Medicare B CONNECTION
medicare.fcso.com
FIRST COAST SERVICE OPTIONS, INC.
A Newsletter for MAC Jurisdiction N Providers
May 2020

In this issue

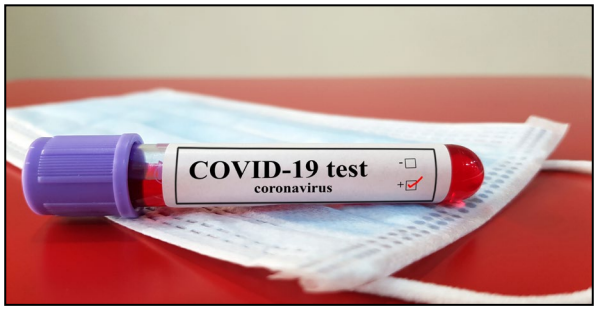
Medicare Pharmacies and Other Suppliers May Temporarily Enroll as Independent Clinical Diagnostic Laboratories to Help Address COVID-19 Testing

Provider type affected

This MLN Matters Article is for Medicare-enrolled pharmacies and other Medicare-enrolled suppliers, or pharmacies and suppliers seeking to enroll temporarily as independent clinical diagnostic laboratories to help address the urgent need for COVID-19 testing.

What you need to know

Pharmacies and other suppliers currently enrolled in Medicare may also enroll temporarily as independent clinical diagnostic laboratories during the COVID-19 public health emergency via the provider enrollment hotline. This will provide additional laboratory resources to meet the urgent need to increase COVID-19 testing capability.



Pharmacies and other suppliers who are not currently enrolled in Medicare and want to enroll as an Independent Clinical Diagnostic Laboratory, must submit a *CMS-855B* enrollment application to the Medicare Administrative Contractor (MAC) serving your geographic area. To locate your designated MAC, see *https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Downloads/MACs-by-State-June-2019.pdf*.

Enrollment guidance

Medicare-enrolled pharmacies and other Medicare-enrolled

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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.

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*. 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*.

Reproducible copies of Form CMS-R-131 ABNs (in English and Spanish) and other BNI information may be found *here*.

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.

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suppliers can initiate temporary Medicare independent clinical diagnostic laboratory billing privileges via the provider enrollment hotline (see hotline information below). To start the process, you will need to provide limited information, including:

- Legal Business Name
- National Provider Identifier (NPI)
- Tax Identification Number (TIN)
- State license
- CLIA certificate number (see below)
- Address information
- Contact information (telephone number)

Your MAC will collect this information from you over the phone, however, temporary Medicare billing privileges will not be established during the phone conversation. The MAC will notify the pharmacy or other supplier of their temporary Medicare billing privileges and effective date via email within 2 business days.

To maintain billing privileges as an Independent Clinical Diagnostic Laboratory, the pharmacy or other supplier must submit a *CMS-855B* enrollment application within 30 days after the public health emergency ends to the MAC serving your geographic area.

Provider Enrollment Hotline Information

Medicare-enrolled pharmacies and other Medicare-enrolled suppliers seeking to initiate temporary Medicare independent clinical diagnostic laboratory billing privileges should only contact the hotline for the MAC serving your geographic area. To locate your designated MAC see *https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Downloads/MACs-by-State-June-2019.pdf*.

The hotlines are operational Monday – Friday and at the specified times below.

CGS Administrators, LLC (CGS)

- The toll-free Hotline Telephone Number: 1-855-769-9920
- Hours of Operation: 7:00 am – 4:00 pm CT

First Coast Service Options Inc. (FCSO)

- The toll-free Hotline Telephone Number: 1-855-247-8428
- Hours of Operation: 8:30 AM – 4:00 PM EST

National Government Services (NGS)

- The toll-free Hotline Telephone Number: 1-888-802-3898
- Hours of Operation: 8:00 am – 4:00 pm CT

National Supplier Clearinghouse (NSC)

- The toll-free Hotline Telephone Number: 1-866-238-9652
- Hours of Operation: 9:00 AM – 5:00 PM ET

Novitas Solutions, Inc.

- The toll-free Hotline Telephone Number: 1-855-247-8428
- Hours of Operation: 8:30 AM – 4:00 PM EST

Noridian Healthcare Solutions

- The toll-free Hotline Telephone Number: 1-866-575-4067
- Hours of Operation: 8:00 am – 6:00 pm CT

Palmetto GBA

- The toll-free Hotline Telephone Number: 1-833-820-6138
- Hours of Operation: 8:30 am – 5:00 pm ET

Wisconsin Physician Services (WPS)

- The toll-free Hotline Telephone Number: 1-844-209-2567
- Hours of Operation: 7:00 am – 4:00 pm CT

Important Clinical Laboratory Improvement Amendments (CLIA) Certificate Number Information

Note that the CLIA program does not allow the Centers for Medicare & Medicaid Services (CMS) to approve section 1135 waiver requests with respect to waivers of CLIA program requirements for public health emergencies. The section 1135 waiver authority is only applicable to specified programs (or penalties) authorized by the Social Security Act (SSA). The CLIA program does not fall into this category of programs. CMS does not have the authority to grant waivers or exceptions that are not established in statute or regulation.

If you would like to apply for a CLIA certificate, please submit your application form (*CMS-116, CLIA Application Form*) to the state (*SA Contacts*) where the laboratory is located.

CMS wants to ensure that laboratories located in the United States applying for a CLIA certificate are able to begin testing for COVID-19 as quickly as possible. Once the laboratory has identified a qualified laboratory director and has provided all required information on the CMS-116 application, a CLIA number will be assigned. Once the CLIA number has been assigned, the laboratory can begin testing as long as applicable CLIA requirements have been met (for example, establishing performance specifications).

Note that different CLIA program certificates correspond to the complexity of tests performed by a given laboratory. For example, laboratories with a Certificate of Waiver can only conduct tests designated as waived by the Food and Drug Administration (FDA). More information is available at *https://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/Downloads/HowObtainCLIACertificate.pdf*.

Information specific to obtaining a CLIA Certificate of Waiver is available at *https://www.cms.gov/Regulations-and-Guidance/legislation/CLIA/downloads/howobtaincertificateofwaiver.pdf*.

Additional information

Frequently Asked Questions (FAQs) about CLIA guidance

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during the COVID-19 emergency are available at *https://www.cms.gov/files/document/clia-laboratory-covid-19-emergency-frequently-asked-questions.pdf*.

CLIA laboratory guidance to state agencies during the COVID-19 Public Health Emergency are available at *https://www.cms.gov/files/document/qso-20-21-clia.pdf-0*.

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

Document history

Date of change	Description
May 8, 2020	Initial article released.

