Medicare A Connection

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FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction N Providers

October 2019

In this issue

Notify First Coast Service Options if you file bankruptcy

If you have filed a bankruptcy petition or are involved in a bankruptcy proceeding, First Coast requests that you notify us immediately so that we can properly coordinate with the Centers for Medicare & Medicaid Services (CMS) and the Department of Justice (DOJ) to resolve Medicare financial obligations. Even if there are no outstanding payments at the time of the bankruptcy filing, this notification ensures that we handle your situation properly.

Notify us of the bankruptcy by email at *FCSO-BankruptcyNotification@fcso.com* providing:

- Name the bankruptcy is filed under
- District where the bankruptcy was filed
- Docket number
- National Provider Identifier (NPI).

You must also serve CMS and the DOJ with notice of bankruptcy under the applicable federal laws, rules and regulations. Hyperlink: *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Bankruptcy/index.html*.

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.

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.

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* 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 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* 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***. This exclusive online resource features an intuitive interface that allows you to search for fee information by procedure code. Plus, you can find any associated local coverage determinations (LCDs) with just the click of a button.

Retired LCDs

Azacitidine (Vidaza®) -- retired Part A and Part B LCD

LCD ID number: L33266 (Florida, Puerto Rico/ U.S. Virgin Islands)

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

Effective date

The retirement of this LCD is effective for services rendered **on or after October 30, 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*.

Bendamustine hydrochloride -- retired Part A and Part B LCD

LCD ID number: L33268 (Florida, Puerto Rico/ U.S. Virgin Islands)

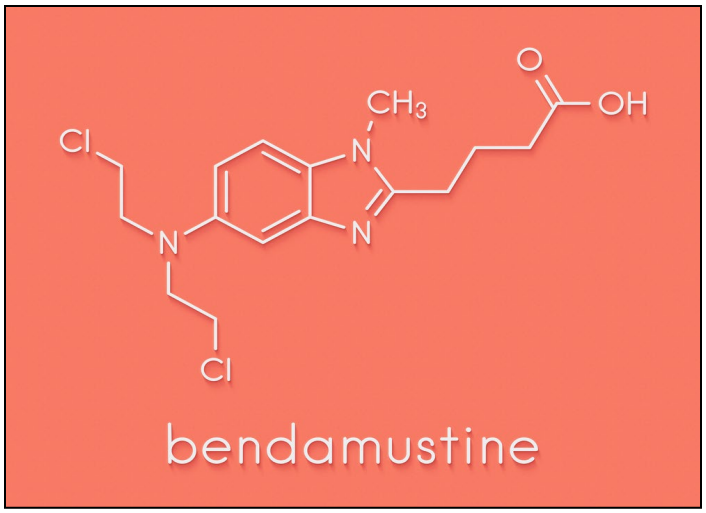
Based on data analysis review of the local coverage determination (LCD) for bendamustine hydrochloride, it was determined that it is no longer required, Therefore, the LCD, related billing and coding article (A56665) and related local coverage article (A56662) are also being retired.

Effective date

The retirement of this LCD, related billing and coding article and local coverage article is effective for services rendered **on or after October 30, 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*.

Gemcitabine (Gemzar®) -- retired Part A and Part B LCD

LCD ID number: L33726 (Florida, Puerto Rico/ U.S. Virgin Islands)

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

Effective date

The retirement of this LCD is effective for services rendered **on or after October 30, 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*.

Revisions to LCDs

BRCA1 and BRCA2 genetic testing -- revision to the Part A and Part B LCD

LCD ID number: L36499 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 10901, the local coverage determination (LCD) for BRCA1 and BRCA2 genetic testing 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.

In addition, based on CR 11406, CR 11412 and CR 11451 (October 2019 Quarterly Updates), Current Procedural Terminology (CPT®) codes 0129U, 0131U, 0132U, 0134U, 0135U, 0137U, and 0138U were added to the newly created billing and coding article.

