Medicare B CONNECTION

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FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction N Providers

October 2017

In this issue

2018 annual update for the HPSA bonus payments

Provider type affected

This *MLN Matters*® article is intended for physicians submitting claims to Medicare administrative contractors (MACs) for services provided in health professional shortage areas (HPSAs) to Medicare beneficiaries.

Provider action needed

Change request (CR) 10317 alerts you that the Centers for Medicare & Medicaid Services (CMS) will make the annual HPSA bonus payment file for 2018 available to your MAC to use for HPSA bonus payments on applicable claims with dates of service on or after January 1, 2018, through December 31, 2018. You should review the Physician Bonuses webpage at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HPSAPSAPhysicianBonuses/* each year to determine whether you need to add modifier AQ to your claim in order to receive the bonus payment, or to see if the ZIP code in which you rendered services will automatically receive the HPSA bonus payment. Make sure that your billing staffs are aware of these changes.

Background

Section 413(b) of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 mandated an annual update to the automated HPSA bonus payment file. The HPSA ZIP code file is populated using the latest designations as close as possible to November 1 of each year. The HPSA ZIP code file shall be made available to your MAC in early December of each year. MACs will implement the HPSA ZIP code file and for claims with dates of service January 1 to December 31 of the following year, shall

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

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Articles included in the *Medicare B 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.

About the Medicare B Connection

The *Medicare B Connection* is a comprehensive publication developed by First Coast Service Options Inc. (First Coast) for Part B providers in Florida, Puerto Rico, and the U.S. Virgin Islands and is distributed on a monthly basis.

Important notifications that require communication in between publications will be posted to the First Coast Medicare provider education website at *https://medicare.fcso.com*. In some cases, additional unscheduled special issues may be posted.

Who receives the *Connection*

Anyone may view, print, or download the *Connection* from our provider education website(s). Providers who cannot obtain the *Connection* from the internet are required to register with us to receive a complimentary hardcopy.

Distribution of the *Connection* in hardcopy is limited to providers who have billed at least one Part B claim to First Coast Medicare during the twelve months prior to the release of each issue. Providers meeting these criteria are eligible to receive a complimentary copy of that issue, if a technical barrier exists that prevents them from obtaining it from the internet and they have returned a completed registration form to us.

Registration forms must be submitted annually or when you experience a change in circumstances that impacts your electronic access.

For additional copies, providers may purchase a separate annual subscription (see order form in the back of this issue). All issues published since 1997 may be downloaded from the internet, free of charge.

We use the same mailing address for all correspondence, and cannot designate that the *Connection* be sent to a specific person/department within a provider's office. To ensure continued receipt of all Medicare correspondence, providers must keep their addresses current with the Medicare provider enrollment department. Please remember that address changes must be done using the appropriate CMS-855.

Publication format

The *Connection* is arranged into distinct sections.

- The **Claims** section provides claim submission requirements and tips.
- The **Coverage/Reimbursement** section discusses specific CPT® and HCPCS procedure codes. It is arranged by categories (not specialties). For example, "Mental Health" would present coverage information of interest to psychiatrists, clinical psychologists and clinical social workers, rather than listing articles separately under individual provider specialties. Also presented in this section are changes to the Medicare physician fee schedule, and other pricing issues.

- The section pertaining to **Electronic Data Interchange** (EDI) submission also includes information pertaining to the Health Insurance Portability and Accountability Act (HIPAA).
- The **Local Coverage Determination** section features summaries of new and revised local coverage determinations (LCDs) developed as a result of either local medical review or comprehensive data analysis initiatives.
- The **General Information** section includes fraud and abuse, and national provider identifier topics, plus additional topics not included elsewhere.
- In addition to the above, other sections include:
- **Educational Resources**, and
- **Contact information** for Florida, Puerto Rico, and the U.S. Virgin Islands.

The *Medicare B Connection* represents formal notice of coverage policies

Articles included in each edition represent formal notice that specific coverage policies either have or will take effect on the date given. Providers are expected to read, understand, and abide by the policies outlined in this document to ensure compliance with Medicare coverage and payment guidelines.

Never miss an appeals deadline again

When it comes to submitting a claims appeal request, *timing is everything*. Don't worry – you won't need a desk calendar to count the days to your submission deadline. Try our *"time limit" calculators on our Appeals of claim decisions page*. Each calculator will *automatically calculate* when you must submit your request based upon the date of either the initial claim determination or the preceding appeal level.

Medicare Part B advance beneficiary notices

Medicare Part B allows coverage for services and items deemed medically reasonable and necessary for treatment and diagnosis of the patient.

For some services, to ensure that payment is made only for medically necessary services or items, coverage may be limited based on one or more of the following factors (this list is not inclusive):

- Coverage for a service or item may be allowed only for specific diagnoses/conditions. Always code to the highest level of specificity.
- Coverage for a service or item may be allowed only when documentation supports the medical need for the service or item.
- Coverage for a service or item may be allowed only when its frequency is within the accepted standards of medical practice (i.e., a specified number of services in a specified timeframe for which the service may be covered).

If the provider believes that the service or item may not be covered as medically reasonable and necessary, the patient must be given an acceptable advance notice of Medicare's possible denial of payment if the provider does not want to accept financial responsibility for the service or item. Advance beneficiary notices (ABNs) advise beneficiaries, before items or services actually are furnished, when Medicare is likely to deny payment.

Patient liability notice

The Centers for Medicare & Medicaid Services' (CMS) has developed the Advance Beneficiary Notice of Noncoverage (ABN) (Form CMS-R-131), formerly the "Advance Beneficiary Notice." Section 50 of the *Medicare Claims Processing Manual* provides instructions regarding the notice that these providers issue to beneficiaries in advance of initiating, reducing, or terminating what they believe to be noncovered items or services. The ABN must meet all of the standards found in Chapter 30. Beginning March 1, 2009, the ABN-G and ABN-L was no longer valid; and notifiers must use the revised Advance Beneficiary Notice of Noncoverage (CMS-R-131). Section 50 of the *Medicare Claims Processing Manual* is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c30.pdf#page=44*.

Reproducible copies of Form CMS-R-131 ABNs (in English and Spanish) and other BNI information may be found at *https://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html*.

ABN modifiers

When a patient is notified in advance that a service or item may be denied as not medically necessary, the provider must annotate this information on the claim (for both paper and electronic claims) by reporting modifier GA (waiver of liability statement on file) or GZ (item or service expected to be denied as not reasonable and necessary) with the service or item.

Failure to report modifier GA in cases where an appropriate advance notice was given to the patient may result in the provider having to assume financial responsibility for the denied service or item.

Modifier GZ may be used in cases where a signed ABN is not obtained from the patient; however, when modifier GZ is billed, the provider assumes financial responsibility if the service or item is denied.

Note: Line items submitted with the modifier GZ will be automatically denied and will not be subject to complex medical review.

GA modifier and appeals

When a patient is notified in advance that a service or item may be denied as not medically necessary, the provider must annotate this information on the claim (for both paper and electronic claims) by reporting the modifier GA (waiver of liability statement on file).

Failure to report modifier GA in cases where an appropriate advance notice was given to the patient may result in the provider having to assume financial responsibility for the denied service or item.

Nonassigned claims containing the modifier GA in which the patient has been found liable must have the patient's written consent for an appeal. Refer to the applicable contact section located at the end of this publication for the address in which to send written appeals requests.

January update to the NCCI procedure to procedure edits, version 24.0, effective January 1, 2018

Provider type affected

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

Provider action needed

Change request (CR) 10306 informs the MACs about the update to the National Correct Coding Initiative (NCCI) procedure to procedure edits (PTP). This notice applies to Chapter 23, Section 20.9 of the *Medicare Claims Processing Manual*. Make sure your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) developed the NCCI to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment in Part B claims.

Version 24.0 will include all previous versions and updates from January 1, 1996, to the present. In the past, CCI was organized in two tables: Column 1/column 2 correct coding edits and mutually exclusive code (MEC) edits. In order to simplify the use of NCCI edit files (two tables), on April 1, 2012, CMS consolidated these two edit files into the column one/column two correct coding edit file. Separate consolidations have occurred for the two practitioner NCCI edit files and the two NCCI edit files used for the outpatient code editor (OCE). It will only be necessary to search the column one/column two correct coding edit file for active or previously deleted edits. CMS no longer publishes a mutually exclusive edit file on its website for either practitioner or outpatient hospital services, since all active and deleted edits will appear in the single column one/column two correct coding edit file on each website. **The edits previously contained in the mutually exclusive edit file are NOT being deleted but are being moved to the column one/column two correct coding edit file. Refer to the CMS NCCI webpage for additional information at** *https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html*.

The coding policies developed are based on coding conventions defined in the American Medical Association's *Current Procedural Terminology* manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practice, and review of current coding practice.

Additional information

The official instruction, CR 10306, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3869CP.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/*.

Document history

Date of change	Description
October 2, 2017	Initial article released.

MLN Matters® Number: MM10306
Related CR Release Date: September 29, 2017
Related CR Transmittal Number: R3869CP
Related Change Request (CR) Number: CR10306
Effective Date: January 1, 2018
Implementation Date: January 2, 2018

HPSA

from front page

make automatic HPSA bonus payments to physicians providing eligible services in a ZIP code contained on the file.

Additional information

The official instruction, CR 10317, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3870CP.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/*.

Document history

Date of change	Description
September 29, 2017	Initial article released.

MLN Matters® Number: MM10317
Related CR Release Date: September 29, 2017
Related CR Transmittal Number: R3870CP
Related Change Request (CR) Number: 10317
Effective Date: January 1, 2018
Implementation Date: January 2, 2018

Preventing duplicate claim denials

Providers are responsible for all claims submitted to Medicare under their provider number. Preventable duplicate claims are counterproductive and costly, and continued submission to Medicare may lead to program integrity action. Please share the following information with your billing company, vendor and/or clearinghouse.

Claim system edits search for duplicate, suspect duplicate and repeat services, procedures and items within paid, finalized, *pending* and *same claim details* in history. Duplicate claims and claim lines are automatically denied. *Suspect* duplicate claims and claim lines are suspended and reviewed by the Medicare administrative contractor (MAC) to make a determination to pay or deny. *Click here for additional information*.

Medicare correct coding rules include the appropriate use of condition codes and modifiers. When you submit a claim for multiple instances of a service, procedure or item, the claim should include an appropriate modifier to indicate that the service, procedure or item is not a duplicate. The modifier should be added to the second through subsequent line items for the repeat service, procedure or item. An example is listed below. In many instances, this will allow the claim to process and pay, if applicable.

However, in some instances, even when an appropriate modifier is included, the claim may deny as a duplicate, based on medically unlikely edits (MUEs). MUEs are maximum units of service that are typically reported for a service, medical procedure or item, under most instances, for a beneficiary on a single date of service. Note that these duplicate denials may not always be considered preventable.

Review your billing procedures and software. If billing for a service, procedure or item that is not a duplicate, add the appropriate modifier(s) before submitting claim. Listed below are a few examples of modifiers that may be used, as applicable. For a complete list, please review the *Current Procedural Terminology* (CPT®) codebook.