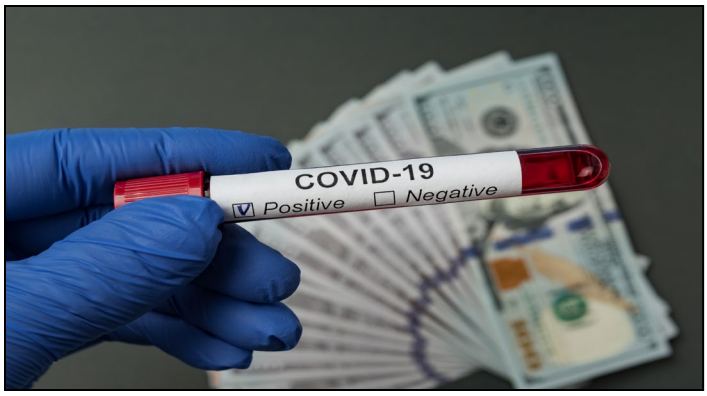
MLN Matters® Number: SE20017
Article Release Date: May 8, 2020
Related CR Transmittal Number: N/A
Related Change Request (CR) Number: N/A
Effective Date: N/A
Implementation Date: N/A

Fee News

COVID-19: Allowances for laboratory test codes U0001-U0004 and 87635

The Centers for Medicare & Medicaid Services (CMS) has established new codes for laboratory tests for the novel coronavirus (COVID-19). CMS provided pricing for codes U0001 and U0002, but instructed Medicare administrative contractors (MACs) to develop the allowance for the remaining codes. The codes and allowances are as follows:

Code	Allowance
U0001	$35.92
U0002	$51.31
U0003	$100.00
U0004	$100.00
87635	$51.31



Source: *https://www.cms.gov/files/document/mac-covid-19-test-pricing.pdf*

Take the time to 'chat' with the website team

You now have the opportunity to save your valuable time by asking your website-related questions online – with First Coast's new Live Chat service.

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 webpage* for full-text LCDs, including final LCDs, draft LCDs available for comment, LCD statuses, and LCD comment/response summaries.

Effective and notice dates

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

Electronic notification

To receive quick, automatic notification when new and revised LCDs are posted to the website, subscribe to the *First Coast eNews mailing list*. Simply enter your email address and select the subscription option that best meets your needs.

More information

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

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

Looking for LCDs?

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

Advance beneficiary notice

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

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

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

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

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.

New LCD/Article

Magnetic-resonance-guided focused ultrasound surgery (MRgFUS) for essential tremor – new Part A and Part B LCD/billing and coding article

LCD/Article ID number: L38506/A57884 (Florida/Puerto Rico/U.S. Virgin Islands)

This is a new local coverage determination (LCD) that clarifies coverage indications and limitations for magnetic-resonance-guided focused ultrasound surgery (MRgFUS) for essential tremor (ET) that is refractory to more traditional treatment (e.g., medical therapy, deep brain stimulation [DBS]). Also, the related billing and coding article (A57884) addresses coding guidelines in support of the reasonable and necessary services as outlined in the LCD.

Effective date

This new LCD/billing and coding article is effective for services rendered **on or after July 12, 2020**.

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

A billing and coding article for an LCD 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*.

Revised LCDs/Articles

Percutaneous vertebral augmentation (PVA) for vertebral compression fracture (VCF) – revision to the Part A and Part B LCD

LCD/Article ID number: L34976/A57872 (Florida/Puerto Rico/U.S. Virgin Islands)

Based on review of new literature and current data analysis, the local coverage determination (LCD) for vertebroplasty, vertebral augmentation; percutaneous has been revised to provide clarification of coverage indications and limitations. The "Covered Indications", "Limitations", "Summary of Evidence", "Analysis of Evidence", and "Bibliography" sections of the LCD have been updated to include language which supports the limited coverage outlined in the LCD. In addition, the LCD title was changed to "percutaneous vertebral augmentation (PVA) for vertebral compression fracture (VCF)". Also, a new percutaneous vertebral augmentation (PVA) for vertebral compression fracture (VCF) billing and coding article (A57872) was created to address coding guidelines in support of the reasonable and necessary services as outlined in the LCD.

Furthermore, when the revised LCD and new billing and coding article (A57872) become effective, the current billing and coding article (A57705) will be retired.

Effective date

This LCD revision and new billing and coding article are effective for services rendered **on or after July 12, 2020**.

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

A billing and coding article for an LCD 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*.

Scanning computerized ophthalmic diagnostic imaging (SCODI) – revision to the Part A and Part B billing and coding article

Article ID number: A57804 (Florida/Puerto Rico/U.S. Virgin Islands)

Due to the retirement of the fundus photography local coverage determination (L33670), the "Coding Guidelines" section of this billing and coding article was revised to remove all language related to the fundus photography LCD (L33670). In addition, language to define a monthly bill cycle timeframe as 28 calendar days for billing purposes was added to the "Article Guidance/ Article Text" section of the billing and coding article.

Effective date

This billing and coding article revision is effective for services rendered **on or after April 24, 2020**.

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

A billing and coding article for an LCD 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*.

Micro-invasive glaucoma surgery (MIGS) – revision to the Part A and Part B billing and coding article

Article ID number: A56647 (Florida/Puerto Rico/U.S. Virgin Islands)

Based on further review, the "Coding Guidelines" section of the micro-invasive glaucoma surgery (MIGS) billing and coding article was revised to add Current Procedural Terminology (CPT®) codes 66987 and 66988.

Effective date

This billing and coding article revision is effective for claims processed **on or after April 27, 2020**, for services rendered **on or after January 1, 2020**.

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

A billing and coding article for an LCD 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*.

Dysphagia/swallowing diagnosis and therapy – revision to the Part A and Part B billing and coding article

Article ID number: A57675 (Florida/Puerto Rico/U.S. Virgin Islands)

Due to the retirement of the Part B diagnostic nasal endoscopy local coverage determination LCD (L33815), the "CPT®/HCPCS Codes/Group 1 Paragraph:" section of the dysphagia/swallowing diagnosis and therapy billing and coding article was revised to remove all language related to the diagnostic nasal endoscopy LCD (L33815).

Effective date

This billing and coding article revision is effective for services rendered **on or after April 29, 2020**.

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

A billing and coding article for an LCD 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*.

Noncovered services – revision to the Part A and Part B billing and coding article

Article ID number: A57743 (Florida/Puerto Rico/U.S. Virgin Islands)

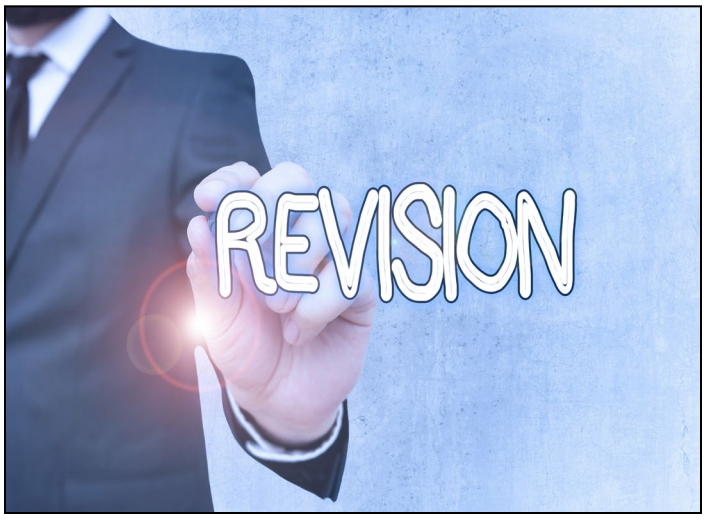
Based on a local coverage determination (LCD) challenge, the noncovered services billing and coding article was revised to remove the implantable interstitial glucose sensor Current Procedural Terminology (CPT®) codes 0446T, 0447T, and 0448T from the "CPT®/HCPCS Codes/ Group 1 Codes:" section of the billing and coding article.