Also, ICD-10-CM diagnosis code Z85.3 was added to "ICD-10-CM Codes that Support Medical Necessity" section of the newly created billing and coding article

Effective date

This 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 CR 11406, CR 11412 and CR 11451 is effective for services rendered on or after October 1, 2019.

The LCD revision related to ICD-10-CM diagnosis code Z85.3 is effective for services rendered **on or after November 12, 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*.

Genetic testing for lynch syndrome -- revision to the Part A and Part B LCD

LCD ID number: L34912 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 10901, the local coverage determination (LCD) for genetic testing for lynch syndrome 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. 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.

In addition, based on CR 11406, CR 11412 and CR 11451 (October 2019 Quarterly Updates), Current Procedural Terminology (CPT®) code 0130U was added to the newly created billing and coding article "CPT®/HCPCS Codes/ Group 1 Paragraph" section.

Effective date

This 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 CR 11406, CR 11412 and CR 11451 is effective for services rendered on or after October 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*.

Molecular pathology procedures -- revision to the Part A and Part B LCD

LCD ID number: L34519 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 10901, the local coverage determination (LCD) for molecular pathology procedures 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, 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. In addition, the Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual (IOM) language has been removed from the "Coverage Guidance" section of the LCD and instead, the IOM citation related to this language is referenced. In addition, based on CR 11406, CR 11412 and CR 11451 (October 2019 Quarterly Updates), Current Procedural Terminology (CPT®) codes 0111U, 0129U, and 0130U were added to the newly created billing and coding article.

Effective date

This 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 CR 11406, CR 11412 and CR 11451 is effective for services rendered on or after October 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*.

Ophthalmoscopy -- revision to the Part A and Part B LCD

LCD ID number: L34017 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 10901, the local coverage determination (LCD) for ophthalmoscopy 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. In addition, the Social Security Act, Code of Federal Regulations, and the Internet Only Manual (IOM) reference sections were updated.

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 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*.

Sinus x-ray(s) -- revision to the Part A and Part B LCD

LCD ID number: L33600 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 10901, the local coverage determination (LCD) for sinus x-ray(s) 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. In addition, the Social Security Act, Code of Federal Regulations, and Internet Only Manual (IOM) reference sections were updated.

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 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*.

Polysomnography and sleep testing -- revision to the Part A and Part B LCD

LCD ID number: L33405 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 10901, the local coverage determination (LCD) for polysomnography and sleep testing 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.

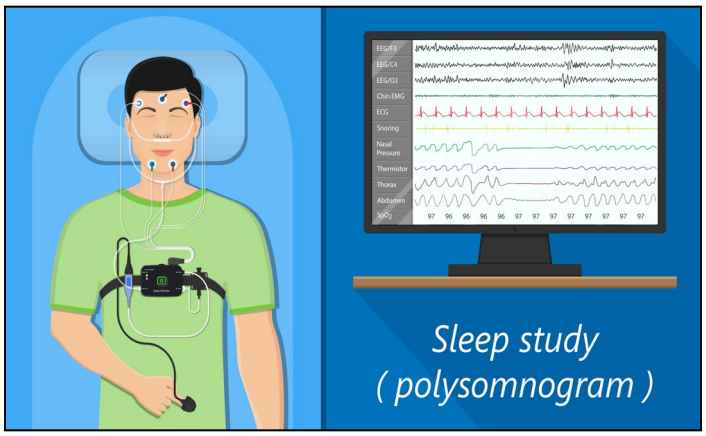
During the process of moving the ICD-10-CM diagnosis codes to the billing and coding article, the ICD-10-CM diagnosis code ranges were broken out and listed individually.

Also, the 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, the Social Security Act, Code of Federal Regulations, and IOM reference sections were updated.

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 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*.

Psychiatric diagnostic evaluation and psychotherapy services -- revision to the Part A and Part B LCD

LCD ID number: L33252 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 10901, the local coverage determination (LCD) for psychiatric diagnostic evaluation and psychotherapy services 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.