- **Modifier 59**: Service or procedure by the same provider, distinct or independent from other services, performed on the same day. Services or procedures that are normally reported together but are appropriate to be billed separately under certain circumstances.

  Refer to *MLN Matters®* article *SE1418* for more details on the use of modifier 59, including coding examples.
- The Centers for Medicare & Medicaid Services (CMS) established four new modifiers, effective January 1, 2015, to define subsets of modifier 59. Refer to *MLN Matters®* article *MM8863* for details.
- **Modifier 76**: *Repeat* procedure or service other than evaluation and management (e/m) by the **same provider**, subsequent to the original service or procedure.
- **Modifier 77**: *Repeat* procedure or service-other than e/m-by **another provider**, subsequent to the original service or procedure.
- **Modifier 91**: Repeat clinical diagnostic laboratory tests. This modifier is added only when additional test results are medically necessary on the same day.
  - **Example**: Laboratory submits Medicare claim for two lactate dehydrogenase (LD) tests, CPT® code 83615.

    Line 1: 83615

    Line 2: 83615 and modifier 91
- Modifiers RT (right side) and LT (left side): Append applicable modifier to the procedure code, *even if the diagnosis indicates the exact site of the procedure*.
  - **Example**: Provider submits Medicare claim for diagnosis code M1711 (unilateral primary osteoarthritis, *right knee)* and/or diagnosis code M1712 (unilateral primary osteoarthritis, *left knee*). Modifier RT should be added to the procedure code billed with diagnosis code M1711. Modifier LT should be added to the procedure code billed with diagnosis code M1712.

Note: All claims submitted to Medicare should be supported by documentation in the patient's medical record.

***Sources**: CMS MLN Matters® MM8121, CMS internet-only manual (IOM), Publication 100-04, chapter 1, Section 120-Detection of duplicate claims,*
CMS MLN Matters® MM8863 and the American Medical Association's (AMA) 2013 Current Procedural Terminology (CPT®) codebook.

Your Feedback Matters

To ensure that our website meets the needs of our provider community, we carefully analyze your feedback and implement changes to better meet your needs. Discover the results of your feedback on our "*Website enhancements*" page. You'll find the latest enhancements to our provider websites and find out how you can share your thoughts and ideas with First Coast's Web team.

Drugs & Biologicals

January 2018 quarterly average sales price Medicare Part B drug pricing files

Provider type affected

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

What you need to know

Change request (CR) 10320 instructs MACs to download and implement the January 2018 and, if released, the revised October 2017, July 2017, April 2017, and January 2017, ASP drug pricing files for Medicare Part B drugs via the Centers for Medicare & Medicaid Services (CMS) Data Center (CDC). Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after January 2, 2018, with dates of service January 1, 2018, through March 31, 2018. Make sure your billing staffs are aware of these changes.

Background

The average sales price (ASP) methodology is based on quarterly data that manufacturers submit to the CMS. CMS supplies the MACs with the ASP and not otherwise classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the outpatient prospective payment system (OPPS) are incorporated into the outpatient code editor (OCE) through separate instructions that are in Chapter 4, Section 50 of the Internet Only Manual (IOM) which is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf*.

- **File**: January 2018 ASP and ASP NOC -- effective for dates of service: January 1 March 31, 2018
- **File**: October 2017 ASP and ASP NOC – effective for dates of service: October 1 December 31, 2017
- **File**: July 2017 ASP and ASP NOC – effective for dates of service: July 1 through September 30, 2017
- **File**: April 2017 ASP and ASP NOC – effective for dates of service: April 1 through June 30, 2017
- **File**: January 2017 ASP and ASP NOC – effective for dates of service: January 1 through March 31, 2017

For any drug or biological not listed in the ASP or NOC drug-pricing files, MACs will determine the payment allowance limits in accordance with the policy described in the *Medicare Claims Processing Manual*, Chapter 17, Section 20.1.3, which is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c17.pdf*. For any drug or biological not listed in the ASP or NOC drug-pricing files that is billed with the KD modifier, MACs will determine the payment allowance limits in accordance with instructions for pricing and payment changes for infusion drugs furnished through an item of durable medical equipment (DME) on or after January 1, 2017, associated with the passage of the 21st Century Cures Act.

Additional information

The official instruction, CR 10320, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3878CP.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/*.

Document history

Date of change	Description
October 6, 2017	Initial article released.

MLN Matters® Number: MM10320
Related Change Request (CR) Number: 10320
Related CR Release Date: October 6, 2017
Effective Date: January 1, 2018
Related CR Transmittal Number: R3878CP
Implementation Date: January 2, 2018

Quarterly HCPCS drug/biological code changes – October 2017 update

Provider type affected

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

What you need to know

The Healthcare Common Procedure Coding System (HCPCS) code set is updated on a quarterly basis. The October 2017 HCPCS file includes a new HCPCS modifier. Change request (CR) 10234 informs MACs about the new modifier, ZC, Merck/Samsung Bioepis. The ZC modifier will become effective for claims submitted beginning October 1, 2017, and applies retroactively to dates of service on or after July 24, 2017.

MACs shall add the following modifier to the required modifiers that must be used when HCPCS code Q5102 is billed on a claim:

- HCPCS modifier: ZC
- Short description: Merck/Samsung Bioepis
- Long description: Merck/Samsung Bioepis

A second biosimilar version of infliximab was marketed July 24, 2017, creating a situation where products from two manufacturers may appear on claims. To allow the identification of the manufacturer of the specific biosimilar biological product that was administered to a patient, either existing HCPCS modifier ZB, or new modifier ZC is required when HCPCS code Q5102 is billed on a claim that is submitted after October 1, 2017.

Additional information

The official instruction, CR 10234, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3850CP.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/*.

Document history

Date of change	Description
September 26, 2017	Initial article released.

MLN Matters® Number: MM10234
Related CR Release Date: August 25, 2017
Related CR Transmittal Number: R3850CP
Related Change Request (CR) Number: 10234
Effective Date: July 24, 2017
Implementation Date: October 2, 2017

2018 Medicare physician fee schedule payment rates and participation program

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

The 2018 Medicare physician fee schedule (MPFS) payment rates will be posted to First Coast Service Options' Medicare Provider website after publication of the MPFS final rule in the *Federal Register*. This publication usually occurs in mid-November.

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

Laboratory/Pathology

Clinical laboratory fee schedule: Not otherwise classified, not otherwise specified or unlisted service or procedure code data collection

Provider type affected

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

What you need to know

Change request (CR) 10232 instructs MACs to assure that providers submit private payor data on unique tests currently being paid as a not otherwise classified (NOC) code, not otherwise specified (NOS) code, or unlisted service or procedure code. Make your billing staff aware of this change.

Background

Section 216(a) of the Protecting Access to Medicare Act of 2014 (PAMA) added Section 1834A to the Social Security Act (the Act), which requires revisions to the payment methodology for clinical diagnostic laboratory tests paid under the clinical laboratory fee schedule (CLFS). PAMA requires reporting entities to report private payor payment rates for laboratory tests and the corresponding volumes of tests. In compliance with PAMA, the Centers for Medicare & Medicaid Services (CMS) must collect private payor data on unique tests currently being paid as an NOC) code, NOS code, or unlisted service or procedure code. In compliance with PAMA, CMS is collecting private payor data on unique tests currently being paid as a NOC code, NOS code, or unlisted service or procedure code. The update of the *Medicare Claims Processing Manual*, Chapter 26, *Completing and Processing Form CMS-1500 Data Set*, clarifies how providers of service or suppliers should populate field 19 of the form when billing NOC codes. Specifically, when billing for unlisted laboratory tests using a NOC code, field 19 must be populated with the specific name of the laboratory test(s) and/or a short descriptor of the test(s).

Additional information

The official instruction, CR 10232, issued to your

MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3881CP.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/*.

Document history

Date of change	Description
October 13, 2017	Initial article released.

MLN Matters® Number: MM10232
Related CR Release Date: October 13, 2017
Related CR Transmittal Number: R3881CP
Related Change Request (CR) Number: 10232
Effective Date: January 16, 2018
Implementation Date: January 16, 2018

How can the PDS help my practice?

The Provider Data Summary (PDS) can help you quickly identify potential billing issues through detailed analysis of personal billing patterns in comparison with those of similar providers. Additional information, including a quick-start guide to help you easily get started right away, is available at *http://medicare.fcso.com/PDS/index.asp.*

Changes to the laboratory national coverage determination edit software for January 2018

Provider type affected

This *MLN Matters*® article is intended for physicians, providers, and suppliers submitting claims to Medicare contractors (regional home health intermediaries (RHHIs) and A/B Medicare administrative contractors (A/B MACs)) for services to Medicare beneficiaries.

What you need to know

This article is based on change request (CR) 10309 which informs MACs about the changes that will be included in the January 2018 quarterly release of the edit module for clinical diagnostic laboratory services. CR 10309 applies to Chapter 16, Section 120.2, Publication 100-04. Make sure that your billing staffs are aware of these changes.

See the *Background* and *Additional information* sections of this article for further details regarding these changes.

Background

CR 10309 announces the changes that will be included in the January 2018 quarterly release of the edit module for clinical diagnostic laboratory services. NCDs for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee, and the final rule was published on November 23, 2001. Nationally uniform software was developed and incorporated in the Medicare shared systems so that laboratory claims subject to one of the 23 NCDs (Publication 100-03, Sections 190.12 - 190.34) were processed uniformly throughout the nation effective April 1, 2003.

In accordance with Chapter 16, Section 120.2, Publication 100-04, the laboratory edit module is updated quarterly as necessary to reflect ministerial coding updates and substantive changes to the NCDs developed through the NCD process. The changes are a result of coding analysis decisions developed under the procedures for maintenance of codes in the negotiated NCDs and biannual updates of the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes. CR 10309 communicates requirements to shared system maintainers (SSMs) and contractors, notifying them of changes to the laboratory edit module to update it for changes in laboratory NCD code lists for January 2018. Please access the link below for the NCD spreadsheets included with CR 10309: *https://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/CR207300-January2018.zip*.

MACs will adjust claims brought to their attention, but will not search their files to retract payment for claims already paid or retroactively pay claims.

Additional information

The official instruction, CR 10309, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3872CP.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/*.

Document history

Date of change	Description
October 12, 2017	Initial article released.

MLN Matters® Number: MM10309
Related CR Release Date: October 6, 2017
Related CR Transmittal Number: R3872CP
Related Change Request (CR) Number: CR10309
Effective Date: October 1, 2017
Implementation Date: January 2, 2018

Correct your claims on the 'SPOT'

The SPOT offers registered users the time-saving advantage of not only viewing claim data online but also the option of correcting clerical errors on their eligible Part B claims quickly, easily, and securely – online.