Effective date

This billing and coding article revision is effective for services rendered **on or after May 7, 2020**.

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

A billing and coding article for an LCD 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*.

Independent diagnostic testing facility (IDTF) – revision to the Part B billing and coding article

Article ID number: A57807 (Florida/Puerto Rico/U.S. Virgin Islands)

Based on a review, the "Credentialing Matrix" section of the independent diagnostic testing facility (IDTF) billing and coding article was revised to add Current Procedural Terminology (CPT®) codes 19081, 19082, 19083, 19084, 19085, and 19086.

Effective date

This billing and coding article revision is effective for services rendered **on or after May 14, 2020**.

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

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

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

Retired LCDs/Articles

Gene expression profiling panel for use in the management of breast cancer treatment – retired Part A and Part B LCD and billing and coding article

LCD/ Article ID number: L33586/A57756 (Florida/Puerto Rico/U.S. Virgin Islands)

Based on review of the local coverage determination (LCD) and billing and coding article for gene expression profiling panel for use in the management of breast cancer treatment, it was determined that they are no longer required and therefore, are being retired.

Effective date

This LCD and billing and coding article retirement is effective for services rendered **on or after May 1, 2020**.

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

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

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

Retired LCDs/Articles

Multiple Part A and Part B LCDs and billing and coding articles being retired

LCD and Article ID numbers: L33600/A57541, L33670/A57075, L33997/A57714 (Florida/ Puerto Rico/U.S. Virgin Islands)

Based on review of the following local coverage determinations (LCDs) and billing and coding articles, it was determined that they are no longer required and therefore, are being retired.

- L33600/A57541 Sinus X-ray(s)
- L33670/A57075 Fundus Photography
- L33997/A57714 Fluorescein Angiography

Effective date

The retirement of these LCDs and billing and coding articles is effective for services rendered **on or after April 24, 2020.**

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

A billing and coding article for an LCD 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*.

Multiple Part B LCDs and billing and coding articles being retired

LCD and Article ID numbers: L33815/A57082, L33911/A57784, L33925/A57463, L33927/ A57785, L33935/A57537 (Florida/Puerto Rico/ U.S. Virgin Islands)

Based on review of the following local coverage determinations (LCDs) and billing and coding articles, it was determined that they are no longer required and therefore, are being retired.

- L33815/A57082 - Diagnostic Nasal Endoscopy
- L33911/A57784 - Indocyanine-Green Angiography
- L33925/A57463 - Ophthalmological Diagnostic Services
- L33927/A57785 - Optical Coherence Biometry
- L33935/A57537 - Post-Voiding Residual Ultrasound

Effective date

The retirement of these LCDs and billing and coding articles is effective for services rendered **on or after April 29, 2020**.

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

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

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

Find out first: Subscribe to First Coast *eNews*

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

Upcoming provider outreach and educational events

Medicare quarterly updates (B)

Date: Wednesday, June 17
Time: 11 a.m. - 12:30 p.m. ET
Type of Event: Webcast

View our complete calendar of events

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

Two easy ways to register

Online – Visit our provider training website at *First Coast University*, log on to your account and select the course you wish to register. Class materials are available under "My Courses" no later than one day before the event**.**

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

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

Please Note:

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

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Provider Address: _____

City, State, ZIP Code: _____

Keep checking our *website* for details and newly scheduled educational events (teleconferences, webcasts, etc.).

Never miss a training opportunity

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

Take advantage of 24-hour access to free online training

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

CMS MLN Connects®

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

MLN Connects® – Special Edition – Monday, April 20, 2020

COVID-19: Nursing Home Transparency, Recommendations for Areas with Low Incidence of Disease

- *Trump Administration Announces New Nursing Homes COVID-19 Transparency Effort*
- *CMS Issues Recommendations to Re-Open Health Care Systems in Areas with Low Incidence of COVID-19*

Trump Administration Announces New Nursing Homes COVID-19 Transparency Effort

Agencies partner with nursing homes to keep nursing home residents safe

On April 19, under the leadership of President Trump, the Centers for Medicare & Medicaid Services (CMS) announced *new regulatory requirements* that will require nursing homes to inform residents, their families, and representatives of COVID-19 cases in their facilities. In addition, as part of President Trump's Opening Up America, CMS will now require nursing homes to report cases of COVID-19 directly to the Centers for Disease Control and Prevention (CDC). This information must be reported in accordance with existing privacy regulations and statute. This measure augments longstanding requirements for reporting infectious disease to state and local health departments. Finally, CMS will also require nursing homes to fully cooperate with CDC surveillance efforts around COVID-19 spread.

CDC will be providing a reporting tool to nursing homes that will support federal efforts to collect nationwide data to assist in COVID-19 surveillance and response. This joint effort is a result of the CMS-CDC Work Group on Nursing Home Safety. CMS plans to make the data publicly available. This effort builds on recent recommendations from the *American Health Care Association* and *Leading Age*, two large nursing home industry associations, that nursing homes quickly report COVID-19 cases.

This data sharing project is only the most recent in the Trump Administration's rapid and aggressive response to the COVID-19 pandemic. More details are available in the *Press Release* and *Guidance Memo*.

CMS Issues Recommendations to Re-Open Health Care Systems in Areas with Low Incidence of COVID-19

On April 19, the Centers for Medicare & Medicaid Services issued new recommendations specifically targeted to communities that are in Phase 1 of the Guidelines for President Trump's Opening Up America Again with low incidence or relatively low and stable incidence of COVID-19 cases. The recommendations update earlier guidance provided by CMS on limiting non-essential surgeries and medical procedures. The new CMS guidelines recommend a gradual transition and encourage health care providers to coordinate with local and state public health officials and to review the availability of Personal Protective Equipment (PPE) and other supplies, workforce availability, facility readiness, and testing capacity when making the decision to re-start or increase in-person care.