In addition, the Social Security Act, Code of Federal Regulations, and Internet Only Manual (IOM) reference sections were updated.

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 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*.

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

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

Based on an internal correspondence inquiry, the local coverage determination (LCD) for erythropoiesis stimulating agents (ESA) was revised to update language related to the enrollment and compliance with the ESA APPRISE oncology program in the "Limitations" section of the LCD. Also, the "Sources of Information" section of the LCD was updated to include a published source from an internal correspondence inquiry.

In addition, based on change request (CR) 10901, the 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," 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. Furthermore, the Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual (IOM) language has been removed from the LCD and billing and coding article, and instead the IOM citations related to this language is referenced throughout the LCD and billing and coding article. Similarly, the Food and Drug Administration (FDA) language has been removed from the LCD and billing and coding article, and instead the FDA citation related to this language is referenced to the FDA approved product labels. Moreover, the LCD was revised to update the "CMS National Coverage Policy" section of the LCD to add additional CMS IOM citations and Social Security Act (Title XVIII) Standard References.

Additionally, Healthcare Common Procedure Coding System (HCPCS) codes J0882, J0887 and Q5105 were removed from the "Group 2 Codes" in the "CPT®/HCPCS Codes" section of the billing and coding article.

Also, the "ICD-10-CM Codes that are covered" section of the billing and coding article was updated for the following groups.

For Group 1 codes and Group 6 codes, ICD-10-CM diagnosis codes N18.1, N18.2, and N18.9 were removed.

For Group 2 codes and Group 4 codes the following ICD-10-CM diagnosis codes were removed: C00.2, C00.5, C00.9, C02.9, C03.9, C04.9, C05.9, C06.9, C08.9, C10.9, C11.9, C13.9, C14.0, C15.9, C16.9, C17.9, C18.9, C21.0, C24.9, C25.9, C26.0, C26.9, C31.9, C32.9, C34.00, C34.10, C34.30, C34.80, C34.90, C39.0, C39.9, C40.00, C40.10, C40.20, C40.30, C40.80, C40.90, C43.10, C43.20, C43.30, C43.60, C43.70, C43.9, C4A.10, C4A.20, C4A.30, C4A.60, C4A.70, C4A.9, C44.00, C44.101, C44.1021, C44.1022, C44.1091, C44.1092, C44.111, C44.121, C44.131, C44.191, C44.201, C44.202, C44.209, C44.211, C44.221, C44.291, C44.300, C44.301, C44.309, C44.310, C44.320, C44.390, C44.40, C44.500, C44.501, C44.509, C44.601, C44.602, C44.609, C44.611, C44.621, C44.691, C44.701, C44.702, C44.709, C44.711, C44.721, C44.791, C44.80, C44.90, C44.91, C44.92, C44.99, C45.9, C46.50, C46.9, C47.10, C47.20, C47.6, C47.9, C48.2, C49.10, C49.20, C49.6, C49.9, C49.A0, C50.019, C50.029, C50.119, C50.129, C50.219, C50.229, C50.319, C50.329, C50.419, C50.429, C50.519, C50.529, C50.619, C50.629, C50.819, C50.829, C50.919, C50.929, C51.9, C53.9, C54.9, C55, C56.9, C57.00, C57.10, C57.20, C57.9, C60.9, C62.00, C62.10, C62.90, C62.91, C62.92, C63.00, C63.10, C63.9, C64.9, C65.9, C66.9, C67.9, C68.9, C69.00, C69.10, C69.20, C69.30, C69.40, C69.50, C69.60, C69.80, C69.90, C69.91, C69.92, C70.9, C71.9, C72.20, C72.30, C72.40, C72.50, C72.9, C74.00, C74.10, C74.90, C74.91, C74.92, C75.9, C7A.00, C7A.019, C7A.029, C7A.094, C7A.095, C7A.096, C7B.00, C76.40, C76.50, C77.9, C78.00, C78.30, C78.80, C79.00, C79.10, C79.40, C79.60, C79.70, C79.9, C80.1, C81.00, C81.10, C81.20, C81.30, C81.40, C81.70, C81.90, C82.00, C82.10, C82.20, C82.30, C82.40, C82.50, C82.60, C82.80, C82.90, C83.00, C83.10, C83.30, C83.50, C83.70, C83.80, C83.90, C84.00, C84.10, C84.40, C84.60, C84.70, C84.A0, C84.Z0, C84.90, C85.10, C85.20, C85.80, C85.90, C88.9, C90.01, C90.11, C90.21, C90.31, C91.01, C91.11, C91.31, C91.41, C91.51, C91.61, C91.A1, C91.Z1, C91.91, D00.00, D01.40, D01.9, D02.20, D02.4, D03.10, D03.20, D03.30, D03.60, D03.70, D03.9, D04.10, D04.20, D04.30, D04.60, D04.70, D04.9, D05.00, D05.10, D05.80, D05.90, D06.9, D07.30, D07.60, D09.10, D09.20, D09.9, D37.9, D38.6, D39.10, D39.9, D40.10, D40.9, D41.00, D41.10, D41.20, D41.9, D42.9, D43.9, D44.10, D44.9, D45, D48.60, D48.9, D49.519, D49.9, and Q85.00.

