Medicare B CONNECTION
medicare.fcso.com
FIRST COAST SERVICE OPTIONS, INC.
A Newsletter for MAC Jurisdiction N Providers
November 2017

In this issue

Ambulance inflation factor for 2018 and productivity adjustment

Provider type affected

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

Provider action needed

Change request (CR) 10323 furnishes the calendar year (CY) 2018 ambulance inflation factor (AIF) for determining the payment limit for ambulance services. The AIF for CY 2018 is 1.1 percent. Make sure that your billing staffs are aware of this change.

Background

CR 10323 furnishes the CY 2018 AIF for determining the payment limit for ambulance services required by Section 1834(l)(3)(B)) of the Social Security Act (the Act) which is available at *https://www.ssa.gov/OP_Home/ssact/title18/1834.htm*.

Section 1834(l)(3)(B) of the Act provides the basis for an update to the payment limits for ambulance services that is equal to the percentage increase in the consumer price index for all urban consumers (CPI-U) for the 12-month period ending with June of the previous year. Section 3401 of the Affordable Care Act amended Section 1834(l)(3)) of the Act to apply a productivity adjustment to this update equal to the 10-year moving average of changes in economy-wide private nonfarm business multi-factor productivity (MFP) beginning January 1, 2011. The resulting update percentage is referred to as the AIF.

The MFP for CY 2018 is 0.5 percent and the CPI-U for 2018 is 1.6 percent. According to the Affordable Care Act, the CPI-U is reduced by the MFP, even if this reduction

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Contents

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.

Publication staff:

Marielba Cancel
Terri Drury
Maria Murdoch
Mark Willett
Robert Petty

Fax comments about this publication to:

Medicare Publications
904-361-0723

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.

Consolidated Billing

Annual update of HCPCS codes used for home health consolidated billing enforcement

Provider type affected

This *MLN Matters*® article is intended for home health agencies (HHAs) and other providers submitting claims to Medicare administrative contractors (MACs) for services to Medicare beneficiaries in a home health period of coverage.

Provider action needed

Change request (CR) 10308 provides the 2018 annual update to the list of Healthcare Common Procedure Coding System (HCPCS) codes used by Medicare systems to enforce consolidated billing of home health services. Make sure your billing staffs are aware of these updates.

Background

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of HCPCS codes that are subject to the consolidated billing provision of the home health prospective payment system (HH PPS). With the exception of therapies performed by physicians, supplies incidental to physician services and supplies used in institutional settings, services appearing on this list that are submitted on claims to MACs will not be paid separately on dates when a beneficiary for whom such a service is being billed is in a home health episode (that is, under a home health plan of care administered by an HHA).

In such cases, Medicare will only directly reimburse the primary HHAs that have opened such episodes during the episode periods. Therapies performed by physicians, supplies incidental to physician services, and supplies used in institutional settings are not subject to HH consolidated billing.

The HH consolidated billing code lists are updated annually to reflect the yearly changes to the HCPCS code set itself. Additional updates may occur as frequently as quarterly in order to reflect the creation of temporary HCPCS codes (for example, "K" codes) throughout the calendar year. The new coding identified in each update describes the same services that were used to determine the applicable HH PPS payment rates. No additional services will be added by these updates. That is, new updates are required by changes to the coding system, not because the services subject to HH consolidated billing are being redefined.

Section 1842(b)(6) of the Social Security Act requires that payment for HH services provided under a HH plan of care is made to the HHA. This requirement is in Medicare regulations at 42 CFR 409.100 and in Medicare instructions in Chapter 10, Section 20 of the Medicare Claims Processing Manual.

The recurring updates in CR 10308 provide annual HH consolidated billing updates effective January 1, 2018. The following HCPCS codes are added to the HH consolidated billing therapy code list:

- 97763 – Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes
  - This code replaces 97762.
- G0515 – Development of cognitive skills to improve attention, memory, problem solving (includes

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results in a negative AIF update. Therefore, the AIF for CY 2018 is 1.1 percent.

Part B coinsurance and deductible requirements apply to payments under the ambulance fee schedule.

Additional information

The official instruction, CR 10323, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3893CP.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 27, 2017	Initial article released.

MLN Matters® Number: MM10323
Related CR Release Date: October 27, 2017
Related CR Transmittal Number: R3893CP
Related Change Request (CR) Number: CR 10323
Effective Date: January 1, 2018
Implementation Date: January 2, 2018

Laboratory/Pathology

New waived tests

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

Change request (CR) 10321 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 after approval, the Centers for Medicare & Medicaid Services (CMS) must notify its MACs of the new tests so they can accurately process claims. Make sure your billing staffs are aware of these updates.

Background

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

CR 10321 describes the latest tests approved by the FDA as waived tests under CLIA. The *Current Procedural Terminology* (CPT®) codes for the new tests must have the modifier QW to be recognized as a waived test. However, the tests mentioned on the first page of the list found in the attachment CR 10321 (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 include:

- 87807QW, June 30, 2017, Quidel Sofia 2 {Sofia RSV FIA}
- 82274QW, G0328QW, June 5, 2017, Henry Schein OneStep Pro+FIT (1)
- 80305QW, August 10, 2017, CLIAwaived Inc. Instant Drug Test Cup/Card II (IDTC II)
- 80305QW, September 5, 2017, Premier Biotech Inc., Premier UTox Cup
- 87804QW, September 7, 2017, McKesson Consult Influenza A & B {Nasal and Nasopharyngeal Swabs}
- 87804QW, September 8, 2017, PBM Princeton Biomedical Corp. ImmunoCard STAT! Flu A&B {Nasal and Nasopharyngeal Swabs}.

The attachment to CR 10321 contains the test name, manufacturer, and use for each of the above listed CPT® codes. You should be aware that MACs will not search their files to either retract payment or retroactively pay claims; however, they should adjust claims that you bring to their attention.

Additional information

The official instruction, CR 10321, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3902CP.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
November 3, 2017	Initial article released.

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compensatory training), direct (one-on-one) patient contact, each 15 minutes

- This code replaces 97532.

Additional information

The official instruction, CR 10308, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3877CP.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
November 13, 2017	Initial article released.

MLN Matters® Number: MM10308
Related CR Release Date: October 6, 2017
Related CR Transmittal Number: R3877CP
Related Change Request (CR) Number: 10308
Effective Date: January 1, 2018
Implementation Date: January 2, 2018

Preventive Services

Influenza vaccine payment allowances -annual update for 2017-2018 season

***Note**: This article was revised on November 3, 2017 to reflect an updated change request (CR). That CR changed the instruction to the MACs for searching files- see note at end of "Background" section. The CR release date, transmittal number and link to the transmittal also changed. All other information is unchanged. This information was previously published in the September 2017 Medicare B Connection, pages 14-15.*

Provider types affected

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

Provider action needed

Change request (CR) 10224 informs MACs about the payment allowances for seasonal influenza virus vaccines, which are updated on August 1 of each year. The Centers for Medicare & Medicaid Services (CMS) will post the payment allowances for influenza vaccines that are approved after the release of CR 10224 at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html*. Make sure your billing staffs are aware that the payment allowances are being updated.

Background

The Medicare Part B payment allowance limits for influenza and pneumococcal vaccines are 95 percent of the average wholesale price (AWP) as reflected in the published compendia except where the vaccine is furnished in a hospital outpatient department, rural health clinic (RHC), or federally qualified health center (FQHC). Where the vaccine is furnished in the hospital outpatient department, RHC, or FQHC, payment for the vaccine is based on reasonable cost.

The Medicare Part B payment allowances for the following *Current Procedural Terminology* (CPT®) or Healthcare Common Procedure Coding System (HCPCS) codes below apply for the effective dates of August 1, 2017-July 31, 2018:

- CPT® 90653 Payment allowance is $50.217.
- CPT® 90655 Payment allowance is pending.
- CPT® 90656 Payment allowance is $19.247.
- CPT® 90657 Payment allowance is pending.
- CPT® 90661 Payment allowance is pending.
- CPT® 90685 Payment allowance is $21.198.
- CPT® 90686 Payment allowance is $19.032.
- CPT® 90687 Payment allowance is $9.403.
- CPT® 90688 Payment allowance is $17.835.
- HCPCS Q2035 Payment allowance is $17.685.
- HCPCS Q2036 Payment allowance is pending.
- HCPCS Q2037 Payment allowance is $17.685.
- HCPCS Q2038 Payment allowance is pending.

