Medicare A Connection

medicare.fcso.com

FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction N Providers

July 2019

In this issue

Prompt payment interest rate revision

Medicare must pay interest on clean claims if payment is not made within the applicable number of calendar days after the date of receipt. The applicable number of days is also known as the payment ceiling.

The interest rate is determined by the applicable rate on the day of payment. This rate is determined by the Treasury Department on a six-month basis, effective every January 1 and July 1. Providers may access the Treasury Department webpage *https://www.fiscal.treasury.gov/fsservices/gov/pmt/promptPayment/rates.htm* for the correct rate. The interest period begins on the day after payment is due and ends on the day of payment.

The new rate of 2.625 percent is in effect July through December 2019.

Interest is not paid on:

- Claims requiring external investigation or development by the Medicare contractor
- Claims on which no payment is due
- Claims denied in full
- Claims for which the provider is receiving periodic interim payment
- Claims requesting anticipated payments under the home health prospective payment system.

Note: The Medicare contractor reports the amount of interest on each claim on the remittance advice to the provider when interest payments are applicable.

Contents

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

Publication staff:
Marielba Cancel
Maria Murdoch
Cesar Hernandez

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.

Claims

Activation of Systematic Validation Edits for OPPS Providers with Multiple Service Locations

***Note**: This article was revised on June 28, 2019, to provide an update on Round 3 testing and to announce a delay of full implementation until October 2019. This information was previously published in the April 2019 Medicare A Connection, pages 3-5, 7.*

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.

Claim Level Information

Medicare outpatient service providers report the service facility location for an off-campus, outpatient, provider-based department of a hospital in the 2310E loop of the 837 institutional claim transaction. Direct Data Entry (DDE) submitters also must report the service facility location for an off-campus, outpatient, provider-based department of a hospital. Paper submitters report the service facility address information in Form Locator (FL) “01” on the paper claim form. For MPFS services, Medicare systems use this service facility information to determine the applicable payment method or locality whenever it is present.

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 address and services were also rendered at other off-campus department practice locations, providers should report the campus address where the services

See **ACTIVATION**, page 4

ACTIVATION

from page 3

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.

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 edits. CMS plans to conduct a June 2019 national testing to ensure providers have used the new practice location screen tool and made necessary claims submission updates to their systems.

Round 3 Testing Update & Full Production Delayed Another Quarter

CMS has completed round 3 testing. We are in the process of analyzing the data, but at this point we have discovered no major issues during round 3 testing. Based on stake-holder comments and to allow additional time to review the round 3 testing, however, CMS has decided to postpone full production implementation for three additional months until October 2019. Once the October 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

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
June 28, 2019	We revised this article to provide an update on Round 3 testing and to announce a delay of full implementation until October 2019.
March 26, 2019	Initial article released.

MLN Matters® Number: SE19007 *Revised*
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

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 webpage 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

Wireless capsule endoscopy – revision to the Part A and Part B LCD

LCD ID number: L33774 (Florida/Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 10901, the local coverage determination (LCD) for wireless capsule endoscopy was revised to remove all billing and coding information as well as 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. During the process of moving the ICD-10-CM diagnosis codes to the billing and coding article, any ICD-10-CM diagnosis codes listed in ranges were broken out and listed individually.

Effective date

This LCD revision 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 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*.

Intensity modulated radiation therapy (IMRT) – revision to the Part A and Part B LCD

LCD ID number: L36773 (Florida/Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 10901, the local coverage determination (LCD) for intensity modulated radiation therapy (IMRT) 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 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.