For Group 3 codes the following ICD-10-CM diagnosis code were added: B97.35, M05.611, M05.612, M05.621, M05.622, M05.631, M05.632, M05.641, M05.642, M05.651, M01.652, M05.661, M05.662, M05.671, M05.672, and M05.69 and the following ICD-10-CM diagnosis codes were removed: M05.40, M05.419, M05.429, M05.439, M05.449, M05.459, M05.469, M05.479, M05.50, M05.519, M05.529, M05.539, M05.549, M05.559, M05.569, M05.579, M05.70, M05.719, M05.729, M05.739, M05.749, M05.759, M05.769, M05.779, M05.80, M05.819, M05.829, M05.839, M05.849, M05.859, M05.869, M05.879, M05.9, M06.00, M06.019, M06.029, M06.039, M06.049, M06.059, M06.069, M06.079, M06.20, M06.219, M06.229, M06.239, M06.249, M06.259, M06.269, M06.279, M06.30, M06.319, M06.329, M06.339, M06.349, M06.359, M06.369, M06.379, M06.80, M06.819, M06.829, M06.839, M06.849, M06.859, M06.869, M06.879, M06.9, N18.1, N18.2, and N18.9.

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Effective date

The revision related to the internal correspondence inquiry is effective for claims processed **on or after October 29, 2019**, for services rendered **on or after April 13, 2017**.

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 removal of HCPCS codes J0882, J0887, and Q5105 is effective for claims processed **on or after October 29, 2019.** The addition and removal of ICD-10 CM diagnosis codes is effective for services rendered **on or after October 29, 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*.

Allergy testing -- revision to the Part A and Part B LCD

LCD ID number: L33261 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 10901, the local coverage determination (LCD) for allergy testing 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. 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. In addition, the Social Security Act, Code of Federal Regulations, and Internet Only Manual (IOM) reference sections were updated.

Also, after review of the information that was moved from the LCD to the billing and coding article, the following revisions were made: Current Procedural Terminology (CPT®) codes 86343, 95831, 95832, 95833, and 95834 were removed as they are already included in First Coast Service Options noncovered services LCD and do not apply to this LCD and CPT codes 83516, 84600, 86140, 86628, 88341, 88342, 88344, and 88346 were removed as they do not apply to this LCD. In addition, ICD-10-CM codes T63.001A-T63.414S, T63.431A-T63.434S, T63.481A-T63.94XS were removed from the "ICD-10-CM Codes that Support Medical Necessity/Group 1 Codes and Group 2 Codes" sections of the billing and coding article as they do not apply to this LCD. Furthermore, CPT codes 86001, 86332, 86485, and 95065 were added to the "ICD-10-CM Codes that Do Not Support Medical Necessity/ Group 1 Paragraph" section of the billing and coding article as the allergy testing limitations apply to these CPT codes.