The new recommendations can be found here: *https://www.cms.gov/files/document/covid-flexibility-reopen-essential-non-covid-services.pdf*

The Guidelines for Opening Up America Again can be found here: *https://www.whitehouse.gov/openingamerica/#criteria*

MLN Connects® for Thursday, April 23, 2020

MLN Connects® for Thursday, April 23, 2020

View this edition as a PDF

News

- Trump Administration Champions Reporting of COVID-19 Clinical Trial Data through Quality Payment Program, Announces New Clinical Trials Improvement Activity
- CMS Releases Additional Blanket Waivers for Long-Term Care Hospitals, Rural Health Clinics, Federally Qualified Health Centers and Intermediate Care Facilities
- IRF PPS FY 2021 Proposed Rule
- Bill Correctly for Inhalant Drugs

Events

- Ground Ambulance Organizations: Data Collection for Medicare Providers Call — May 7

MLN Matters® Articles

- New and Expanded Flexibilities for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) During the COVID-19 Public Health Emergency (PHE)
- New Waived Tests
- April 2020 Integrated Outpatient Code Editor (I/OCE) Specifications Version 21.1 — Revised
- April 2020 Update of the Ambulatory Surgical Center (ASC) Payment System — Revised
- Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - April 2020 Update — Revised
- Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update — Revised
- Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update — Revised

Publications

- Provider Compliance Tips for Nebulizers and Related Drugs Fact Sheet — Revised

Multimedia

- Medicare Home Health Benefit Web-Based Training Course — Revised

MLN Connects® – Special Edition – Monday, April 27, 2020

CMS Reevaluates Accelerated Payment Program and Suspends Advance Payment Program

On April 26, the Centers for Medicare & Medicaid Services (CMS) announced that it is reevaluating the amounts that will be paid under its Accelerated Payment Program and suspending its Advance Payment Program to Part B suppliers effective immediately. The agency made this announcement following the successful payment of over $100 billion to health care providers and suppliers through these programs and in light of the $175 billion recently appropriated for health care provider relief payments.

CMS had expanded these temporary loan programs to ensure providers and suppliers had the resources needed to combat the beginning stages of the 2019 Novel Coronavirus (COVID-19). Funding will continue to be available to hospitals and other health care providers on the front lines of the coronavirus response primarily from the *Provider Relief Fund*. The Accelerated and Advance Payment (AAP) Programs are typically used to give providers emergency funding and address cash flow issues for providers and suppliers when there is disruption in claims submission or claims processing, including during a public health emergency or Presidentially-declared disaster.

Since expanding the AAP programs on March 28, 2020, CMS approved over 21,000 applications totaling $59.6 billion in payments to Part A providers, which includes hospitals. For Part B suppliers, including doctors, non-physician practitioners and durable medical equipment suppliers, CMS approved almost 24,000 applications advancing $40.4 billion in payments. The AAP programs are not a grant, and providers and suppliers are typically required to pay back the funding within one year, or less, depending on provider or supplier type. Beginning today, CMS will not be accepting any new applications for the Advance Payment Program, and CMS will be reevaluating all pending and new applications for Accelerated Payments in light of historical direct payments made available through the Department of Health & Human Services' (HHS) Provider Relief Fund.

Significant additional funding will continue to be available to hospitals and other health care providers through other programs. Congress appropriated $100 billion in the Coronavirus Aid, Relief, and Economic Security (CARES) Act (PL 116-136) and $75 billion through the Paycheck Protection Program and Health Care Enhancement Act (PL 116-139) for health care providers. HHS is distributing this money through the Provider Relief Fund, and these payments do not need to be repaid.

The CARES Act Provider Relief Fund is being administered through HHS and has already released $30 billion to providers and is in the process of releasing an additional $20 billion, with more funding anticipated to be released soon. This funding will be used to support health care-related expenses or lost revenue attributable to the COVID-19 pandemic and to ensure uninsured Americans can get treatment for COVID-19.

For more information on the CARES Act Provider Relief Fund and how to apply, visit: *hhs.gov/providerrelief*.

For an updated fact sheet on the Accelerated and Advance Payment Programs, visit: *https://www.cms.gov/files/document/Accelerated-and-Advanced-Payments-Fact-Sheet.pdf*

MLN Connects® for Thursday, April 30, 2020

MLN Connects® for Thursday, April 30, 2020

View this edition as a PDF

News

- Infection Control Guidance to Home Health Agencies on COVID-19
- Now Available: Nursing Home Five Star Quality Rating System Updates, Nursing Home Staff Counts, and Frequently Asked Questions
- CMS Adds New COVID-19 Clinical Trials Improvement Activity to the Quality Payment Program
- Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier

Claims, Pricers & Codes

- Home Health Claims: Correcting Recoding Errors

Events

- COVID-19: Lessons from the Front Lines Calls — May 1 and 8
- COVID-19: Home Health and Hospice Call — May 5
- COVID-19: Office Hours Call — May 5
- COVID-19: Nursing Homes Call — May 6

MLN Matters® Articles

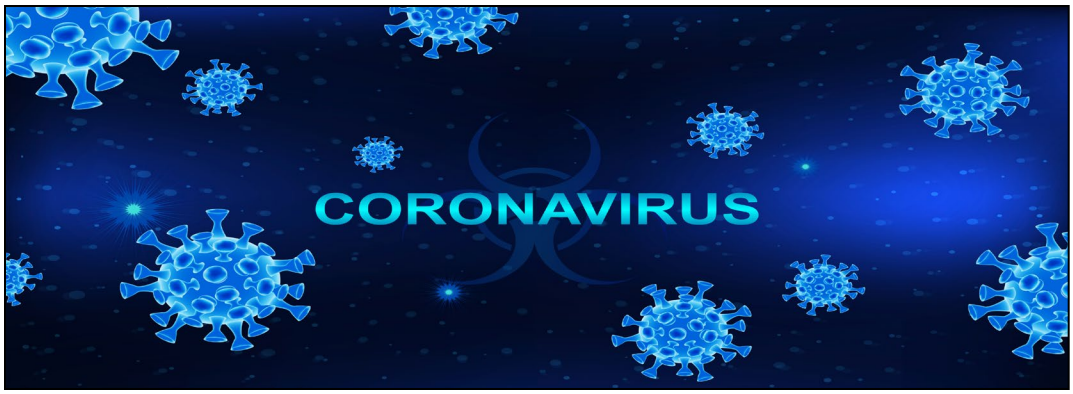
- July 2020 Quarterly Update to the Inpatient Prospective Payment System (IPPS) Fiscal Year (FY) 2020 Pricer
- Quarterly Update to the Long Term Care Hospital (LTCH) Prospective Payment System (PPS) Fiscal Year (FY) 2020 Pricer
- Healthcare Common Procedure Coding System (HCPCS) Codes Subject to and Excluded from Clinical Laboratory Improvement Amendment (CLIA) Edits — Revised
- Implement Operating Rules - Phase III Electronic Remittance Advice (ERA) Electronic Funds Transfer (EFT): Committee on Operating Rules for Information Exchange (CORE) 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) Rule - Update from Council for Affordable Quality Healthcare (CAQH) CORE — Revised

Publications

- April 2020 Medicare Quarterly Provider Compliance Newsletter
- Advanced Practice Registered Nurses, Anesthesiologist Assistants, and Physician Assistants — Revised
- Ambulatory Surgical Center Payment System — Revised
- Dual Eligible Beneficiaries Under Medicare and Medicaid — Revised
- Hospital Outpatient Prospective Payment System — Revised
- How to Use the Searchable Medicare Physician Fee Schedule — Revised
- Long-Term Care Hospital Prospective Payment System — Revised

