), the "Centers for Medicare & Medicaid Services (CMS) National Coverage Policy" section of the LCD was updated for CMS Manual System, Pub. 100-03, Medicare National Coverage Determinations (NCD) Manual, Chapter 1, Part 2 to delete sections 100.0, 100.01, 100.08, 100.11 and 100.14 and replace them with section 100.1.

Effective date

This LCD revision is effective for services rendered **on or after November 6, 2018.** LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

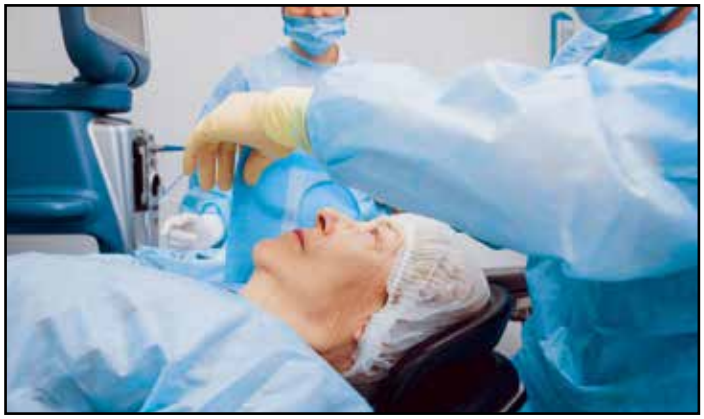
A coding article for an LCD (when present) may be found by selecting "Related Local Coverage Documents" in the "Section Navigation" drop-down menu at the top of the LCD page.

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

Additional Information

Insertion of anterior segment aqueous drainage device – Current Procedural Terminology (CPT®) codes 0191T, 0474T and 0449T

Insertion of a Food and Drug Administration (FDA)-approved/cleared anterior segment aqueous drainage device can be performed alone, or in conjunction with cataract surgery for the treatment of adults with mild or moderate open-angle glaucoma who also have a cataract. In determining the fees for *Current Procedural Terminology* (CPT®) codes 0191T and 0449T, First Coast Service Options, Inc. (First Coast) used the trabeculectomy procedure as a comparison. The Part B physician fee for CPT® code 0191T reflects the fact that this procedure will always be performed in conjunction with a cataract surgery. The fee for CPT® code 0449T reflects the fact that this procedure can be performed alone, or in conjunction with a cataract surgery. For these Category III CPT® codes, the -51 modifier cannot be used to indicate a multiple surgery reduction. For Ambulatory Surgery Centers (ASCs) billing under Part B, these procedures have fees on the ASC Fee Schedule. For outpatient hospitals billing under Part A, these codes are assigned to an Ambulatory Payment Classification (APC) under the Outpatient Prospective Payment System (OPPS).



Note: Due to the voluntary recall of the CyPass Micro-Stent **on August 29, 2018**, First Coast has determined that this device is unsafe at this time. As such, First Coast will deny Part A and Part B claims for the CyPass Micro-Stent device, reported with CPT® code 0474T, for services rendered **on or after August 29, 2018**. When billing for insertion of a stent with cataract surgery, providers should report both procedures on the same claim.

Keep updated...

Use the tools and useful information found on *medicare.fcso.com* to stay updated on changes associated with the Medicare program.

Hospital and CAH swing-bed manual revisions

Provider type affected

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

Provider action needed

Change request (CR) 10962 clarifies policies related to hospitals and CAHs with respect to services furnished to swing-bed patients, including policies related to pass-through reimbursement for certified registered nurse anesthetist (CRNA) services. Make sure your billing staffs are aware of these changes.

Background

CAH swing-bed services are not subject to the skilled nursing facility (SNF) prospective payment system. Instead, CAHs are paid based on 101 percent of reasonable cost for swing-bed services. As is the case with CAH inpatient services, CAH swing-bed services are subject to the hospital bundling requirements at section 1862(a)(14) of the Social Security Act and in the regulations at 42 CFR § 411.15(m). Therefore, because CAH swing-bed services are subject to the hospital bundling requirements, the Centers for Medicare & Medicaid Services (CMS) is clarifying that nonprofessional services provided to a CAH swing-bed patient must be included on the CAH's swing-bed bill.