In addition, 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 ICD-10-CM diagnosis codes not meeting LCD medical necessity were removed. They are as follows: D49.511, D49.512, and D49.59. Also the following ICD-10-CM diagnosis codes were added: C09.9, C34.91, C34.92, C38.3, C4A.59, C43.59, C44.09, C49.A1, C7A.090, C7B.02, C7B.04, C7B.1, C76.0, C77.1, C77.2, C77.3, C77.4, C77.5, C77.8, C78.01, C78.02, C78.1, C78.2, C78.39, C78.4, C78.5, C78.6, C78.7, C78.89, C79.82, C83.09, C83.19, C83.39, C83.59, C83.79, C85.21, C85.22, C85.23, C85.24, C85.25, C85.26, C85.27, C85.28, C85.29, C85.81, C85.82, C85.83, C85.84, C85.85, C85.86, C85.87, C85.88, C85.89, C85.91, C85.92, C85.93, C85.94, C85.95, C85.96, C85.97, C85.98, C85.99, C88.4, C90.20, C90.22, C90.32, D33.0, D33.1, D33.4, D33.7, D35.5, D43.0, D43.1, D43.3, D43.4, D43.8, D44.3, D44.4, D44.5, D44.6, D44.7, and D48.1.

Effective date

The LCD 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 addition and removal of ICD-10-CM diagnosis codes is effective for services rendered **on or after July 31, 2019**.

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*.

Vascular endothelial growth factor inhibitors for the treatment of ophthalmological diseases – revision to the Part A and Part B LCD

LCD ID number: L36962 (Florida/Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 10901, the local coverage determination (LCD) for vascular endothelial growth factor inhibitors for the treatment of ophthalmological diseases was revised to remove all billing and coding information as well as 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. 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. Also, the Food and Drug Administration (FDA) language has been removed from the LCD and instead the FDA citation related to this language is referenced to the FDA approved product labels. Furthermore, Internet-Only Manual (IOM) references have been updated and language from the Centers for Medicare & Medicaid Services (CMS) IOM and/or regulations was removed and instead the applicable manual/regulation reference was listed.

In addition, brand names were removed throughout the LCD and based on a reconsideration related to the new Food and Drug Administration (FDA) approved indication, diabetic retinopathy in patients without diabetic macular edema, the following ICD-10-CM diagnosis codes were added to the "ICD-10 Codes that are covered" section of the newly created billing and coding article for Healthcare Common Procedure Coding System (HCPCS) code J0178: E08.319, E08.3291, E08.3292, E08.3293, E08.3391, E08.3392, E08.3393, E08.3491, E08.3492, E08.3493, E08.3521, E08.3522, E08.3523, E08.3531, E08.3532, E08.3533, E08.3541, E08.3542, E08.3543, E08.3551, E08.3552, E08.3553, E08.3591, E08.3592, E08.3593, E09.319, E09.3291, E09.3292, E09.3293, E09.3391, E09.3392, E09.3393, E09.3491, E09.3492, E09.3493, E09.3521, E09.3522, E09.3523, E09.3531, E09.3532, E09.3533, E09.3541, E09.3542, E09.3543, E09.3551, E09.3552, E09.3553, E09.3591, E09.3592, E09.3593, E10.319, E10.3291, E10.3292, E10.3293, E10.3391, E10.3392, E10.3393, E10.3491, E10.3492, E10.3493, E10.3521, E10.3522, E10.3523, E10.3531,

E10.3532, E10.3533, E10.3541, E10.3542, E10.3543, E10.3551, E10.3552, E10.3553,E10.3591, E10.3592, E10.3593, E11.319, E11.3291, E11.3292, E11.3293, E11.3391, E11.3392, E11.3393, E11.3491, E11.3492, E11.3493, E11.3521, E11.3522, E11.3523, E11.3531, E11.3532, E11.3533, E11.3541, E11.3542, E11.3543, E13.319, E13.3291, E13.3292, E13.3293, E13.3391, E13.3392, E13.3393, E13.3491, E13.3492, E13.3493, E13.3521, E13.3522, E13.3523, E13.3531, E13.3532, E13.3533, E13.3541, E13.3542, E13.3543, E13.3551, E13.3552, E13.3553, E13.3591, E13.3592, and E13.3593.

Effective date

The LCD 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 LCD revision related to the addition of diagnoses is effective for claims processed **on or after July 25, 2019,** for services rendered **on or after May 13, 2019.** 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*.

Retired LCDs

Rituximab (Rituxan®) – retired Part A and Part B LCD

LCD ID number: L33746 (Florida/Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for rituximab (Rituxan®) is being retired after extensive review of the LCD.