New waived tests

***Note**: This article was revised September 28, 2017, to reflect a revised change request (CR) 10198. In the article, the CR release date, transmittal number, and the web address for accessing the CR are revised. All other information remains the same. This information was previously published in the August 2017 Medicare B Connection, pages 10-11.*

Provider type affected

This *MLN Matters*® article is intended for clinical diagnostic laboratories submitting claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

Provider action needed

CR 10198 informs MACs of new Clinical Laboratory Improvement Amendments of 1988 (CLIA) waived tests approved by the Food and Drug Administration (FDA). Since these tests are marketed immediately following approval, the Centers for Medicare & Medicaid Services (CMS) must notify the MACs of the new tests so that they can accurately process claims. CR 10198 lists 17 newly added waived complexity tests.

Background

The CLIA regulations require a facility to be appropriately certified for each test performed. To ensure that Medicare and Medicaid only pay for laboratory tests categorized as waived complexity under CLIA in facilities with a CLIA certificate or waiver, laboratory claims are currently edited at the CLIA certificate level.

This article includes the latest tests approved by the FDA as waived tests under CLIA. The *Current Procedural Terminology* (CPT®) codes for the following new tests must have the modifier QW to be recognized as a waived test. However, the tests mentioned on the first page of the attached list (that is, CPT® codes 81002, 81025, 82270, 82272, 82962, 83026, 84830, 85013, and 85651) do not require a QW modifier to be recognized as a waived test.

The CPT® code, effective date, and description for the latest tests approved by the FDA as waived tests under CLIA include:

- 87880QW, December 8, 2016, Quidel Sofia Strep A+ FIA (from throat swab only);
- 80305QW, April 28, 2017, Alere Toxicology Services Alere iCup Rx Multi-Drug Urine Test Cup;
- 82044QW, and 82570QW, May 10, 2017, Acon Laboratories, Inc. Mission U120 Urine Chemistry Test System (Mission Urinalysis Reagent Strips (Microalbumin/Creatinine));
- 80305QW, May 16, 2017, Assure Tech. Co., Ltd. AssureTech Amphetamine Dip;
- 80305QW, May 16, 2017, Assure Tech. Co., Ltd. AssureTech Oxazepam Panel Dip;
- 80305QW, May 16, 2017, Assure Tech. Co., Ltd. AssureTech Cocaine Panel Dip;
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- 80305QW, May 16, 2017, Assure Tech. Co., Ltd. AssureTech Methylenedioxymethamphetamine Panel Dip;
- 80305QW, May 16, 2017, Assure Tech. Co., Ltd. AssureTech Phencyclidine Panel Dip;
- 80305QW, May 16, 2017, Assure Tech. Co., Ltd. AssureTech Methadone Panel Dip;
- 87804QW, May 30, 2017, Quidel Sofia 2 {Sofia Influenza A+B FIA}; and
- 82274QW, G0328QW, June 5, 2017, Jant Pharmacal Coporation Accutest ValuPak Immunochemical Fecal Occult Blood Test.

Note: MACs will not search their files to either retract payment or retroactively pay claims; however, MACs should adjust claims if they are brought to their attention.

Additional information

The official instruction, CR 10198, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3867CP.pdf*. If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/*.

Document history

Date of change	Description
September 28, 2017	This article was revised to reflect a revised CR 10198. In the article, the CR release date, transmittal number, and the web address for accessing the CR are revised. All other information remains the same.
July 28, 2017	Initial article released.

MLN Matters® Number: MM10198 *Revised*
Related CR Release Date: September 28, 2017
Related CR Transmittal Number: R3867CP
Related Change Request (CR) Number: 10198
Effective Date: October 1, 2017
Implementation Date: October 2, 2017

Processing Issues

Mass adjustment of 2017-2018 influenza vaccine claims

Issue

Contractors are required to implement 2017-2018 influenza vaccine payment allowances no later than October 2. Once files are updated, reprocessing will occur for claims processed on or after August 1.

Resolution

Medicare administrative contractors (MACs) will initiate a mass adjustment process to reprocess claims by November 1. These instructions supersede instructions given in *MLN Matters*® *MM10224* regarding claim adjustments.

Status/date resolved

Open

Provider action

There is no action required by the provider.

Current processing issues

Here is a link to a table of *current processing issues* for both Part A and Part B.

General Information

Changes ahead for HETS application: HCPCS code changes and new preventive codes

The Centers for Medicare & Medicaid Services (CMS) has released several changes to the Health Insurance Portability and Accountability Act (HIPAA) eligibility transaction system (HETS) application, which will go into effect November 4, 2017. The changes will impact providers who use First Coast Service Options' (First Coast's) Secure Provider Online Tool (SPOT) to access eligibility data through HETS.

This article announces the first two of the 10 upcoming changes. It is the first in a series of articles – one will be published each week CMS has released several changes to the HETS application, which will go into effect November 4, 2017. The changes will impact providers who use First Coast's SPOT to access eligibility data through HETS.

This article announces the first two of the 10 upcoming changes. It is the first in a series of articles – one will be published each week – explaining the changes before the November 4, 2017, implementation date.

Preventive HCPCS code changes

HETS 270/271 will return only preventive HCPCS code information for the current date, instead of the current calendar year.

Newly supported preventive HCPCS codes

HETS 270/271 will begin supporting the following HCPCS codes:

- **81528** – Oncology (colorectal) screening, quantitative real-time target and signal amplification of 10 DNA markers (KRAS mutations, promoter methylation of NDRG4 and BMP3) and fecal hemoglobin, utilizing stool, algorithm reported as a positive or negative result
- **G0297** – Low dose CT scan (LDCT) for lung cancer screening
- **G0442** – Annual alcohol misuse screening, 15 minutes
- **G0443** – Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes
- **G0472** – Hepatitis C antibody screening, for individual at high risk and other covered indications
- **G0473** – Face-to-face behavioral counseling for obesity, group (2-10), 30 minutes
- **G0475** – HIV antigen/antibody, combination assay, screening explaining the changes before the November 4, 2017, implementation date.

Hurricane Nate and Medicare disaster-related Alabama, Florida, Louisiana, and Mississippi claims

Provider type affected

This *MLN Matters*® special edition article is intended for providers and suppliers who submit claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries in the states of Alabama, Florida, Louisiana, and Mississippi, who were affected by Hurricane Nate.

Provider action needed

Pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, President Trump declared that, as a result of the effects of Hurricane Nate, an emergency exists in Alabama, Florida, Louisiana, and Mississippi.

On October 8, 2017, Acting Secretary Wright of the Department of Health & Human Services declared that a public health emergency exists in the states of Louisiana retroactive to October 5, 2017; Mississippi, and Alabama retroactive to October 6, 2017; and Florida retroactive to October 7, 2017, and authorized waivers and modifications under §1135 of the Social Security Act.

On October 10, 2017, the Administrator of the Centers for Medicare & Medicaid Services (CMS) authorized waivers under §1812(f) of the Social Security Act for the States of Louisiana retroactive to October 5, 2017; Mississippi, and Alabama retroactive to October 6, 2017; and Florida retroactive to October 7, 2017, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of Hurricane Nate in 2017. These waivers will prevent gaps in access to care for beneficiaries impacted by the emergency. Providers do not need to apply for an individual waiver if a blanket waiver has been issued. Providers can request an individual Section 1135 waiver, if there is no blanket waiver, by following the instructions available at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Requesting-an-1135-Waiver-Updated-11-16-2016.pdf*.

The most current waiver information can be found at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Hurricanes.html*. See the *Background* section of this article for more details.

Background

Section 1135 and Section 1812(f) Waivers

As a result of the aforementioned declaration, CMS has instructed the MACs as follows:

Change request (CR) 6451 (Transmittal 1784, Publication 100-04) issued on July 31, 2009, applies to items and services furnished to Medicare beneficiaries within the within Alabama, Florida, Louisiana and Mississippi for the duration of the emergency. In accordance with CR 6451, use of the "DR" condition code and the "CR" modifier are mandatory on claims for items and services for which Medicare payment is conditioned on the presence of a "formal waiver" including, but not necessarily limited to, waivers granted under either Section 1135 or Section 1812(f) of the Act.

The most current information can be found at *https://www.cms.gov/emergency* posted in the downloads section at the bottom of the Emergency Response and Recovery webpage.

Also referenced below are Q&As that are applicable for items and services furnished to Medicare beneficiaries within the Alabama, Florida, Louisiana, and Mississippi. These Q&As are displayed in two files:

- One file addresses policies and procedures that are applicable **without** any Section 1135 or other formal waiver. These policies are always applicable in any kind of emergency or disaster, including the current emergency in Alabama, Florida, Louisiana and Mississippi.
- Another file addresses policies and procedures that are applicable **only with** approved Section 1135 waivers or, when applicable, approved Section 1812(f) waivers. These Q&As are applicable for approved Section 1135 blanket waivers and approved individual 1135 waivers requested by providers for Alabama, Florida, Louisiana, and Mississippi.

In both cases, the links below will open the most current document. The date included in the document filename will change as new information is added, or existing information is revised.

a. Q&As applicable **without any Section 1135** or other formal waiver are available at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Consolidated_Medicare_FFS_Emergency_QsAs.pdf*.

b. Q&As applicable **only with a Section 1135** waiver or, when applicable, a Section 1812(f) waiver, are available at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/MedicareFFS-EmergencyQsAs1135Waiver.pdf*.

Blanket waivers for Alabama, Florida, Louisiana, and Mississippi

Under the authority of Section 1135 (or, as noted below, Section 1812(f)), CMS has issued the following blanket waivers in the affected areas of Alabama, Florida, Louisiana and Mississippi. Individual facilities do not need to apply for the following approved blanket waivers.

Skilled nursing facilities

- Section 1812(f): Waiver of the requirement for a three-day prior hospitalization for coverage of a skilled nursing facility (SNF) stay provides temporary emergency coverage of SNF services without a qualifying hospital stay, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of Hurricane Nate in Alabama,

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Florida, Louisiana, and Mississippi in 2017. In addition, for certain beneficiaries who recently exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period. (Blanket waiver for all impacted facilities).

- 42 CFR 483.20: Waiver provides relief to skilled nursing facilities on the timeframe requirements for minimum data set assessments and transmission. (Blanket waiver for all impacted facilities)

Home health agencies

42 CFR 484.20(c)(1): This waiver provides relief to home health agencies on the timeframes related to OASIS transmission (Blanket waiver for all impacted agencies)

Critical access hospitals

This action waives the requirements that critical access hospitals limit the number of beds to 25, and that the length of stay be limited to 96 hours (Blanket waiver for all impacted hospitals).

Housing acute care patients in excluded distinct part units

CMS has determined it is appropriate to issue a blanket waiver to IPPS hospitals that, as a result of Hurricane Nate, need to house acute care inpatients in excluded distinct part units, where the distinct part unit's beds are appropriate for acute care inpatient. The IPPS hospital should bill for the care and annotate the patient's medical record to indicate the patient is an acute care inpatient being housed in the excluded unit because of capacity issues related to the hurricane. (Blanket waiver for all IPPS hospitals located in the affected areas that need to use distinct part beds for acute care patients as a result of the hurricane.)

