Medicare B CONNECTION

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FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction N Providers September 2020

In this issue

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

First Coast Service Options (First Coast) has noticed an increase in errors for claims submitted on the CMS-1500 (02/12) claim form when going through the optical character recognition (OCR) scanning process. To avoid these issues, we wanted to reiterate some important instructions to 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**.
- Submission of the CMS 1500 (02/12) claim form should either be typed or computer printed forms. Handwritten forms can cause delays and errors in processing and slow down time for reimbursement.
- Ensure to use all **capital typeface** with Courier New or Tines New Roman font style and size 10. This is especially important when indicating letter "I" and "L" in Item 24E.
  - Maintain the same font type and size on the entire form.
- Use black ink only. Do not use red or blue ink as the scanner is unable to "read" the data and can cause your claims to be **returned as unprocessable**.
- Do not use a rubber stamp for any fields on the CMS-1500 (02/12) claim form.
- Do not use correction fluid or correction tape.
- Avoid the use of special characters.
- Do not highlight the claim form or attachments.
- Periodically review the fields spacing and placement of information contained within Items 1-33 when using computer printed or typed CMS 1500 (02/12) claim forms. Information should only be located within the specified block placement on the form.
- Claims submitted with a national provider identifier (NPI) and without one of the *Item 17 qualifiers* or an invalid qualifier will **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*.

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.

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 Affairs at:

First Coast Service Options
Medical Affairs
2020 Technology Parkway
Suite 100
Mechanicsburg, PA 17050-9419

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 Article

Chiropractic services – new Part A and Part B billing and coding article

Article ID number: A58412 (Florida/Puerto Rico/U.S. Virgin Islands)

This new billing and coding article for chiropractic services is being developed to provide coverage guidance for chiropractic services as outlined in the Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual (IOM) Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15, Sections 30.5, 240, 240.1, 240.1.1, 240.1.2, 240.1.3, 240.1.4, and 240.1.5 and Publication 100-04, *Medicare Claims Processing Manual*, Chapter 12, Section 220 and Chapter 30. The current local coverage determination (LCD) (L36617) and related billing and coding article (A57681) will be retired when this new billing and coding article becomes effective.

Effective date

This new billing and coding article is effective for services rendered **on or after October 1, 2020**.

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

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

Retired LCD/Article

Syphilis test – retired Part A and Part B LCD/billing and coding article

LCD and Article ID number: L33754/A57546 (Florida/Puerto Rico/U.S. Virgin Islands)

Based on review of the local coverage determination (LCD) and billing and coding article for syphilis test, it was determined that they are no longer required and therefore, are being retired.

Effective date

The retirement of this LCD and billing and coding article is effective for services rendered **on or after September 17, 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 (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*.

Revised Articles

Infliximab – revision to the Part A and Part B billing and coding article

Article ID number: A57653 (Florida/Puerto Rico/U.S. Virgin Islands)

Based on change request (CR) 11944 (October 2020 Integrated Outpatient Code Editor [I/OCE]) and CR 11960 (Update of the Hospital Outpatient Prospective Payment System [OPPS]), the status indicator for Healthcare Common Procedure Coding System (HCPCS) code Q5121 was changed from “E2” to “K” for services rendered **July 6, 2020-September 30, 2020** and from “E2” to “G” for services rendered on or after **October 1, 2020**. Therefore, the “CPT®/HCPCS Code/Group 1 Paragraph:” section of the billing and coding article was revised to no longer indicate that HCPCS code Q5121 was only applicable to Part B.

Effective date

This billing and coding article revision related to the status indicator changes is effective for services rendered **on or after July 6, 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 an inquiry, the billing and coding article for independent diagnostic testing facility (IDTF) was revised to add Current Procedural Terminology (CPT®) codes 10005, 10006, 10007, 10008, 10009, 10010, 10011, 10012, and 10021 to the "Credentialing Matrix".

Effective date

This billing and coding article revision is effective for services rendered **on or after September 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*.

Additional Information

2021 ICD-10-CM Coding Changes (Part A/B, Part A and Part B)

The 2021 update to the ICD-10-CM diagnosis coding structure (change requests [CRs] 11845 and 11895) is effective for services rendered on or after **October 1, 2020**. First Coast Service Options Inc. (First Coast) medical affairs team has evaluated all active local coverage determination (LCD) billing and coding articles for diagnosis criteria that are impacted by the 2021 ICD-10-CM update. As a reminder, diagnosis codes included in the billing and coding articles are surrogate to the indications addressed within the LCD and providers are required to bill the highest level of specificity for the applicable diagnosis code when reporting services. ICD-10-CM diagnosis codes have been added, revised, and deleted. The following is a list of the impacted billing and coding articles.

Note: The billing and coding articles will be viewable to the public in the Medicare Coverage Database on **October 1, 2020**.