Effective date

The retirement of this LCD is effective for services **rendered on or after July 11, 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*.

Screening and diagnostic mammography – retired Part A and Part B LCD

LCD ID number: L36342 (Florida/Puerto Rico/ U.S. Virgin Islands)

After review of the local coverage determination (LCD) for screening and diagnostic mammography, it was determined to retire the LCD based on national coverage determination (NCD) 220.4. Therefore, the related coding guideline article is also being retired.

Effective date

The retirement of this LCD and related coding guideline article is effective for services rendered **on or after July 31, 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*.

Find out first: Subscribe to First Coast *eNews*

Subscribe to First Coast Service Options *eNews*, to learn the latest Medicare news and critical program changes affecting the provider community. Join as many lists as you wish, in English or Spanish, and customize your subscription to fit your specific needs, line of business, specialty, or topics of interest. So, *subscribe to eNews, and stay informed.*

Preventive services

Pre-Diabetes Services: Referring Patients to the Medicare Diabetes Prevention Program

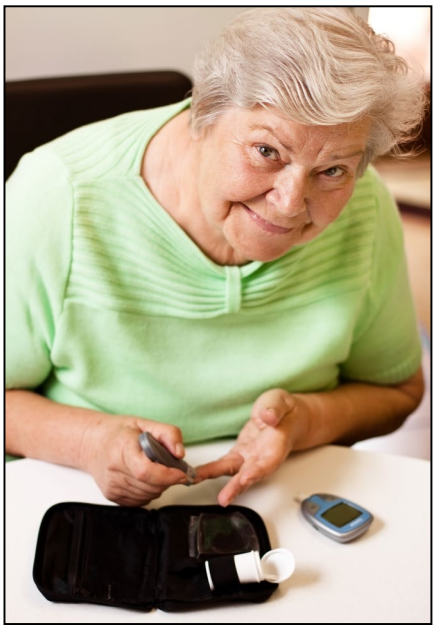
Provider type affected

This MLN Matters Article is for providers who may refer Medicare patients to the Medicare Diabetes Prevention Program (MDPP) for services to reduce diabetes risk.

What you need to know

MDPP is a Behavior Change Intervention:

- An estimated half of all adults age 65 and older have pre-diabetes. The MDPP is an evidence-based, structured behavior change intervention to prevent or delay type 2 diabetes in individuals with an indication of pre-diabetes.
- The primary goal of MDPP services is to help individuals lose at least 5 percent of their weight, which is associated with a clinically significant reduction in risk for type 2 diabetes. When studied, this intervention reduced the incidence of diabetes by 71 percent in individuals over age 60.



MDPP is a New Medicare-Covered Service:

- MDPP suppliers began enrolling in Medicare in January 2018 and Medicare began paying for MDPP services on April 1, 2018.
- Both traditional health care providers and community-based organizations can enroll as MDPP suppliers (a new Medicare supplier type) to provide MDPP services.
- Screen, test, and refer. You can screen and test your patients' risk for pre-diabetes and refer your patients to a Medicare-enrolled MDPP supplier. Medicare doesn't require providers' referral for MDPP services, but your patients may want to discuss MDPP services with you.
- There is no co-pay or deductible for MDPP services for patients who have Medicare Part B (Fee-For-Service) and meet other eligibility criteria. Patients in a Medicare Advantage plan can contact their plan for cost-sharing information

Background

MDPP Services for People with Medicare

Eligible participants can get up to 2 years of MDPP services with the primary goal of achieving and maintaining at least 5 percent weight loss. MDPP services include:

- Training to make realistic, lasting lifestyle changes
- Tips on getting more exercise
- Strategies for controlling weight
- Support from people with similar goals
- At least 16 "Core Sessions" in the first 6 months
- An additional 6 months of less-intensive monthly sessions to help maintain healthy habits
- An additional 12 months of ongoing maintenance sessions (if the patient meets certain weight loss and attendance goals)

To Start MDPP Services, People with Medicare Must Have:

- Medicare Part B coverage through Original Medicare or a Medicare Advantage (MA) plan
- Results from one of three blood tests taken within 12 months before they started MDPP services:
  - Hemoglobin A1c test with a value of 5.7-6.4 percent
  - Fasting plasma glucose test with a value of 110-125 mg/dl
  - Oral glucose tolerance test with a value of 140-199 mg/dl
- A Body Mass Index (BMI) of at least 25 (or 23 if the patient self-identifies as Asian)
- No history of type 1 or type 2 diabetes with the exception of gestational diabetes
- No End Stage Renal Disease (ESRD)
- Never received MDPP services before

MDPP Outcomes for People with Medicare

Outcomes of MDPP services for eligible patients may include:

- Reduced or delayed risk of developing type 2 diabetes
- Feeling healthier, greater self-confidence and more energized
- Improved quality of life

Some MDPP participants report that they like the support and accountability of a group-based class setting. Diet and physical activity changes mean that some participants may also be able to better manage other conditions.

See **PRE-DIABETES**, page 10

PRE-DIABETES

from page 9

MDPP Suppliers

Organizations must get recognition through the Centers for Disease Control and Prevention (CDC) Diabetes Prevention Recognition Program (DPRP), before enrolling in Medicare. Once enrolled in Medicare, MDPP suppliers may deliver MDPP services in community or health care settings. Only organizations can enroll in MDPP as suppliers, individuals cannot enroll. Organizations must enroll as an MDPP supplier even if they're already enrolled with Medicare as another provider or supplier type. Medicare payments to MDPP suppliers are performance-based, meaning that Medicare pays suppliers based on their success in helping participants lose weight.

Finding Enrolled MDPP Suppliers

Use the interactive *MDPP Supplier Map* to search for suppliers by ZIP code. Or, browse a *list of all currently enrolled MDPP suppliers*, including supplier location and contact information.

Your Role in the MDPP Referral Process

Screen, Test, and Refer

- Screen patients for their risk of pre-diabetes – do they have a BMI over 25 (or 23, if the patient self-identifies as Asian)? Do they have elevated blood glucose levels in the above-specified ranges?
- Order blood tests (for example, oral glucose tolerance test or fasting plasma glucose) for patients who may be at risk of diabetes and could qualify for MDPP services. (Note that the Hemoglobin A1c is not currently covered by Medicare for pre-diabetes screening).
- Refer eligible patients. Identify if your patients meet other MDPP eligibility requirements, such as having Medicare Part B, no diagnosis of type 1 or type 2 diabetes, and no diagnosis of ESRD. While your patients don't need a referral to get MDPP services, you can help spread the word about MDPP and answer patients' questions.
- Increase your patients' awareness of new MDPP services and eligibility requirements. In the *Medicare & You handbook for 2019* go to the Preventive Services section for MDPP information.
- Help your eligible patients find a local MDPP supplier by using the *MDPP Supplier Map*.

Additional information

- MDPP overview: *https://innovation.cms.gov/initiatives/medicare-diabetes-prevention-program/*
- MDPP Sessions Journey Map: *https://innovation.cms.gov/Files/x/mdpp-journeymap.pdf*
- Beneficiary Eligibility Fact Sheet: *https://innovation.cms.gov/Files/fact-sheet/mdpp-beneelig-fs.pdf*
- Preparing to Enroll as an MDPP Supplier Fact Sheet: *https://innovation.cms.gov/Files/x/mdpp-enrollmentfs.pdf*
- Frequently Asked Questions (FAQs) about becoming an MDPP supplier: *https://innovation.cms.gov/initiatives/medicare-diabetes-prevention-program/faq.html*
- Centers for Disease Control and Prevention (CDC) Diabetes prevention information: *https://www.cdc.gov/diabetes/prevention/index.html*
- CDC's Screen, Test, Refer process for diabetes prevention: *https://www.cdc.gov/diabetes/prevention/lifestyle-program/deliverers/screening-referral.html*
- MDPP Supplier Map: *https://innovation.cms.gov/initiatives/medicare-diabetes-prevention-program/mdpp-map.html*
- List of current MDPP Suppliers: *https://data.cms.gov/Special-Programs-Initiatives/Medicare-Diabetes-Prevention-Program/vwz3-d6x2/data*
- Sign up for the *MDPP listserv*

Document history

Date of change	Description
June 27, 2019	Initial article released.