In addition, CRNA pass-through payments (42 CFR § 412.113 (c)) provide qualifying hospitals and CAHs with reasonable cost-based payments for CRNA services. CMS is clarifying that qualifying hospitals and CAHs are eligible to receive pass-through payments for CRNA services provided to hospital and CAH swing-bed patients since these patients are considered inpatients for Medicare payment purposes. CRNA pass-through services provided to swing-bed patients must be included on the hospital's or CAH's swing-bed bill.

As a result of CR 10962:

- MACs will allow CAHs to bill for: (1) bed and board; (2) such nursing services and other related services, such use of hospital facilities, and such medical social services as are ordinarily furnished by the hospital for the care and treatment of inpatients, and such drugs, biologicals, supplies, appliances, and equipment, for use in the hospital, as are ordinarily furnished by such hospital for the care and treatment of inpatients; and (3) such other diagnostic or therapeutic items or services, furnished by the hospital or by others under arrangements with them made by the hospital, as are ordinarily furnished to inpatients either by such hospital or by others under such arrangements; which are rendered in a CAH swing-bed on Type of bill (TOB) 18x where the provider number range begins with Z300 through Z399,
- MACs will allow for services rendered by a CRNA in a CAH swing-bed, where the CAH has CRNA pass-through using TOB 18x; revenue code (REV) 0964 professional service; REV: 037x technical; and a provider number range beginning with Z300 through Z399.
- MACs will allow for services rendered by a CRNA in a hospital swing-bed, where the short-term acute care hospital has CRNA pass-through, using TOB 18x; REV 0964 professional service; REV: 037x technical; and a provider number range beginning with U001 through U879.

Additional information

The official instruction, CR 10962, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4157CP.pdf*. CR 10962 updates Chapters 3, 4, and 6 of the *Medicare Claims Processing Manual*. These updated chapters are attached to the CR.

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
November 2, 2018	Initial article released.

MLN Matters® Number: MM10962
Related CR Release Date: November 2, 2018
Related CR Transmittal Number: R4157CP
Related Change Request (CR) Number: 10962
Effective Date: April 1, 2019
Implementation April 1, 2019

Hospitals: Incorrect Maximum Payment for Sentinel Cerebral Protection System™

The FY 2019 Inpatient Prospective Payment System (IPPS) Pricer contained an incorrect maximum new technology add-on payment for Sentinel Cerebral Protection System™. The issue will be corrected in November. Your Medicare Administrative Contractor (MAC) will reprocess these claims with a discharge date on or after October 1 through the implementation of the corrected IPPS Pricer. No action is required by hospitals.

January 2019 quarterly ASP Medicare Part B drug pricing files and revisions to prior quarterly pricing files

Provider type affected

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

Provider action needed

Change request (CR) 11016 provides the quarterly update for average sales price (ASP) Medicare Part B drug pricing files and revisions to the prior quarterly pricing files. CR 11016 instructs MACs to download and implement the January 2019 and, if released, the revised October 2018, July 2018, April 2018, and January 2018 files. Medicare shall use the January 2019 ASP and not otherwise classified (NOC) drug pricing files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after January 1, 2019 with dates of service January 1, 2019, through March 31, 2019. Make sure your billing staffs are aware of these updates.

Background

The ASP methodology is based on quarterly data submitted to the Centers for Medicare & Medicaid Services (CMS) by manufacturers. CMS will supply MACs with the ASP and not otherwise classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the OPPS are incorporated into the outpatient code editor (OCE) through separate instructions that can be located in Chapter 4, Section 50 of the *Medicare Claims Processing Manual* at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf*.

- **File: January 2019 ASP and ASP NOC** -- effective dates of service: January 1, 2019, through March 31, 2019
- **File: October 2018 ASP and ASP NOC** -- effective dates of service: October 1, 2018, through December 31, 2018
- **File: July 2018 ASP and ASP NOC** -- effective dates of service: July 1, 2018, through September 30, 2018
- **File: April 2018 ASP and ASP NOC** -- effective dates of service: April 1, 2018, through June 30, 2018
- **File: January 2018 ASP and ASP NOC** -- effective dates of service: January 1, 2018, through March 31, 2018

For any drug or biological not listed in the ASP or NOC drug pricing files, your MACs will determine the payment allowance limits in accordance with the policy described in the *Medicare Claims Processing Manual*, Chapter 17, Section 20.1.3 at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c17.pdf*.