Durable medical equipment

- As a result of Hurricane Nate, CMS has determined it is appropriate to issue a blanket waiver to suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) where DMEPOS is lost, destroyed, irreparably damaged, or otherwise rendered unusable. Under this waiver, the face-to-face requirement, a new physician's order, and new medical necessity documentation are not required for replacement. Suppliers must still include a narrative description on the claim explaining the reason why the equipment must be replaced and are reminded to maintain documentation indicating that the DMEPOS was lost, destroyed, irreparably damaged or otherwise rendered unusable as a result of the hurricane.
- As a result of Hurricane Nate, CMS is temporarily extending the 10-business day deadline to provide notification of any subcontracting arrangements. During the temporary extension period, affected contract suppliers will have 30-business days to provide notice to the competitive bidding implementation contractor of any subcontracting arrangements. CMS will notify DMEPOS competitive bidding contract suppliers via e-mail when this temporary extension expires. All other competitive bidding program requirements remain in force. **Note**: CMS will provide notice of any changes to reporting timeframes for future events.
- For more information refer to the *Durable Medical Equipment, Prosthetics, Orthotics, and Supplies for Medicare Beneficiaries Impacted by an Emergency or Disaster* fact sheet at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Emergency-DME-Beneficiaries-pdf*.

Replacement prescription fills

Medicare payment may be permitted for replacement prescription fills (for a quantity up to the amount originally dispensed) of covered Part B drugs in circumstances where dispensed medication has been lost or otherwise rendered unusable by damage due to the emergency.

Care for excluded inpatient psychiatric unit patients in the acute care unit of a hospital

CMS has determined it is appropriate to issue a blanket waiver to IPPS and other acute care hospitals with excluded distinct part inpatient psychiatric units that, as a result of Hurricane Nate, need to relocate inpatients from the excluded distinct part psychiatric unit to an acute care bed and unit. The hospital should continue to bill for inpatient psychiatric services under the inpatient psychiatric facility prospective payment system for such patients and annotate the medical record to indicate the patient is a psychiatric inpatient being cared for in an acute care bed because of capacity or other exigent circumstances related to the hurricane. This waiver may be utilized where the hospital's acute care beds are appropriate for psychiatric patients and the staff and environment are conducive to safe care. For psychiatric patients, this includes assessment of the acute care bed and unit location to ensure those patients at risk of harm to self and others are safely cared for.

Care for excluded inpatient rehabilitation unit patients in the acute care unit of a hospital

CMS has determined it is appropriate to issue a blanket waiver to IPPS and other acute care hospitals with excluded distinct part inpatient Rehabilitation units that, as a result of Hurricane Nate, need to relocate inpatients from the excluded distinct part Rehabilitation unit to an acute care bed and unit. The hospital should continue to bill for inpatient rehabilitation services under the inpatient rehabilitation facility prospective payment system for such patients and annotate the medical record to indicate the patient is a rehabilitation inpatient being cared for in an acute care bed because of capacity or other exigent circumstances related to the hurricane. This waiver may be utilized where the hospital's acute care beds are appropriate for providing care to rehabilitation patients and such patients continue to receive intensive rehabilitation services.

These temporary emergency policies would apply to the

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Hurricane Maria and Medicare disaster-related US Virgin Islands and Puerto Rico claims

***Note**: The article was updated October 2, 2017, to include the section 'Applicability of reporting requirements for inpatient psychiatric facilities, skilled nursing facilities, home health agencies, hospices, inpatient rehabilitation facilities, ambulatory surgical centers, and renal dialysis facilities affected by Hurricane Maria.' All other information remains the same. This information was previously published in the September 2017 Medicare B Connection, pages 31-33.*

Provider type affected

This *MLN Matters*® special edition article is intended for providers and suppliers who submit claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries in the United States Virgin Islands and commonwealth of Puerto Rico who were affected by Hurricane Maria.

Provider action needed

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

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

Under Section 1135 or 1812(f) of the Social Security Act, the CMS has issued several blanket waivers in the impacted counties and geographical areas of the United States Virgin Islands and the commonwealth of Puerto Rico. These waivers will prevent gaps in access to care for beneficiaries impacted by the emergency. Providers do not need to apply for an individual waiver if blanket waiver has been issued. Providers can request an individual Section 1135 waiver, if there is no blanket waiver, by following the instructions available at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Requesting-an-1135-Waiver-Updated-11-16-2016.pdf*.

The most current waiver information can be found at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Hurricanes.html*. See the *Background* section of this article for more details.

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timeframes specified in the waiver(s) issued under Section 1135 of the Act in connection with the effect of Hurricane Nate in Alabama, Florida, Louisiana, and Mississippi. More information is available in the 1135 waiver letter, which is posted in the *Downloads* section at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Hurricanes.html*.

Requesting an 1135 waiver

Information for requesting an 1135 waiver, when a blanket waiver hasn't been approved, can be found at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Requesting-an-1135-Waiver-Updated-11-16-2016.pdf*.

Additional information

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/*.

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

Document history

Date of change	Description
October 11, 2017	Initial article released.

MLN Matters® Number: SE17034
Article Release Date: October 11, 2017
Related CR Transmittal Number: N/A
Related Change Request (CR) Number: N/A
Effective Date: N/A
Implementation Date: N/A

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Background

Section 1135 and Section 1812(f) Waivers

As a result of the aforementioned declaration, CMS has instructed the MACs as follows:

1. Change request (CR) 6451 (Transmittal 1784, Publication 100-04) issued July 31, 2009, applies to items and services furnished to Medicare beneficiaries within the United States Virgin Islands from September 16, 2017, and the commonwealth of Puerto Rico from September 17, 2017, for the duration of the emergency. In accordance with CR 6451, use of the "DR" condition code and the "CR" modifier are mandatory on claims for items and services for which Medicare payment is conditioned on the presence of a "formal waiver" including, but not necessarily limited to, waivers granted under either Section 1135 or Section 1812(f) of the Act.
2. The most current information can be found at *https://www.cms.gov/emergency*. Medicare FFS questions & answers (Q&As) posted in the downloads section at the bottom of the Emergency Response and Recovery webpage and also referenced below are applicable for items and services furnished to Medicare beneficiaries within the United States Virgin Islands and the commonwealth of Puerto Rico. These Q&As are displayed in two files:

- One file addresses policies and procedures that are applicable **without** any Section 1135 or other formal waiver. These policies are always applicable in any kind of emergency or disaster, including the current emergency in the United States Virgin Islands and the commonwealth of Puerto Rico.
- Another file addresses policies and procedures that are applicable **only with** approved Section 1135 waivers or, when applicable, approved Section 1812(f) waivers. These Q&As are applicable for approved Section 1135 blanket waivers and approved individual 1135 waivers requested by providers and are effective September 16, 2017, for the United States Virgin Islands and the commonwealth of Puerto Rico.

In both cases, the links below will open the most current document. The date included in the document filename will change as new information is added, or existing information is revised.

a. Q&As applicable **without any Section 1135** or other formal waiver are available at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Consolidated_Medicare_FFS_Emergency_QsAs.pdf*.

b. Q&As applicable **only with a Section 1135** waiver or, when applicable, a Section 1812(f) waiver, are available at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/MedicareFFS-EmergencyQsAs1135Waiver.pdf*.

Blanket waivers Issued by CMS

Under the authority of Section 1135 (or, as noted below, Section 1812(f)), CMS has issued blanket waivers in the affected area of **the United States Virgin Islands, commonwealth of Puerto Rico, and state of Florida**. Individual facilities do not need to apply for the following approved blanket waivers:

Skilled nursing facilities

- Section 1812(f): Waiver of the requirement for a three-day prior hospitalization for coverage of a skilled nursing facility (SNF) stay provides temporary emergency coverage of SNF services without a qualifying hospital stay, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of Hurricane Maria in the United States Virgin Islands and the commonwealth of Puerto Rico in 2017. In addition, for certain beneficiaries who recently exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period. (Blanket waiver for all impacted facilities)
- 42 CFR 483.20: Waiver provides relief to skilled nursing facilities on the timeframe requirements for minimum data set assessments and transmission. (Blanket waiver for all impacted facilities)

Home health agencies

- 42 CFR 484.20(c)(1): This waiver provides relief to home health agencies on the timeframes related to OASIS transmission. (Blanket waiver for all impacted agencies)

Critical access hospitals

This action waives the requirements that critical access hospitals limit the number of beds to 25, and that the length of stay be limited to 96 hours. (Blanket waiver for all impacted hospitals)

Housing acute care patients in excluded distinct part units

CMS has determined it is appropriate to issue a blanket waiver to IPPS hospitals that, as a result of Hurricane Maria, need to house acute care inpatients in excluded distinct part units, where the distinct part unit's beds are appropriate for acute care inpatient. The IPPS hospital should bill for the care and annotate the patient's medical record to indicate the patient is an acute care inpatient being housed in the excluded unit because of capacity issues related to Hurricane Maria. (Blanket waiver for all IPPS hospitals located in the affected areas that need to use distinct part beds for acute care patients as a result of the hurricane.)

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Care for excluded inpatient psychiatric unit patients in the acute care unit of a hospital

CMS has determined it is appropriate to issue a blanket waiver to IPPS and other acute care hospitals with excluded distinct part inpatient psychiatric units that, as a result of Hurricane Maria, need to relocate inpatients from the excluded distinct part psychiatric unit to an acute care bed and unit. The hospital should continue to bill for inpatient psychiatric services under the inpatient psychiatric facility prospective payment system for such patients and annotate the medical record to indicate the patient is a psychiatric inpatient being cared for in an acute care bed because of capacity or other exigent circumstances related to the hurricane. This waiver may be utilized where the hospital's acute care beds are appropriate for psychiatric patients and the staff and environment are conducive to safe care. For psychiatric patients, this includes assessment of the acute care bed and unit location to ensure those patients at risk of harm to self and others are safely cared for.

Care for excluded inpatient rehabilitation unit patients in the acute care unit of a hospital

CMS has determined it is appropriate to issue a blanket waiver to IPPS and other acute care hospitals with excluded distinct part inpatient rehabilitation units that, as a result of Hurricane Maria, need to relocate inpatients from the excluded distinct part rehabilitation unit to an acute care bed and unit. The hospital should continue to bill for inpatient rehabilitation services under the inpatient rehabilitation facility prospective payment system for such patients and annotate the medical record to indicate the patient is a rehabilitation inpatient being cared for in an acute care bed because of capacity or other exigent circumstances related to the hurricane. This waiver may be utilized where the hospital's acute care beds are appropriate for providing care to rehabilitation patients and such patients continue to receive intensive rehabilitation services.

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

As a result of Hurricane Maria, CMS has determined it is appropriate to issue a blanket waiver to suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) where DMEPOS is lost, destroyed, irreparably damaged, or otherwise rendered unusable. Under this waiver, the face-to-face requirement, a new physician's order, and new medical necessity documentation are not required for replacement. Suppliers must still include a narrative description on the claim explaining the reason why the equipment must be replaced and are reminded to maintain documentation indicating that the DMEPOS was lost, destroyed, irreparably damaged or otherwise rendered unusable as a result of the hurricane.

