

Medicare A CONNECTION

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A Newsletter for MAC Jurisdiction N Providers

April 2019



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Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - April 2019 Update

Note: This article was revised on March 19, 2019, to reflect an updated Change Request (CR) that revised the attachment for codes G2014 and G2015 (see page 2 below). The CR release date, transmittal number and link to the transmittal was also changed. All other information remains the same. *This information was previously published in the February 2019 Medicare A Connection, page 14.*

Provider type affected

This MLN Matters Article is for physicians, providers and suppliers billing Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider action needed

This article informs you that the Centers for Medicare & Medicaid Services (CMS) has issued payment files to the MACs based upon the 2019 Medicare Physician Fee Schedule (MPFS) Final Rule. CR 11163 amends those payment files. Please be sure your billing staffs are aware of these changes.

Background

The 2019 Medicare Physician Fee Schedule (MPFS) Final Rule, published in the Federal Register on November 23, 2018, is effective for services furnished between January 1, 2019, and December 31, 2019.

Below is a summary of the changes for the April update to the 2019 Medicare Physician Fee Schedule Database (MPFSDB). These changes are effective for dates of service on and after January 1, 2019. CMS has added new HCPCS codes (G2001-G2009 and G2013-G2015) to the 2019 MPFSDB and updated another code (G9987) as shown in the table below. CMS communicated instructions for these new codes (G2001-G2009 and G2013-G2015) through a separate CR (CR 10907).

Please consult MLN Matters article MM10907 at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10907.pdf> for these instructions and other information.

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WHEN EXPERIENCE COUNTS & QUALITY MATTERS

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Claims

Activation of systematic validation edits for OPPS providers with multiple service locations

Provider types affected

This MLN Matters® Special Edition Article is for Outpatient Prospective Payment System (OPPS) providers that have multiple service locations submitting claims to Medicare A/B Medicare Administrative Contractors (MACs).

What you need to know

This article conveys the activation of systematic validation edits to enforce the requirements in the Medicare Claims Processing Manual, Chapter 1, Section 170, which describes Payment Bases for Institutional Claims. These requirements are not new requirements. The Centers for Medicare & Medicaid Services (CMS) discussed these requirements in CRs 9613 and 9907, both of which were effective on January 1, 2017. MLN Matters articles for CRs 9613 and 9907 are available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-NetworkMLN/MLNMattersArticles/Downloads/MM9613.pdf> and <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9907.pdf>, respectively. Make sure your billing staff is aware of these instructions.

Background

Increasingly, hospitals operate an off-campus, outpatient, provider-based department of a hospital. In some cases, these additional locations are in a different payment locality than the main provider. For Medicare Physician Fee Schedule (MPFS) and OPPS payments to be accurate, CMS uses the service facility address of the off-campus, outpatient, provider-based department of a hospital facility to determine the locality in these cases.

Additionally, in accordance with Section 1833(t)(21) of the Social Security Act (the Act), as added by Section 603 of the Bipartisan Budget Act of 2015 (Pub. L. 114-74), non-excepted services provided at an off-campus, outpatient, provider-based department of a hospital were required to be identified as the payment rate for non-excepted items and services billed on an institutional claim are to be paid under the MPFS and not the OPPS rates.

Claim Level Information

Additionally, in accordance with Section 1833(t)(21) of the Social Security Act (the Act), as added by Section 603 of the Bipartisan Budget Act of 2015 (Pub. L. 114-74), non-excepted services provided at an off-campus, outpatient, provider-based department of a hospital were required to be identified as the payment rate for non-excepted items and services billed on an institutional claim are to be paid under the MPFS and not the OPPS rates.

Additionally, Medicare systems will validate service facility location to ensure services are provided in a Medicare

enrolled location. The validation will be exact matching based on the information on the Form CMS-855A submitted by the provider and entered into the Provider Enrollment, Chain and Ownership System (PECOS). Providers need to ensure that the claims data matches their provider enrollment information.

When all the services rendered on the claim are from the billing provider address, providers are:

- To report the billing provider address only in the billing provider loop 2010AA and not to report any service facility location in loop 2310E (or in DDE MAP 171F screen for DDE submitters).