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 billing and coding article revision is effective for services rendered **on or after November 19, 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*.

Syphilis test -- revision to the Part A and Part B LCD

LCD ID number: L33754 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 10901, the local coverage determination (LCD) for syphilis test 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. In addition, the Social Security Act, Code of Federal Regulations, and Internet Only Manual (IOM) reference sections were updated.

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 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*.

Surgical decompression for peripheral polyneuropathy -- revision to the Part A and Part B LCD

LCD ID number: L34025 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 10901, the local coverage determination (LCD) for surgical decompression for peripheral polyneuropathy 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 DO NOT 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. In addition, the Social Security Act and Internet Only Manual (IOM) reference sections were updated.

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 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*.

Bisphosphonates (intravenous [IV]) and monoclonal antibodies in the treatment of osteoporosis and their other indications -- revision to the Part A and Part B LCD

LCD ID number: L33270 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 10901, the local coverage determination (LCD) bisphosphonates (intravenous [IV]) and monoclonal antibodies in the treatment of osteoporosis and their other indications 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.

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 Centers for Medicare & Medicaid (CMS) 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," "Covered Indications," and "Limitations" sections of the LCD. In addition, the Social Security Act and IOM reference sections were updated.

Also, after review of the information that was moved from the LCD to the billing and coding article the language/"Z" ICD-10-CM diagnosis codes in the "ICD-10-CM Codes that Support Medical Necessity" section of the billing and coding article related to the triple diagnosis requirement for treatment of bone loss in women/men at high risk for fracture has been removed.

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 billing and coding article revision is effective for services rendered **on or after October 15, 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*.

Additional Information

Frequency of hemodialysis -- revision to Part A and Part B billing and coding Article

LCD ID number: L37564 (Florida, Puerto Rico/ U.S. Virgin Islands)

The Local Coverage Article A56666 Billing and Coding: Frequency of Hemodialysis for the local coverage determination (LCD) for frequency of hemodialysis was revised and published October 3, 2019. This version was created in collaboration with the All Medicare Administrative Contactor (MAC) End-Stage Renal Disease (ESRD) workgroup. Some of the verbiage in the article text has been revised for clarification. There will not be a lapse in coverage and there has been no change to the coverage content of the LCD.

Effective date

This Billing and Coding Article revision is effective for services rendered **on or after October 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 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*.

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

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

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

The following drugs have been added to the Medicare administrative contractor (MAC) Jurisdiction N (JN) self-administered drug (SAD) list: Actemra® (tocilizumab) subcutaneous (J3262), Aimovig® (erenumab-aooe) (C9399/J3490/J3590), Ajovy™ (fremanezumab-vfrm) (J3031), Benlysta® (belimumab) subcutaneous (J0490), Cyltezo™ (adalimumab-adbm) (C9399/J3490/J3590), Emgality® (galcanezumab-gnlm) (C9399/J3490/J3590), Kevzara® (sarilumab) (C9399/J3490/J3590), LANTUS SoloStar® (insulin glargine injection) (C9399/J3490/J3590), Ozempic® (semaglutide) (C9399/J3490/J3590), Takhzyro® (lanadelumab-flyo) (J0593) and Tymlos™ (abaloparatide) (C9399/J3490/J3590).

In addition, a "Route of Administration Modifier" section has been added for drugs that have multiple routes of administration. The JB modifier must be billed when the subcutaneous form of the drug is administered. Drugs that require the JB modifier have been listed with an asterisk in the coding table. The following drugs require the JB modifier when the subcutaneous form of the drug is administered: Actemra® (J3262), Benlysta® (J0490), Orencia® (J0129), and Sandostatin® (J2354).