Payment for the following CPT® or HCPCS codes may be made if your MAC determines its use is reasonable and necessary for the beneficiary, for the effective dates of August 1, 2017 -July 31, 2018:

- CPT® 90630 Payment allowance is $20.343.
- CPT® 90654 Payment allowance is pending.
- CPT® 90662 Payment allowance is $49.025.
- CPT® 90672 Payment allowance is pending.
- CPT® 90673 Payment allowance is $40.613.
- CPT® 90674 Payment allowance is $24.047.
- CPT® 90682 Payment allowance is $46.313. (new code)
- CPT® 90756 Payment allowance is $22.793. **Effective dates**: 1/1/2018-7/31/2018 (**Note**: Providers and Medicare administrative contractors shall use HCPCS Q2039 for dates of service from 8/1/2017 – 12/31/2017. See special note under HCPCS Q2039 for payment amounts for this product prior to 1/1/2018.)

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MLN Matters® Number: MM10321
Related CR Release Date: November 3, 2017
Related CR Transmittal Number: R3902CP
Related Change Request (CR) Number: 10321
Effective Date: January 1, 2018
Implementation Date: January 2, 2018

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- HCPCS Q2039 Flu vaccine adult - not otherwise classified. Payment allowance is to be determined by your MAC with effective dates of 8/1/2017 -7/31/2018.

  Special note: Until CPT® code 90756 is implemented on 1/1/2018, Q2039 shall 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 8/1/2017 -12/31/2017 is $22.793.

CMS will post payment limits for influenza vaccines that are approved after the release date of CR 10224 on the CMS Seasonal Influenza Vaccines Pricing webpage at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html* as information becomes available. Effective dates for these vaccines shall be the date of Food and Drug Administration (FDA) approval.

The payment allowances for pneumococcal vaccines are based on 95 percent of the AWP and are updated on a quarterly basis via the quarterly average sales price (ASP) drug pricing files.

Providers should note that:

- 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 annual Part B deductible and coinsurance amounts do not apply.

Note: MACs will reprocess any previously processed and paid claims for the current flu season, that were paid using influenza vaccine payment allowances other than the allowances published in the influenza vaccine pricing website for the 2017/2018 season that began August 1, 2017. MACs will initiate the mass adjustment process to reprocess claims by November 1, 2017. A MAC that requires more time to meet this deadline may contact their Contracting Officer's Representative (COR) for additional direction.

Additional information

The official instruction, CR 10224, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3908CP.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
November 3, 2017	The article was revised to reflect an updated change request (CR). That CR changed the instruction to the MACs for searching files- see note at end of *Background* section. The CR release date, transmittal number and link to the transmittal also changed.
November 2, 2017	This article was revised to add a reference to *MLN Matters*® article SE17026 which 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.)
August 18, 2017	Initial article released.

MLN Matters® Number: MM10224 *Revised*
Related CR Release Date: November 3, 2017
Related CR Transmittal Number: R3908CP
Related Change Request (CR) Number: CR 10224
Effective Date: August 1, 2017
Implementation Date: No later than October 2, 2017

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*.

Radiology

New positron emission tomography radiopharmaceutical/ tracer unclassified codes

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

Positron Emission Tomography (PET) is a nuclear medicine imaging study used to detect normal and abnormal tissues. All PET scan services are billed using PET or PET/ computed tomography (CT) *Current Procedural Terminology* (CPT®) codes 78459, 78491, 78492, 78608, and 78811 through 78816. Each of these CPT® codes always requires the use of a radiopharmaceutical code, also known as a tracer code. Therefore, an applicable tracer code, along with an applicable CPT® code, is necessary for claims processing of any PET scan services.

While there are a number of PET tracers already billable for a diverse number of medical indications, there have been, and may be in the future, additional PET indications that might require a new PET tracer. Under those circumstances, the process to request/approve/implement a new code could be time-intensive.

To help alleviate inordinate spans of time between when a coverage determination is made and when it can be fully implemented via valid claims processing, the Centers for Medicare & Medicaid Services (CMS) has created two new PET radiopharmaceutical unclassified tracer codes that can be used temporarily pending the creation/approval/ implementation of permanent CPT® codes that would later specifically define their function.

Effective January 1, 2017, with the January 2017 quarterly Healthcare Common Procedure Coding System (HCPCS) update, the two temporary PET HCPCS codes are:

- A9597 - Positron emission tomography radiopharmaceutical, diagnostic, for tumor identification, not otherwise classified
- A9598 - Positron emission tomography radiopharmaceutical, diagnostic, for non-tumor identification, not otherwise classified

Make sure that your billing staffs are aware of these changes.

Note: HCPCS codes A9597 and A9598 are **not** to be reported for any CMS-approved PET indication where a dedicated PET radiopharmaceutical is already assigned. In other words, HCPCS A9597 and A9598 are not replacements for currently approved PET radiopharmaceuticals A9515, A9526, A9552, A9555, A9580, A9586, A9587, or A9588.

Background

Effective with dates of service on or after January 1, 2018, the above two HCPCS codes shall be used ONLY AS NECESSARY FOR AN INTERIM PERIOD OF TIME under the circumstances explained below:

(1) After U.S. Food and Drug Administration (FDA) approval of a PET oncologic indication, or

(2) After CMS approves coverage of a new PET indication, **BUT**,

ONLY IF either of the above situations requires the use of a dedicated PET radiopharmaceutical/tracer that is currently non-existent.

Once permanent replacement codes are implemented via a subsequent CMS CR, that subsequent CR will also discontinue use of the temporary code for that PET particular indication.

Effective for claims with dates of service on and after January 1, 2018, MACs will ensure when PET tracer code A9597 or A9598 are present on a claim, that claim must also include:

- An appropriate PET HCPCS code, either 78459, 78491, 78492, 78608, 78811, 78812, 78813, 78814, 78815, or 78816
- If tumor-related, either the PI or PS modifier as appropriate
- If clinical trial-, registry-, or study-related outside of NCD 220.6.17 PET for solid tumors, clinical trial modifier Q0
- If Part A outpatient and study-related outside of NCD 220.6.17 PET for solid tumors, also include condition code 30 and ICD-10 diagnosis Z00.6
- If clinical trial-, registry-, or study-related, all claims require the eight-digit clinical trial number

Effective for claims with dates of service on and after

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Therapy Services

Therapy cap values for calendar year 2018

Provider type affected

This *MLN Matters*® article is intended for physicians, therapists, and other providers submitting claims to Medicare administrative contractors (MACs), including home health & hospice MACs, for outpatient therapy services provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 10341 provides the amounts for outpatient therapy caps for 2018. For physical therapy and speech-language pathology combined, the 2018 cap is $2,010. For occupational therapy, the 2018 cap is $2,010. Make sure that your billing staffs are aware of these therapy cap value updates.

Background

The Balanced Budget Act of 1997, P.L. 105-33, Section 4541(c) applies, per beneficiary, annual financial limitations on expenses considered incurred for outpatient therapy services under Medicare Part B, commonly referred to as "therapy caps." The therapy caps are updated each year based on the Medicare economic index.

Section 5107 of the Deficit Reduction Act of 2005 required an exceptions process to the therapy caps for reasonable and medically necessary services. The exceptions process for the therapy caps has been continuously extended several times through subsequent legislation. Most recently, Section 202 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) extended the therapy caps exceptions process through December 31, 2017.

Additional information

The official instruction, CR 10341, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3918CP.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
November 13, 2017	Initial article released.

