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

In this issue

MLN Connects® – Special Edition – October 16, 2020

Enforcement Discretion Relating to Certain Pharmacy Billing

The Centers for Medicare & Medicaid Services ("CMS") appreciates its long-standing partnership with immunizers, including pharmacies, to facilitate the efficient administration of vaccinations, particularly for vulnerable populations in long-term care facilities and other congregate care settings across America. Leveraging immunizers' capabilities and expertise will play an important role in the Department's ability to broadly distribute and administer COVID-19 vaccinations, including Medicare beneficiaries.

America is facing an unprecedented challenge. Quickly, safely, and effectively vaccinating our most vulnerable citizens in settings that have accounted for about 30 percent of U.S. COVID-19 deaths is a top-priority mission for the Trump Administration. Unfortunately, many long-term care facilities may not have sufficient capacity to receive, store, and administer vaccines. And some long-term care facility residents cannot safely leave the facility to receive vaccinations.

Outside immunizers can help fill that urgent need and provide onsite vaccinations at skilled nursing facilities ("SNFs"). But to do so during this global emergency, Medicare-enrolled vaccinators must be able to bill directly and receive direct reimbursement from the Medicare program.

However, the Social Security Act requires SNFs to bill for certain services, including vaccine administration, even when SNFs rely on an outside vendor to perform the service. See Social Security Act §§ 1862(a)(18), 1842(b)(6)(E).

Therefore, in order to facilitate the efficient administration of COVID-19 vaccines to SNF residents, CMS will exercise enforcement discretion with respect to these statutory provisions as well as any associated statutory references and implementing regulations, including as interpreted in pertinent guidance (collectively, "SNF Consolidated Billing Provisions"). Through the exercise of that discretion, CMS will allow Medicare-enrolled immunizers, including but not limited to pharmacies working with the United States, to bill directly and receive direct reimbursement from the Medicare program for vaccinating Medicare SNF residents.

CMS will exercise such discretion (1) during the emergency period defined in paragraph (1)(B) of section 1135(g) of the Social Security Act (42 U.S.C. § 1320b-5(g)) and ending on the last day of the calendar quarter in which the last day of such emergency period occurs; or (2) so long as CMS determines that there is a public health need for mass COVID-19 vaccinations in congregate care settings—whichever is later. While CMS exercises this enforcement discretion, compliance with SNF Consolidated Billing Provisions is not material to CMS' decision to reimburse for COVID-19 vaccine administration. If CMS decides in the future to cease exercising this enforcement discretion, CMS will provide public notice in advance and allow at least 60 days for affected outside immunizers to modify their business practices.

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

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.

Local coverage determinations

The *LCDs/Medical Affairs* section of our website provides you with the latest *medical affairs news*, *active LCDs*, and *proposed LCDs*.

You can also find information on *self-administered drug exclusions* and *clinical trials*.

First Coast has made it easy to locate active, proposed, and retired LCDs on the *Active LCD Index*.

The *LCD search tool* 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.

In addition to using the search tools, First Coast's LCDs are available using CMS' *Medicare Coverage Database (MCD)*.

Reasonable and necessary guidelines

In the absence of an LCD, *national coverage determination (NCD)*, or CMS manual instruction, reasonable and necessary guidelines still apply.

Section 1862(a) (1) (A) of the Social Security Act directs the following:

No payment may be made under Part A or Part B for any expenses incurred for items or services not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Note: Malformed is defined as (of a person or part of the body) abnormally formed; misshapen.

The Medicare administrative contractor will determine if an item or service is "reasonable and necessary" under §1862(a) (1) (A) of the Act if the service is:

- Safe and effective
- Not experimental or investigational; and
- Appropriate, including the duration and frequency in terms of whether the service or item is:
- Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the beneficiary's condition or to improve the function of a malformed body member;
- Furnished in a setting appropriate to the beneficiary's medical needs and condition;
- Ordered and furnished by qualified personnel; and
- One that meets, but does not exceed, the beneficiary's medical need

Medicare news

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.

2021 ICD-10-CM coding changes

The billing and coding articles were revised with the 2021 updates to the ICD-10-CM diagnosis coding structure 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 a LCD (when present) may be found at the bottom of the LCD 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*.