For more information refer to the *DMEPOS for Medicare Beneficiaries Impacted by an Emergency or Disaste*r fact sheet at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Emergency-DME-Beneficiaries-Hurricanes.pdf*.

Appeal administrative relief for areas affected by Hurricane Maria

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

Replacement prescription fills

Medicare payment may be permitted for replacement prescription fills (for a quantity up to the amount originally dispensed) of covered Part B drugs in circumstances where dispensed medication has been lost or otherwise rendered unusable by damage due to the emergency.

Applicability of reporting requirements for inpatient psychiatric facilities, skilled nursing facilities, home health agencies, hospices, inpatient rehabilitation facilities, ambulatory surgical centers, and renal dialysis facilities affected by Hurricane Maria – This information added October 2, 2017.

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

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

Requesting an 1135 waiver

Information for requesting an 1135 waiver, when a blanket waiver hasn't been approved, can be found at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Requesting-an-1135-Waiver-Updated-11-16-2016.pdf*.

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Appeals and overpayment requests for providers/suppliers affected by a natural disaster

When filing an appeal or responding to an overpayment request with First Coast Service Options, the following information is required:

- Patient name
- Medicare ID number
- The specific service(s) and/or item(s) for which the redetermination is being requested
- Date of service
- The name and signature of the party or the representative of the party

If you were affected by Hurricanes Irma, Harvey, Maria, or Nate, and are unable to file a timely claims appeal, you can *contact First Coast* in writing to request an extension.

Likewise, if you are unable to respond timely to a request for overpayment or need to appeal an overpayment request, you should *contact First Coast* in writing.

All written requests for extensions of an appeal or overpayment request extensions should include the following verbiage in the subject line: "Natural Disaster exception." If the information above is not available or you are otherwise unable to submit a written request, you are encouraged to call the Provider Contact Center customer service at:

Florida/U.S. Virgin Islands: (888) 664-4112 (Part A) or (866) 454-9007 (Part B)

Puerto Rico: (877) 908-8433 (Part A) or (877) 715-1921 (Part B)

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Additional information

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/*.

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

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

Document history

Date of change	Description
October 2, 2017	The article was updated to include the section 'Applicability of reporting requirements for inpatient psychiatric facilities, skilled nursing facilities, home health agencies, hospices, inpatient rehabilitation facilities, ambulatory surgical centers, and renal dialysis facilities affected by Hurricane Maria.' All other information remains the same.

Date of change	Description
September 21, 2017	Initial article released.

MLN Matters® Number: SE17028 *Revised*
Article Release Date: October 2, 2017
Related CR Transmittal Number: N/A
Related Change Request (CR) Number: N/A
Effective Date: N/A
Implementation Date: N/A

Providers affected by hurricanes Harvey, Irma, and Maria

In response to the devastation of Hurricanes Harvey, Irma, and Maria, the Centers for Medicare & Medicaid Services (CMS) are granting widespread administrative relief. This administrative relief is in addition to any individual needs required on a case by case basis. First Coast Service Options Inc. (First Coast) will work with these providers to ensure payment is received for covered services.

Widespread administrative relief will include the suspension of additional documentation requests (ADRs) related to medical review editing for a period of 30 days, ending October 26, 2017. (**Note**: Due to Hurricane Maria, this date has been extended for Puerto Rico and the U.S. Virgin Islands to October 30, 2017.) Additionally, providers will be automatically granted 30 additional days to respond to any documentation request that may have already been requested during this 30-day period.

If you are unable to submit records due to a disaster related situation, you may attach a letter to the ADR explaining your situation. This will ensure that your claim is handled appropriately. There are some billing situations that may require an explanation or a description of the service billed (e.g., unlisted Healthcare Common Procedure Coding System [HCPCS] codes, modifiers, etc.). If you are including a letter to indicate that you are unable to provide the medical documentation you must provide a contact person as well a telephone number in the event that clarification is needed for claim processing. You may follow your normal process for responding. This information may be found within your ADR letter.

Accepting payment from patients with a Medicare set-aside arrangement

***Note**: This article was rescinded October 3, 2017. This information was previously published in the September 2017 Medicare B Connection, pages 42-43.*

Document history

Date of change	Description
September 19, 2017	Initial article released.
October 3, 2017	Article rescinded

MLN Matters® Number: SE17019 *Rescinded*
Article Release Date: September 19, 2017

Related CR Transmittal Number: N/A
Related Change Request (CR) Number: N/A
Effective Date: N/A
Implementation Date: N/A

Prohibition on billing dually eligible individuals enrolled in the QMB program

***Note**: This article was revised October 18, 2017, to indicate that the provider remittance advice and the Medicare summary notice for beneficiaries identifies the QMB status of beneficiaries and exemption from cost-sharing for Part A and B claims processed on or after October 2, 2017, and to recommend how providers can use these and other upcoming system changes to promote compliance with QMB billing requirements. This information was previously published in the October 2017 Medicare B Connection, pages 44-46.*

Provider types affected

This article pertains to all Medicare physicians, providers and suppliers, including those serving beneficiaries enrolled in original Medicare or a Medicare advantage (MA) plan.

Provider action needed

This special edition *MLN Matters*® article from the Centers for Medicare & Medicaid Services (CMS) reminds **all Medicare providers and suppliers that they may not bill beneficiaries enrolled in the QMB program for Medicare cost-sharing.** Medicare beneficiaries enrolled in the QMB program have no legal obligation to pay Medicare Part A or B deductibles, coinsurance, or copays for any Medicare-covered items and services.

Look for new information and messages in CMS' HIPAA eligibility transaction system (HETS) (effective November 4, 2017) and the provider remittance advice (RA) (effective October 2, 2017), to identify patients' QMB status and exemption from cost-sharing prior to billing. If you are an MA provider, contact the MA plan for more information about verifying the QMB status of plan members.

Implement key measures to ensure compliance with QMB billing requirements. Ensure that billing procedures and third-party vendors exempt individuals enrolled in the QMB program from Medicare charges. If you have erroneously billed an individual enrolled in the QMB program, recall the charges (including referrals to collection agencies)

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and refund the invalid charges he or she paid. For information about obtaining payment for Medicare cost-sharing, contact the Medicaid agency in the states in which you practice. Refer to the *Background* and *Additional information* sections for further details and important steps to promote compliance.

Background

All original Medicare and MA providers and suppliers–not only those that accept Medicaid–must refrain from charging individuals enrolled in the QMB program for Medicare cost-sharing. Providers who inappropriately bill individuals enrolled in QMB are subject to sanctions. Providers and suppliers may bill state Medicaid programs for these costs, but states can limit Medicare cost-sharing payments under certain circumstances.

Billing of QMBs is prohibited by federal law

Federal law bars Medicare providers and suppliers from billing an individual enrolled in the QMB program for Medicare Part A and Part B cost-sharing under any circumstances (see Sections 1902(n)(3)(B), 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A), and 1848(g)(3)(A) of the Social Security Act [the Act]). The QMB program is a state Medicaid benefit that assists low-income Medicare beneficiaries with Medicare Part A and Part B premiums and cost-sharing, including deductibles, coinsurance, and copays. In 2015, 7.2 million individuals (more than one out of 10 beneficiaries) were enrolled in the QMB program. See the chart at the end of this article for more information about the QMB benefit.

Providers and suppliers may bill state Medicaid agencies for Medicare cost-sharing amounts. However, as permitted by federal law, states can limit Medicare cost-sharing payments, under certain circumstances. Regardless, persons enrolled in the QMB program have no legal liability to pay Medicare providers for Medicare Part A or Part B cost-sharing. Medicare providers who do not follow these billing prohibitions are violating their Medicare provider agreement and may be subject to sanctions (see Sections 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A), and 1848(g)(3)(A) of the Act.)

Note that certain types of providers may seek reimbursement for unpaid Medicare deductible and coinsurance amounts as a Medicare bad debt discussed in Chapter 3 of the *Provider Reimbursement Manual* (Pub.15-1).

Refer to the *Important Reminders concerning QMB billing requirements* section for key policy clarifications.

Inappropriate billing of QMB individuals persists

Despite federal law, improper billing of QMB individuals persists. Many beneficiaries are unaware of the billing restrictions (or concerned about undermining provider relationships) and simply pay the cost-sharing amounts. Others may experience undue distress when unpaid bills are referred to collection agencies. For more information, refer to *Access to Care Issues Among Qualified Medicare Beneficiaries (QMB), Centers for Medicare & Medicaid Services July 2015*.

Ways to promote compliance with QMB billing rules

Be aware of the following policy clarifications to ensure compliance with QMB billing requirements.

1. All original Medicare and MA providers–not only those that accept Medicaid–must abide by the billing prohibitions.
2. QMB individuals retain their protection from billing when they cross state lines to receive care. Providers cannot charge QMB individuals even if the patient's QMB benefit is provided by a different state than the state in which care is rendered.
3. Note that QMBs cannot choose to "waive" their QMB status and pay Medicare cost-sharing. The federal statute referenced above supersedes Section 3490.14 of the state Medicaid manual, which is no longer in effect.

Ways to improve processes related to QMBs

Take the following steps to ensure compliance with QMB billing prohibitions:

1. Establish processes to routinely identify the QMB status of your Medicare patients prior to billing for items and services.
   - Beginning November 4, 2017, providers and suppliers can use Medicare eligibility data provided to Medicare providers, suppliers, and their authorized billing agents (including clearinghouses and third party vendors) by CMS' HETS to verify a patient's QMB status and exemption from cost-sharing charges. For more information on HETS, see *https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/index.html*.
   - Starting October 3, 2017, original Medicare providers and suppliers can readily identify the QMB status of patients and billing prohibitions from the Medicare provider RA, which will contain new notifications and information about a patient's QMB status. Refer to *Qualified Medicare Beneficiary Indicator in the Medicare Fee-For-Service Claims Processing System* for more information about these improvements.
   - MA providers and suppliers should also contact the MA plan to learn the best way to identify the

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QMB status of plan members.

- Providers and suppliers may also verify a patient's QMB status through state online Medicaid eligibility systems or other documentation, including Medicaid identification cards and documents issued by the state proving the patient is enrolled in the QMB program.

2. Ensure that billing procedures and third-party vendors exempt individuals enrolled in the QMB program from Medicare charges and that you remedy billing problems should they occur. If you have erroneously billed an individual enrolled in the QMB program, recall the charges (including referrals to collection agencies) and refund the invalid charges he or she paid.
3. Determine the billing processes that apply to seeking payment for Medicare cost-sharing from the states in which you operate. Different processes may apply to original Medicare and MA services provided to individuals enrolled in the QMB program. For original Medicare claims, nearly all states have electronic crossover processes through the Medicare Benefits Coordination & Recovery Center (BCRC) to automatically receive Medicare-adjudicated claims.
   - If a claim is automatically crossed over to another payer, such as Medicaid, it is customarily noted on the Medicare RA.
   - Understand the processes you need to follow to request payment for Medicare cost-sharing amounts if they are owed by your state. You may need to complete a state provider registration process and be entered into the state payment system to bill the state.