MLN Matters® Number: SE19001
Related CR Release Date: June 27, 2019
Related CR Transmittal Number: N/A
Related Change Request (CR) Number: N/A
Effective Date: N/A
Implementation N/A

Upcoming provider outreach and educational events

Medicare Speaks 2019 Tampa

Date: August 20-21
Time: 8 a.m. - 4:30 p.m. ET
Type of Event: Face-to-face

https://medicare.fcso.com/Medicare_Speaks/0438275.asp

View our complete calendar of events

https://medicare.fcso.com/Events/139814.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 *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.).

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.

MLN Connects®

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 June 27, 2019

MLN Connects® for Thursday, June 27, 2019

View this edition as a PDF

News

- Medicare Shared Savings Program: Submit Notice of Intent to Apply by June 28
- MIPS Data Validation and Audit for Performance Years 2017 and 2018

Claims, Pricers & Codes

- FY 2020 ICD-10-CM Diagnosis Code Updates

Events

- DMEPOS Competitive Bidding: Round 2021 Webcast Series

MLN Matters® Articles

- Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes – July 2019 Update — Revised
- Clarification of Billing and Payment Policies for Negative Pressure Wound Therapy (NPWT) Using a Disposable Device — Revised

MLN Connects® for July 11, 2019

MLN Connects® for Thursday, July 11, 2019

View this edition as a PDF

News

- New Medicare Card: Transition Period Ends in Less Than 6 Months
- HHS To Transform Care Delivery for Patients with Chronic Kidney Disease
- CMS Expands Coverage of Ambulatory Blood Pressure Monitoring
- Open Payments: Program Year 2018 Data
- SNF PPS Patient Driven Payment Model: Get Ready for Implementation on October 1

Events

- DMEPOS Competitive Bidding: Round 2021 Webcast Series
- Enrollment: Multi–Factor Authentication for I&A System Webcast — July 30

MLN Matters® Articles

- Medicare Plans to Modernize Payment Grouping and Code Editor Software
- Medicare Part A Skilled Nursing Facility (SNF) Prospective Payment System (PPS) Pricer Update FY 2020
- October 2019 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files
- Medicare Summary Notice (MSN) Changes to Assist Beneficiaries Enrolled in the Qualified Medicare Beneficiary (QMB) Program — Revised
- July 2019 Integrated Outpatient Code Editor (I/OCE) Specifications Version 20.2 — Revised
- July Quarterly Update for 2019 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule — Revised
- Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment — Revised

Publications

- Get Your New Medicare Card
- Medicare Documentation Job Aid for Doctors of Chiropractic
- Medicare Preventive Services — Revised

Multimedia

- CMS: Beyond the Policy Podcast: Throwback to HIMSS Conference

MLN Connects® – Special Edition for July 11, 2019

HHAs: CY 2020 and 2021 New Home Infusion Therapy Benefit and Payment and Policy Changes

On July 11, CMS issued a proposed rule [CMS-1711-P] that proposes routine updates to the home health payment rates for CY 2020, in accordance with existing statutory and regulatory requirements. This rule will also include:

- Proposal to modify the payment regulations pertaining to the content of the home health plan of care
- Proposal to allow therapist assistants to furnish maintenance therapy
- Proposal related to the split percentage payment approach under the Home Health Prospective Payment System (PPS)
- Proposals related to the implementation of the permanent home infusion therapy benefit in 2021

This proposed rule sets forth implementation of the Patient-Driven Groupings Model (PDGM), an alternate case-mix adjustment methodology, and a 30-day unit of payment as mandated by the Bipartisan Budget Act of 2018 (BBA of 2018). CMS projects that Medicare payments to Home Health Agencies (HHAs) in CY 2020 will increase in aggregate by 1.3 percent, or $250 million, based on proposed policies. The increase reflects the effects of the 1.5 percent home health payment update percentage ($290 million increase) mandated by BBA of 2018. It also reflects a 0.2 percent decrease in aggregate payments due to reductions made by the new rural add-on policy mandated by the BBA of 2018 for CY 2020 (i.e., an estimated $40 million decrease in rural add-on payments). The rate updates also include adjustments for anticipated changes with implementation of the PDGM and a change to a 30-day unit of payment, the use of updated wage index data for the home health wage index, and updates to the fixed-dollar loss ratio to determine outlier payments.