MLN Matter® Number: MM10341
Related CR Release Date: November 9, 2017
Related CR Transmittal Number: R3918CP
Related Change Request (CR) Number: 10341
Effective Date: January 1, 2018
Implementation Date: January 2, 2018

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January 1, 2018, MACs for Part A shall line-item deny and MACs for Part B shall line-item reject, PET claims for A9597 or A9598 that do not include the above elements, as appropriate. When denying or rejecting line items, MACs will use the following remittance messages:

- Remittance advice remark code (RARC) N386
- Claim adjustment reason code (CARC) 50, 96, 16, and/or 119
- Group code CO (contractual obligation) assigning financial liability to the provider

MACs will not search for and adjust previously processed claims but will adjust such claims that you bring to their attention.

Additional information

The official instruction, CR 10319, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3911CP.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
November 16, 2017	Initial article released.

MLN Matters® Number: MM10319
Related CR Release Date: November 9, 2017
Related CR Transmittal Number: R3911CP
Related Change Request (CR) Number: 10319
Effective Date: January 1, 2018
Implementation Date: December 11, 2017 – MACs; April 2, 2018 - FISS, 2018

Revision of PWK (paperwork) fax/mail cover sheets

Provider type affected

This *MLN Matters*® article is intended for all physicians, providers, and suppliers who submit claims to Medicare administrative contractors (MACs), including durable medical equipment (DME) MACs, and home health and hospices (HH+H) MACs, for services provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 10124 alerts providers that their MAC will provide revised fax/mail cover sheets via hardcopy and/or electronic download. These revised documents are attached to CR 10124. There are three paperwork (PWK) attachments to CR 10124: (1) Medicare Part A fax/mail cover sheet (2) Medicare Part B fax/mail cover sheet and (3) Medicare DME MAC fax/mail cover sheet.

Background

CR 10124 revises the three PWK fax/mail cover sheets to remove health insurance claim number (HICN) from the forms and replace it with Medicare ID. HICN is being removed from the forms as part of the Medicare Access and CHIP Re-authorization Act (MACRA) of 2015, which requires removal of the Social Security number-based HICN from Medicare cards within four years of enactment. These fax/mail cover sheets are used so that providers are able to continue to submit electronic claims, which require additional documentation.

Additional information

The official instruction, CR 10124, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1974OTN.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
November 13, 2017	Initial article released.

MLN Matters® Number: MM10124
Related CR Release Date: November 9, 2017
Related CR Transmittal Number: R1974OTN
Related Change Request (CR) Number: 10124
Effective Date: April 1, 2018
Implementation Date: April 2, 2018

Remittance advice remark code, claims adjustment reason code, Medicare Remit Easy Print and PC Print updates

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) 10270 updates the remittance advice remark codes (RARC) and claims adjustment reason code (CARC) lists and instructs Medicare shared system maintainers (SSMs) to update Medicare Remit Easy Print (MREP) and PC Print. Be sure your staffs are aware of these changes and obtain the updated MREP and PC Print software if they use that software.

Background

The Health Insurance Portability and Accountability Act of 1986 (HIPAA) instructs health plans to be able to conduct standard electronic transactions adopted under HIPAA using valid standard codes. Medicare policy states that CARCs and RARCs, as appropriate, which provide either supplemental explanation for a monetary adjustment or policy information that generally applies to the monetary adjustment, are required in the remittance advice and coordination of benefits transactions.

The Centers for Medicare & Medicaid Services (CMS) instructs MACs to conduct updates based on the code update schedule that results in publication three times per year – around March 1, July 1, and November 1.

SSMs have the responsibility to implement code deactivation, making sure that any deactivated code is not used in original business messages and allowing the deactivated code in derivative messages. SSMs must make sure that Medicare does not report any deactivated code on or after the effective date for deactivation as posted on the Washington Publishing Company (WPC) website. If any new or modified code has an effective date later than the implementation date specified in CR 10270, MACs must implement on the date specified on the WPC website, available at: *http://wpc-edi.com/Reference/*.

A discrepancy between the dates may arise as the WPC website is only updated three times per year and may not match the CMS release schedule.

Additional information

The official instruction, CR 10270, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3910CP.pdf*.

See **RARC**, next page

Claim status category codes and claim status codes update

Provider type affected

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

Provider action needed

Change request (CR) 10271 informs MACs about system changes to update, as needed, the claim status codes and claim status category codes used for the Accredited Standards Committee (ASC) X12 276/277 health care claim status request and response and ASC X12 277 health care claim acknowledgment transactions. Make sure your billing staffs are aware of these changes.

Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all covered entities to use only claim status category codes and claim status codes approved by the National Code Maintenance Committee in the ASC X12 276/277 health care claim status request and response transaction standards adopted under HIPAA for electronically submitting health care claims status requests and responses. These codes explain the status of submitted claim(s). Proprietary codes may not be used in the ASC X12 276/277 transactions to report claim status.

The National Code Maintenance Committee meets at the beginning of each ASC X12 trimester meeting (January/February, June, and September/October) and makes decisions about additions, modifications, and retirement of existing codes. The National Code Maintenance Committee has decided to allow the industry six months for implementation of newly added or changed codes.

The codes sets are available at *https://www.wpc-edi.com/reference/codelists/healthcare/claim-status-category-codes/* and *https://www.wpc-edi.com/reference/codelists/healthcare/claim-status-codes/*.

Included in the code lists are specific details, including the date when a code was added, changed, or deleted. All code changes approved during the January 2018 committee meeting will be posted on these sites on or about February 1, 2018.

The Centers for Medicare & Medicaid Services (CMS) will issue notifications regarding the need for future updates to these codes. When instructed, MACs must update their claims systems to ensure that the current version of these codes is used in their claim status responses. MAC and shared systems changes will be made as necessary as part of a routine release to reflect applicable changes such as retirement of previously used codes or newly created codes.

These code changes are to be used in editing of all ASC X12 276 transactions processed on or after the date of implementation and to be reflected in the ASC X12 277 transactions issued on and after the date of implementation of change request (CR) 10271.

Note: References in CR 10271 to "277 responses" and "claim status responses" encompass both the ASC X12 277 health care claim status request and response and ASC X12 277 health care claim acknowledgment transactions.

Additional information

The official instruction, CR 10271, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3916CP.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
November 13, 2017	Initial article released.

MLN Matters® Number: MM10271
Related CR Release Date: November 9, 2017
Related CR Transmittal Number: R3916CP
Related Change Request (CR) Number: 10271
Effective Date: April 1, 2018
Implementation Date: April 2, 2018

RARC

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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
November 13, 2017	Initial article released.

MLN Matters® Number: MM10270
Related CR Release Date: November 9, 2017
Related CR Transmittal Number: R3910CP
Related Change Request (CR) Number: 10270
Effective Date: April 1, 2018
Implementation Date: April 2, 2018

CORE 360 uniform use of CARC, RARC and CAGC rule

Provider type affected

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

Provider action needed

Change request (CR) 10268 instructs MACs and shared system maintainers (SSMs) to update systems based on the CORE 360 uniform use of claims adjustment reason codes (CARC), remittance advice remark codes (RARC), and claim adjustment group code (CAGC) rule publication. These system updates are based on the Committee on operating rules for information exchange (CORE) code combination list to be published on or about February 1, 2018. Make sure that your billing staff is aware of these changes.

Background

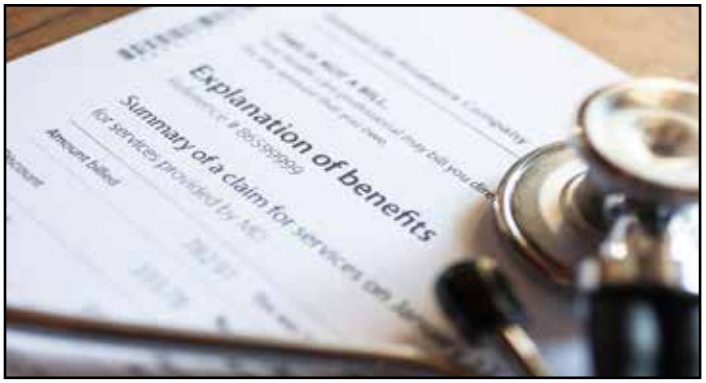
The Department of Health and Human Services (DHHS) adopted the Phase III Council for Affordable Quality Healthcare (CAQH) CORE, EFT, and ERA operating rule set that was implemented January 1, 2014, under the Affordable Care Act.