Part A/B Combined Billing and Coding Articles

- A57531 Allergy Testing
- A57603 Bisphosphonates (Intravenous [IV]) and Monoclonal Antibodies in the Treatment of Osteoporosis and Their Other Indications
- A56952 Cardiology Non-emergent Outpatient Stress Testing
- A57077 Controlled Substance Monitoring and Drugs of Abuse Testing
- A57682 Cystatin C Measurement
- A57063 Diagnostic and Therapeutic Esophagogastroduodenoscopy
- A55937 Diagnostic Colonoscopy
- A57636 Duplex Scanning
- A57066 Electrocardiography
- A57628 Erythropoiesis Stimulating Agents
- A57716 Flow Cytometry
- A56953 Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea
- A57653 Infliximab
- A57778 Intravenous Immune Globulin
- A57120 Ionized Calcium
- A57121 Magnesium
- A57123 Nerve Conduction Studies and Electromyography
- A57126 Noninvasive Physiologic Studies of Upper or Lower Extremity Arteries
- A57122 Parathormone (Parathyroid Hormone)
- A57520 Psychiatric Diagnostic Evaluation and Psychotherapy Services
- A57780 Psychological and Neuropsychological Tests
- A57127 Pulmonary Diagnostic Services
- A57804 Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI)

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- A57657 Sedimentation Rate, Erythrocyte
- A57650 Serum Phosphorus
- A57667 Special EEG Tests
- A57275 Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiation Therapy (SBRT)
- A57145 Surgical Management of Morbid Obesity
- A57156 Therapy and Rehabilitation Services
- A57637 Visual Field Examination
- A56841 Vitamin D; 25 hydroxy, includes fraction(s), if performed

Part A only Billing and Coding Articles

- A57058 Diagnostic Aerosol or Vapor Inhalation

Part B only Billing and Coding Articles

- A57699 Computerized Corneal Topography
- A57802 Hepatic (Liver) Function Panel
- A57783 Incision and Drainage of Abscess of Skin, Subcutaneous and Accessory Structures
- A57787 Paravertebral Facet Joint Blocks
- A57788 Peripheral Nerve Blocks
- A57188 Routine Foot Care
- A57540 Somatosensory Testing

Effective date

These billing and coding article revisions are effective for services rendered **on or after October 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 (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*.

Keep updated...

Use the tools and useful information found on *medicare.fcso.com* to stay updated on changes associated with the Medicare program.

Upcoming provider outreach and educational events

Telehealth services and the expansion of benefits during COVID-19 (B)

Date: October 15
Time: 10-11:30 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® for Thursday, August 20, 2020

Routine Provider Inspections Resume

MLN Connects® for Thursday, August 20, 2020

View this edition as a PDF

News

- CMS Announces Resumption of Routine Inspections of All Provider and Suppliers, Issues Updated Enforcement Guidance to States, and Posts Toolkit to Assist Nursing Homes
- Reduce Provider Burden: Electronic Medical Documentation Interoperability Pilot Program

Events

- CMS-CDC Fundamentals of COVID-19 Prevention for Nursing Homes: New Format

MLN Matters® Articles

- New COVID-19 Policies for Inpatient Prospective Payment System (IPPS) Hospitals, Long-Term Care Hospitals (LTCHs), and Inpatient Rehabilitation Facilities (IRFs) due to Provisions of the CARES Act—Revised

Publications

- Enhancing RN Supervision of Hospice Aide Services

Multimedia

- Medicare Secondary Payer (MSP) Provision (June 2020)

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MLN Connects® for Thursday, August 27, 2020

COVID-19: Training to Strengthen Nursing Home Infection Control Practices

MLN Connects® for Thursday, August 27, 2020

View this edition as a PDF

News

- Trump Administration Launches National Training Program to Strengthen Nursing Home Infection Control Practices
- SNF Provider Preview Reports: Review Your Data by August 30
- COVID: Nursing Home Toolkit
- Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier

Claims, Prices & Codes

- COVID-19: Waive Cost Sharing for These HCPCS Codes

MLN Matters® Articles

- Medicare Part A Skilled Nursing Facility (SNF) Prospective Payment System (PPS) Pricer Update FY 2021 — Revised
- October 2020 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files — Revised

Publications

- Creating an Effective Hospice Plan of Care

Multimedia

- Physician Fee Schedule Listening Session: Audio Recording and Transcript

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MLN Connects® – Special Edition – Friday, August 28, 2020

CMS Offers Comprehensive Support for Louisiana and Texas with Hurricane Laura

On August 27, CMS announced efforts underway to support Louisiana and Texas in response to Hurricane Laura. On August 26, 2020, Department of Health and Human Services (HHS) Secretary Alex Azar declared public health emergencies (PHEs) in these states, retroactive to August 22, 2020 for the state of Louisiana and to August 23, 2020 for the state of Texas. CMS is working to ensure hospitals and other facilities can continue operations and provide access to care despite the effects of Hurricane Laura.