Multimedia

- Combating Medicare Parts C and D Fraud, Waste, and Abuse Web-Based Training Course — Revised
- Medicare Parts C and D General Compliance Training Web-Based Training Course — Revised



MLN Connects® – Special Edition – Thursday, April 30, 2020

COVID-19: Second Round of Sweeping Changes, RHC & FQHC Flexibilities, EMTALA

- *Trump Administration Issues Second Round of Sweeping Changes to Support U.S. Healthcare System During COVID-19 Pandemic*
- *New and Expanded Flexibilities for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) During the COVID-19 Public Health Emergency (PHE) MLN Matters Article*
- *New Frequently Asked Questions on EMTALA*

Trump Administration Issues Second Round of Sweeping Changes to Support U.S. Healthcare System During COVID-19 Pandemic

At President Trump's direction, and building on its recent historic efforts to help the U.S. healthcare system manage the 2019 Novel Coronavirus (COVID-19) pandemic, on April 30, 2020, the Centers for Medicare & Medicaid Services, issued another round of sweeping regulatory waivers and rule changes to deliver expanded care to the nation's seniors and provide flexibility to the healthcare system as America reopens. These changes include making it easier for Medicare and Medicaid beneficiaries to get tested for COVID-19 and continuing CMS's efforts to further expand beneficiaries' access to telehealth services.

Full press release

New and Expanded Flexibilities for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) During the COVID-19 Public Health Emergency (PHE) MLN Matters Article

A revised MLN Matters Special Edition Article SE20016 on *New and Expanded Flexibilities for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) During the COVID-19 Public Health Emergency (PHE)* is available. Learn new information on billing for distant site telehealth services during the COVID-19 PHE, including:

- New telehealth services that can be provided by RHCs and FQHCs, including audio only telephone evaluation and management services
- Revised bed count methodology for determining the exemption to the RHC payment limit for provider-based RHC

New Frequently Asked Questions on EMTALA

CMS issued Frequently Asked Questions (FAQs) clarifying requirements and considerations for hospitals and other providers related to the Emergency Medical Treatment and Labor Act (EMTALA) during the COVID-19 pandemic. The FAQs address questions around patient presentation to the emergency department, EMTALA applicability across facility types, qualified medical professionals, medical screening exams, patient transfer and stabilization, telehealth, and other topics.

Frequently Asked Questions

MLN Connects® for Thursday, May 7, 2020

MLN Connects® for Thursday, May 7, 2020

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News

- CMS Announces Independent Commission to Address Safety and Quality in Nursing Homes
- Home Health Plans of Care: NPs, CNSs and PAs Allowed to Certify
- Health Care Supply Chain, Provider Self-Care, and Emergency Preparedness Resources

Claims, Pricers & Codes

- COVID-19: Modified Ordering Requirements for Laboratory Billing
- Hospital OPPS: New Coronavirus Specimen Collection Code

Events

- COVID-19: Office Hours Call — May 7
- COVID-19: Lessons from the Front Lines Calls — May 8

MLN Matters® Articles

- Addition of the QW modifier to Healthcare Common Procedure Coding System (HCPCS) code U0002 and 87635
- Modify Edits in the Fee for Service (FFS) System when a Beneficiary has a Medicare Advantage (MA) Plan
- New Codes for Therapist Assistants Providing Maintenance Programs in the Home Health Setting
- Updates to Ensure the Original 1-Day and 3-Day Payment Window Edits are Consistent with Current Policy — Revised

Publications

- Evaluation and Management Services — Revised

MLN Connects® – Special Edition – Friday, May 8, 2020

COVID-19: Nursing Home Reporting, Updated Telehealth Video, Pharmacies & Other Suppliers Can Enroll as Labs, IRF Flexibilities

- *New Guidance Available on Requirements for Notification of Confirmed and Suspected COVID-19 Cases Among Residents and Staff in Nursing Homes*
- *Telehealth Video: Medicare Coverage and Payment of Virtual Services*
- *Medicare Pharmacies and Other Suppliers May Temporarily Enroll as Independent Clinical Diagnostic Laboratories to Help Address COVID-19 Testing MLN Matters® Article*
- *COVID-19: IRF Flexibilities During the PHE*
- *COVID-19: IRF Interdisciplinary Team Meetings During the Pandemic*

New Guidance Available on Requirements for Notification of Confirmed and Suspected COVID-19 Cases Among Residents and Staff in Nursing Homes

Nursing homes are now required to report the first week of COVID-19 data to the Centers for Disease Control and Prevention (CDC) beginning May 8 but no later than May 17. For the first time, all 15,000 nursing homes will be reporting this data directly to the CDC through its reporting tool. This reporting requirement is the first action of its kind in the agency's history. On April 19, *CMS announced* the agency would be requiring facilities to report COVID-19 information to the CDC and to families. Within three weeks of that announcement, on April 30, CMS issued an Interim *Final Rule with Comment Period* with the new regulatory requirements. As nursing homes report this data to the CDC, we will be taking swift action and publicly posting this information so all Americans have access to accurate and timely information on COVID-19 in nursing homes.

CMS has a longstanding requirement for nursing homes to report cases of communicable diseases, such as COVID-19, to the appropriate state or local health department. This new requirement not only helps health departments intervene when needed but serves to provide awareness to the public (e.g., families) and surveillance for public health agencies and the CDC. The importance of ongoing transparency and information sharing has proven to be one of the keys to the battle against this pandemic. Building upon the successes of the Trump Administration prior to COVID-19, CMS has strongly supported transparency, such as the work done over the past several years to improve public access and understanding of nursing home inspection reports and expand the information available to consumers on Nursing Home Compare. The agency remains committed to greater transparency and plans to publicly release new data by the end of May. CMS will never stop working to give patients, residents, and families the clearest and most accurate information possible.

Guidance and Frequently Asked Questions

Telehealth Video: Medicare Coverage and Payment of Virtual Services

This updated *video* provides answers to common questions about the expanded Medicare telehealth services benefit under the 1135 waiver authority and Coronavirus Preparedness and Response Supplemental Appropriations Act.

Medicare Pharmacies and Other Suppliers May Temporarily Enroll as Independent Clinical Diagnostic Laboratories to Help Address COVID-19 Testing MLN Matters® Article

A new MLN Matters Special Edition Article SE20017 on *Medicare Pharmacies and Other Suppliers May Temporarily Enroll as Independent Clinical Diagnostic Laboratories to Help Address COVID-19 Testing* is available. Learn how to temporarily enroll to be an additional laboratory resource to meet the urgent need to increase COVID-19 testing capability.

COVID-19: IRF Flexibilities During the PHE

CMS is exercising regulatory flexibilities for Inpatient Rehabilitation Facilities (IRFs) during the COVID-19 Public Health Emergency (PHE) to waive the 60 percent rule.