Also, "subcutaneous" has been added to the descriptor for Sandostatin® (J2354) and HAEGARDA® (J0599) and any typographical errors that were identified have been corrected.

Furthermore, the unlisted Healthcare Common Procedure Coding System (HCPCS) codes (C9399, J3490, and J3590) have been removed and replaced with HCPCS code J0129 for Orencia®.

Effective date

This article revision is effective for **services rendered on or after December 2, 2019**.

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

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

Upcoming provider outreach and educational events

LCD coverage criteria for drug assays

Date: November 19
Time: 10-11:30 a.m. ET
Type of Event: Webcast

View our complete calendar of events

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* 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.

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 Thursday, September 26, 2019

MLN Connects® for Thursday, September 26, 2019

View this edition as a PDF

News

- New Medicare Card: More Questions about Using the MBI?
- Quality Payment Program: Submit Comments on 2020 Proposed Rule by September 27
- SNF PPS Patient Driven Payment Model: Get Ready for Implementation on October 1
- 2019 QRDA I Implementation Guide and Sample File for Hospital Quality Reporting: Updated
- Post-Acute Care and Hospice Utilization and Payment Public Use Files
- Clinical Diagnostic Laboratories: Resources about the Private Payor Rate-Based CLFS
- Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier
- Hospice Quality Reporting Program Quarterly Updates
- National Cholesterol Education Month and World Heart Day

Compliance

- DME Proof of Delivery Documentation Requirements

Claims, Pricers & Codes

- Medicare Diabetes Prevention Program: Valid Claims

Events

- IRF/LTCH: Reporting Health Care Personnel Influenza Vaccination Data Webinars — October 1, 3, or 9

MLN Matters® Articles

- Quarterly Update for the Temporary Gap Period of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP) - January 2020
- October 2019 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files — Revised
- Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes – October 2019 Update — Revised

Publications

- Quality Payment Program: Resources for Clinicians New to the Program in 2019
- Medicare Enrollment for Physicians and Other Part B Suppliers — Reminder
- Medicare Preventive Services Poster — Reminder
- Safeguard Your Identity and Privacy Using PECOS — Reminder

Multimedia

- Quality Payment Program: All-Payer Combination Option in 2019 Web-Based Training Course
- Quality Payment Program Merit-based Incentive Payment System (MIPS): Promoting Interoperability Performance Category in 2019 Web-Based Training Course
- Dementia Care Call: Audio Recording and Transcript
- Quality Payment Program for Advanced APMs in 2019 Web-Based Training Course — Revised
- Quality Payment Program Merit-based Incentive Payment System (MIPS): Participation in 2019 Web-Based Training Course — Revised
- Transitioning to an Advanced APM: 2019 Update Web-Based Training Course — Revised

MLN Connects® – Special Edition for September 26, 2019

Omnibus Burden Reduction (Conditions of Participation) Final Rule

On September 26, CMS took action at President Trump's direction to "cut the red tape," by reducing unnecessary burden for American's health care providers allowing them to focus on their priority – patients.

The Omnibus Burden Reduction (Conditions of Participation) Final Rule removes Medicare regulations identified as unnecessary, obsolete, or excessively burdensome on hospitals and other health care providers to reduce inefficiencies and moves the nation closer to a health care system that delivers value, high quality care and better outcomes for patients at the lowest possible cost.

This rule advances the Patients over Paperwork initiative by saving providers an estimated 4.4 million hours of time previously spent on paperwork with an overall total projected savings to providers of $800 million annually.

This rule finalizes the provisions of three proposed rules

- Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction ("Omnibus Burden reduction"), published September 20, 2018
- Hospital and Critical Access Hospital (CAH) Changes to Promote Innovation, Flexibility, and Improvement in Patient Care, published June 16, 2016
- Fire Safety Requirements for Certain Dialysis Facilities, published November 4, 2016

For more information:

- *Final Rule*
- *Press Release*

See the full text of this excerpted *CMS Fact Sheet* (issued September 26).