In addition, the proposed rule includes:

- Proposed payment rate changes for home infusion therapy temporary transitional payments for CY 2020
- Payment proposals for new home infusion therapy benefit for CY 2021

- Regulatory burden reduction – Patients over paperwork and enhance and modernize program integrity
- Paraprofessional roles – Improving access to care
- Home Health Quality Reporting Program – Support MyHealthEData Initiative
- Home Health Value-Based Purchasing model

For More Information:

- *Proposed Rule*
- *Press Release*
- *Home Health PPS* website
- *Home Health Quality Reporting Requirements* webpage
- *Home Health Value-Based Purchasing Model* webpage

See the full text of this excerpted *CMS Fact Sheet* (issued July 11).

Where do I find...

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

MLN Connects® for July 18, 2019

MLN Connects® for Thursday, July 18, 2019

View this edition as a PDF

News

- Is Your Vendor/Clearinghouse Submitting Your Claims with the MBI?
- DMEPOS Competitive Bidding: Round 2021 Bid Window is Open
- Nursing Homes: Updating Requirements for Arbitration Agreements and New Regulations
- CMS Proposes to Cover Acupuncture for Chronic Low Back Pain for Medicare Beneficiaries Enrolled in Approved Studies
- Quality Payment Program: 2018 MIPS Performance Feedback and Final Score
- Quality Payment Program Participation: Preliminary Data on 2018
- Physician Compare: 2017 Quality Payment Program Performance Information
- PEPPERs for HHAs, PHPs
- 2017 Physician and Other Supplier PUF
- 2017 Referring Provider DMEPOS PUF
- Qualified Medicare Beneficiary Billing Requirements
- Mass Casualty Triage White Paper and June Express
- Looking for Educational Materials?

Compliance

- Cardiac Device Credits: Medicare Billing

Events

- DMEPOS Competitive Bidding: Round 2021 Webcast Series
- Enrollment: Multi–Factor Authentication for I&A System Webcast — July 30
- IRF Appeals Settlement Initiative Call — August 13

MLN Matters® Articles

- Tropical Storm Barry and Medicare Disaster Related Louisiana Claims
- Reduce Risk of Opioid Overdose Deaths by Avoiding and Reducing Co-Prescribing Benzodiazepines
- Pre-Diabetes Services: Referring Patients to the Medicare Diabetes Prevention Program
- Emergency Medical Treatment and Labor Act (EMTALA) and the Born-Alive Infant Protection Act
- Changes to the Laboratory National Coverage Determination (NCD) Edit Software for October 2019
- Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Edits, Version 25.3 Effective October 1, 2019
- Quarterly Update for the Temporary Gap Period of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP) - October 2019
- Update to Coverage of Intravenous Immune Globulin for Treatment of Primary Immune Deficiency Diseases in the Home
- July 2019 Update of the Ambulatory Surgical Center (ASC) Payment System
- Activation of Systematic Validation Edits for OPPS Providers with Multiple Service Locations — Revised

Publications

- Provider Compliance Tips for Respiratory Assistive Devices — Revised
- Provider Compliance Tips for Enteral Nutrition — Revised

Multimedia

- Post-Acute Care Call: Audio Recording and Transcript

Medicare Learning Network®

The *Medicare Learning Network®* (*MLN*) is the home for education, information, and resources for the health care professional community. The *MLN* provides access to CMS Program information you need, when you need it, so you can focus more on providing care to your patients. Find out what the *MLN* has to offer you and your staff at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html*.

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

Overpayments

904-791-6029

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* (FL/USVI)
EDOC-CS-PRINQA@fcso.com (PR)

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 44179
Jacksonville, FL 32231-4179

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