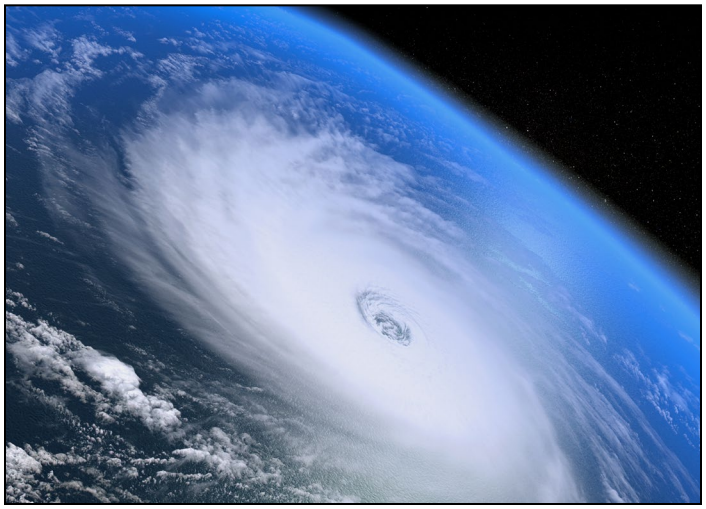
CMS provided numerous waivers to health care providers during the current coronavirus disease 2019 (COVID-19) pandemic to meet the needs of beneficiaries and providers. The *waivers* already in place will be available to health care providers to use during the duration of the COVID-19 PHE determination timeframe and for the Hurricane Laura PHE. CMS may waive certain additional Medicare, Medicaid, and Children's Health Insurance Program (CHIP) requirements, create special enrollment opportunities for individuals to access healthcare quickly, and take steps to ensure dialysis patients obtain critical life-saving services.

"Our thoughts are with everyone who is in the path of this powerful and dangerous hurricane and CMS is doing everything within its authority to provide assistance and relief to all who are affected," said CMS Administrator Seema Verma. "We will partner and coordinate with state, federal, and local officials to make sure that in the midst of all of the uncertainty a natural disaster can bring, our beneficiaries will not have to worry about access to healthcare and other crucial life-saving and sustaining services they may need."

Below are key administrative actions CMS will be taking in response to the PHEs declared in Louisiana and Texas:

Waivers and Flexibilities for Hospitals and Other Healthcare Facilities: CMS has already waived many Medicare, Medicaid, and CHIP requirements for facilities. The CMS Dallas Survey & Enforcement Division, under the Survey Operations Group, will grant other provider-specific requests for specific types of hospitals and other facilities in Louisiana and Texas. These waivers, once issued, will help provide continued access to care for beneficiaries. For more information on the waivers CMS has granted, visit *www.cms.gov/emergency*.

Special Enrollment Opportunities for Hurricane Victims: CMS will make available special enrollment periods for certain Medicare beneficiaries and certain individuals seeking health plans offered through the Federal Health Insurance Exchange. This gives people impacted by the hurricane the opportunity to change their Medicare health and prescription drug plans and gain access to health coverage on the Exchange if eligible for the special enrollment period. For more



information, please visit:

- *https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/8-9-natural-disaster-SEP.pdf*
- *https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Past-Emergencies/Hurricanes-and-tropical-storms.html*

Disaster Preparedness Toolkit for State Medicaid Agencies: CMS developed an inventory of Medicaid and CHIP flexibilities and authorities available to states in the event of a disaster. For more information and to access the toolkit, visit: *https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/index.html*.

Dialysis Care: CMS is helping patients obtain access to critical life-saving services. The Kidney Community Emergency Response (KCER) program has been activated and is working with the End Stage Renal Disease (ESRD) Network, Network 13 – Louisiana, and Network 14 - Texas, to assess the status of dialysis facilities in the potentially impacted areas related to generators, alternate water supplies, education and materials for patients and more.

The KCER is also assisting patients who evacuated ahead of the storm to receive dialysis services in the location to which they evacuated. Patients have been educated to have an emergency supply kit on hand including important personal, medical, and insurance information; contact information for their facility, the ESRD Network hotline number, and contact information of those with whom they may stay or for out-of-state contacts in a waterproof bag. They have also been instructed to have supplies on hand to follow a three-day emergency diet. The ESRD Network 8 – Mississippi hotline is 1-800-638-8299, Network 13 – Louisiana hotline is 800-472-7139, the ESRD Network 14 - Texas hotline is 877-886-4435, and the KCER hotline is 866-901-3773. Additional information is available on the KCER website *https://www.kcercoalition.com/*.

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During the 2017 and 2018 hurricane seasons, CMS approved special purpose renal dialysis facilities in several states to furnish dialysis on a short-term basis at designated locations to serve ESRD patients under emergency circumstances in which there were limited dialysis resources or access-to-care problems due to the emergency circumstances.