We are also waiving IRF coverage and classification requirements if all of these criteria are satisfied:

- Patient is admitted to a freestanding IRF to alleviate acute care hospital bed capacity issues
- IRF is located in an area that is in Phase 1 or has not entered Phase 1; see *Guidelines for Opening Up America Again*

Add the following letters at the end of your unique hospital patient identification number (the number that identifies the patient's medical record in the IRF) to identify patients eligible for each waiver:

- D- 60 percent rule
- DS- Coverage and classification requirements
- DDS- Both 60 percent rule and coverage and classification requirements

For More Information:

- *COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers*: See page 10 for 60 percent rule
- *Interim Final Rule*: Coverage and classification requirements

COVID-19: IRF Interdisciplinary Team Meetings During the Pandemic

CMS expects Inpatient Rehabilitation Facilities (IRFs) to hold in-person weekly interdisciplinary team meetings to discuss Medicare Part A fee-for-service patients. During the public health emergency, it may be safest to conduct meetings electronically. We will accept all appropriate forms of social distancing precautions

MLN Connects® – Special Edition – Tuesday, May 12, 2020

COVID-19: Additional Waivers, Price Transparency, and CMS Letter to Nursing Homes

- *CMS Releases Additional Waivers for Hospitals and Other Facilities*
- *Price Transparency: Requirement to Post Cash Prices Online for COVID-19 Diagnostic Testing*
- *CMS Letter to Nursing Home Facility Management and Staff*

CMS Releases Additional Waivers for Hospitals and Other Facilities

CMS continues to release waivers for the health care community that provide the flexibilities needed to take care of patients during the COVID-19 Public Health Emergency (PHE). CMS recently provided additional blanket waivers for the duration of the PHE that:

- Expand hospitals' ability to offer long-term care services ("swing beds")
- Waive distance requirements, market share, and bed requirements for Sole Community Hospitals
- Waive certain eligibility requirements for Medicare-Dependent, Small Rural Hospitals (MDHs)
- Update specific life safety code requirements for hospitals, hospice, and long-term care facilities

For more information, see *Emergency Declaration Blanket Waivers*.

Price Transparency: Requirement to Post Cash Prices Online for COVID-19 Diagnostic Testing

The Coronavirus Aid, Relief, and Economic Security (CARES) Act includes a number of provisions to provide relief to the public from issues caused by the pandemic, including price transparency for COVID -19 testing. Section 3202(b) of the CARES Act requires providers of

diagnostic tests for COVID-19 to post the cash price for a COVID-19 diagnostic test on their website from March 27 through the end of the public health emergency. For more information, see the *FAQs*.

CMS Letter to Nursing Home Facility Management and Staff

On May 11, CMS Administrator Seema Verma penned a *letter* to nursing home management and staff. Administrator Verma shared her gratitude for the unwavering dedication and commitment of nursing home management and staff in keeping residents safe and for continuing to compassionately care for those who rely on them during this unprecedented time. The letter also provides links to previously shared infection control resources

MLN Connects® for Thursday, May 14, 2020

MLN Connects® for Thursday, May 14, 2020

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News

- IPPS and LTCH PPS: FY 2021 Proposed Rule
- Medicare FFS 2nd Level Appeals: Submission Options

Events

- COVID-19: Office Hours Call — May 14
- COVID-19: Lessons from the Front Lines Calls — May 15

MLN Matters® Articles

- Medicare Clarifies Recognition of Interstate License Compacts
- Extension of Payment for Section 3712 of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act)
- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs) - October 2020 Update
- Updates to Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM) to Correct the Adjustment Process
- Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - April 2020 Update — Revised

Publications

- How to Use the Medicare Coverage Database — Revised

MLN Connects® – Special Edition – Friday, May 15, 2020

COVID-19: Nursing Home Deadline, Telephone E&M Visits, Hospital Time Studies, and Calls

Deadline Approaching: Notification Requirements of Confirmed and Suspected COVID-19 Cases Among Nursing Home Residents and Staff

On April 19, CMS announced the agency will be requiring facilities to report COVID-19 information to the CDC and to families. Within three weeks of that announcement, on April 30, CMS issued an *Interim Final Rule with Comment Period* with new regulatory requirements. With the new regulatory requirements, nursing homes are required to report the first week of data to the CDC beginning May 8 but no later than May 17. For the first time, all 15,000 nursing homes will be reporting this data directly to the CDC through its reporting tool.

In order to report, facilities must enroll in the CDC's National Healthcare Safety Network (NHSN). Information on how to enroll is available *here*. As nursing homes report this data to the CDC, CMS will be taking swift action and publicly posting this information so all Americans have access to accurate and timely information on COVID-19 in nursing homes. More information on the CDC's NHSN COVID-19 module can be found *here*.

CMS Releases Nursing Home Toolkit with Best Practices and Additional Resources

CMS released a new toolkit developed to aid nursing homes, Governors, states, departments of health, and other agencies who provide oversight and assistance to these facilities. These additional resources will help in the fight against the COVID-19 pandemic within nursing homes. The toolkit builds on previous actions taken by CMS, which provide a wide range of tools and guidance to states, healthcare providers and others during the public health emergency. The toolkit is comprised of best practices from a variety of front line health care providers, Governors' COVID-19 task forces, associations and other organizations, and experts, and is intended to serve as a catalogue of resources dedicated to addressing the specific challenges facing nursing homes as they combat COVID-19.

Press Release

Toolkit (PDF)

Telephone Evaluation and Management Visits

The March 30 *Interim Final Rule with Comment Period* added coverage during the Public Health Emergency for audio-only telephone evaluation and management visits (CPT codes 99441, 99442, and 99443) retroactive to March 1. On April 30, a new Physician Fee Schedule was implemented increasing the payment rate for these codes. Medicare Administrative Contractors (MACs) will reprocess claims for those services that they previously denied and/or paid at the lower rate.

There are also a number of add on services (CPT codes 90785, 90833, 90836, 90838, 96160, 96161, 99354, 99355, and G0506) which Medicare may have denied during this Public Health Emergency. MACs will reprocess those claims for dates of service on or after March 1.

You do not need to do anything.

Hospitals: Physician Time Studies During the COVID-19 PHE

Hospitals that incur physician compensation costs must allocate those costs based on the percentage of total time spent furnishing:

- Part A services
- Part B services
- Non-Medicare allowable activities

Hospitals must submit physician allocation agreements annually as part of the cost report filing process. During the Public Health Emergency (PHE), any one of these time study options is acceptable:

- One week time study every 6 months (two weeks per year)
- Time studies completed in the cost report period prior to January 27, the PHE effective date (e.g. hospital with a 7/1/2019 -- 6/30/2020 cost reporting period, could use the time studies collected 7/1/2019 through 1/26/2020; no time studies needed for 1/27/2020 -- 6/30/2020)
- Time studies from the same period in CY 2019 (e.g., if unable to complete time studies during February through July 2020, use time studies completed February through July 2019)

For more information, see the *Provider Reimbursement Manual*:

- Chapter 21, section 2182.3.E.3 - allocation agreements
- Chapter 23, section 2313.2.E and Chapter 21, section 212182.3.E - instructions for time studies

See **SPECIAL**, page 20

SPECIAL

from page 19

Trump Administration Announces Call for Nominations for Nursing Home Commission

CMS announced a call for nominations for the new contractor-led Coronavirus Commission on Safety and Quality in Nursing Homes. The commission's work will build on the Trump Administration's long history of decisive actions to protect nursing home residents. The commission will conduct a comprehensive assessment of the overall response to the COVID-19 pandemic in nursing homes and will inform immediate and future actions to safeguard the health and quality of life for an especially vulnerable population of Americans.