For any drug or biological not listed in the ASP or NOC drug pricing files that is billed with the KD modifier, MACs will determine the payment allowance limits in accordance with instructions for pricing and payment changes for infusion drugs furnished through an item of durable medical equipment (DME) on or after January 1, 2017, associated with the passage of the 21st Century Cures Act which is available at *https://www.gpo.gov/fdsys/pkg/PLAW-114publ255/pdf/PLAW-114publ255.pdf*.

Note: MACs will not search and adjust claims that have already been processed unless you bring such claims to their attention.

Additional information

The official instruction, CR 11016, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4154CP.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
October 26, 2018	Initial article released.

MLN Matters® Number: MM11016
Related CR Release Date: October 26, 2018
Related CR Transmittal Number: R4154CP
Related Change Request (CR) Number: 11016
Effective Date: January 1, 2019
Implementation January 7, 2019

2019 Medicare physician fee schedule payment rates and participation program

The annual physician and supplier participation period begins January 1 of each year, and runs through December 31. The annual participation enrollment is scheduled to begin mid-November of each year. (**Note**: The dates listed for release of the participation enrollment/fee disclosure material are subject to publication of the annual final rule.)

The 2019 Medicare physician fee schedule (MPFS) payment rates will be posted to First Coast Service Options' Medicare Provider website after publication of the MPFS final rule in the *Federal Register*. This publication usually occurs in mid-November.

Source: Publication 100-04, Chapter 1, Section 30.3.12.1 (B2)

Upcoming provider outreach and educational events

Topic: Ask-the-contractor teleconference (ACT): MSP conditional and residual payment claims

Date: Wednesday, December 12
Time: 10:00 -11:30 a.m.
Type of Event: Webcast

https://medicare.fcso.com/Events/0420970.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 October 25, 2018

MLN Connects® for October 25, 2018
View this edition as a PDF

News & Announcements

- New Medicare Card: Handouts and Videos for Patients
- DME: Formal Telephone Discussion Demonstration Expansion
- Emergency Preparedness: Hospital-based Incident Command System, Earthquakes, Medical Surge

Provider Compliance

- Coding for Specimen Validity Testing Billed in Combination with Urine Drug Testing — Reminder

Upcoming Events

- Physician Compare: Preview Period and Public Reporting Webcast — October 30
- Meeting the Needs of Dually Eligible Older Adults with Schizophrenia Webinar — November 6
- IRF Payment and Coverage Policies: FY 2019 Final Rule Call — November 15

Medicare Learning Network Publications & Multimedia

- Order Requirements When Prescribing Practitioner is DMEPOS Supplier MLN Matters Article — New
- Updating CY 2019 MDPP Payment Rates MLN Matters Article — New
- Quality Payment Program 2018 MIPS Cost Performance Category Web-Based Training Course — New

- Quality Payment Program 2018 MIPS Improvement Activities Performance Category Web-Based Training Course — Revised
- Quality Payment Program 2018 MIPS APMs Web-Based Training Course — Revised
- Quality Payment Program 2018 Advanced APMs Web-Based Training Course — Revised
- Items and Services Not Covered under Medicare Booklet — Revised

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MLN Connects® – Special Edition for November 1, 2018

Final 2019 Payment Policies: Physician Fee Schedule, DME & ESRD

- **Physician Fee Schedule and QPP: Changes to Advance Innovation, Restore Focus on Patients**
- **DME and ESRD Programs: Policies to Modernize and Drive Innovation**

Physician Fee Schedule and QPP: Changes to Advance Innovation, Restore Focus on Patients

On November 1, CMS finalized bold proposals that address provider burnout and provide clinicians immediate relief from excessive paperwork tied to outdated billing practices. The final 2019 Physician Fee Schedule (PFS) and the Quality Payment Program (QPP) rule also modernizes Medicare payment policies to promote access to virtual care, saving Medicare beneficiaries time and money while improving their access to high-quality services, no matter where they live. It makes changes to ease health information exchange through improved interoperability and updates QPP measures to focus on those that are most meaningful to positive outcomes. The rule also updates some policies under Medicare's Accountable Care Organization program that streamline quality measures to reduce burden and encourage better health outcomes. This rule is projected to save clinicians $87 million in reduced administrative costs in 2019 and $843 million over the next decade.