Medical equipment and supplies replacements: Under the COVD-19 waivers, CMS suspended certain requirements necessary for Medicare beneficiaries who have lost or realized damage to their durable medical equipment, prosthetics, orthotics, and supplies as a result of the PHE. This will help to make sure that beneficiaries can continue to access the needed medical equipment and supplies they rely on each day. Medicare beneficiaries can contact 1-800-MEDICARE (1-800-633-4227) for assistance.

Ensuring Access to Care in Medicare Advantage and Part D: During a public health emergency, Medicare Advantage Organizations and Part D Plan sponsors must take steps to maintain access to covered benefits for beneficiaries in affected areas. These steps include allowing Part A/B and supplemental Part C plan benefits to be furnished at specified non-contracted facilities and waiving, in full, requirements for gatekeeper referrals where applicable.

Emergency Preparedness Requirements: Providers and suppliers are expected to have emergency preparedness programs based on an all-hazards approach. To assist in the understanding of the emergency preparedness requirements, CMS Central Office and the Regional Offices hosted two webinars in 2018 regarding Emergency Preparedness requirements and provider expectations. One was an all provider training on June 19, 2018 with more than 3,000 provider participants and the other an all-surveyor training on August 8, 2018. Both presentations covered the emergency preparedness final rule which included emergency power supply; 1135 waiver process; best practices and lessons learned from past disasters; and helpful resources and more. Both webinars are available at *https://qsep.cms.gov/welcome.aspx*.

CMS also compiled a list of Frequently Asked Questions (FAQs) and useful national emergency preparedness resources to assist state Survey Agencies (SAs), their state, tribal, regional, local emergency management partners and health care providers to develop effective and robust emergency plans and tool kits to assure compliance with the emergency preparedness rules. The tools can be located at:

- *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Emergency-Prep-Rule.html*
- *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Templates-Checklists.html*

CMS Regional Offices have provided specific emergency preparedness information to Medicare providers and suppliers through meetings, dialogue, and presentations. The regional offices also provide regular technical assistance in emergency preparedness to state agencies and staff, who, since November 2017, have been regularly surveying providers and suppliers for compliance with emergency preparedness regulations.

Additional information on the emergency preparedness requirements can be found here: *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_z_emergprep.pdf*

CMS will continue to work with all geographic areas impacted by Hurricane Laura. We encourage beneficiaries and providers of healthcare services that have been impacted to seek help by visiting CMS' emergency webpage *(www.cms.gov/emergency)*.

For more information about the HHS PHE, please visit: *https://www.hhs.gov/about/news/2020/08/26/hhs-secretary-azar-declares-public-health-emergencies-in-louisiana-and-texas-due-to-hurricane-laura.html*.

Medicare Learning Network®

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

MLN Connects® – Special Edition – Wednesday, September 2, 2020

CMS Advancing Seniors' Access to Cutting-edge Therapies and Technology in Medicare Hospital Rule

Finalized policy changes expand new technology add-on payment pathway for certain antimicrobials

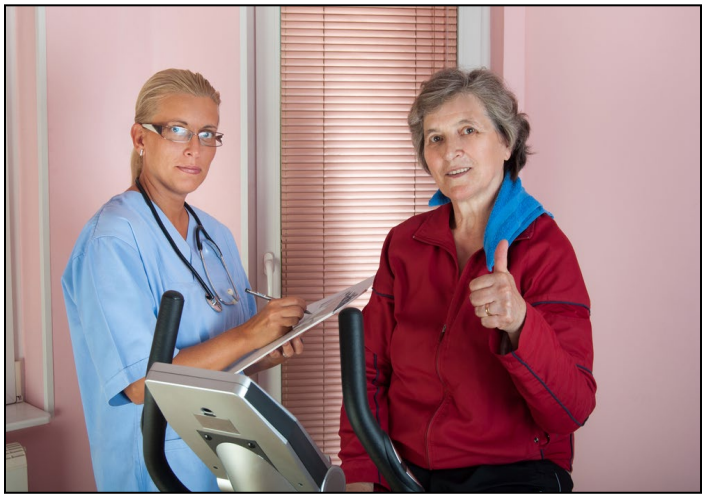
On September 2, CMS issued the FY 2021 Medicare Hospital Inpatient Prospective Payment System and Long Term Acute Care Hospital (LTCH) final rule, which includes important provisions designed to ensure access to potentially life-saving diagnostics and therapies for hospitalized Medicare beneficiaries. The changes will affect approximately 3,200 acute care hospitals and approximately 360 LTCHs. CMS estimates that total Medicare spending on acute care inpatient hospital services will increase by about $3.5 billion in FY 2021, or 2.7 percent.