Press Release

Nursing Home Commission Nominations

COVID-19: Home Health and Hospice Call — May 19

Tuesdays from 3 to 3:30 pm ET

These calls provide targeted updates on the agency's latest COVID-19 guidance. Leaders in the field also share best practices. There is an opportunity to ask questions if time allows.

To Participate on May 19:

- Conference lines are limited; we encourage you to join via *audio webcast*
- Or, call 833-614-0820; Access Passcode: 6477704

For More Information:

- *Coronavirus.gov*
- *CMS Current Emergencies* website
- *Podcast and Transcripts* webpage: Audio recordings and transcripts

Target Audience: Home health and hospice providers

COVID-19: Nursing Home Call — May 20

Wednesdays from 4:30 to 5 pm ET

These calls provide targeted updates on the agency's latest COVID-19 guidance. Leaders in the field also share best practices. There is an opportunity to ask questions if time allows.

To Participate on May 20:

- Conference lines are limited; we encourage you to join via *audio webcast*
- Or, call 833-614-0820; Access Passcode: 4879622

For More Information:

- *Coronavirus.gov*
- *CMS Current Emergencies* website
- *Podcast and Transcripts* webpage: Audio recordings and transcripts

Target Audience: Nursing home providers

COVID-19: Dialysis Organization Call — May 20

Wednesdays from 5:30 to 6 pm ET

These calls provide targeted updates on the agency's latest COVID-19 guidance. Leaders in the field also share best practices. There is an opportunity to ask questions if time allows.

To Participate on May 20:

- Conference lines are limited; we encourage you to join via *audio webcast*
- Or, call 833-614-0820; Access Passcode: 3287645

For More Information:

- *Coronavirus.gov*
- *CMS Current Emergencies* website
- *Podcast and Transcripts* webpage: Audio recordings and transcripts

Target Audience: Dialysis organizations

COVID-19: Nurses Call — May 21

Thursdays from 3 to 3:30 pm ET

These calls provide targeted updates on the agency's latest COVID-19 guidance. Leaders in the field also share best practices. There is an opportunity to ask questions if time allows.

To Participate on May 21:

- Conference lines are limited; we encourage you to join via *audio webcast*
- Or, call 833-614-0820; Access Passcode: 2874976

For More Information:

- *Coronavirus.gov*
- *CMS Current Emergencies* website
- *Podcast and Transcripts* webpage: Audio recordings and transcripts

Target Audience: Nurses

See **SPECIAL**, page 21

SPECIAL

from page 20

COVID-19: Office Hours Call — May 21

Tuesdays and Thursdays from 5 to 6 pm ET

Hospitals, health systems, and providers: Ask CMS questions about our temporary actions that empower you to:

- Increase hospital capacity – CMS Hospitals Without Walls
- Rapidly expand the health care workforce
- Put patients over paperwork
- Promote telehealth

To Participate on May 21:

- Conference lines are limited; we encourage you to join via *audio webcast*
- Or, call 833-614-0820; Access Passcode: 9984433

For More Information:

- *Coronavirus.gov*
- *CMS Current Emergencies* website
- *Podcast and Transcripts* webpage: Audio recordings and transcripts

Target Audience: Physicians and other clinicians

COVID-19: Lessons from the Front Lines Call — May 22

Fridays from 12:30 to 2 pm ET

These weekly calls are a joint effort between CMS Administrator Seema Verma, Food and Drug Administration Commissioner Stephen Hahn, MD, and the White House Coronavirus Task Force. Physicians and other clinicians: Share your experience, ideas, strategies, and insights related to your COVID-19 response. There is an opportunity to ask questions.

To Participate on May 22:

- Conference lines are limited; we encourage you to join via *audio webcast*
- Or, call 877-251-0301; Access Code: 6086125

For More Information:

- *Coronavirus.gov*
- *CMS Current Emergencies* website
- *Podcast and Transcripts* webpage: Audio recordings and transcripts

Target Audience: Physicians and other clinicians

Medicare Learning Network®

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

Phone numbers

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

Electronic data interchange (EDI)
888-670-0940

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

Interactive voice response (IVR) system
877-847-4992

Provider enrollment
888-845-8614
877-660-1759 (TTY)
FAX: 904-361-0737

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

Addresses

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

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

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

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

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

EDOC-CS-FLINQB@fcso.com>>
Online form

Provider enrollment
Provider Enrollment
P.O. Box 3409
Mechanicsburg, PA 17055-1849

Special or overnight deliveries
Provider Enrollment
2020 Technology Parkway Suite 100
Mechanicsburg, PA 17055-1849

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

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

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

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

Medicare Education and Outreach
FAX: 904-361-0407
elearning@fcso.com

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

Freedom of Information Act requests
FOIA Florida
P.O. Box 2078
Jacksonville, FL 32231-2078

Overnight mail and/or special courier service
First Coast Service Options Inc.
532 Riverside Avenue
Jacksonville, FL 32202-4914

Websites

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

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

Centers for Medicare & Medicaid Services

E-learning Center
First Coast University

Beneficiaries
Centers for Medicare & Medicaid Services
medicare.gov

Phone numbers

Provider Contact Center

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

Electronic data interchange (EDI)

888-670-0940

Fax number (for general inquiries)

904-361-0696

Interactive voice response (IVR) system

877-847-4992

Provider enrollment

888-845-8614
877-660-1759 (TTY)
FAX: 904-361-0737

The SPOT help desk

855-416-4199
FCSOSPOTHelp@FCSO.com

Addresses

Claims

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

Redeterminations

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

Redetermination of overpayments

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

Reconsiderations

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

General inquiries

First Coast Service Options Inc.
P.O. Box 45098
Jacksonville, FL 32232-5098
EDOC-CS-FLINQB@fcso.com>>
Online form

Provider enrollment

CMS-855 Applications
P. O. Box 3409
Mechanicsburg, PA 17055-1849

Special or overnight deliveries
Provider Enrollment
2020 Technology Parkway Suite 100
Mechanicsburg, PA 17055-1849

Medical policy

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

Medicare secondary payer

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

Electronic data interchange (EDI)