"The historic reforms CMS finalized today move us closer to a health care system that delivers better care for Americans at lower cost," said HHS Secretary Alex Azar. "Among other advances, improving how CMS pays for drugs and for physician visits will help deliver on two HHS priorities: bringing down the cost of prescription drugs and creating a value-based health care system that empowers patients and providers."

"Today's rule finalizes dramatic improvements for clinicians and patients and reflects extensive input from the medical community," said CMS Administrator Seema Verma. "Addressing clinician burnout is critical to keeping doctors in the workforce to meet the growing needs of America's seniors. Today's rule offers immediate relief from onerous requirements that contribute to burnout in the medical profession and detract from patient care. It also delays even more significant changes to give clinicians the time they need for implementation and provides time for us to continue to work with the medical community on this effort."

Coding requirements for physician services known as "Evaluation and Management" (E/M) visits have not been updated in 20 years. This final rule addresses longstanding issues and also responds to concerns raised by commenters on the proposed rule. CMS is finalizing several burden-reduction proposals immediately (effective January 1, 2019), where commenters provided overwhelming support. In response to concerns raised on the proposal, the final rule includes revisions that preserve access to care for complex patients, equalize certain payments for primary and specialty care, and

allow for continued stakeholder engagement by delaying implementation of E/M coding reforms until 2021.

For the first time this rule will also provide access to "virtual" care. Medicare will pay providers for new communication technology-based services, such as brief check-ins between patients and practitioners and pay separately for evaluation of remote pre-recorded images and/or video. CMS is also expanding the list of Medicare-covered telehealth services. This will give seniors more choice and improved access to care.

In addition, the rule continues our work to deliver on President Trump's commitment to lowering prescription drug costs. Effective January 1, 2019, payment amounts for new drugs under Part B will be reduced, decreasing the amount seniors have to pay out-of-pocket, especially for drugs with high launch prices.

CMS is also finalizing an overhaul of Electronic Health Record (EHR) requirements in order to focus on promoting interoperability. The rule finalized changes to help make EHR tools that actually support efficient care instead of hindering care. Final policies for Year 3 of the QPP, part of the agency's implementation of MACRA, will advance the Meaningful Measures initiative while reducing clinician burden, ensuring a focus on outcomes, and promoting interoperability. CMS also introduced an opt-in policy so that certain clinicians who see a low volume of Medicare patients can still participate in the Merit-based Incentive Payment System program if they choose to do so. In addition, CMS is providing the option for clinicians who are based at a health care facility to use facility-based scoring to reduce the burden of having to report separately from their facility.

For More Information:

- *Final Rule*
- *PFS Fact Sheet*
- *QPP Fact Sheet*
- *E/M Payment Amounts Chart*

See the full text of this excerpted *CMS Press Release* (November 1).

See **POLICIES**, page 32

POLICIES

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DME and ESRD Programs: Policies to Modernize and Drive Innovation

On November 1, CMS finalized innovative changes to the Medicare payment rules for Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) and the End-Stage Renal Disease (ESRD) programs. The policies aim to increase access to items and services for patients, drive competition and increase affordability.

"The rule finalized today makes innovative changes to the Medicare payment rules for the durable medical equipment and end-stage renal disease programs. It also helps to ensure continued access to durable medical equipment and makes significant improvements to our competitive bidding system." said CMS Administrator Seema Verma. "Based on many comments we received on our DME proposal from suppliers, manufacturers and their associations -- all of whom supported our proposals -- we are implementing market-oriented reforms to Medicare's DMEPOS Competitive Bidding Program that also reduce burden on suppliers by simplifying the bidding process."

Improved Access to Durable Medical Equipment (DME)

The rule finalizes market-oriented reforms to the Medicare's DMEPOS Competitive Bidding Program (CBP). The final rule will increase beneficiary access to items and services, leverage opportunities to increase the program's effectiveness and better ensure the long-term sustainability of the DMEPOS CBP by streamlining the program and strengthening the bidding rules. Changes to the DMEPOS CBP that we finalized also will reduce burden on suppliers by simplifying the bidding process. This rule establishes lead item bidding, which means suppliers will only need to submit one bid per product category. In addition, the single payment amounts for items in each product category under the DMEPOS CBP would apply to the lead item in the product category. These changes streamline the program, enhance quality and access to innovative products, and help ensure the long term sustainability of the program and the savings it generates. Also, the rule finalizes increases in DMEPOS fee schedule rates, using a blend of adjusted and unadjusted fee amounts, in order to protect access to needed durable medical equipment in rural areas that are not subject to the DMEPOS CBP.