Discharge Planning Rule Supports Interoperability and Patient Preferences

On September 26, CMS issued a final rule that empowers patients preparing to move from acute care into Post-Acute Care (PAC), a process called discharge planning. The rule puts patients in the driver's seat of their care transitions and improves quality by requiring hospitals to provide patients access to information about PAC provider choices, including performance on important quality measures and resource-use measures, including:

- Number of pressure ulcers
- Proportion of falls that lead to injury
- Number of readmissions back to the hospital

The rule also:

- Advances CMS's interoperability efforts by requiring the seamless exchange of patient information between health care settings, and ensuring that a patient's health care information follows them after discharge from a hospital or PAC provider.
- Revises the discharge planning requirements that hospitals (including long-term care hospitals, Critical Access Hospitals (CAHs) psychiatric hospitals, children's hospitals, and cancer hospitals), inpatient rehabilitation facilities, and home health agencies must meet to participate in Medicare and Medicaid programs. It requires the discharge planning process to focus on a patient's goals and treatment preferences. Hospitals are mandated to ensure each patient's right to access their medical records in an electronic format.
- Implements requirements from the Improving Medicare Post-Acute Care Transformarion Act of 2014 (*IMPACt Act*) that includes how facilities will account for and document a patient's goals of care and treatment preferences.

Hospitals and CAHs are already conducting most of the revised discharge planning requirements, with the exception of the discharge planning requirements of the IMPACT Act.

MLN Connects® – Special Edition for September 30, 2019

New HCPCS Code J0642 for levoleucovorin Injection

For dates of service on or after October 1, use HCPCS code J0642 for levoleucovorin injection products marketed under the brand name of Khapzory.

MLN Connects® for Thursday, October 3, 2019

MLN Connects® for Thursday, October 3, 2019

View this edition as a PDF

News

- New Medicare Card: Do You Refer Patients?
- Opioid Treatment Programs: Get Ready to Participate in the New Benefit
- Home Health Preview Reports for January 2020 Refresh
- LTCH Provider Preview Reports: Review Your Data by October 11
- IRF Provider Preview Reports: Review Your Data by October 11
- Hospice Provider Preview Reports: Review Your Data by October 11
- CLFS CY 2020 Preliminary Payment Determinations: Comment by October 27
- MIPS: Virtual Group Election Period Open Through December 31
- LTCH Compare Refresh
- IRF Compare Refresh
- Qualified Medicare Beneficiary Billing Requirements
- Ostomies are Life-Savers
- Looking for Educational Materials?

Compliance

- Outpatient Services Payment: Beneficiaries Who Are Inpatients of Other Facilities

MLN Matters® Articles

- Changes to the Laboratory National Coverage Determination (NCD) Edit Software for January 2020
- January 2020 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files
- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs) - January 2020 Update — Revised

Publications

- Quality Payment Program: 2019 APM Incentive Payment Fact Sheet
- Billing Information for Rural Providers and Suppliers — Revised

Multimedia

- Reducing Opioid Misuse Listening Session: Audio Recording and Transcript
- SNF PPS: Patient Driven Payment Model Videos

MLN Connects® – Special Edition for October 9, 2019

Modernizing and Clarifying the Physician Self-Referral Regulations Proposed Rule

On October 9, CMS issued a proposed rule to modernize and clarify the regulations that interpret the Medicare physician self-referral law (often called the "Stark Law"), which has not been significantly updated since it was enacted in 1989.

The proposed rule supports the CMS "Patients over Paperwork" initiative by reducing unnecessary regulatory burden on physicians and other health care providers while reinforcing the Stark Law's goal of protecting patients from unnecessary services and being steered to less convenient, lower quality, or more expensive services because of a physician's financial self-interest.

Through the Patients over Paperwork initiative, the proposed rule opens additional avenues for physicians and other health care providers to coordinate the care of the patients they serve – allowing providers across different health care settings to work together to ensure patients receive the highest quality of care.