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 and wish 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

Upcoming provider outreach and educational events

Medicare's medical review programs (A/B)

Date: Tuesday, November 10, 2020
Time: 10 - 11:30 a.m. ET
Type of Event: Webcast

View our complete calendar of events

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

Two easy ways to register

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

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

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

Please Note:

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

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Provider Address: _____

City, State, ZIP Code: _____

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

Never miss a training opportunity

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

Take advantage of 24-hour access to free online training

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

CMS MLN Connects®

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

MLN Connects® for September 24, 2020

MLN Connects® for September 24, 2020

View this edition as a PDF

News

- CMS to Expand Successful Ambulance Program Integrity Payment Model Nationwide
- Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier
- COVID-19: Maintaining Safety, Critical Care Load-Balancing, & Behavioral Health
- National Cholesterol Education Month & World Heart Day

Claims, Pricers & Codes

- Medicare Diabetes Prevention Program: Valid Claims

Events

- CMS-CDC Fundamentals of COVID-19 Prevention for Nursing Home Management Call — September 24

MLN Matters® Articles

- 2021 Annual Update of Healthcare Common Procedure Coding System (HCPCS) Codes for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Update
- National Coverage Determination (NCD 90.2): Next Generation Sequencing (NGS) for Medicare Beneficiaries with Germline (Inherited) Cancer
- Update to the Medicare Claims Processing Manual
- Update to the Model Admission Questions for Providers to Ask Medicare Beneficiaries — Revised

Publications

- Checking Medicare Eligibility

Find out first: Subscribe to First Coast *eNews*

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

MLN Connects® for October 1, 2020

MLN Connects® for October 1, 2020

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Editor's Note

This edition includes a new section, Information for Your Medicare Patients, which mirrors information your patients get from Medicare. We'll include occasional messages to help you answer questions from your patients.

News

- Hospital Price Transparency: Requirements Effective January 1
- IRF Provider Preview Reports: Review Your Data by October 26
- LTCH Provider Preview Reports: Review Your Data by October 26
- Therapeutic Injections and Infusions: Comparative Billing Report
- SNF Healthcare-Associated Infections Confidential Dry Run Report
- COVID-19: Optimizing Health Care PPE and Supplies
- Hospice Quality Reporting Program News
- October is National Breast Cancer Awareness Month

MLN Matters® Articles

- Fiscal Year (FY) 2021 Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital (LTCH) PPS Changes
- Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Edits, Version 27.0, Effective January 1, 2021
- Change to the Payment of Allogeneic Stem Cell Acquisition Services — Revised
- New Physician Specialty Code for Micrographic Dermatologic Surgery (MDS) and Adult Congenital Heart Disease (ACHD) and a New Supplier Specialty Code for Home Infusion Therapy Services — Revised
- October 2020 Update of the Ambulatory Surgical Center (ASC) Payment System — Revised
- October 2020 Update of the Hospital Outpatient Prospective Payment System (OPPS) — Revised
- Penalty for Delayed Request for Anticipated Payment (RAP) Submission -- Implementation — Revised
- Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment — Revised

Multimedia

- ICD-10 Coordination and Maintenance Committee Meeting Materials
- SNF Consolidated Billing Web-Based Training Course — Revised

Information for Medicare Patients

- Making Insulin More Affordable for Medicare Patients Beginning January 1

MLN Connects® for October 8, 2020

MLN Connects® for October 8, 2020

View this edition as a PDF

News

- Hospice Quality Reporting Program: Successful Facilities for FY 2021
- Laboratories: Pay Your CLIA Certification Fees Online
- Institutional Providers: Give Us Your Feedback on the Provider Specific File by November 1
- Submit Medicare GME Affiliation Agreements during COVID-19 PHE by January 1
- COVID-19: Optimizing PPE and Child Health and Wellness
- Ostomies are Life-Savers

Events

- CMS-CDC Fundamentals of COVID-19 Prevention for Nursing Home Management Call — October 8

Publications

- Laboratory Quick Start Guide for CLIA Certification
- Provider Compliance Tips — Revised
- ICD-10-CM, ICD-10-PCS, CPT, and HCPCS Code Sets — Revised
- DMEPOS Accreditation — Revised
- SNF and LTCH Quality Reporting Programs: COVID-19 Public Reporting — Revised

Multimedia

- Dementia Care Call: Audio Recording and Transcript

MLN Connects - Special Edition – October 8, 2020

CMS Announces New Repayment Terms for Medicare Loans Made to Providers During COVID-19

New recoupment terms allow providers and suppliers one additional year to start loan payments

CMS announced amended terms for payments issued under the Accelerated and Advance Payment (AAP) Program as required by recent action by President Trump and Congress.

This Medicare loan program allows CMS to make advance payments to providers, which are typically used in emergency situations. Under the Continuing Appropriations Act, 2021 and Other Extensions Act, repayment will now begin one year from the issuance date of each provider or supplier's accelerated or advance payment. CMS issued $106 billion in payments to providers and suppliers in order to alleviate the financial burden health care providers faced while experiencing cash flow issues in the early stages of combating the Coronavirus Disease 2019 (COVID-19) public health emergency.

"In the throes of an unprecedented pandemic, providers and suppliers on the frontlines needed a lifeline to help keep them afloat," said CMS Administrator Seema Verma. "CMS' advanced payments were loans given to providers and suppliers to avoid having to close their doors and potentially causing a disruption in service for seniors. While we are seeing patients return to hospitals and doctors providing care we are not yet back to normal," she added.