When all the services rendered on the claim are from one campus of a multi-campus provider that reports a billing provider address, providers are:

- To report the campus address where the services were rendered in the service facility location in loop 2310E if the service facility address is different from the billing provider address loop 2010AA (or in DDE MAP 171F screen for DDE submitters).

When all the services rendered on the claim are from the same off-campus, outpatient, provider-based department of a hospital, providers are:

- To report the off-campus, outpatient, provider-based department service facility address in the service facility provider loop 2310E (or in DDE MAP 171F screen for DDE submitters).

When there are services rendered on the claim from multiple locations:

- If any services on the claim were rendered at the billing provider address, providers should report the billing provider address only in the billing provider loop 2010AA and do not report the service facility location in loop 2310E (or in DDE MAP 171F screen for DDE submitters).
- If any services on the claim were rendered at more than one of the campus locations of a multi-campus provider that is not the main billing provider address, providers should report the service facility address in loop 2310E if all of the service facility addresses are different from the billing provider address in loop 2010AA (or in DDE MAP 171F screen for DDE submitters) from the first registered campus encounter of the "From" date on the claim.
- If any services on the claim were rendered at one of the campus locations of a multi-campus provider that is not the main billing provider

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ACTIVATION

from page 3

address and services were also rendered at other off-campus department practice locations, providers should report the campus address where the services were rendered in the service facility location in loop 2310E if the service facility address is different from the billing provider address in loop 2010AA (or in DDE MAP 171F screen for DDE submitters).

- If no services on the claim were rendered at the billing provider address or any campus location of a multi-campus provider, providers should report the service facility address in loop 2310E (or in DDE MAP 171F screen for DDE submitters) from the first registered department practice location encounter of the "From" date on the claim.

NM1 - SERVICE FACILITY LOCATION NAME – 60 Characters 837I – 25, UB-04

N3 - SERVICE FACILITY LOCATION ADDRESS

N301 – 55 Characters 837I – 25 Characters on the UB-04

N302 – 55 Characters 837I – not on UB-04 paper form

N4 - SERVICE FACILITY LOCATION CITY, STATE, ZIP CODE

N401 City Name – 30 Characters 837I – 12 Characters on the UB-04

N402 State Code – 2 Characters 837I – 2 Characters on the UB-04

N403 Postal Code – 15 Characters 837I – 9 Characters on the UB-04

DDE Screen MAP 171F:

```

MAP171F PAGE .. ..... ..../..
..... SC ..      INST CLAIM ..... ..:..
HIC ..... TOB ... S../LOC.....

      PROVIDER PRACTICE LOCATION ADDRESS
ADDRESS 1: .....

ADDRESS 2: .....

CITY   : ..... STATE: .. ZIP:.....
.....
.....

```

Line Level Information

In the CY 2015 OPFS Final Rule (79 FR 66910-66914), CMS created a HCPCS modifier for hospital claims that is to be reported with each claim line with a HCPCS for

outpatient hospital items and services furnished in an off-campus provider-based department of a hospital. CMS added this 2-digit modifier to the HCPCS annual file as of January 1, 2015, with the label "PO." Reporting of this new modifier was voluntary for CY 2015, with reporting required beginning on January 1, 2016.

In accordance with Section 1833(t)(21) of the Act, as added by Section 603 of the Bipartisan Budget Act of 2015 (Pub. L. 114-74), CMS established a new modifier "PN" (Non-excepted service provided at an off-campus, outpatient, provider-based department of a hospital) to identify and pay non-excepted items and services billed on an institutional claim. Effective January 1, 2017, non-excepted off-campus provider-based departments of a hospital are required to report this modifier on each claim line with a HCPCS for non-excepted items and services. The use of modifier "PN" will trigger a payment rate under the MPFS. CMS expects you to report the PN modifier with each non-excepted line item and service including those for which payment will not be adjusted, such as separately payable drugs, clinical laboratory tests, and therapy services; with reporting required beginning on January 1, 2017.

As a result, effective January 1, 2017, excepted off-campus provider-based departments of a hospital must continue to report existing modifier "PO" (Services, procedures and/or surgeries provided at off-campus provider-based outpatient departments) for all excepted items for services reported with a HCPCS furnished.