For more information:

- *Proposed Rule* Public comments due by December 31
- *Press Release*

See the full text of this excerpted *CMS Fact Sheet* (issued October 9).

MLN Connects® for Thursday, October 10, 2019

MLN Connects® for Thursday, October 10, 2019

View this edition as a PDF

News

- New Medicare Card: 80% of Claims Submitted with MBI
- Nursing Homes: Enhancing Transparency about Abuse and Neglect
- Quality Payment Program: MIPS Dates and Deadlines
- October is National Breast Cancer Awareness Month

Compliance

- Proper Use of the KX Modifier for Part B Immunosuppressive Drug Claims

Claims, Pricers & Codes

- FY 2020 IPPS and LTCH PPS Claims Hold

Events

- Submitting Your Medicare Part A Cost Report Electronically Webcast — November 5

MLN Matters® Articles

- Ambulance Inflation Factor for Calendar Year (CY) 2020 and Productivity Adjustment
- Provider Enrollment Rebuttal Process
- Implementation of the Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM) — Revised
- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs) – January 2020 Update — Revised
- Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Updates for Fiscal Year (FY) 2020 — Revised

Publications

- Medicare Preventive Services — Revised
- Medicare Enrollment for Providers Who Solely Order or Certify — Reminder
- Medicare Fraud & Abuse Poster — Reminder
- Medicare Fraud & Abuse: Prevent, Detect, Report — Reminder
- Medicare Overpayments — Reminder
- PECOS for DMEPOS Suppliers — Reminder
- PECOS for Physicians and NPPs — Reminder
- PECOS for Provider and Supplier Organizations — Reminder

Multimedia

- Opioid Treatment Program Listening Session: 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*.

MLN Connects® for Thursday, October 17, 2019

MLN Connects® for Thursday, October 17, 2019

View this edition as a PDF

News

- New Medicare Card: MBI Transition Ends in Less Than 10 Weeks
- Guide for Appropriate Tapering or Discontinuation of Long-Term Opioid Use
- ICD-10 Coordination and Maintenance: Deadline for Comments November 8
- CMS Health Equity Award: Submit Nomination by November 15
- Quality Payment Program: Participation Status Tool Includes Second Snapshot of Data
- Atherectomy: Comparative Billing Report in October
- Protect Your Patients from Influenza this Season

Compliance

- Cardiac Device Credits: Medicare Billing

Events

- Submitting Your Medicare Part A Cost Report Electronically Webcast — November 5
- Atherectomy: Comparative Billing Report Webinar — November 6
- Provider Compliance Focus Group Meeting — November 12

MLN Matters® Articles

- Add Dates of Service (DOS) for Pneumococcal Pneumonia Vaccination (PPV) Health Care Procedure Code System (HCPCS) Codes (90670, 90732), and Remove Next Eligible Dates for PPV HCPCS
- Fiscal Year (FY) 2020 Inpatient Prospective Payment System (IPPS) and Long Term Care Hospital (LTCH) PPS Changes
- Home Health Orders for Nurse Practitioners under the Maryland Total Cost of Care (TCOC) Model
- Implementation of the Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM) — Revised
- October 2019 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files — Revised
- October 2019 Update of the Ambulatory Surgical Center (ASC) Payment System — Revised
- October 2019 Update of the Hospital Outpatient Prospective Payment System (OPPS) — Revised

Publications

- Quality Payment Program: MIPS and APM Resources
- Roster Billing for Mass Immunizers — Revised
- Acute Care Inpatient Hospital Prospective Payment System — Reminder
- Hospice Payment System — Reminder
- Hospital Outpatient Prospective Payment System — Reminder
- Inpatient Psychiatric Facility Prospective Payment System — Reminder
- Inpatient Rehabilitation Facility Prospective Payment System — Reminder
- Long-Term Care Hospital Prospective Payment System — Reminder
- Telehealth Services — Reminder

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

Provider websites

English
Spanish

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)
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)

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