The Health Insurance Portability and Accountability Act (HIPAA) amended the Social Security Act by adding Part C—Administrative Simplification—to Title XI, requiring the Secretary of DHHS to adopt standards for certain transactions to enable health information to be exchanged more efficiently and to achieve greater uniformity in the transmission of health information.

The Centers for Medicare & Medicaid Services (CMS) instructs MACs to conduct updates based on the code update schedule that results in publication three times per year – around March 1, July 1, and November 1. CR10268 deals with the regular update in CAQH CORE defined code combinations per Operating Rule 360 - Uniform Use of CARC and RARC (835) Rule.

CAQH CORE will publish the next version of the code combination list on or about February 1, 2018. This update is based on the CARC and RARC updates as posted at the Washington Publishing Company (WPC) website on or about November 1, 2017. This will also include updates based on market-based review that CAQH CORE conducts once a year to accommodate code combinations that are currently being used by health plans including Medicare as the industry needs them. You can find CARC and RARC updates at *https://www.wpc-edi.com/reference* and CAQH CORE defined code combination updates at *https://www.caqh.org/CORECodeCombinations.php*.

A discrepancy between the dates may arise as the WPC website is only updated three times per year and may not match the CMS release schedule. For CR 10268, the MACs and the SSMs must get the complete list for both



CARCs and RARCs from the WPC website to obtain the comprehensive lists for both code sets and determine the changes included on the code list since the last code update CR (CR 10140).

Per the Affordable Care Act mandate, all health plans including Medicare must comply with CORE 360 Uniform Use of CARCs and RARCs (835) rule or CORE developed maximum set of CARC/RARC and CAGC combinations for a minimum set of four business scenarios. Medicare can use any code combination if the business scenario is not one of the four CORE-defined business scenarios. With the four CORE-defined business scenarios, Medicare must use the code combinations from the lists published by CAQH CORE.

Additional information

The official instruction, CR 10268, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3915CP.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
November 13, 2017	Initial article released.

MLN Matters® Number: MM10268
Related CR Release Date: November 9, 2017
Related CR Transmittal Number: R3915CP
Related Change Request (CR) Number: 10268
Effective Date: April 1, 2018
Implementation Date: April 2, 2018

Accepting payment from patients with a Medicare set-aside arrangement

***Note**: This article was reissued November 8 to clarify information. The title of the article was also changed to better reflect the information. This information was previously published in the October 2017 Medicare B Connection, page 19.*

Provider type affected

This *MLN Matters*® article is intended for providers, physicians, and other suppliers who are told by patients that they must pay the bill themselves because they have a Medicare set-aside arrangement (MSA).

What you need to know

This article is based on information received from Medicare beneficiaries, their legal counsel, and other entities that assist these individuals, indicating that physicians, providers, and other suppliers are often reluctant to accept payment directly from Medicare beneficiaries who state they have a MSA and must pay for their services themselves. This article explains what a MSA is and explains why it is appropriate to accept payment from a patient that has a funded MSA.

Please review your billing practices to be sure they are in line with the information provided.

Background

Medicare is always a secondary payer to liability insurance (including self-insurance), no-fault insurance, and workers' compensation benefits. The law precludes Medicare payment for services to the extent that payment has been made, or can reasonably be expected to be made promptly. When future medical care is claimed, or a settlement, judgment, award, or other payment releases (or has the effect of releasing) claims for future medical care, it can reasonably be expected that the monies from the settlement, judgment, award, or other payment are available to pay for future medical items and services which are otherwise covered and reimbursable by Medicare.

Medicare should not be billed for future medical services until those funds are exhausted by payments to providers for services that would otherwise be covered and reimbursable by Medicare.

A MSA is a financial arrangement that allocates a portion of a settlement, judgment, award, or other payment to pay for future medical services. The law mandates protection of the Medicare trust funds but does not mandate a MSA as the vehicle used for that purpose. MSAs are the most frequently used formal method of preserving those funds for the Medicare beneficiary to pay for future items or services which are otherwise covered and reimbursable by Medicare and which are related to what was claimed or the settlement, judgment, award, or other payment had the effect of releasing. These funds must be exhausted before Medicare will pay for treatment related to the claimed injury, illness, or disease.

Medicare beneficiaries are advised that before receiving treatment for services to be paid by their MSA, they should advise their health care provider about the existence of the MSA. They are also notified that their health care providers should bill them directly, and that they should pay those charges out of the MSA **if**:

- The treatment or prescription is related to what was claimed or the settlement, judgment, award, or other payment had the effect of releasing AND
- The treatment or prescription is something Medicare would cover.

The obligation to protect the Medicare trust funds exists regardless of whether or not there is a formal CMS approved MSA amount. A Medicare beneficiary may or may not have documentation they can provide the physician, provider, or supplier from Medicare approving a Medicare set-aside amount.

Provider action needed

Where a patient who is a Medicare beneficiary states that he/she is required to use funds from the settlement, judgment, award, or other payment to pay for the items or services related to what was claimed or which the settlement, judgment, award, or other payment, it is appropriate for you to document your records with that information and accept payment directly from the patient for such services.

Additional information

If you have any questions, please contact your Medicare administrative contractor (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
November 8, 2017	The article was reissued to clarify information in the initial release. The title of the article was also changed to better reflect the information.
October 3, 2017	Rescinded
September 19, 2017	Initial article released.

MLN Matters® Number: SE17019 *Reissued*
Article Release Date: November 8, 2017
Related CR Transmittal Number: N/A
Related Change Request (CR) Number: N/A
Effective Date: N/A
Implementation Date: N/A

Qualified Medicare beneficiary indicator in the Medicare fee-for-service claim processing system

Note: *The article was revised November 16 to reflect a revised change request (CR) 9911 issued November 15. In the article, the CR release date, transmittal number, and the web address of CR 9911 are revised. All other information remains the same.* *August 2017 Medicare B Connection, pages 24-26*.

Provider type affected

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

Provider action needed

CR 9911 modifies the Medicare claim processing systems to help providers more readily identify the QMB status of each patient and to support providers' ability to follow QMB billing requirements. Beneficiaries enrolled in the QMB program are not liable to pay Medicare cost-sharing for all Medicare A/B claims. CR 9911 adds an indicator of QMB status to Medicare's claims processing systems. This system enhancement will trigger notifications to providers (through the provider remittance advice) and to beneficiaries (through the Medicare summary notice) to reflect that the beneficiary is enrolled in the QMB program and has no Medicare cost-sharing liability. Make sure that your billing staffs are aware of these changes.

Background

QMB is a Medicaid program that assists low-income beneficiaries with Medicare premiums and cost-sharing. In 2015, 7.2 million persons (more than one out of every ten Medicare beneficiaries) were enrolled in the QMB program.

Federal law bars Medicare providers from billing a QMB individual for Medicare Part A and B deductibles, coinsurance, or copayments, under any circumstances. Sections 1902(n)(3)(B); 1902(n)(3)(C); 1905(p)(3); 1866(a)(1)(A); 1848(g)(3)(A) of the Social Security Act. State Medicaid programs may pay providers for Medicare deductibles, coinsurance, and copayments. However, as permitted by federal law, states can limit provider payment for Medicare cost-sharing, under certain circumstances. Regardless, QMB individuals have no legal liability to pay Medicare providers for Medicare Part A or Part B cost-sharing. Providers may seek reimbursement for unpaid Medicare deductible and coinsurance amounts as a Medicare bad debt related to dual eligible beneficiaries under CMS Pub. 15-1, Chapter 3 of the *Provider Reimbursement Manual (PRM)*.