Important Reminders Concerning QMB Billing Requirements

Be aware of the following policy clarifications on QMB billing requirements:

1. All original Medicare and MA providers and suppliers–not only those that accept Medicaid–must abide by the billing prohibitions.
2. Individuals enrolled in the QMB program retain their protection from billing when they cross state lines to receive care. Providers and suppliers cannot charge individuals enrolled in QMB even if their QMB benefit is provided by a different state than the state in which care is rendered.
3. Note that individuals enrolled in QMB cannot choose to "waive" their QMB status and pay Medicare cost-sharing. The federal statute referenced above supersedes Section 3490.14 of the state Medicaid Manual, which is no longer in effect.

QMB eligibility and benefits (see page XX)

Additional information

For more information about dual eligibles under Medicare and Medicaid, please visit *https://www.medicaid.gov/affordable-care-act/dual-eligibles/index.html* and *https://www.medicaid.gov/medicaid/eligibility/medicaid-enrollees/index.html* and refer to *Dual Eligible Beneficiaries Under Medicare and Medicaid*. For general Medicaid information, please visit *http://www.medicaid.gov/index.html*.

Document history

Date of change	Description
October 18, 2017	The article was revised to indicate that the provider remittance advice and the Medicare summary notice for beneficiaries identifies the QMB status of beneficiaries and exemption from cost-sharing for Part A and B claims processed on or after October 2, 2017, and to recommend how providers can use these and other upcoming system changes to promote compliance with QMB billing requirements. All other information remains the same.
August 23, 2017	The article was revised to highlight upcoming system changes that identify the QMB status of beneficiaries and exemption from Medicare cost-sharing, recommend key ways to promote compliance with QMB billing rules, and remind certain types of providers that they may seek reimbursement for unpaid deductible and coinsurance amounts as a Medicare bad debt.
May 12, 2017	This article was revised May 12, 2017, to modify language pertaining to billing beneficiaries enrolled in the QMB program. All other information is the same.
January 12, 2017	This article was revised to add a reference to *MLN Matters*® article *MM9817*, which instructs Medicare administrative contractors to issue a compliance letter instructing named providers to refund any erroneous charges and recall any existing billing to QMBs for Medicare cost sharing.
February 4, 2016	The article was revised on February 4, 2016, to include updated information for 2016 and a correction to the second sentence in paragraph 2 under *Important Clarifications Concerning QMB Balance Billing Law*.
February 1, 2016	The article was revised to include updated information for 2016 and a clarifying note regarding eligibility criteria in the table.

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Date of change	Description
March 28, 2014	The article was revised to change the name of the coordination of benefits contractor (COBC) to BCRC.

MLN Matters® Number: SE1128 *Revised*
Related Change Request (CR) #: N/A

Release Date of Revised Article: October 17, 2017
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

QMB eligibility and benefits

Program	Income criteria*	Resources criteria*	Medicare Part A and Part B enrollment	Other criteria	Benefits
QMB only	≤100% of federal poverty line (FPL)	≤3 times SSI resource limit, adjusted annually in accordance with increases in consumer price index	Part A***	Not applicable	▪ Medicaid pays for Part A (if any) and Part B premiums, and may pay for deductibles, coinsurance, and copayments for Medicare services furnished by Medicare providers to the extent consistent with the Medicaid state plan (even if payment is not available under the state plan for these charges, QMBs are not liable for them)
QMB plus	≤100% of FPL	Determined by state	Part A***	Meets financial and other criteria for full Medicaid benefits	▪ Full Medicaid coverage ▪ Medicaid pays for Part A (if any) and Part B premiums, and may pay for deductibles, coinsurance, and copayments to the extent consistent with the Medicaid state plan (even if payment is not available under the state plan for these charges, QMBs are not liable for them)

* States can effectively raise these Federal income and resources criteria under Section *1902(r)(2)* of the Act.

*** To qualify as a QMB or a QMB plus, individuals must be enrolled in Part A (or if uninsured for Part A, have filed for premium-Part A on a "conditional basis"). For more information on this process, refer to Section HI 00801.140 of the *Social Security Administration Program Operations Manual System*.

Learn the secrets to billing Medicare correctly

Who has the power to improve your billing accuracy and efficiency? You do – visit the *Tools to improve your billing* section where you'll discover the tools you need to learn how to consistently bill Medicare correctly – the first time. You'll find First Coast's most popular self-audit resources, including the E/M interactive worksheet, provider data summary (PDS) report, and the comparative billing report (CBR).

This section of *Medicare B Connection* features summaries of new and revised local coverage determinations (LCDs) developed as a result of either local medical review or comprehensive data analysis initiatives. These initiatives are designed to ensure the appropriateness of medical care and to make sure that the Medicare administrative contractor (MAC) jurisdiction N (JN) Part A LCDs and review guidelines are consistent with accepted standards of medical practice.

Refer to our LCDs/Medical Coverage web page at *https://medicare.fcso.com/Landing/139800.asp* for full-text LCDs, including final LCDs, draft LCDs available for comment, LCD statuses, and LCD comment/response summaries.

Effective and notice dates

Effective dates are provided in each LCD, and are based on the date services are furnished unless otherwise noted in the LCD. Medicare contractors are required to offer a 45-day notice period for LCDs; the date the LCD is posted to the website is considered the notice date.

Electronic notification

To receive quick, automatic notification when new and revised LCDs are posted to the website, subscribe to the First Coast eNews mailing list. Simply go to *https://medicare.fcso.com/Header/137525.asp*, enter your email address and select the subscription option that best meets your needs.

More information

For more information, or, if you do not have internet access, to obtain a hardcopy of a specific LCD, contact Medical Policy at:

Medical Policy and Procedures
PO Box 2078
Jacksonville, FL 32231-0048

Looking for LCDs?

Would you like to find local coverage determinations (LCD) in 10 seconds or less? First Coast's LCD lookup, available at *https://medicare.fcso.com/coverage_find_lcds_and_ncds/lcd_search.asp*, helps you find the coverage information you need quickly and easily. Just enter a procedure code, keyword, or the LCD's "L number," click the corresponding button, and the application will automatically display links to any LCDs applicable to the parameters you specified. Best of all, depending upon the speed of your internet connection, the LCD search process can be completed in less than 10 seconds.

Advance beneficiary notice

Modifier GZ must be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they **have not had** an advance beneficiary notification (ABN) signed by the beneficiary.

Note: Line items submitted with the modifier GZ will be automatically denied and will not be subject to complex medical review.

Modifier GA must be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny a service as not reasonable and necessary and they **do have** on file an ABN signed by the beneficiary.

All claims not meeting medical necessity of a local coverage determination must append the billed service with modifier GA or GZ.

Social Security Number Removal Initiative (SSNRI)

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, requires the Centers for Medicare & Medicaid Services (CMS) to remove Social Security numbers (SSNs) from all Medicare cards by April 2019. A new Medicare Beneficiary Identifier (MBI) will replace the SSN-based Health Insurance Claim Number (HICN) on the new Medicare cards for Medicare transactions like billing, eligibility status, and claim status.

New Medicare cards will be mailed between April 2018 and April 2019. Resources are available to prepare you for this change at *https://medicare.fcso.com/Claim_submission_guidelines/0380240.asp*.

New LCD

Wound care – new Part A and Part B LCD

LCD ID number: L37166 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for wound care was developed based on data analysis, which identified an increase in utilization of wound care procedures. Furthermore, the existing wound debridement services LCD (L33566) was incorporated when creating this new LCD, which will be retired when the new LCD becomes effective.

Effective date

This LCD is effective for services rendered **on or after December 7, 2017.** LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Revisions to LCD

Infliximab (Remicade™) – revision to the Part A and B LCD

LCD ID number: L33704 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on CR 10230 (October 2017 Integrated Outpatient Code Editor (I/OCE) Specifications Version 18.3), CR 10234 (Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes - October 2017 Update), CR 10236 (October 2017 Update of the Hospital Outpatient Prospective Payment System (OPPS)), and CR 10259 (October 2017 Update of the Ambulatory Surgical Center (ASC) Payment System), the "CPT®/HCPCS codes" section of the local coverage determination (LCD) for infliximab (Remicade™) was revised to add modifier ZC (Merck/Samsung Bioepis) to the asterisk explanation for HCPCS code Q5102.

Effective date

This LCD revision for CR 10234 is effective for claims processed **on or after October 01, 2017**, for services rendered **on or after July 24, 2017.** This LCD revision for CR 10230, CR 10236, and CR 10259 is effective for claims processed **on or after October 01, 2017**, for services rendered **on or after July 01, 2017.** First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

Coding guidelines for an LCD (when present) may be found by selecting "Attachments" in the "Section Navigation" drop-down menu at the top of the LCD page.

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

Psychological and neuropsychological tests – revision to the Part A and B LCD

LCD ID number: L34520 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on a reconsideration request asking for additional diagnosis codes for Parkinson's disease and epilepsy, the local coverage determination (LCD) for psychological and neuropsychological tests was revised. Diagnosis codes G20, G40.001 - G40.319, G40.A01 - G40.B19, and G40.401 - G40.919 were added to the "ICD-10 Codes that Support Medical Necessity" section of the LCD for *Current Procedural Terminology* (CPT®) codes 96101, 96102, 96103, 96118, 96119, 96120, and Healthcare Common Procedure Coding System (HCPCS) code G0451.

Effective date

This LCD revision is effective for services rendered **on or after October 31, 2017.**

First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

Coding guidelines for an LCD (when present) may be found by selecting "Attachments" in the "Section Navigation" drop-down menu at the top of the LCD page.

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

Upcoming provider outreach and educational events

Topic: New Medicare cards are coming: Will you be ready?

Date: Tuesday, November 14
Time: 11:30 a.m.-12:30 p.m.
Type of Event: Webcast
https://medicare.fcso.com/Events/0387453.asp

Topic: E/M services: Documenting hospital care services

Date: Wednesday, November 15
Time: 10:00-11:30 a.m.
Type of Event: Webcast
https://medicare.fcso.com/Events/0388841.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 *http://www.fcsouniversity.com*, log on to your account and select the course you wish to register. Class materials are available under "My Courses" no later than one day before the event**.**

First-time User? Set up an account by completing *Request User Account Form* online. Providers who do not have yet a national provider identifier may enter "99999" in the NPI field. You will receive logon information within 72 hours of your request.

Fax – Providers without internet access may request a fax registration form through our Registration Hotline at 1-904-791-8103. Class materials will be faxed to you the day of the event.

Please Note:

- Pre-registration is required for all teleconferences, webcasts and in-person educational seminars.
- Dates and times are subject to change prior to opening of event registration.

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Provider Address: _____

City, State, ZIP Code: _____

Keep checking our website, *medicare.fcso.com*, for details and newly scheduled educational events (teleconferences, webcasts, etc.) or call the First Coast Provider Education Registration Hotline at 1-904-791-8103 to learn more about the about our newest training opportunities for providers.