New Practice Location Screen Available in DDE

CMS issued instructions to the Fiscal Intermediary Shared System (FISS) maintainer to make the practice location address screen received from the PECOS available to providers in DDE at the April 2019 system quarterly release. Starting in April 2019, the practice location screen will be available in DDE. Providers can compare what is on file with PECOS for their practice locations to ensure that their claims submitted for their practice locations is an exact match.

The PECOS information has been transmitted into the FISS and a comparison of claims with the PECOS information is made when the Provider Practice Location

```

MAP1702

INQUIRY MENU

BENEFICIARY/CWF          10  ZIP CODE FILE          19
DRG (PRICER/GROUPER)    11  OSC REPOSITORY INQUIRY 1A
CLAIM SUMMARY            12  CLAIM COUNT SUMMARY    56
REVENUE CODES            13  HOME HEALTH PYMT TOTALS 67
HCPC CODES               14  ANSI REASON CODES      68
DX/PROC CODES ICD-9      15  CHECK HISTORY          FI
ADJUSTMENT REASON CODES  16  DX/PROC CODES ICD-10    1B
REASON CODES             17  CMHC PAYMENT TOTALS    1C
INVOICE NO/DCN TRANS     88  PROV PRACTICE ADDR QUER 1D

ENTER MENU SELECTION:  1D

```

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from page 4

Address is completed for a claim being processed. Providers can access this inquiry screen by going into the Inquiry Menu MAP1702 in DDE and selecting "1D".

```

MAP1AB1
SC
NPI 1234567890 OSCAR
MNT:
SEL NPI OSCAR PRAC PRAC
EFF DT TERM DT ADDRESS ZIP
1234567890 ABCDEF 07011966 123102010 1234 MAIN ST 123456789
1234567890 ABCDEF 01012011 123119999 1236 MAIN ST 123456789
S 1234567890 ABCDEF 07012011 123119999 1239 MAIN ST 123459111
1234567890 ABCDEF 01012018 123119999 666 ELM ST 123459666

PLEASE MAKE A SELECTION, ENTER NEW KEY DATA, OR PRESS PF3 TO EXIT
PRESS PF3-EXIT PF5-SCROLL BKWD PF6-SCROLL FWD
    
```

The following display is made for each provider NPI on file. Providers can select the line they wish to view which matches the service facility being billed. PF6 to scroll forward for addition practice locations on file for their NPI.

```

MAP1AB2
SC
NPI 1234567890 OSCAR ABCDEF
MNT:
PRAC EFF DT 07012011 PRAC TERM DT 123119999
PRACTICE LOCATION KEY 00000000000000000000
OTHER PRACTICE Y
TYPE OF PRACTICE
ADDRESS 1 1239 MAIN ST
ADDRESS 2
CITY ANYTOWN STATE AA ZIP 123459111
NPI EFF DT 07012011 NPI TERM DT 123119999

PRESS PF3-EXIT PF6-SCROLL FWD PF7-PREV
    
```

The following display is made for each practice location on file. Providers can PF6 to scroll forward for additional practice locations on file.

National Testing

Round 1 Testing

During the week of July 23, 2018, through July 30, 2018, CMS performed a national trial activation of the FISS Edits 34977 and 34978 in production environments. Reason Codes 34977 (claim service facility address doesn't match provider practice file address) and 34978 (Off-campus provider claim line that contains a HCPCS must have a PN or PO) were activated. The testing was transparent to providers as most claims impacted by the test were suspended for one (1) billing cycle and then editing was turned off so the claim could continue processing as normal.

This national test brought to light that many providers are not sending the correct exact service facility location on the

claim that produces an exact match with the Medicare enrolled location as based on the information entered into the PECOS for their off-campus provider departments.

Most discrepancies had to do with spelling variations. For example, in PECOS the word entered was "Road" as part of their address, but the provider entered "Rd" or "Rd." as part of their address on the claim submission. Another example, in PECOS the word entered was "STE" as part of their address, but the provider entered "Suite" as part of their address on the claim submission.

Round 2 Testing

Providers should also ensure that all practice locations are present in PECOS and if any locations are not in PECOS to submit the 855A to add the location(s). Providers can review their practice locations in PECOS and/or the confirmation letter from PECOS when they last enrolled that was received from their A/B MAC to ensure that their service facility address for their off-campus provider department locations provided on claims is an exact match.