CR 9911 aims to support Medicare providers' ability to meet these requirements by modifying the Medicare claims processing system to clearly identify the QMB status of all Medicare patients. Currently, neither the Medicare eligibility systems (the HIPAA eligibility transaction system (HETS)), nor the claim processing systems (the fee-for-service (FFS) shared systems), notify providers about their patient's QMB status and lack of Medicare cost-sharing liability. Similarly, Medicare summary notices (MSNs) do not inform those enrolled in the QMB program that they do not owe Medicare cost-sharing for covered medical items and services.

CR 9911 includes modifications to the FFS claims processing systems and the *Medicare Claims Processing Manual* to generate notifications to Medicare providers and beneficiaries regarding beneficiary QMB status and lack of liability for cost-sharing.

With the implementation of CR 9911, Medicare's common working file (CWF) will obtain QMB indicators so the claim processing systems will have access to this information.

- CWF will provide the claim processing systems the QMB indicators if the dates of service coincide with a QMB coverage period (one of the occurrences) for the following claim types: Part B professional claims; durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) claims; and outpatient institutional types of bill (TOB) 012x, 013x, 014x, 022x, 023x, 034x, 071x, 072x, 074x, 075x, 076x, 077x, and 085x); home health claims (TOB 032x) only if the revenue code for the line item is 0274, 029x, or 060x; and skilled nursing facility (SNF) claims (based on occurrence code 50 date for revenue code 0022 lines on TOBs 018x and 021x).
- CWF will provide the claim processing systems the QMB indicator if the "through date" falls within a QMB coverage period (one of the occurrences) for inpatient hospital claims (TOB 011x) and religious non-medical health care institution claims (TOB 041x).

The QMB indicators will initiate new messages on the remittance advice that reflect the beneficiary's QMB status and lack of liability for Medicare cost-sharing with three new remittance advice remark codes (RARC) that are specific to those enrolled in QMB. As appropriate, one or more of the following new codes will be returned:

- N781 – No deductible may be collected as patient is a Medicaid/Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance, deductible or co-payments.
- N782 – No coinsurance may be collected as patient is a Medicaid/Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance, deductible or co-payments.
- N783 – No co-payment may be collected as patient is a Medicaid/Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance, deductible or co-payments.

In addition, the MACs will include a claim adjustment reason code of 209 ("Per regulatory or other agreement.

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The provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected. (Use only with group code OA (other adjustment)).

Finally, CR 9911 will modify the MSN to inform beneficiaries if they are enrolled in QMB and cannot be billed for Medicare cost-sharing for covered items and services.

Additional information

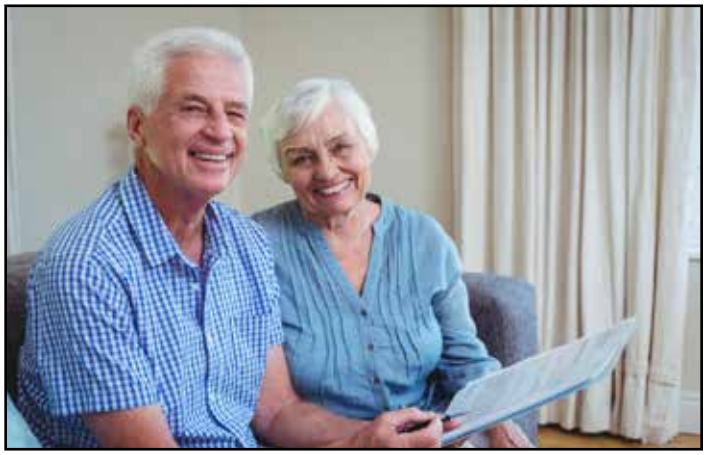
The official instruction, CR 9911, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3920CP.pdf*.

For more information regarding billing rules applicable to individuals enrolled in the QMB Program, see the *MLN Matters*® article, SE1128, at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se1128.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
November 16, 2017	The article was revised November 16 to reflect a revised change request (CR) 9911 issued November 15. In the article, the CR release date, transmittal number, and the web address of CR 9911 are revised. All other information remains the same.
July 24, 2017	The article was revised to add links to related *MLN Matters*® articles. *SE1128* reminds all Medicare providers that they may not bill beneficiaries enrolled in the QMB program for Medicare cost-sharing. *MM9817* states that CR 9817 instructs MACs to issue a compliance letter instructing named providers and suppliers to refund any erroneous charges and recall any past or existing billing with regard to improper QMB billing



Date of change	Description
June 29, 2017	The article was revised to reflect a revised CR 9911 issued June 28, 2017. In the article, the CR release date, transmittal number, and the web address of CR 9911 are revised. Clarifications were also made to the second paragraph of the *Background* section.
May 1, 2017	The article was revised to reflect a revised CR 9911 issued April 28, 2017. In the article, the CR release date, transmittal number, and the web address of CR 9911 are revised.
February 3, 2017	Initial article released

MLN Matters® Number: MM9911 *Revised*
Related CR Release Date: November 15, 2017
Related CR Transmittal Number: R3920CP
Related Change Request (CR) Number: CR 9911
Effective Date: For claims processed on or after October 2, 2017
Implementation Date: October 2, 2017

Prohibition on billing dually eligible individuals enrolled in the QMB program

***Note**: The article was revised to show the HIPAA eligibility transaction system (HETS) qualified Medicare beneficiary (QMB) release will be in November 2017. Previously, the 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. All other information remains the same. This information was previously published in the October 2017 Medicare B Connection, pages 19-22.*

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' 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) 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

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

- Establish processes to routinely identify the QMB status of your Medicare patients prior to billing for items and services.

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- Beginning in November 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, visit *https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/index.html*.
- Original Medicare providers and suppliers can readily identify the QMB status of patients and billing prohibitions on the Medicare provider RA, which will contain new notifications and information about a patient's QMB status for Part A and B claims processed on or after October 2, 2017. 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 QMB status of plan members.

- Providers and suppliers may also verify patient's QMB status through state online Medicaid eligibility systems or by asking patients for other proof such as their Medicaid identification card or a copy of their Medicare summary notice, the quarterly summary of claims sent to original Medicare beneficiaries that reflects, among other things, the patients' QMB status for Part A and B claims processed on or after October 2, 2017. 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 individuals enrolled in the QMB program, recall the charges (including referrals to collection agencies) and refund the invalid charges they paid.
- 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 19)

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
November 3, 2017	Article revised to show the HETS QMB release will be in November 2017. All other information remains the same.
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.

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from previous page

Date of change	Description
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 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.
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: November 3, 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*.

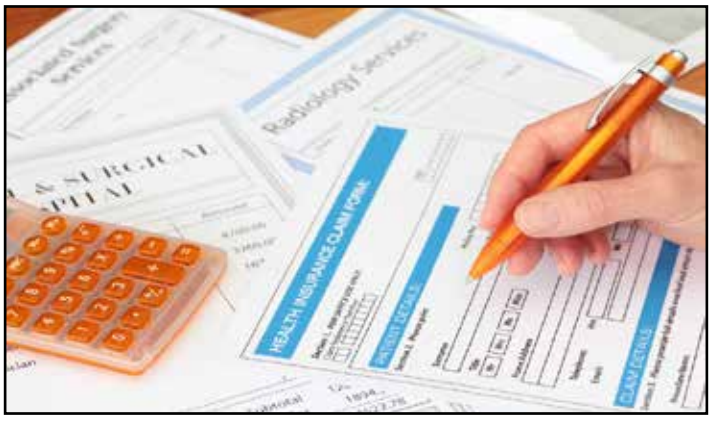
Important instructions for paper claim form CMS-1500 (version 02/12)

First Coast Service Options (First Coast) has noticed a reoccurring issue for several claims when they go through the optical character recognition (OCR) process. To avoid these issues, we wanted to reiterate some important instructions for our paper claim submitters:

- All paper claims are required to be submitted using an original red/white CMS-1500 (02/12) form. Black and white copies will be **returned as unprocessable**.
- When completing the claim form, ensure to use all **capital typeface**. This is especially important when indicating letter "I" and "L" in Item 24E.
- Claims submitted with a national provider identifier (NPI) and without one of the *Item 17 qualifiers* or an invalid qualifier will be **returned as an unprocessable claim (RUC)**.