Never miss a training opportunity

If you or your colleagues were unable to attend one of our past Medicare educational webcasts, you still have the opportunity to learn about the topics covered during the training session. Visit the First Coast Medicare training website, download the recording of the event, and listen to the webcast when you have the time.

Take advantage of 24-hour access to free online training

In addition to live training events, we also offer you the advantage of self-paced, free online courses that will allow you and your staff to train when and where it is most convenient for you. In addition, our comprehensive course catalog allows you to find the Medicare training that fits your specific needs, and several of our online courses offer CEUs. Learn more on the First Coast Medicare training website and explore our catalog of online courses.

CMS MLN Connects®

The Centers for Medicare & Medicaid Services (CMS) *MLN Connects*® is an official *Medicare Learning Network*® (*MLN*) – branded product that contains a week's worth of news for Medicare fee-for-service (FFS) providers. CMS sends these messages weekly to national health industry provider associations, who then disseminates the *MLN Connects*® to its membership as appropriate.

MLN Connects® for September 28, 2017

MLN Connects® for September 28, 2017

View this edition as a PDF

News & Announcements

- Medicare Clinical Laboratory Fee Schedule: Preliminary CY 2018 Payment Rates
- 2016 PQRS Feedback Reports and Annual QRURs Updates
- Quality Payment Program: New Resources Available
- Quality Payment Program: View Recordings of Recent Webinars
- MIPS Eligible Measure Applicability: New Resources Available
- National Cholesterol Education Month and World Heart Day

Provider Compliance

- Psychiatry and Psychotherapy CMS Provider Minute Video — Reminder

Claims, Pricers & Codes

- Clinicians: Medicare Part B Crossover Claims Issue Tied to Error Code H51082

Upcoming Events

- Home Health Agencies: Quality of Patient Care Star Rating Algorithm Call — October 10
- 2016 Annual QRURs Webcast — October 19

Medicare Learning Network Publications & Multimedia

- 2017-2018 Influenza Resources for Health Care Professionals *MLN Matters*® article — New
- Billing in Medicare Secondary Payer Liability Insurance Situations *MLN Matters*® article — New

- Accepting Payment from Patients with Set-Aside Arrangements *MLN Matters*® article — New
- Clarification of Billing and Payment Policies for Negative Pressure Wound Therapy Using a Disposable Device *MLN Matters*® article — New
- Transition to New Medicare Numbers and Cards Fact Sheet — New
- Nursing Home Call: Audio Recording and Transcript — New
- SNF Consolidated Billing Web-Based Training Course — Reminder
- Remittance Advice Resources and FAQs Fact Sheet — Reminder
- Medicare Enrollment Guidelines for Ordering/Referring Providers Booklet — Reminder

MLN Connects® for October 5, 2017

MLN Connects® for October 5, 2017

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News & Announcements

- National Partnership to Improve Dementia Care Achieves Goals to Reduce Unnecessary Antipsychotic Medications in Nursing Homes
- 2018 eCQM Value Set Addendum Available
- 2018 eCQM Logic Flows Available
- Health Services Research Health Equity Issue: Submit Abstracts by November 1
- Extension of Medicare IVIG Demonstration through December 31, 2020
- October is National Breast Cancer Awareness Month

Provider Compliance

- Hospice Election Statements Lack Required Information or Have Other Vulnerabilities — Reminder

Claims, Pricers & Codes

- FY 2018 IPPS and LTCH PPS Claims Hold

Upcoming Events

- 2016 Annual QRURs Webcast — October 19
- Definition of a Hospital: Primarily Engaged Requirement Call — November 2

Medicare Learning Network Publications & Multimedia

- Medicare Basics: Parts A and B Appeals Overview Video — New
- Updates to Medicare's Cost Report Worksheet S-10 to Capture Uncompensated Care Data *MLN Matters®* article — New
- Qualified Medicare Beneficiary Program Call: Audio Recording and Transcript — New
- Hospice Quality Reporting Program Call: Audio Recording and Transcript — New
- Hurricane Maria and Medicare Disaster Related United States Virgin Islands and Commonwealth of Puerto Rico Claims *MLN Matters®* article — Updated
- Reading a Professional Remittance Advice Booklet — Reminder
- Reading an Institutional Remittance Advice Booklet — Reminder

MLN Connects® for October 12, 2017

MLN Connects® for October 12, 2017
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News & Announcements

- New Medicare Card Web Updates
- 2018 Medicare EHR Incentive Program Payment Adjustment Fact Sheet for Hospitals
- Qualifying APM Participant Look-Up Tool
- Hospice Quality Reporting Program: New and Updated Resources
- SNF Quality Reporting Program: Quick Reference Guide
- Protect Your Patients from Influenza this Season

Provider Compliance

- Cochlear Devices Replaced Without Cost: Bill Correctly — Reminder

Claims, Pricers & Codes

- Home Health Claims Will Be Returned When No OASIS Is Found

Upcoming Events

- 2016 Annual QRURs Webcast — October 19
- Definition of a Hospital: Primarily Engaged Requirement Call — November 2

Medicare Learning Network Publications & Multimedia

- PQRS Call: Audio Recording and Transcript — New

MLN Connects® for October 19, 2017

MLN Connects® for October 19, 2017

View this edition as a PDF

News & Announcements

- Preview Draft eCQM Specifications through November 13
- MIPS Virtual Group Election Period Ends December 1
- Quality Payment Program: New Resources
- SNF Quality Reporting Program Confidential Feedback Reports for Claims-Based Measures
- SNF Review and Correct Report Update
- Post-Acute Care Quality Reporting Programs FY 2018 APU: Successful Facilities
- New CMS Legionella Requirement for Hospitals, Critical Access Hospitals, and Nursing Homes

Provider Compliance

- Coudé Tip Catheters CMS Provider Minute Video – Reminder

Claims, Pricers & Codes

- October 2017 OPPS Pricer File
- Outpatient Claims: Correcting Deductible and Coinsurance for Code G0473

Upcoming Events

- Definition of a Hospital: Primarily Engaged Requirement Call – November 2
- New Medicare Card Project Special Open Door Forum – November 9
- SNF Value-Based Purchasing Program FY 2018 Final Rule Call – November 16

Medicare Learning Network Publications & Multimedia

- Medicare FFS Response to the 2017 California Wildfires *MLN Matters®* article – New
- Hurricane Nate and Medicare Disaster Related Alabama, Florida, Louisiana and Mississippi Claims *MLN Matters®* article – New
- Medicare Quarterly Provider Compliance Newsletter Educational Tool – New
- Physician Compare Call: Audio Recording and Transcript — New
- Prohibition on Billing Dually Eligible Individuals Enrolled in the QMB Program *MLN Matters®* article – Revised
- Critical Access Hospital Booklet – Revised

Preventive Resources

2017-2018 influenza resources for health care professionals

Provider type affected

- All health care professionals who order, refer, or provide flu vaccines and vaccine administration to Medicare beneficiaries.

What you need to know

- Keep this special edition *MLN Matters®* article and refer to it throughout the 2017 - 2018 flu season.
- Take advantage of each office visit as an opportunity to encourage your patients to protect themselves from the flu and serious complications by getting a flu shot.
- Continue to provide the flu shot if you have vaccine available, even after the New Year.
- Remember to immunize yourself and your staff.

Background

The Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare Part B reimburses health care providers for flu vaccines and their administration. (*Medicare provides coverage of the flu vaccine without any out-of-pocket costs to the Medicare patient. No deductible or copayment/coinsurance applies.*)

You can help your Medicare patients reduce their risk for contracting seasonal flu and serious complications by using every office visit as an opportunity to recommend they take advantage of Medicare's coverage of the annual flu shot. As a reminder, please help prevent the spread of flu by immunizing yourself and your staff!

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Know what to do about the flu!

Payment rates for 2017-2018

Each year, CMS updates the Medicare Healthcare Common Procedure Coding System (HCPCS) and *Current Procedure Terminology* (*CPT*®) codes and payment rates for personal flu and pneumococcal vaccines. Payment allowance limits for such vaccines are 95 percent of the average wholesale price (AWP), except where the vaccine is furnished in a hospital outpatient department, rural health clinic (RHC), or federally qualified health center (FQHC). In these cases, the payment for the vaccine is based on reasonable cost.

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

The following Medicare Part B payment allowances for HCPCS and *CPT*® codes apply:

Codes, payment allowances, and effective dates for the 2017-18 flu season

CPT® or HCPCS code	Payment allowance	Effective date
90630	$20.343	8/1/2017-7/31/2018
90653	$50.217	8/1/2017-7/31/2018
90654		Pending 8/1/2017-7/31/2018
90655		Pending 8/1/2017-7/31/2018
90656	$19.247	8/1/2017-7/31/2018
90657		Pending 8/1/2017-7/31/2018
90661		Pending 8/1/2017-7/31/2018
90662	$49.025	8/1/2017-7/31/2018
90672		Pending 8/1/2017-7/31/2018
90673	$40.613	8/1/2017-7/31/2018
90674	$24.047	8/1/2017-7/31/2018
90682	$46.313	8/1/2017-7/31/2018 (New code)
90685	$21.198	8/1/2017-7/31/2018
90686	$19.032	8/1/2017-7/31/2018
90687	$9.403	8/1/2017-7/31/2018
90688	$17.835	8/1/2017-7/31/2018
90756*	$22.793	1/1/2018-7/31/2018
Q2039**	**See Note below**	8/1/2017-7/31/2018
Q2035	$17.685	8/1/2017-7/31/2018
Q2036		Pending 8/1/2017-7/31/2018
Q2037	$17.685	8/1/2017-7/31/2018
Q2038		Pending 8/1/2017-7/31/2018

**Until CPT code 90756 is implemented on 1/1/2018, Q2039 will be used for products described by the following language: influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5mL dosage, for intramuscular use. The payment allowance for these products, effective for dates of service from 8/1/2017 to 12/31/2017, is $22.793.*

***Providers and MACs will use HCPCS Q2039 for dates of service from 8/1/201712/31/2017. HCPCS Q2039 (Flu vaccine adult – not otherwise classified). The payment allowance will be determined by the local claim processing contractor with effective dates of 8/1/2017-7/31/2018.*

Providers are encouraged to review *MLN Matters*® article *MM10224* for more information on 2017-2018 influenza vaccines pricing.

Also, updates to payment limits and effective dates, when necessary, will be posted at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-BDrugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html*.

Additional information

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/*.

Educational products for health care professionals

The *Medicare Learning Network*® (*MLN*®) has developed a variety of educational resources to help you understand Medicare guidelines for seasonal flu vaccines and their administration.