CMS conducted a second round of national testing in November 2018. Providers should have used the time before this national testing to correct the off-campus



provider department location addresses within their billing systems to match exactly PECOS for their off-campus provider departments.

Round 3 Testing

Prior to conducting round 3 testing, CMS issued instructions to the FISS maintainer to make the practice location address screen available to providers in DDE at the April 2019 system quarterly release. Starting in April 2019, the practice location screen will be available in DDE. CMS has postponed full production implementation for three additional months to allow time for providers to adjust to the new practice location screen.

CMS will continue with additional round(s) of testing to ensure that we have a smooth implementation of the

See **ACTIVATION**, page 7

Billing

Billing for Hospital Part B Inpatient Services

Provider type affected

This MLN Matters Article is for physicians, providers, and suppliers billing Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider information available

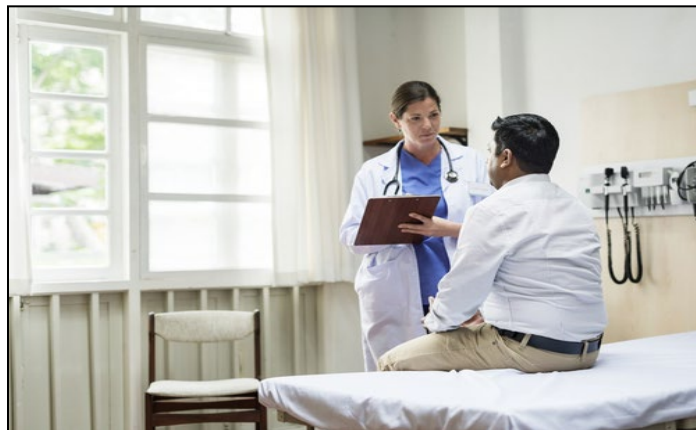
CR11181 provides billing instructions for hospital Part B inpatient services. Make sure your billing staffs are aware if these instructions.

Background

Medicare pays for hospital, including Critical Access Hospital (CAH), inpatient Part B services in the circumstances provided in the Medicare Benefit Policy Manual, Chapter 6, Section 10 (Medical and Other Health Services Furnished to Inpatients of Participating Hospitals). Hospitals must bill Part B inpatient services on a 12x Type of Bill. This Part B inpatient claim is subject to the statutory time limit for filing Part B claims described in the Medicare Claims Processing Manual, Chapter 1, Section 70.

A hospital may bill for Part B inpatient services if the hospital determines under Medicare's utilization review requirements that a beneficiary should have received hospital outpatient rather than hospital inpatient services, and the hospital already discharged the beneficiary from the hospital (commonly referred to as hospital self-audit). If the hospital already submitted a claim to Medicare for payment under Part A, the hospital must cancel its Part A claim prior to submitting a claim for payment of Part B inpatient services.

Whether or not the hospital submitted a claim to Part A for payment, Medicare requires the hospital to submit a Part A claim indicating that the provider is liable under Section 1879 of the Social Security Act for the cost of the Part A services. The hospital could then submit an inpatient claim for payment under Part B for all services that would have been reasonable and necessary if the hospital treated the beneficiary as a hospital outpatient rather than admitted as a hospital inpatient, except where those services specifically require an outpatient status.



Additional information

The official instruction, CR11181, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2019Downloads/R4259CP.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
March 22, 2019	Initial article released.

MLN Matters® Number: MM11181
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 Related CR Transmittal Number: R4259CP
 Related Change Request (CR) Number: 11181
 Effective Date: October 1, 2013
 Implementation June 29, 2019

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PARD

Medicare-Medicaid crossover bad debt accounting classification

Providers claiming Medicare bad debt must meet 42 CFR 413.89 and all requirements from Chapter 3 of the Provider Reimbursement Manual (<https://go.usa.gov/xEuwD>).

Correctly classify unpaid deductible and coinsurance amounts for Medicare-Medicaid crossover claims in your accounting records. For bad debt amounts:

- Do not write off to a contractual allowance account
- Charge to an expense account for uncollectible accounts (bad debt)

Effective for cost reporting periods beginning on or after October 1, 2019, providers must comply with these longstanding Medicare bad debt requirements.