"President Trump is committed to ensuring that seniors on Medicare have access to the latest life-saving diagnostics and therapies," said CMS Administrator Seema Verma. "This rule is another critical step in our effort to modernize the program and strip away bureaucratic barriers between our seniors and the latest innovative treatments."

CMS' rule creates a new Medicare Severity Diagnostic Related Group (MS-DRG) that provides a predictable payment to help adequately compensate hospitals for administering Chimeric Antigen Receptor (CAR) T-cell therapies. The current FDA-approved CAR-T-cell cancer therapies use a patient's genetically modified immune cells to treat specific types of cancer.

Also in the final rule, CMS approved a record number of 24 New Technology Add-on Payments (NTAPs), which is an additional payment to hospitals for cases involving eligible new and relatively high cost technologies. Last year, to remove barriers to innovation, CMS established alternative streamlined pathways for FDA Breakthrough Devices and FDA Qualified Infectious Disease Products (QIDPs) to qualify for NTAPs. Among CMS' approval of these 24 additional NTAPs are two technologies for new medical devices that are part of the FDA's Breakthrough Devices Program and six technologies that received FDA QIDP designation. This will provide additional Medicare payment for these technologies while real-world evidence is emerging, giving Medicare beneficiaries timely access to the latest innovations.

CMS is also expanding the add-on payment alternative pathway for antimicrobial products approved under FDA's Limited Population Pathway for Antibacterial and Antifungal Drugs (LPAD pathway), which encourages the development of safe and effective drug products that



address unmet needs of patients with serious bacterial and fungal infections. Specifically, an antibacterial or antifungal drug approved under the LPAD pathway is used to treat a serious or life-threatening infection in a limited population of patients with unmet needs.

CMS is also taking steps to ensure that the Medicare Fee-for-Service (FFS) program adopts pricing strategies based on real world market forces. Medicare generally pays hospitals a rate that is weighted by the relative cost of providing certain services based on a patient's diagnosis. These weights are currently based in large part on the charges that hospitals report to the federal government, which often have little relevancy to the actual rates paid by insurance companies. Hospitals are already required to report these negotiated rates as part of the Trump Administration's efforts to promote price transparency, and CMS is now finalizing a requirement for hospitals to report to CMS the median rate negotiated with Medicare Advantage Organizations for inpatient services to use instead of the charge based data. CMS will begin to collect this data in 2021 and will use it in the methodology for calculating inpatient hospital payments beginning in 2024. These provisions will introduce the influences of market competition into hospital payment and help advance CMS's goal of utilizing market- based pricing strategies in the Medicare FFS program.

For More Information:

- *Final Rule*
- *Fact Sheet*

MLN Connects® for Thursday, September 3, 2020

CMS Acts to Spur Innovation for America's Seniors

MLN Connects® for Thursday, September 3, 2020

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News

- CMS Acts to Spur Innovation for America's Seniors
- Hospital Opioid Toolkit
- CMS Offers Comprehensive Support for California due to Wildfires
- PEPPERs for Short-term Acute Care Hospitals
- Office Visits by Nurse Practitioners: Comparative Billing Report

Events

- Dementia Care Call — September 22

MLN Matters® Articles

- 2021 Annual Update for the Health Professional Shortage Area (HPSA) Bonus Payments
- Annual Clotting Factor Furnishing Fee Update 2021
- Claim Status Category and Claim Status Codes Update
- 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
- Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Updates for Fiscal Year (FY) 2021
- The Intravenous Immune Globulin (IVIG) Demonstration: Demonstration is ending on December 31, 2020
- October 2020 Integrated Outpatient Code Editor (I/OCE) Specifications Version 21.3
- October Quarterly Update for 2020 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule
- Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment — Revised
- Update to the International Classification of Diseases, Tenth Revision (ICD-10) Diagnosis Codes for Vaping Related Disorder and Diagnosis and Procedure Codes for the 2019 Novel Coronavirus (COVID-19) — Revised

Publications

- Medicare Preventive Services — Revised
- Medicare Preventive Services Poster — Revised

MLN Connects® for Thursday, September 10, 2020

CMS Care Compare Empowers Patients

MLN Connects® for Thursday, September 10, 2020

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News

- CMS Care Compare Empowers Patients When Making Important Health Care Decisions
- Open Payments: Adding 5 Provider Types in 2021
- Breast Re-Excision: Comparative Billing Report in September

Events

- CMS-CDC Fundamentals of COVID-19 Prevention for Nursing Home Management Call — September 10
- Dementia Care Call — September 22

MLN Matters® Articles

- October 2020 Update of the Hospital Outpatient Prospective Payment System (OPPS)
- Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index and Hospice Pricer for FY 2021
- Inpatient Rehabilitation Facility (IRF) Annual Update: Prospective Payment System (PPS) Pricer Changes for FY 2021
- Internet Only Manual Update to Pub. 100-04, Chapter 16, Section 60.1.2 and Pub. 100-04, Chapter 26, Section 10.4, Item 19
- Update to the Model Admission Questions for Providers to Ask Medicare Beneficiaries
- National Coverage Determination (NCD 30.3.3): Acupuncture for Chronic Low Back Pain (cLBP) — Revised