1. *MLN*® influenza-related products for health care professionals

- **Medicare Part B Immunization Billing chart** – *https://www.cms.gov/Outreach-and- Education/Medicare-Learning-Network- MLN/MLNProducts/downloads/qr_immun_bill.pdf*
- **Preventive Services chart** – *https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html*
- **MLN Preventive Services Educational Products webpage** – *https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/ProviderResources.html*

2. Other CMS resources

- **Immunizations webpage** – *https://www.cms.gov/*

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Medicare/Prevention/Immunizations/index.html

- **Prevention General Information** – *https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/index.html*
- **CMS Frequently Asked Questions** – *http://questions.cms.gov/faq.php*
- **Medicare Benefit Policy Manual** - Chapter 15, Section 50.4.4.2 – Immunizations *https://www.cms.gov/Regulations-and- Guidance/Guidance/Manuals/downloads/bp102c15.pdf*
- ***Medicare Claims Processing Manual*** – Chapter 18, Preventive and Screening Services *https://www.cms.gov/Regulations-and- Guidance/Guidance/Manuals/downloads/clm104c18.pdf*

3. Other resources

The following non-CMS resources are just a few of the many available in you may find useful information and tools for the 2016-2017 flu season:

- **Advisory Committee on Immunization Practices** – *https://www.cdc.gov/vaccines/acip/index.html*

Other sites with helpful information include:

- **Centers for Disease Control and Prevention** – *https://www.cdc.gov/flu*
- **Flu.gov** – *https://www.flu.gov*
- **Food and Drug Administration** – *https://www.fda.gov*
- **Immunization Action Coalition** – *https://www.immunize.org*
- **Indian Health Services** – *https://www.ihs.gov*
- **National Alliance for Hispanic Health** – *https://www.hispanichealth.org*
- **National Foundation For Infectious Diseases** – *https://www.nfid.org/influenza*
- **National Library of Medicine and NIH Medline Plus** – *https://www.nlm.nih.gov/medlineplus/immunization.html*

- **National Vaccine Program** – *https://www.hhs.gov/nvpo*
- **Office of Disease Prevention and Health Promotion** – *https://healthfinder.gov/FindServices/Organizations/Organization/HR2013/office-of-disease-prevention-and-health-promotion-us-department-of-health-and-human-services*
- **World Health Organization** – *https://www.who.int/en*

Document history

Date of change	Description
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Implementation Date: N/A

Take action to combat the flu

Now is the perfect time for providers to vaccinate Medicare beneficiaries, as it can take two weeks after vaccination to develop antibodies that protect against seasonal influenza. As a health care provider, you play an important role in setting an example by getting yourself vaccinated and recommending and promoting influenza vaccination.

Phone numbers

Customer service

866-454-9007
877-660-1759 (speech and hearing impaired)

Education event registration hotline

904-791-8103 (NOT toll-free)

Electronic data interchange (EDI)

888-670-0940

Electronic funds transfers (EFT) (CMS-588)

866-454-9007
877-660-1759 (TTY)

Fax number (for general inquiries)

904-361-0696

Interactive voice response (IVR) system

877-847-4992

Provider enrollment

866-454-9007
877-660-1759 (TTY)

The SPOT help desk

855-416-4199
email: *FCSOSPOTHelp@FCSO.com*

Addresses

Claims

Medicare Part B Claims
P.O. Box 2525
Jacksonville, FL 32231-0019

Redeterminations

Medicare Part B Redetermination
P.O. Box 2360
Jacksonville, FL 32231-0018

Redetermination of overpayments

Overpayment Redetermination, Review Request
P.O Box 45248
Jacksonville, FL 32232-5248

Reconsiderations

C2C Innovative Solutions, Inc.
Part B QIC South Operations
ATTN: Administration Manager
PO Box 45300
Jacksonville, FL 32232-5300

General inquiries

General inquiry request
P.O. Box 2360
Jacksonville, FL 32231-0018

Email**:** *FloridaB@fcso.com*
Online form: *https://medicare.fcso.com/Feedback/161670.asp*

Provider enrollment

Provider Enrollment
P.O. Box 44021
Jacksonville, FL 32231-4021

Medical policy

Medical Policy and Procedure
P.O. Box 2078
Jacksonville, FL 32231-0048
Email: *medical.policy@fcso.com*

Medicare secondary payer

Medicare Part B Secondary Payer Dept.
P.O. Box 44078
Jacksonville, FL 32231-4078

Electronic data interchange (EDI)

Medicare EDI
P.O. Box 44071
Jacksonville, FL 32231-4071

Overpayments

Medicare Part B Debt Recovery
P.O. Box 44141
Jacksonville, FL 32231-4141

Medicare Education and Outreach

Medicare Education and Outreach
P.O. Box 45157
Jacksonville, FL 32232-5157

Fraud and abuse

Fraud and abuse complaints
P.O. Box 45087
Jacksonville, FL 32232-5087

Freedom of Information Act requests

FOIA Florida
P.O. Box 45268
Jacksonville, FL 32232-5268

Overnight mail and/or special courier service

First Coast Service Options Inc.
532 Riverside Avenue
Jacksonville, FL 32202-4914

Websites

Provider

First Coast Service Options Inc. (First Coast), your CMS-contracted Medicare administrative contractor
https://medicare.fcso.com

Find your *other contractors* (e.g. DME, HHA, etc)

Centers for Medicare & Medicaid Services
https://www.cms.gov

First Coast University
http://www.fcsouniversity.com/

Beneficiaries

Centers for Medicare & Medicaid Services
https://www.medicare.gov

Phone numbers

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866-454-9007
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877-660-1759 (TTY)

Fax number (for general inquiries)
904-361-0696

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877-847-4992

Provider enrollment
888-845-8614
877-660-1759 (TTY)

The SPOT help desk
855-416-4199
Email: *FCSOSPOTHelp@FCSO.com*

Addresses

Claims
Medicare Part B Claims
P.O. Box 45098
Jacksonville, FL 32232-5098

Redeterminations
Medicare Part B Redetermination
P.O. Box 45024
Jacksonville, FL 32232-5024

Redetermination of overpayments
First Coast Service Options Inc.
P.O Box 45091
Jacksonville, FL 32232-5091

Reconsiderations
C2C Innovative Solutions, Inc.
Part B QIC South Operations
ATTN: Administration Manager
PO Box 45300
Jacksonville, FL 32232-5300

General inquiries
First Coast Service Options Inc.
P.O. Box 45098
Jacksonville, FL 32232-5098

Email: *askFloridaB@fcso.com*
Online form: *https://medicare.fcso.com/Feedback/161670.asp*

Provider enrollment
Provider Enrollment
P.O. Box 44021
Jacksonville, FL 32231-4021

Medical policy
Medical Policy and Procedure
P.O. Box 2078
Jacksonville, FL 32231-0048
Email: *medical.policy@fcso.com*

Medicare secondary payer
Medicare Part B Secondary Payer Dept.
P.O. Box 44078
Jacksonville, FL 32231-4078

Electronic data interchange (EDI)
Medicare EDI, 4C
P.O. Box 44071
Jacksonville, FL 32231-4071

Overpayments
Medicare Part B Debt Recovery
P.O. Box 44141
Jacksonville, FL 32231-4141

Medicare Education and Outreach
Medicare Education and Outreach
P.O. Box 45157
Jacksonville, FL 32232-5157

Fraud and abuse
Fraud and abuse complaints
P.O. Box 45087
Jacksonville, FL 32232-5087

Freedom of Information Act requests
FOIA USVI
P.O. Box 45073
Jacksonville, FL 32231-5073

Special courier service
First Coast Service Options Inc.
532 Riverside Avenue
Jacksonville, FL 32202-4914

Websites

Provider
First Coast Service Options Inc. (First Coast), your CMS-contracted Medicare administrative contractor

https://medicare.fcso.com

Find your *other contractors* (e.g. DME, HHA, etc)

Centers for Medicare & Medicaid Services

https://www.cms.gov

First Coast University

http://www.fcsouniversity.com/

Beneficiaries
Centers for Medicare & Medicaid Services

https://www.medicare.gov

Phone numbers

Customer service

1-877-715-1921
1-888-216-8261 (speech and hearing impaired)

Education event registration hotline

904-791-8103 (NOT toll-free)
904-361-0407 (FAX)

Electronic data interchange (EDI)

888-875-9779

Electronic funds transfers (EFT) (CMS-588)

877-715-1921
877-660-1759 (TTY)

General inquiries

877-715-1921
888-216-8261 (TTY)

Interactive voice response (IVR) system

877-847-4992

Provider enrollment

877-715-1921
877-660-1759 (TTY)

The SPOT help desk

855-416-4199
email: *FCSOSPOTHelp@FCSO.com*

Addresses

Claims

Medicare Part B Claims
P.O. Box 45036
Jacksonville, FL 32232-5036

Redeterminations

Medicare Part B Redetermination
P.O. Box 45056
Jacksonville, FL 32232-5056

Redetermination of overpayments

First Coast Service Options Inc.
P.O Box 45015
Jacksonville, FL 32232-5015

Reconsiderations

C2C Innovative Solutions, Inc.
Part B QIC South Operations
ATTN: Administration Manager
PO Box 45300
Jacksonville, FL 32232-5300

General inquiries

First Coast Service Options Inc.
P.O. Box 45098
Jacksonville, FL 32232-5098

Email: *askFloridaB@fcso.com*
Online form: *https://medicare.fcso.com/Feedback/161670.asp*

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Jacksonville, FL 32231-4021

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Jacksonville, FL 32231-0048
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Jacksonville, FL 32231-4078

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Jacksonville, FL 32231-4071

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Medicare Part B Debt Recovery
P.O. Box 45040
Jacksonville, FL 32231-5040

Medicare Education and Outreach

Medicare Education and Outreach
P.O. Box 45157
Jacksonville, FL 32232-5157

Fraud and abuse

Fraud and abuse complaints
P.O. Box 45087
Jacksonville, FL 32232-5087

Freedom of Information Act requests

FOIA Puerto Rico
P.O. Box 45092
Jacksonville, FL 32232-5092,

Special courier service

First Coast Service Options Inc.
532 Riverside Avenue
Jacksonville, FL 32202-4914

Websites

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First Coast University
http://www.fcsouniversity.com/

Beneficiaries

Centers for Medicare & Medicaid Services
https://www.medicare.gov

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The following materials are available for purchase. To order these items, please complete and **submit this form along with your check/money order** payable to First Coast Service Options Inc. account # (use appropriate account number). Do not fax your order; it must be mailed.

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2017 fee schedule – The Medicare Part B Physician and Nonphysician Practitioner Fee Schedules, effective for services rendered January 1 through December 31, 2017, are available free of charge online at *https://medicare.fcso.com/Data_files/* (English) or *https://medicareespanol.fcso.com/Fichero_de_datos/* (Español). Additional copies are available for purchase. The fee schedules contain payment rates for all localities. These items do not include the payment rates for injectable drugs, clinical lab services, mammography screening, or DMEPOS items. **Note:** Requests for hard copy paper disclosures will be completed as soon as CMS provides the direction to do so. Revisions to fees may occur; these revisions will be published in future editions of the Medicare Part B publication.	40300270	$12		
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P.O. Box 2078 Jacksonville, FL. 32231-0048

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