ASCA reminder

Only providers that meet the Administrative Simplification Compliance Act (ASCA) exception requirements are permitted to submit their claims to Medicare on paper, which must be submitted on a valid CMS-1500 claim



form. Providers meeting these exceptions are permitted to submit their claims to Medicare on paper.

More information about ASCA exceptions can be found in Chapter 24 of the *Medicare Claims Processing Manual*.

***Source**: CMS internet-only manual (IOM) Pub. 100-04 Medicare Claims Processing Manual, Chapter 24, section 20.4; Chapter 26; Change request (CR) 8509; NUCC website*

Medicare establishes two new MSP set-aside arrangements

***Note**: This article was rescinded. This information was previously published in the June 2017 Medicare B Connection, pages 28-29.*

MLN Matters® Number: MM9893 *Rescinded*
Related Change Request (CR) #: CR 9893
Related CR Release Date: N/A
Effective Date: October 1, 2017
Related CR Transmittal #: N/A

Implementation Date: October 2, 2017

Disclaimer: This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT® only copyright 2016 American Medical Association.

Amount in controversy updates for 2018

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) provides for annual reevaluation of the dollar amount in controversy (AIC) required for an administrative law judge (ALJ) hearing (third level review) and federal district court review (fifth level review).

For requests made on or after January 1, 2018:

- The amount that must remain in controversy for ALJ hearing requests will remain at $160.
- The amount that must remain in controversy for federal district court review is increased to $1,600.

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.

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*.

Retired LCDs

Corticotropin – retired Part B LCD

LCD ID number: L33811 (Florida, Puerto Rico/ U.S. Virgin Islands)

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

Effective date

The retirement of this LCD is effective for services rendered **on or after November 16, 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, *click here*.

Creatine Kinase (CK), (CPK) – retired Part A and Part B LCD

LCD ID number: L34042 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on an annual review of the Creatine Kinase local coverage determination (LCD), it was determined that this LCD is no longer required and, therefore, is being retired.

Effective date

The retirement of this LCD is effective for services rendered **on or after November 9, 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, *click here*.

Multiple Part B local coverage determinations (LCDs) being retired

LCD ID number: L33920, L33819 (Florida, Puerto Rico/U.S. Virgin Islands)

Based on an annual review and data analysis review of the following local coverage determinations (LCDs), it was determined that these LCDs are no longer required and, therefore, are being retired.

- L33920 – Mastoidectomy cavity debridement
- L33819 – External ocular photography

Effective date

The retirement of these LCDs is effective for services rendered **on or after November 9, 2017.** 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*.

Multiple Part A and Part B local coverage determinations (LCDs) being retired

Based on an annual review and data analysis review of the following local coverage determinations (LCDs), it was determined that these LCDs are no longer required and, therefore, are being retired.

- L34019 – Rho (D) Immune Globulin Intravenous
- L34015 – Mitomycin (Mutamycin, Mitomycin-C)

Effective date

The retirement of these LCDs is effective for services rendered **on or after November 9, 2017.** 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, please *click here*.

Revisions to LCD

Cardiology— non-emergent outpatient testing: exercise stress test, stress echo, MPI SPECT, and cardiac PET – revision to the Part A and B LCD

LCD ID number: L36209 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on a reconsideration request, the cardiology – nonemergent outpatient testing: exercise stress test, stress echo, MPI SPECT, and cardiac PET local coverage determination was revised. Language added to the National Coverage Determination (NCD) for PET for Perfusion of the Heart (220.6.1) indication when PET scan (whether at rest alone or rest with stress) is performed in place of, but not in addition to, SPECT was removed. In addition, italics were removed from language italicized in error.

Effective date

This LCD revision is effective for services rendered **on or after December 9, 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, *click here*.

Noncovered services – revision to the Part A and Part B LCD

LCD ID number: L33777 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on a local coverage determination (LCD) reconsideration request, the LCD for Noncovered services was revised to remove *Current Procedural Terminology* (CPT®) code 84145 [Procalcitonin (PCT)] under the "CPT®/ HCPCS Codes" section of the LCD under the subtitle "Procedures for Part A and Part B".

Effective date

The LCD revision is effective for services rendered **on or after November 13, 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, *click here*.

Upper eyelid and brow surgical procedures – revision to the Part A and Part B LCD

LCD ID number: L34028 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on change requests (CRs) 9658, 9668, 10236 and 10259, the "CMS National Coverage Policy" section of the upper eyelid and brow surgical procedures local coverage determination (LCD) was updated. In addition, an associated coding article was developed to include clarifying language related to upper eyelid blepharoplasty and blepharoptosis repair from the above CRs.

Effective date

The LCD revision is effective for services rendered **on or after October 1, 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*.

Upcoming provider outreach and educational events

Topic: Medicare Part B changes and regulations

Date: Wednesday, December 13
Time: 11:30 a.m.-1:00 p.m.
Type of Event: Webcast
https://medicare.fcso.com/Events/0393452.asp

Topic: Targeted Probe and Educate: Reducing provider burden

Date: Thursday, December 14
Time: 10:30-noon
Type of Event: Webcast
https://medicare.fcso.com/Events/0393648.asp

Note: Unless otherwise indicated, designated times for educational events are stated as ET, and the focus is to Florida, Puerto Rico, and the U.S. Virgin Islands.

Two easy ways to register

Online – Visit our provider training website at *https://gm1.geolearning.com/geonext/fcso/opensite.geo*, log on to your account and select the course you wish to register. Class materials are available under "My Courses" no later than one day before the event**.**

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

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

Please Note:

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

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Provider Address: _____

City, State, ZIP Code: _____

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

Never miss a training opportunity

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

Take advantage of 24-hour access to free online training

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

CMS MLN Connects®

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

MLN Connects® for October 26, 2017

MLN Connects® for October 26, 2017
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News & Announcements

- New Medicare Numbers/Cards: Coordination of Benefits
- Hospice QRP: Register for HEART Pilot Study by October 31
- MIPS: Participate in Field Testing of Episode-Based Cost Measures by November 15
- Physician Compare Preview Period Closes November 17

Provider Compliance

- Reporting Changes in Ownership — Reminder

Upcoming Events

- Definition of a Hospital: Primarily Engaged Requirement Call — November 2
- Preventive Care and Health Screenings for Persons with Disabilities Webinar — November 2
- SNF Value-Based Purchasing Program FY 2018 Final Rule Call — November 16
- Comparative Billing Report on Emergency Department Services Webinar — December 13

Medicare Learning Network Publications & Multimedia

- Quality Payment Program in 2017: MIPS APMs Web-Based Training Course —New

- HHA Star Rating Call: Audio Recording and Transcript — New
- Prohibition on Billing Dually Eligible Individuals Enrolled in the QMB Program *MLN Matters*® article — Revised
- General Equivalence Mappings FAQs Booklet — Revised
- Medicare Fraud & Abuse: Prevention, Detection, and Reporting Web-Based Training Course — Reminder

Find out first: Subscribe to First Coast *eNews*

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

MLN Connects® for November 2, 2017

MLN Connects® for November 2, 2017
View this edition as a PDF

News & Announcements

- ESRD PPS: Updates to Policies and Payment Rates
- New Medicare Card: Provider Ombudsman Announced
- IRF and LTCH Quality Reporting Programs Submission Deadline: November 15
- Physician Compare Preview Period Extended to December 1
- Hospitals: Take Action before Meaningful Use Attestation Beginning January 2
- SNF Quality Reporting Program Submission Deadline Extended to May 15
- eCQM Value Set Addendum: Updated Technical Release Notes
- Administrative Simplification Enforcement and Testing Tool
- Antipsychotic Drug use in Nursing Homes: Trend Update
- CMS Offers Medicare Enrollment Relief for Americans Affected by Recent Disasters
- November is Home Care and Hospice Month

Provider Compliance

- Advanced Life Support Ambulance Services: Insufficient Documentation — Reminder

Claims, Pricers, & Codes

- Outpatient Claims: Correcting Deductible and Coinsurance for Code G0473

Upcoming Events

- SNF Value-Based Purchasing Program FY 2018 Final Rule Call — November 16

Medicare Learning Network Publications & Multimedia

- QRUR Webcast: Audio Recording and Transcript — New
- ICD-10-CM/PCS the Next Generation of Coding Booklet — Revised
- Diagnosis Coding: Using the ICD-10-CM Web-Based Training Course — Reminder
- Medicare Home Health Benefit Web-Based Training Course — Reminder
- Dual Eligible Beneficiaries under Medicare and Medicaid Booklet — Reminder
- Resources for Medicare Beneficiaries Booklet — Reminder
- Medicare Ambulance Transports Booklet — Reminder
- SNF Billing Reference Booklet — Reminder
- Items and Services Not Covered under Medicare Booklet — Reminder
- Guidelines for Teaching Physicians, Interns, and Residents Fact Sheet — Reminder

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.