Publications

- Understanding Your Remittance Advice Reports
- Home Health, Hospice, IRF, LTCH, & SNF Quality Reporting Programs: COVID-19 Public Reporting

Multimedia

- Pain Management Listening Session: Audio Recording & Transcript
- Introduction to the LTCH Quality Reporting Program Web-Based Training
- Introduction to the Home Health Quality Reporting Program Web-Based Training

MLN Connects® – Special Edition – Friday, September 11, 2020

Community Health Access and Rural Transformation Model

The CMS Innovation Center announced the Community Health Access and Rural Transformation (CHART) Model.

The approximately 57 million Americans living in rural communities, including millions of Medicare and Medicaid beneficiaries, face unique challenges when seeking health care services, such as limited transportation options, shortages of health care services, and an inability to fully benefit from technological and care-delivery innovations.

Current regulations and volume-based payment structures perpetuate these challenges, with unsustainable financial models leading to over 130 rural hospitals closing since 2010. The constellation of reduced access to care and patients not seeking or delaying care leads to rural Americans facing worse health outcomes and having higher rates of preventable diseases than those living in urban areas.

CMS remains focused on the transformation of rural health care delivery and enabling local community collaboration to redesign their systems of care and align across providers and payers based on their unique needs. As part of that rural transformation, including transforming a system built on fee-for-service and volume to one based on value, CMS is testing the CHART Model.

Through the Model, CMS is directly providing a pool of $75M in upfront, seed funding, with 15 rural communities applying for up to $5M to develop local transformation plans. With this upfront seed funding, CMS is also providing regulatory and operational flexibility for updated service delivery models as well as changing how participating hospitals in these communities are paid, from a system based on volume to stable, monthly payments. In additional to supporting these 15 rural communities, CMS is also looking for 20 rural Accountable Care Organizations (ACOs) to participate in the model, paying shared savings upfront so that ACOs have infrastructure funding to be successful on the move towards achieving better outcomes. Taken together, these are substantial and tangible actions to support health care in our rural communities.

Specifically, the CHART Model will:

- Increase financial stability for rural health care providers through multiple new funding approaches, including the use of up-front investments and predictable, capitated payments that pay for quality and patient outcomes over volume
- Provide the necessary operational and regulatory flexibilities to allow health care providers and CMS to test the Model in their local communities and successfully transform themselves

- Support local rural communities' transformation efforts by being directly engaged at CMS, offering real-time technical expertise and other learning when needed to foster success

If successful, beneficiaries' access to health care services should be improved, rural provider's financial sustainability should increase for years to come, and communities can align with payers and other stakeholders to address both their health care service delivery ecosystem and the necessary social support structures, such as food and housing, to deliver improved health. Ultimately, the CHART Model aims to improve quality and health, while reducing Medicare and Medicaid expenditures, in rural communities over the long-term.

CMS is providing funding, regulatory and operational flexibilities, and technical assistance for rural communities to transform their systems of care through a Community Transformation Track. Further, CMS is enabling providers to participate in value-based payment models where they are paid for quality and outcomes, instead of volume, through an ACO Transformation Track.

CMS anticipates the Notice of Funding Opportunity for the Community Transformation Track will be available in September on the Model website. The Request for Application for the ACO Transformation Track will be available in early 2021 on the *CHART Model* website.

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

MLN Connects® for Thursday, September 17, 2020

Participate in Medical Documentation Interoperability Pilot

MLN Connects® for Thursday, September 17, 2020

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News

- SNF Healthcare-Associated Infections Measure: Submit Comments by October 14
- Participate in Medical Documentation Interoperability Pilot
- COVID-19 Lessons Learned & Infectious Disease Surge Annex Template
- Healthy Aging® Month: Discuss Preventive Services with Your Patients
- Prostate Cancer Awareness Month

Events

- Dementia Care Call — September 22

MLN Matters® Articles

- October 2020 Update of the Ambulatory Surgical Center (ASC) Payment System
- New Waivers for Inpatient Prospective Payment System (IPPS) Hospitals, Long-Term Care Hospitals (LTCHs), and Inpatient Rehabilitation Facilities (IRFs) due to Provisions of the CARES Act — Revised
- Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index, and Hospice Pricer for FY 2021 — Revised

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MLN Connects® – Special Edition – Thursday, September 17, 2020

- *Independent Nursing Home COVID-19 Commission Findings Validate Unprecedented Federal Response*
- *CMS Offers Comprehensive Support for Oregon due to Wildfires*
- *Protect Yourself & Your Patients from Flu this Season*

Independent Nursing Home COVID-19 Commission Findings Validate Unprecedented Federal Response

On September 16, CMS received the final report from the independent Coronavirus Commission for Safety and Quality in Nursing Homes (Commission), which was facilitated by MITRE. CMS also released an overview of the robust public health actions the agency has taken to date to combat the spread of the Coronavirus Disease 2019 (COVID-19) in nursing homes. The Commission's findings align with the actions the Trump Administration and CMS have taken to contain the spread of the virus and to safeguard nursing home residents from the ongoing threat of the COVID-19 pandemic. This announcement delivers on the Administration's commitments to keeping nursing home residents safe and to transparency for the American people in the face of this unprecedented pandemic.