QUARTERLY

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Table: April Updates to the 2019 MPFSD

HCCPS	ACTION
G9987	Assistant Surgery, Co-Surgeon, & Team Surgeon indicator = 9
G2001	All MPFS indicators and RVUs = 99341
G2002	All MPFS indicators and RVUs = 99342
G2003	All MPFS indicators and RVUs = 99343
G2004	All MPFS indicators and RVUs = 99344
G2005	All MPFS indicators and RVUs = 99345
G2006	All MPFS indicators and RVUs = 99347
G2007	All MPFS indicators and RVUs = 99348
G2008	All MPFS indicators and RVUs = 99349
G2009	All MPFS indicators and RVUs = 99350
G2013	All MPFS indicators and RVUs = 99345

G2014 - Procedure Status = A; RVUs = Work 1.25, Non-Facility .85, Facility .85, MP 0.07, Multiple Surgery = 0, Bilateral Surgery = 0, Assistant at Surgery = 0, Co-Surgeons = 0, Team Surgeons = 0, PC/TC = 0

G2015 - Procedure Status = A; RVUs = Work 1.80, Non-Facility 1.14, Facility 1.14, MP .11, Multiple Surgery = 0, Bilateral Surgery = 0, Assistant at Surgery = 0, Co-Surgeons = 0, Team Surgeons = 0, PC/TC = 0

Note: MACs will not search their files to retract payment for claims already paid or to retroactively pay claims. However, MACs will adjust claims that you bring to their attention.

ACTIVATION

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Full Production

After the national test in June 2019 is completed, CMS will review the results. CMS has full production implementation until July 2019. CMS may continue with additional round(s) of testing to ensure that we have a smooth implementation of the edits. Once the July 2019 Quarterly release is implemented, CMS will direct A/B MACs to permanently turn on the edits and set them up to Return-to-Provider (RTP) claims that do not exactly match. Providers can make corrections to their service facility address for a claim submitted in the DDE MAP 171F screen for DDE submitters.

Providers who need to add a new or correct an existing practice location address will still need to submit a new 855A enrollment application in PECOS.

CMS expects that the 2½ year time frame that the edits have not been active have provided ample time for providers to validate their claims submission system and the PECOS information for their off-campus provider departments are exact matches.

Additional information

The official instruction, CR 11163, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2019Downloads/R4258CP.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
March 19, 2019	We revised this article to reflect an updated CR that revised the attachment for codes G2014 and G2015 (see page 2 above). The CR release date, transmittal number and link to the transmittal was also changed.
February 8, 2019	Initial article released.

MLN Matters® Number: MM11163 Revised
Related CR Release Date: March 18, 2019
Related CR Transmittal Number: R4258CP
Related Change Request (CR) Number: 11163
Effective Date: January 1, 2019
Implementation Date: April 1, 2019

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Additional information

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

Document history

Date of change	Description
March 26, 2019	Initial article released.

MLN Matters® Number: SE19007
Related CR Release Date: N/A
Related CR Transmittal Numbers: R1704OTN and R1783OTN
Related Change Request (CR) Number: 9613; 9907
Effective Date: N/A
Implementation N/A

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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.



Revisions to LCDs

Diagnostic colonoscopy and colorectal cancer screening -- revisions to the Part A and Part B LCDs

LCD ID number: L33671 and L36355 (Florida, Puerto Rico/U.S. Virgin Islands)

Based on change request (CR) 10901, local coverage determinations (LCDs) for diagnostic colonoscopy and colorectal cancer screening were revised to remove all billing and coding and all language not related to reasonable and necessary provisions ("Bill Type Codes," "Revenue Codes," "CPT®/HCPCS Codes," "ICD-10 Codes that Support Medical Necessity," "Documentation Requirements," and "Utilization Guidelines" sections of the LCD) and place them into billing and coding articles related to the LCDs. In addition, based on CR 10937, the LCDs were revised to add internet-only manual (IOM) references in the "Centers for Medicare & Medicaid Services (CMS) National Coverage Policy" section of the LCDs related to incomplete colonoscopies billed with Modifier 53 for Critical Access Hospital (CAH) Method II Providers. Also, the LCDs were revised to remove outdated language on payment methodology from the "Coverage Indications, Limitations, and/or Medical Necessity" section of the LCDs related to when a covered colonoscopy is attempted but cannot be completed, and instead the IOM citation

related to this language is referenced in the "CMS National Coverage Policy" section of the LCDs. Furthermore, the "Bill Type Codes" and "Revenue Codes" sections of the diagnostic colonoscopy billing and coding article have been updated.