MLN Connects® Special Edition – November 2, 2017

In This Edition:

- Physician Fee Schedule Final Policy, Payment, and Quality Provisions for CY 2018
- Hospital OPPS and ASC Payment System and Quality Reporting Programs Changes for 2018
- HHAs: Payment Changes for 2018
- Quality Payment Program Rule for Year 2

Physician Fee Schedule Final Policy, Payment, and Quality Provisions for CY 2018

On November 2, CMS issued a final rule that includes updates to payment policies, payment rates, and quality provisions for services furnished under the Medicare Physician Fee Schedule (PFS) on or after January 1, 2018.

The overall update to payments under the PFS based on the finalized CY 2018 rates will be +0.41 percent. This update reflects the +0.50 percent update established under the Medicare Access and CHIP Reauthorization Act of 2015, reduced by 0.09 percent, due to the misvalued code target recapture amount, required under the Achieving a Better Life Experience Act of 2014. After applying these adjustments, and the budget neutrality adjustment to account for changes in Relative Value Units, all required by law, the final 2018 PFS conversion factor is $35.99, an increase to the 2017 PFS conversion factor of $35.89.

The Final Rule Includes:

- Patients over Paperwork Initiative
- Changes in valuation for specific services
- Payment rates for nonexcepted off-campus provider-based hospital departments
- Medicare telehealth services
- Malpractice relative value units
- Care management services
- Improvement of payment rates for office-based behavioral health services
- Evaluation and management comment solicitation
- Emergency department visits comment solicitation
- Solicitation of public comments on initial data collection and reporting periods for Clinical Laboratory Fee Schedule
- Part B drugs: Payment for biosimilar biological products
- Part B drug payment: Infusion drugs furnished through an item of durable medical equipment
- New care coordination services and payment for rural health clinics and federally-qualified health centers
- Appropriate use criteria for advanced diagnostic imaging
- Medicare Diabetes Prevention Program expanded model
- Physician Quality Reporting System
- Patient relationship codes
- Medicare Shared Savings Program
- 2018 Value Modifier

For More Information:

- *Final Rule*
- *Press Release*: CMS Finalizes Policies that Reduce Provider Burden, Lower Drug Prices
- See the full text of this excerpted *CMS Fact Sheet* (issued November 2).

Hospital OPPS and ASC Payment System and Quality Reporting Programs Changes for 2018

On November 1, CMS issued the CY 2018 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System final rule with comment period, which includes updates to the 2018 rates and quality provisions and other policy changes. CMS adopted a number of policies that will support care delivery; reduce burdens for health care providers, especially in rural areas; lower beneficiary out of pocket drug costs for certain drugs; enhance the patient-doctor relationship; and promote flexibility in healthcare.

CMS is increasing the OPPS payment rates by 1.35 percent for 2018. The change is based on the hospital market basket increase of 2.7 percent minus both a 0.6 percentage point adjustment for multi-factor productivity and a 0.75 percentage point adjustment required by law. After considering all other policy changes under the final rule, including estimated spending for pass-through payments, CMS estimates an overall impact of 1.4 percent payment increase for providers paid under the OPPS in CY 2018.

CMS updates ASC payments annually by the percentage increase in the Consumer Price Index for all urban consumers (CPI-U). The Medicare statute specifies a Multi-Factor Productivity (MFP) adjustment to the ASC annual update. For CY 2018, the CPI-U update is 1.7 percent. The MFP adjustment is 0.5 percent, resulting in a CY 2018 MFP-adjusted CPI-U update factor of 1.2 percent. Including enrollment, case-mix, and utilization changes, total ASC payments are projected to increase approximately 3 percent in 2018.

The Final Rule Includes:

- Patients over Paperwork Initiative
- Payment for drugs and biologicals purchased through the 340B drug pricing program
- Supervision of hospital outpatient therapeutic services
- Packaging of low-cost drug administration services
- Inpatient only list
- High cost/low cost threshold for packaged skin substitutes
- Revisions to the laboratory date of service policy

See **SPECIAL**, next page

SPECIAL

previous page

- Partial Hospitalization Program rate setting
- Comment solicitation on ASC payment reform
- ASC covered procedures list
- Hospital Outpatient Quality Reporting Program
- Ambulatory Surgical Center Quality Reporting Program

For More Information:

- *Final Rule*
- *Press Release*: CMS Finalizes Policies that Lower Out-of-Pocket Drug Costs and Increase Access to High-Quality Care

See the full text of this excerpted *CMS Fact Sheet* (issued November 1).

HHAs: Payment Changes for 2018

On November 1, CMS issued a final rule that updates the CY 2018 Medicare payment rates and the wage index for Home Health Agencies (HHAs) serving Medicare beneficiaries. The rule also finalizes proposals for the Home Health Value-Based Purchasing Model and the Home Health Quality Reporting Program.

CMS projects that Medicare payments to HHAs in CY 2018 will be reduced by 0.4 percent, or $80 million, based on the finalized policies. This decrease reflects the effects of a one percent home health payment update percentage ($190 million increase); a -0.97 percent adjustment to the national, standardized 60-day episode payment rate to account for nominal case-mix growth for an impact of -0.9 percent ($170 million decrease); and the sunset of the rural add-on provision ($100 million decrease).

The Final Rule Includes:

- Patients over Paperwork Initiative
- Annual home health payment update percentage
- Adjustment to reflect nominal case-mix growth
- Sunset of the rural add-on provision

For More Information:

- *Final Rule*
- *Press Release*

See the full text of this excerpted *CMS Fact Sheet* (issued November 1).

Quality Payment Program Rule for Year 2

On November 2, CMS issued the final rule with comment for the second year of the Quality Payment Program (CY 2018), as required by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), as well as an interim final rule with comment. We finalized policies for Year 2 of the Quality Payment Program to further reduce your burden and give you more ways to participate successfully. We are keeping many of our transition year policies and making some minor changes.