"The Trump Administration's effort to protect the uniquely vulnerable residents of nursing homes from COVID-19 is nothing short of unprecedented," said CMS Administrator Seema Verma. "In tasking a contractor to convene this independent Commission comprised of a broad range of experts and stakeholders, President Trump sought to refine our approach still further as we continue to battle the virus in the months to come. Its findings represent both an invaluable action plan for the future and a resounding vindication of our overall approach to date. We are grateful for the Commission's important contribution."

As the capstone to the Commission's extensive report, on September 17, Administrator Verma will join Vice President Mike Pence and CDC Director Dr. Robert R. Redfield, some members of the Commission, and other public health and elder care experts at the White House. The Vice President, Dr. Redfield, and Administrator Verma will lead the group in a discussion regarding the Commission's findings and general issues facing the nation's elder care system.

Nursing homes and other shared or congregate living facilities have been severely affected by COVID-19, as these facilities often house older individuals who suffer from multiple medical conditions, making them particularly susceptible to complications from the virus. To help CMS inform immediate and future actions as well as identify opportunities for improvement, the Commission was created to conduct an independent review and comprehensive assessments of confronting COVID-19. The Commission's report contains best practices that emphasize and reinforce CMS strategies and initiatives to ensure nursing home residents are protected from COVID-19.

As outlined in the overview released on September 16, the Trump Administration has already taken significant steps to implement many of the Commission's findings. The Administration has worked to support nursing homes financially during this challenging time, distributing over $21 billion to America's nursing homes – more than $1.5 million each on average. To ensure nursing homes had access to supplies, the Trump Administration shipped a 14-day supply of personal protective equipment to more than 15,000 nursing homes across the Nation in May.

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The Administration has also required facilities to report data about COVID-19 cases, deaths, and supply levels, with 99.3 percent of facilities currently reporting. CMS took action to keep COVID-19 out of nursing homes by requiring them to test staff, a requirement that was paired with the Administration's distribution of 13,850 point-of-care testing devices to America's nursing homes. The Administration has also deployed federal Task Force Strike Teams in six waves, in 18 states so far, to 61 facilities particularly affected by COVID-19 to share best practices and gain a deeper understanding of how the virus spreads. CMS also required states to conduct focused infection control inspections at their nursing homes; between June and July, states completed these inspections at 99.8 percent of Medicare and Medicaid certified nursing homes.

Additionally, since March, CMS has conducted weekly calls with nursing homes, issued over 22 guidance documents and established a National Nursing Home COVID-19 Training program focused on infection control and best practices. CMS is also using COVID-19 data to target support to the highest risk nursing homes. In May, CMS released a new toolkit developed to aid nursing homes, Governors, states, departments of health, and other agencies who provide oversight and assistance to nursing homes. The toolkit is a catalogue of resources dedicated to addressing the specific challenges facing nursing homes as they combat COVID-19. CMS updates the toolkit on a biweekly basis.

For More Information:

- *Coronavirus Commission for Safety and Quality in Nursing Homes Report*
- *Trump Administration Response to Commission findings*
- *COVID-19 Guidance and Updates for Nursing Homes during COVID-19*

See the full text of this excerpted *CMS Press Release* (issued September 16), including a list of CMS public health actions for nursing homes on COVID-19 to date.

CMS Offers Comprehensive Support for Oregon due to Wildfires

On September 17, CMS announced efforts underway to support Oregon in response to wildfires across the state. On September 16, HHS Secretary Alex Azar declared a Public Health Emergency (PHE) in Oregon, retroactive to September 8. CMS is working to ensure hospitals and other facilities can continue operations and provide access to care despite the effects of the wildfires. CMS provided numerous waivers to health care providers during the current Coronavirus Disease 2019 (COVID-19) pandemic to meet the needs of beneficiaries and providers. These *waivers* will continue be available to health care providers to use for the duration of the COVID-19 PHE and for the wildfires PHEs. CMS will be waiving certain Medicare, Medicaid, and Children's Health Insurance Program requirements; creating special enrollment opportunities for individuals to access health care quickly; and taking steps to ensure dialysis patients obtain critical life-saving services.

For More Information, visit *http://www.cms.gov/emergency*. See the full text of this excerpted *CMS Press Release* (issued September 17).