Effective date

The revision related to CR 10901 is effective for claims processed **on or after January 8, 2019**, for services rendered **on or after October 3, 2018**. The revision related to CR 10937 is effective for services rendered **on or after April 1, 2019**. LCDs are available through the CMS Medicare coverage database at <https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>.

A billing and 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](#).

Bone mineral density studies -- revision to the Part A and Part B LCD

LCD ID number: L36356 (Florida, Puerto Rico/U.S. Virgin Islands)

Based on change request (CR) 10901, the Current Procedural Terminology (CPT®) codes and ICD-10-CM diagnosis codes were split into two groups. Group 1 consists of CPT® codes 77080 and 77085 and the applicable ICD-10-CM diagnosis codes and Group 2 consists of CPT®/HCPCS codes 76977, 77078, 77081, and G0130 and the applicable ICD-10-CM diagnosis codes. In addition, the local coverage determination (LCD) was revised to remove all billing and coding and all language not related to reasonable and necessary provisions ("Bill Type Codes", "Revenue Codes", "CPT/HCPCS Codes", "ICD-10 Codes that Support Medical Necessity", "Documentation Requirements", "Utilization Guidelines", and "Frequency Standards" sections of the LCD) and place them into a billing and coding article. During the process of moving the ICD-10-CM diagnosis codes to the billing and coding article, the ICD-10-CM diagnosis code ranges were broken out and listed individually and any codes not meeting NCD medical necessity were removed. Also, the Centers for Medicare & Medicaid Services (CMS) internet-only manual (IOM) language has been removed from the LCD and instead, the IOM citation related to this language is referenced in the "CMS National Coverage Policy" section of the LCD.

Furthermore, based on CR 11134, the LCD billing and coding article was revised to add CPT® code 0508T to the "Group 1 Codes:" section of the article.

Effective date

The LCD revision related to the CR 10901 is effective for claims processed **on or after January 8, 2019**, for services rendered **on or after October 3, 2018**.

The LCD revision related to the removal of diagnoses not meeting NCD medical necessity is effective for services rendered **on or after May 7, 2019**.

The LCD revision related to the CR 11134 is effective for claims processed **on or after April 2, 2019**, for services rendered **on or after July 1, 2018**. LCDs are available through the CMS Medicare coverage database at <https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>.

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

Note: To review active, future and retired LCDs, please [click here](#).

Hemophilia clotting factors -- revision to the Part A and Part B LCD

LCD ID number: L33684 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 10901, the local coverage determination (LCD) for hemophilia clotting factors was revised to remove all billing and coding and all language not related to reasonable and necessary provisions ("Bill Type Codes," "Revenue Codes," "CPT®/HCPCS Codes," "ICD-10 Codes that Support Medical Necessity," "Documentation Requirements," and "Utilization Guidelines" sections of the LCD) and place them into a newly created billing and coding article. Also, the LCD was revised to update internet-only manual (IOM) references in the "Centers for Medicare & Medicaid (CMS) National Coverage Policy" section of the LCD. Additionally, based on CRs 11192, 11216, and 11232, the LCD billing and coding article was revised to add HCPCS codes C9141 and J7199 (Injection, factor viii, [antihemophilic factor, recombinant], pegylated-auct [Jivi], 1 i.u).

Effective date

The revision related to CRs 11192, 11216, and 11232 is effective for services rendered **on or after April 1, 2019**.

The revision related to CR 10901 is effective for claims processed **on or after January 8, 2019**, for services rendered **on or after October 3, 2018**. LCDs are available through the CMS Medicare coverage database at:



<https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>.

A billing and 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](#).