The process for recompeting contracts with suppliers currently in effect under the DMEPOS CBP has not yet been initiated and the current contracts for the DMEPOS CBP will expire on December 31, 2018. As a result, starting January 1, 2019, and until new contracts are awarded under the DMEPOS CBP, there will be a temporary gap period in the entire DMEPOS CBP and National Mail Order CBP that CMS expects will last two years until December 31, 2020. During that time, Medicare beneficiaries will continue to receive DMEPOS items from any Medicare-enrolled DMEPOS supplier and in most cases, they won't need to switch suppliers.

As required by the 21st Century Cures Act, this rule also finalizes Medicare fee schedule payments for DME furnished on or after January 1, 2019 in areas of the country where competitive bidding is not in effect. For more information, see the *Temporary Gap Period* fact sheet.

End-Stage Renal Disease Prospective Payment System

CMS is also taking steps to support innovation in Medicare's ESRD Prospective Payment System by expanding the Transitional Drug Add-on Payment Adjustment (TDAPA) for new ESRD drugs and biologicals, effective January 1, 2020. As the largest payer for kidney care, expanding TDAPA to all new renal dialysis drugs and biological products will help incentivize the development and use of transformative and innovative therapies.

Finally, this final rule takes significant steps forward by strengthening quality incentives, improving patient outcomes and reducing administrative burden. These changes advance the *Patients Over Paperwork* initiative and will allow doctors to spend less time on paperwork and more time with their patients. Based on stakeholder feedback, CMS reduced ESRD facility-related documentation burdens for the comorbidity payment adjustment so that the documentation requirements are more consistent with other payment systems. CMS also reduced the reporting burden for the ESRD Quality Incentive Program by finalizing a more limited measure set that better aligns with the CMS Meaningful Measures Initiative.

For More Information:

- *Final Rule*
- *Fact Sheet*
- See the full text of this excerpted *CMS Press Release* (issued November 1).

MLN Connects® for November 1, 2018

MLN Connects® for November 1, 2018
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News & Announcements

- HHS Advances Payment Model to Lower Drug Costs for Patients
- SNF Quality Reporting Program Data on Nursing Home Compare
- IRF, LTCH, and SNF Quality Reporting Programs: Submission Deadline November 15
- Hospital Cost Report Data: User-Friendly Version
- Medicare Diabetes Prevention Program: New Covered Service
- November is Home Care and Hospice Month

Provider Compliance

- Ophthalmology Services: Questionable Billing and Improper Payments — Reminder

Upcoming Events

- IRF Payment and Coverage Policies: FY 2019 Final Rule Call — November 15

Medicare Learning Network Publications & Multimedia

- Typhoon Yutu and Medicare Disaster Related Commonwealth of the Northern Mariana Islands Claims MLN Matters Article — New
- MRI MLN Matters Article — New
- Incomplete Colonoscopies Billed with Modifier 53 MLN Matters Article — New
- CWF Edit of MA Inpatient Claims from Approved Teaching Hospitals MLN Matters Article — New
- Correction to CWF IUR 7272 for Intervening Stay MLN Matters Article — New
- Redesign of Hospice Periods MLN Matters Article — New
- ASP Medicare Part B Drug Pricing Files and Revisions: January 2019 MLN Matters Article — New
- MCReF System Webcast: Audio Recording and Transcript — New
- Patient Relationship Categories and Codes Webcast: Audio Recording and Transcript — New
- Medicare Podiatry Services Fact Sheet — Revised
- Medicare and Medicaid Basics Booklet — Revised

MLN Connects® – Special Edition for November 2, 2018

CY 2019 OPPS and ASC Rule Encourages More Choices and Lower Costs for Seniors

On November 2, CMS released a final rule that strengthens the Medicare program by providing seniors more choices and lower cost options in making the best decisions on their care. The policies adopted in the Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System final rule with comment period will help lay the foundation for a patient-driven healthcare system.

"President Trump is committed to strengthening Medicare and lowering costs for patients. Today's rule advances competition by creating a level playing field for providers so they can compete for patients on the basis of quality and care," said CMS Administrator Seema Verma. "The final policies remove unnecessary and inefficient payment differences so patients can have more affordable choices and options."