The final rule Includes:

- Weighting the Merit-based Incentive Payment System (MIPS) Cost performance category to 10 percent of your total MIPS final score, and the Quality performance category to 50 percent
- Raising the MIPS performance threshold to 15 points in Year 2
- Allowing the use of 2014 Edition and/or 2015 Certified Electronic Health Record Technology (CEHRT) in Year 2 for the Advancing Care Information performance category, and giving a bonus for using only 2015 CEHRT
- Awarding up to 5 bonus points on your MIPS final score for treatment of complex patients
- Automatically weighting the Quality, Advancing Care Information, and Improvement Activities performance categories at 0 percent of the MIPS final score for clinicians impacted by Hurricanes Irma, Harvey and Maria and other natural disasters
- Adding 5 bonus points to the MIPS final scores of small practices
- Adding Virtual Groups as a participation option for MIPS
- Issuing an interim final rule with comment for extreme and uncontrollable circumstances where clinicians can be automatically exempt from these categories in the transition year without submitting a hardship exception application
- Decreasing the number of doctors and clinicians required to participate as a way to provide further flexibility by excluding individual MIPS eligible clinicians or groups with =$90,000 in Part B allowed charges or =200 Medicare Part B beneficiaries
- Providing more detail on how eligible clinicians participating in selected Advanced Alternative Payment Models (APMs) will be assessed under the APM scoring standard
- Creating additional flexibilities and pathways to allow clinicians to be successful under the All Payer Combination Option

For More Information:

- *Final Rule*
- *Fact Sheet*
- *Executive Summary*
- *Press Release*: CMS Finalizes Policies that Reduce Provider Burden, Lower Drug Prices
- *Quality Payment Program* website
- *Register* for a webinar on November 14

MLN Connects® for November 9, 2017

MLN Connects® for November 9, 2017
View this edition as a PDF

News & Announcements

- New Medicare Card: Help Notify Your Patients
- Medicare Diabetes Prevention Program Expanded Model Implementation
- Hospital Value-Based Purchasing Program Results for FY 2018
- Low Volume Appeals Settlements
- Hospice Item Set Data Freeze: November 15
- Draft 2018 CMS QRDA III Implementation Guide: Submit Comments by November 17
- CMS Innovation Center New Direction RFI: Submit Comments by November 20
- Therapeutic Shoe Inserts: Comment on DMEPOS Quality Standards through December 11
- Quality Payment Program Resources in New Location
- Post-Acute Care: Quality Reporting Program Quick Reference Guides Available
- Provider and Pharmacy Access during Public Health Emergencies
- Raising Awareness of Diabetes in November

Provider Compliance

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

Upcoming Events

- Quality Payment Program Year 2 Overview Webinar — November 14
- SNF Value-Based Purchasing Program FY 2018 Final Rule Call — November 16
- Quality Payment Program Virtual Groups Train-the-Trainer Webinar — November 17
- Quality Payment Program Year 2 Final Rule Call — November 30
- Medicare Diabetes Prevention Program Model Expansion Call — December 5
- LTCH Quality Reporting Program In-Person Training — December 6 and 7

Medicare Learning Network Publications & Multimedia

- Quality Payment Program in 2017: Advanced Alternative Payment Models Web-Based Training Course — New
- Medicare FFS Response to the 2017 California Wildfires *MLN Matters®* article — Updated
- Prohibition on Billing Dually Eligible Individuals Enrolled in the QMB Program *MLN Matters®* article— Revised
- Transition to New Medicare Numbers and Cards Fact Sheet — Revised
- Hospital-Acquired Conditions and Present on Admission Indicator Reporting Provision Fact Sheet — Revised
- Remittance Advice Information: An Overview Booklet — Reminder
- SNF Billing Reference Booklet — Reminder
- Items and Services Not Covered under Medicare Booklet — Reminder
- Guidelines for Teaching Physicians, Interns, and Residents Fact Sheet — Reminder

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MLN Connects® for November 16, 2017

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News & Announcements

- New Medicare Card: New Webpage Information
- CAHs: Deadline to Apply for a Hardship Exception is November 30
- Virtual Group for MIPS in 2018: Apply by December 31
- QMB Remittance Advice Issue
- IRF/LTCH Quality Measure Reports: Measures Added
- Hospice Quality Reporting Program: Quarterly Update
- Physician Compare: How to Update Your Listing
- Recognizing Lung Cancer Awareness Month and the Great American Smokeout

Provider Compliance

- Evaluation and Management: Correct Coding — Reminder

Upcoming Events

- Quality Payment Program Year 2 Final Rule Call — November 30
- Medicare Diabetes Prevention Program Model Expansion Call — December 5
- National Partnership to Improve Dementia Care and QAPI Call — December 14

Medicare Learning Network Publications & Multimedia

- Hospital Call: Audio Recording and Transcript — New
- Medicare and Medicaid Basics Booklet — Revised
- Looking for Educational Materials?

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PO Box 45300
Jacksonville, FL 32232-5300

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Email**:** *FloridaB@fcso.com*
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Jacksonville, FL 32231-4021

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Part B QIC South Operations
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Jacksonville, FL 32231-4141

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Jacksonville, FL 32232-5157

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Medicare Part B Redetermination
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Jacksonville, FL 32232-5056

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Jacksonville, FL 32232-5015

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Part B QIC South Operations
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PO Box 45300
Jacksonville, FL 32232-5300

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Jacksonville, FL 32231-4021

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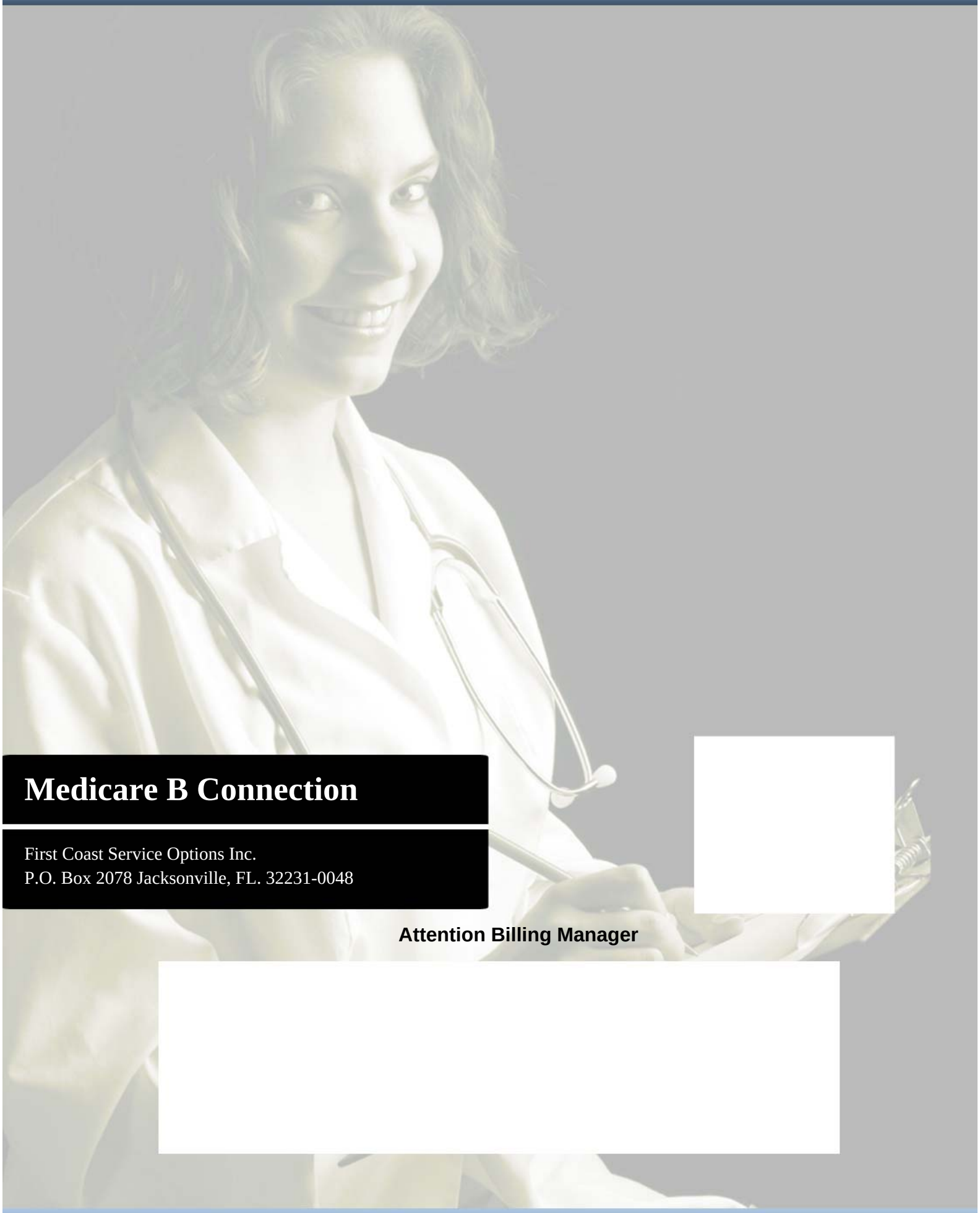

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