Medicare A Connection subscription

Medicare A Connection is published monthly and is available online in both English and Spanish.

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

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Upcoming provider outreach and educational events

Medicare outpatient physical therapy services (A/B)

Date: Thursday, May 16

Time: 10:00 - 11:30 a.m.

Type of Event: Webcast

<https://medicare.fcso.com/Events/0433002.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 [First Coast University](#), 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 the [Create 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.



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 March 21, 2019

MLN Connects[®] for March 21, 2019

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News

- Hospice Provider Preview Reports: Review Your Data by March 31
- LTCH Provider Preview Reports: Review Your Data by April 3
- IRF Provider Preview Reports: Review Your Data by April 3
- Draft 2020 QRDA Category I Implementation Guide — Submit Comments by April 8
- Medicare Promoting Interoperability Program: Submit a Measure Proposal by June 28
- Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier
- Influenza Activity Continues: Are Your Patients Protected?

Compliance

- Improper Payment for Intensity-Modulated Radiation Therapy Planning Services

Events

- Submitting Your Medicare Part A Cost Report Electronically Webcast — March 28

MLN Matters[®] Articles

- I/OCE Specifications: April 2019 Update
- RARC, CARC, MREP and PC Print Update
- Active Billing Hospice Submitting Revocations — Revised
- Next Generation Sequencing NCD — Revised
- SNF Patient Drive Payment Model — Revised

Publications

- Inpatient Rehabilitation Facility Prospective Payment System — Revised
- Medicare Enrollment for Institutional Providers — Revised
- Medicare Enrollment Resources — Revised
- Items and Services Not Covered Under Medicare — Reminder

Multimedia

- Promoting Interoperability Listening Session: Audio Recording and Transcript

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The answer is right at your fingertips

Available Monday-Friday, from 10 AM-2 PM ET, First Coast's Live Chat will allow you to connect with a team of experts who will respond to your **website-related inquiries** and help you get the most out of every visit to *medicare.fcso.com*.



MLN Connects® for March 28, 2019

MLN Connects® for March 28, 2019

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News

- New Medicare Card and MBI Adoption: How Do You Compare?
- SNF PPS Patient Driven Payment Model: Get Ready for Implementation on October 1

Compliance

- DME Proof of Delivery Documentation Requirements

MLN Matters® Articles

- Billing for Hospital Part B Inpatient Services
- Grandfathered Tribal FQHCs: Payment for CY 2019
- Home Health Certification and Recertification Policy Changes
- ASC Payment System: April 2019 Update
- Hospital OPPS: April 2019 Update
- Medicare Physician Fee Schedule Database: April 2019 Update — Revised

MLN Connects® for April 4, 2019

MLN Connects® for April 4, 2019

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News

- New Part D Policies Address Opioid Epidemic
- “Qué está Cubierto”
- Physician Compare: Supplemental Preview Period Open until April 27
- Open Payments: Review and Dispute Data by May 15
- Comparative Billing Report on Subsequent Hospital Visits
- PEPPERS for Hospices, LTCHs, SNFs, IRFs, IPFs, and CAHs
- Hospice Visits when Death is Imminent Measure Pair
- Mapping Medicare Disparities Tool: New Enhancements
- Medicare-Medicaid Crossover Bad Debt Accounting Classification
- Qualified Medicare Beneficiary Billing Requirements
- National Minority Health Month: Active & Healthy
- Looking for Educational Materials?

Compliance

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

Events

- Comparative Billing Report: Subsequent Hospital Visits Webinar — April 11

Publications

- CY 2019 eCQM
- Medicare Promoting Interoperability Program: Scoring Methodology
- Medicare Enrollment for Physicians and Other Part B Suppliers — Revised
- Medicare Preventive Services Poster — Revised
- Medicare Secondary Payer — Revised
- Safeguard Your Identity and Privacy Using PECOS — Revised

Multimedia

- Dementia Care Call: Audio Recording and Transcript
- Open Payments Call: Audio Recording and Transcript
- Medicare Secondary Payer Provisions Web-Based Training Course — Revised