To increase the sustainability of the Medicare program and improve the quality of care for patients, CMS is finalizing its proposed method to control unnecessary volume increases for certain clinical visits by utilizing site-neutral payments for these visits. This change will be phased in over two years. Clinic visits are the most common service billed under the OPPS. Currently, CMS and beneficiaries often pay more for the same type of clinic visit in the hospital outpatient setting than in the physician office setting. This policy would result in lower copayments for beneficiaries and savings for the Medicare program in an estimated amount of $380 million for 2019. For example, for a clinic visit furnished in an excepted off-campus provider-based department (PBD), average beneficiary cost sharing is currently $23. Under this final rule, that cost sharing would be reduced to $16 (based on a two year phase-in), saving beneficiaries an average of $7 each time they visit an off-campus department in CY 2019.

Additionally, CMS is giving patients more options on where to obtain care by increasing the services that can be furnished in ASCs. These changes are intended to help improve access and convenience and ensure that CMS policies are not favoring any particular provider type. For 2019, CMS is finalizing policies that will:

- Expand the number of surgical procedures payable at ASCs to include additional procedures that can safely be performed in that setting
- Ensure ASC payment for procedures involving certain high-cost devices generally parallels the payment amount provided to hospital outpatient departments for these devices

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- Help ensure that ASCs remain competitive by addressing the differential between how ASC payment rates and hospital outpatient department payment rates are updated for inflation

As part of the agency's "Patients Over Paperwork" Initiative—a cross-cutting process that evaluates and streamlines regulations with the goal of reducing burden—CMS is finalizing proposals to remove measures from the Hospital Outpatient Quality Reporting Program and from the Ambulatory Surgery Center Quality Reporting Program. These removals are aimed at enabling providers to focus on tracking and reporting the measures that are most impactful on patient care. This action will decrease burden for providers by approximately $27 million over the next two years.

In 2018, CMS implemented a payment policy to help beneficiaries save on coinsurance for drugs that were administered at hospital outpatient departments that were acquired through the 340B program—a program that allows certain hospitals to buy outpatient drugs at lower cost. Due to CMS' policy change, Medicare beneficiaries are now benefitting from the discounts that 340B hospitals enjoy when they receive 340B-acquired drugs. In 2018 alone, beneficiaries are saving an estimated $320 million on out-of-pocket payments for these drugs. For 2019, CMS is expanding on this policy by extending the 340B payment change to additional off-campus provider-based hospital outpatient departments that are paid under the Physician Fee Schedule.

In response to recommendations from the President's Commission on Combating Drug Addiction and the Opioid Crisis, to comply with the requirements of the SUPPORT for Patients and Communities Act (P.L. 115-271), and to avoid any potential unintended consequences that would encourage overprescribing of opioids, CMS is removing questions regarding pain communication from the hospital patient experience survey. Additionally, CMS is adopting

a policy to encourage increased use of non-opioid drugs following a surgical procedure in the ASC setting.

The President's Commission on Combating Drug Addiction and the Opioid Crisis also recommended that CMS review its payment policies for certain drugs that function as a supply, specifically non-opioid pain management treatments. Payment for drugs that function as a supply in surgical procedures or diagnostic tests is packaged under the OPPS and ASC payment systems. However, in response to this recommendation as well as stakeholder comments and peer-reviewed evidence, for 2019, CMS is finalizing the proposal to pay separately at average sales price plus 6 percent for non-opioid pain management drugs that function as a supply when used in a covered surgical procedure performed in an ASC.

For More Information:

- *Final Rule*
- *Fact Sheet*

Read the full text of this excerpted *CMS Press Release* (issued November 2)

MLN Connects® for November 8, 2018

MLN Connects® for November 8, 2018

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News & Announcements

- New Medicare Card: Questions?
- DMEPOS Competitive Bidding Updates
- SNF Provider Preview Reports: Review Your Data by November 30
- QRURs and PQRS Feedback Reports: Access Ends December 31
- Quality Payment Program: Multi-Payer Other Payer Advanced APMs List
- Quality Payment Program: Visit the Resource Library Website
- Raising Awareness of Diabetes in November