Medicare EDI, 4C
P.O. Box 44071
Jacksonville, FL 32231-4071

Overpayments

Medicare Part B Debt Recovery
P.O. Box 45013
Jacksonville, FL 32232-5013

Medicare Education and Outreach

FAX: 904-361-0407
elearning@fcso.com

Fraud and abuse

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

Freedom of Information Act requests

FOIA USVI
P.O. Box 45073
Jacksonville, FL 32231-5073

Special courier service

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

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First Coast University

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Centers for Medicare & Medicaid Services
medicare.gov

Puerto Rico Contact Information

Phone numbers

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

Electronic data interchange (EDI)
888-875-9779

Interactive voice response (IVR) system
877-847-4992

Provider enrollment
888-845-8614
877-660-1759 (TTY)
FAX: 904-361-0737

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

Addresses

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

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

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

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

General inquiries
First Coast Service Options Inc.
P.O. Box 45036
Jacksonville, FL 32232-5036

EDOC-CS-PRINQB@fcso.com>
Online form

Provider enrollment
CMS-855 Applications
P. O. Box 3409
Mechanicsburg, PA 17055-1849

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Provider Enrollment
2020 Technology Parkway Suite 100
Mechanicsburg, PA 17055-1849

Medical policy
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P.O. Box 2078
Jacksonville, FL 32231-0048
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Medicare secondary payer
Medicare Part B Secondary Payer Dept.
P.O. Box 44078
Jacksonville, FL 32231-4078

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

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

Medicare Education and Outreach
FAX: 904-361-0407
elearning@fcso.com

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

Freedom of Information Act requests
FOIA Puerto Rico
P.O. Box 45092
Jacksonville, FL 32232-5092,

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Centers for Medicare & Medicaid Services

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Beneficiaries
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medicare.gov

Order form for Medicare Part B materials

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

Note: Payment for fee schedules cannot be combined with payment for other items; separate payments are required for purchases of items from different accounts.

Item	Acct Number	Cost per item	Quantity	Total cost
Part B subscription – The Medicare Part B jurisdiction N publications, are available free of charge online in *English* or *Spanish*. Nonprovider entities or providers who need additional copies may purchase an annual subscription. This subscription includes all issues published from October 2019 through September 2020.	40300260	$33		
2020 fee schedule – The Medicare Part B Physician and Nonphysician Practitioner Fee Schedules, effective for services rendered January 1 through December 31, 2020, are available free of charge online in *English* or *Spanish*. Additional copies are available for purchase. The fee schedules contain payment rates for all localities. These items do not include the payment rates for injectable drugs, clinical lab services, mammography screening, or DMEPOS items. **Note:** Requests for hard copy paper disclosures will be completed as soon as CMS provides the direction to do so. Revisions to fees may occur; these revisions will be published in future editions of the Medicare Part B publication.	40300270	$12		
Language preference: **English** [ ] **Español** [ ]				
Please write legibly			Subtotal	$
			Tax (***add % for your area***)	$
			Total	$

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First Coast Service Options Inc.
Medicare Publications
P.O. Box 406443
Atlanta, GA 30384-6443

Contact Name: _____

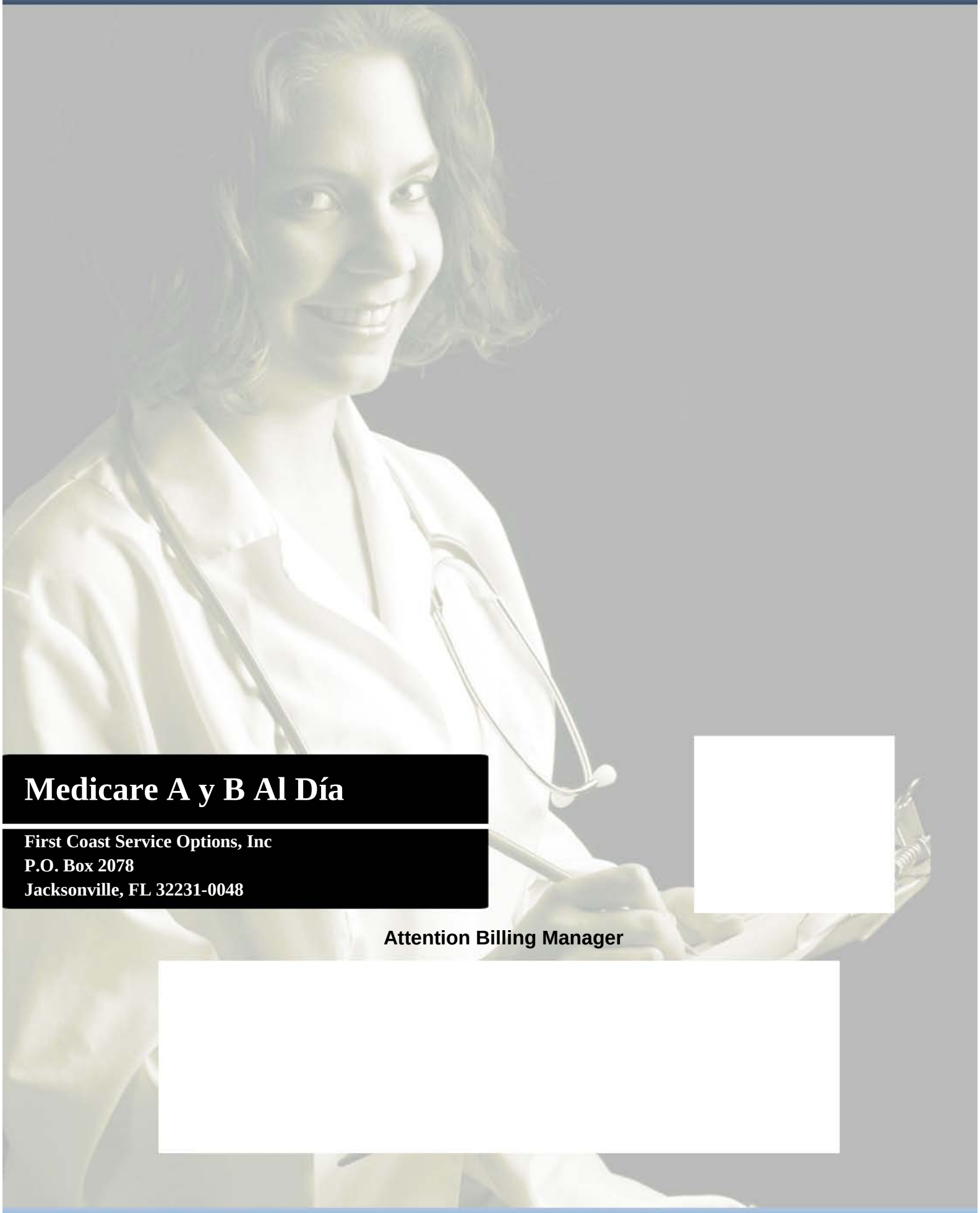
Provider/Office Name: _____

Phone: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

(Checks made to "purchase orders" not accepted; all orders must be prepaid)



Medicare A y B Al Día

First Coast Service Options, Inc
P.O. Box 2078
Jacksonville, FL 32231-0048

Attention Billing Manager