Protect Yourself & Your Patients from Flu this Season

Do your part to prevent the spread of seasonal flu. The CDC published *flu vaccine recommendations* for the 2020-2021 season. Because of the COVID-19 pandemic, reducing the spread of respiratory illness, like flu, this fall and winter is more important than ever.

Frequency and Coverage:

- Medicare Part B covers one flu shot per flu season and additional flu shots if medically necessary
- Flu shots are free for your Medicare patients if you accept assignment

You can give pneumonia and flu shots during the same office visit; see *CDC recommendations*.

The *CDC*, the Advisory Committee on Immunization Practices, and the Healthcare Infection Control Practices Advisory Committee recommend that all U.S. health care workers get annual flu shots.

For More Information:

- *CMS Flu Shot* webpage
- *CDC Flu website*
- CDC Information for Health Professionals webpage
- *CDC Fight Flu Toolkit* webpage
- *Vaccines.gov*

MLN Connects® – Special Edition – Friday, September 18, 2020

- *CMS Announces New Guidance for Safe Visitation in Nursing Homes During COVID-19 Public Health Emergency*
- *CMS Announces Transformative New Model of Care for Medicare Beneficiaries with Chronic Kidney Disease*
- *CMS Announces Innovative Payment Model to Improve Care, Lower Costs for Cancer Patients*

CMS Announces New Guidance for Safe Visitation in Nursing Homes During COVID-19 Public Health Emergency

On September 17, CMS issued revised guidance providing detailed recommendations on ways nursing homes can safely facilitate visitation during the coronavirus disease 2019 (COVID-19) pandemic. After several months of visitor restrictions designed to slow the spread of COVID-19, CMS recognizes that physical separation from family and other loved ones has taken a significant toll on nursing home residents. In light of this, and in combination with increasingly available data to guide policy development, CMS is issuing revised guidance to help nursing homes facilitate visitation in both indoor and outdoor settings and in compassionate care situations. The guidance also outlines certain core principles and best practices to reduce the risk of COVID-19 transmission to adhere to during visitations.

See the full text of this excerpted *CMS Press Release* (issued September 17).

CMS Announces Transformative New Model of Care for Medicare Beneficiaries with Chronic Kidney Disease

Model focuses on reducing costs and improving quality of care for patients

On September 18, CMS announced it has finalized the End-Stage Renal Disease (ESRD) Treatment Choices (ETC) Model, to improve or maintain the quality of care and reduce Medicare expenditures for patients with chronic kidney disease. The ETC Model delivers on President Trump's Advancing Kidney Health Executive Order and encourages an increased use of home dialysis and kidney transplants to help improve the quality of life of Medicare beneficiaries with ESRD. The ETC Model will impact approximately 30 percent of kidney care providers and will be implemented on January 1, 2021 at an estimated savings of $23 million over five and a half years.

"Over the past year, the Trump Administration has taken more action to advance American kidney health than we've seen in decades," said HHS Secretary Alex Azar. "This new payment model helps address a broken set of incentives that have prevented far too many Americans from benefiting from enjoying the better lives that could come with more convenient dialysis options or the possibility of a transplant."

For More Information:

- *Full Press Release*
- *Fact Sheet*

CMS Announces Innovative Payment Model to Improve Care, Lower Costs for Cancer Patients

Radiation Oncology Model will modernize Medicare payments for radiotherapy services

On September 18, CMS finalized a new Innovation Center model expected to improve the quality of care for cancer patients receiving radiotherapy and reduce Medicare expenditures through bundled payments that allow providers to focus on delivering high-quality treatments. The new Radiation Oncology (RO) Model allows this focus on value-based care by creating simpler, more predictable payments that incentivize cost-efficient and clinically effective treatments to improve quality and outcomes. The RO Model, part of a final rule on specialty care models issued by CMS, will begin on January 1, 2021 and is estimated to save Medicare $230 million over 5 years.

"President Trump knows that, for cancer patients, what matters is their quality of life and beating their cancer. But today, Medicare payment for radiotherapy is based on the number of treatments a patient receives and where they receive it, which can lead to spending more time traveling for treatment with little clinical value," said CMS Administrator Seema Verma. "That's why the Trump administration has developed a new innovative model that allows patients and providers to focus on better outcomes for patients."

For More information:

- *Full Press Release*
- *Fact Sheet*
- Radiation Oncology Model webpage

These Models are a part of a CMS *final rule* on Medicare Program; Specialty Care Models To Improve Quality of Care and Reduce Expenditures (CMS-5527-F).

Phone numbers

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866-454-9007
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Fax number (for general inquiries)
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First Coast Service Options
Part B Claims and Claims ADR FL P.O. Box 2009
Mechanicsburg, PA 17055-0709

Redeterminations
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Redetermination of overpayments
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Reconsiderations
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First Coast University

Beneficiaries
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