Provider Compliance

- Reporting Changes in Ownership — Reminder

Claims, Pricers & Codes

- Hospitals: Incorrect Maximum Payment for Sentinel Cerebral Protection System™

Upcoming Events

- Home Health Services: Review Choice Demonstration Call — November 13

See **CONNECTS®**, page 35

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from page 34

- IRF Payment and Coverage Policies: FY 2019 Final Rule Call — November 15
- Quality Payment Program Year 3 Final Rule Overview Webinar — November 15
- Physician Fee Schedule Final Rule: Understanding 3 Key Topics Call — November 19
- IMPACT Act: National Beta Test of Candidate SPADEs Meeting — November 27

Medicare Learning Network Publications & Multimedia

- Prescriber's Guide: New Medicare Part D Opioid Overutilization Policies for 2019 MLN Matters Article — New
- NGACO Model Post Discharge Home Visit HCPCS MLN Matters Article — New
- Hospital and CAH Swing-Bed Manual Revisions MLN Matters Article — New
- Manual Updates to Correct SNF Errors and Omissions: 2018 Q4 MLN Matters Article — New
- Temporary Transitional Payment for HIT Services for CYs 2019 and 2020 MLN Matters Article — New
- Revision of SNF CB Edits for Ambulance Services in a Part A Facility Stay MLN Matters Article — New

- Medicare Diabetes Prevention Program Expanded Model Booklet — New
- Medicare Billing: CMS Form CMS-1450 and the 837 Institutional Booklet — Revised
- Medicare Billing: CMS Form CMS-1500 and the 837 Professional Booklet — Revised
- Medicare Preventive Services National Educational Products Listing — Revised

MLN Connects® – Special Edition for November 13, 2018

New Medicare Card Mailing Update – Wave 6 Ends

CMS finished *mailing cards* to people with Medicare who live in Waves 1-5 and now Wave 6 states (Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Texas, Utah, Washington, and Wyoming). Card mailing in Wave 7 states and territories continues.

If someone with Medicare says they did not get a card, you should instruct them to:

- Sign into *MyMedicare.gov* to see if we mailed their card. If so, they can print an official card. They will need to create an account if they do not already have one.
- Call 1-800-MEDICARE (1-800-633-4227) where we can verify their identity, check their address, and help them get their new card.

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.

Continue to direct people with Medicare 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.

To ensure that people with Medicare continue to get care, health care providers and suppliers can use either the former Social Security number-based Health Insurance Claim Number or the new alpha-numeric Medicare Beneficiary Identifier for all Medicare transactions through December 31, 2019.

People with Medicare should continue to protect their new number to prevent medical identity theft and health care fraud, especially during Medicare Open Enrollment. You can find fraud prevention resources on our Medicare card *Outreach & Education* page to share with people with Medicare.

MLN Connects® for November 15, 2018

MLN Connects® for November 15, 2018
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News & Announcements

- Patients Over Paperwork November Newsletter
- Quality Payment Program Year 1 Performance Results
- Quality Payment Program: Participation Status Tool Updated
- Hospice Quality Reporting Program: Quarterly Update Document
- Hospices: 4.5 Month Data Correction Deadline for Public Reporting
- Hospice Item Set Freeze Date: November 15
- CMS Health Equity Awards: Submit Nominations by December 7
- Physicians: Documentation of Artificial Limbs and Braces
- Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier
- Recognizing Lung Cancer Awareness Month and the Great American Smokeout

Provider Compliance

- Cochlear Devices Replaced Without Cost: Bill Correctly — Reminder

Claims, Pricers & Codes

- DME: Denial of Serial Claims

Upcoming Events

- Physician Fee Schedule Final Rule: Understanding 3 Key Topics Call — November 19

Medicare Learning Network Publications & Multimedia

- Implementation of HCPCS Code J3591 and Changes for ESRD Claims MLN Matters Article — New
- DMEPOS Update MLN Matters Article — New
- Medicare Deductible, Coinsurance and Premium Rates: 2019 Update MLN Matters Article — New
- MCReF MLN Matters Article — Revised
- ICD-10 and Other Coding Revisions to NCDs MLN Matters Article — Revised
- Certifying Patients for the Medicare Home Health Benefit MLN Matters Article — Revised
- Certificate of Medical Necessity Web-Based Training Course — Revised
- Medicare Part B Immunization Billing Educational Tool — Revised

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Quarterly provider update

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

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

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

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