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MLN Matters® Articles

- Activation of Systematic Validation Edits for OPPS Providers with Multiple Service Locations
- ASP Medicare Part B Drug Pricing Files and Revisions: July 2019
- Changes to the Laboratory NCD Edit Software: July 2019
- Correction to FY 2019 IPPS Pricer
- FY 2017 SSI/Medicare Beneficiary Data for IPPS Hospitals, IRFs, LTCHs
- NCCI PTP Edits: Quarterly Update
- E/M and Superficial Radiation Treatment — Revised

Publications

- Understanding the Medicare Beneficiary Identifier
- Acute Care Hospital Inpatient Prospective Payment System — Revised
- Hospice Payment System — Revised
- Ambulatory Surgical Center Payment System — Revised
- Medicare Preventive Services — Revised

Multimedia

- Reducing Opioid Misuse Call: Audio Recording and Transcript
- Promoting Interoperability Call: Audio Recording and Transcript
- SNF Value-Based Purchasing Program Call: Audio Recording and Transcript

MLN Connects® for April 11, 2019

MLN Connects® for April 11, 2019

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News

- Patients Over Paperwork April Newsletter
- New Part D Opioid Overutilization Policies: Myths and Facts
- Medicare Shared Savings Program: Submit Notice of Intent to Apply Beginning June 11
- Quality Payment Program CMS Web Interface and CAHPS for MIPS Survey: Register by July 1
- Quality Payment Program: 2018 MIPS Data Submission Preliminary Feedback
- IRF and SNF Quality Reporting Program: Enhanced Review and Correct Reports
- Part A Providers: Formal Telephone Discussion Demonstration Expansion
- Help Prevent Alcohol Misuse or Abuse
- National Health Care Decisions Day is April 16

Compliance

- Provider Minute Video: The Importance of Proper Documentation

Claims, Pricers & Codes

- Hold Hospice Adjustments to Avoid Underpayments

Publications

- Medicare Fraud & Abuse: Prevent, Detect, Report
- Promoting Interoperability Programs
- Telehealth Services — Revised
- Descriptors of G-codes and Modifiers for Therapy Functional Reporting — Revised
- Medicare Fraud & Abuse Poster — Reminder

Multimedia

- CMS: Beyond the Policy Podcast
- Cost Reports Webcast: Audio Recording and Transcript
- Quality Payment Program Merit-based Incentive Payment System (MIPS): Quality Performance Category in 2019 Web-Based Training Course — Revised

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MLN Connects® for April 18, 2019

MLN Connects® for April 18, 2019

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News

- CMS Proposes Expanding Coverage of Ambulatory Blood Pressure Monitoring
- Vitamin D Testing: Comparative Billing Report in April
- Air Ambulance Transports: Comparative Billing Report in April
- Physician Compare: Supplemental Preview Period Open until April 27
- Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier
- STD Awareness Month: Talk, Test, Treat

Compliance

- Inpatient Rehabilitation Facility Services: Follow Medicare Billing Requirements

Events

- MIPS APMs Scoring Standard Webinar — April 24

MLN Matters® Articles

- Temporary Gap Period of the DMEPOS CBP: July 2019 Update

Publications

- Medicare Enrollment for Providers Who Solely Order or Certify — Revised
- Medicare Overpayments — Revised
- PECOS for DMEPOS Suppliers — Revised
- PECOS for Physicians and NPPs — Revised
- PECOS for Provider and Supplier Organizations — Revised
- Annual Wellness Visit — Reminder
- Initial Preventive Physical Examination — Reminder

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First Coast Service Options

Phone Numbers

(Note: Specific geographic contact information is noted when phone numbers and addresses are different for providers in Florida, U.S. Virgin Islands or Puerto Rico.)

Customer service

Monday to Friday
8:00 a.m. to 4:00 p.m.
888-664-4112 (FL/USVI)
877-908-8433 (Puerto Rico)
877-660-1759 (TDD-FL/USVI)
888-216-8261 (TDD-Puerto Rico)

Electronic data interchange

888-670-0940 (FL/USVI)
888-875-9779 (Puerto Rico)

Interactive Voice Response

877-602-8816

Provider education/outreach

Event registration hotline
904-791-8103

Overpayments

904-791-8123

SPOT Help Desk

FCOSPOTHelp@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)

[\(https://www.cms.gov/\)](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