CMS expanded the AAP Program on March 28, 2020, and gave these loans to health care providers and suppliers in order to combat the financial burden of the pandemic. CMS successfully paid more than 22,000 Part A providers, totaling more than $98 billion in accelerated payments. This included payments to Part A providers for Part B items and services they furnished. In addition, more than 28,000 Part B suppliers, including doctors, non-physician practitioners, and durable medical equipment suppliers received advance payments totaling more than $8.5 billion.

Providers were required to make payments starting in August of this year, but with this action, repayment will be delayed until one year after payment was issued. After that first year, Medicare will automatically recoup 25% of Medicare payments otherwise owed to the provider or supplier for 11 months. At the end of the 11-month period, recoupment will increase to 50% for another 6 months. If the provider or supplier is unable to repay the total amount of the AAP during this time-period (a total of 29 months), CMS will issue letters requiring repayment of any outstanding balance, subject to an interest rate of 4%.

The letter also provides guidance on how to request an Extended Repayment Schedule (ERS) for providers and suppliers who are experiencing financial hardships. An ERS is a debt installment payment plan that allows a provider or supplier to pay debts over the course of 3 years, or, up to 5 years in the case of extreme hardship. Providers and suppliers are encouraged to contact their MAC for information on how to request an ERS.

To allow even more flexibility in paying back the loans, the $175 billion issued in Provider Relief funds can be used towards repayment of these Medicare loans. CMS will be communicating with each provider and supplier in the coming weeks as to the repayment terms and amounts owed as applicable for any accelerated or advance payment issued.

For More Information:

- *Fact Sheet*
- *FAQs*

MLN Connects® for October 15, 2020

MLN Connects® for October 15, 2020

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News

- CMS Takes Action to Protect Integrity of COVID-19 Testing
- Protect Your Patients: Give Them a Flu Shot

Events

- Medicare Part A Cost Report: New Bulk e-Filing Feature Webcast — October 29

MLN Matters® Articles

- New Waived Tests
- January 2021 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files
- October 2020 Integrated Outpatient Code Editor (I/OCE) Specifications Version 21.3 — Revised
- Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index, and Hospice Pricer for FY 2021 — Revised

Publications

- Provider Compliance Tips for Glucose Monitors and Diabetic Accessories/Supplies — Revised

Multimedia

- Coverage of an Annual Wellness Visit Video

Information for Medicare Patients

- Medicare Health and Drug Plans Receive Star Ratings

MLN Connects® – Special Edition – October 15, 2020

Trump Administration Drives Telehealth Services in Medicaid and Medicare

On October 14, CMS expanded the list of telehealth services that Medicare Fee-for-Service will pay for during the COVID-19 Public Health Emergency (PHE). CMS is also providing additional support to state Medicaid and Children's Health Insurance Program (CHIP) agencies in their efforts to expand access to telehealth. The actions reinforce President Trump's Executive Order on Improving Rural Health and Telehealth Access to improve the health of all Americans by increasing access to better care.

"Responding to President Trump's Executive Order, CMS is taking action to increase telehealth adoption across the country," said CMS Administrator Seema Verma. "Medicaid patients should not be forgotten, and today's announcement promotes telehealth for them as well. This revolutionary method of improving access to care is transforming health care delivery in America. President Trump will not let the genie go back into the bottle."

Expanding Medicare Telehealth Services:

For the first time using a new expedited process, CMS added 11 new services to the Medicare telehealth services list since the publication of the May 1 COVID-19 Interim Final Rule with comment period (IFC). Medicare will begin paying eligible practitioners who furnish these newly added telehealth services effective immediately and for the duration of the PHE. These new telehealth services include certain neurostimulator analysis and programming services, and cardiac and pulmonary rehabilitation services. The list of these newly added services is available on the *List of Telehealth Services* webpage.

In the May 1 COVID-19 IFC, CMS modified the process for adding or deleting services from the Medicare telehealth

services list to allow for expedited consideration of additional telehealth services during the PHE outside of rulemaking. This update to the Medicare telehealth services list builds on the efforts CMS has already taken to increase Medicare beneficiaries' access to telehealth services during the COVID-19 PHE.

Since the beginning of the PHE, CMS added over 135 services to the Medicare telehealth services list – such as emergency department visits, initial inpatient and nursing facility visits, and discharge day management services. With this action, Medicare will pay for 144 services performed via telehealth. Between mid-March and mid-

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August, over 12.1 million Medicare beneficiaries – over 36% – of people with Medicare Fee-for-Service received a telemedicine service.

Preliminary Medicaid and CHIP Data Snapshot on Telehealth Utilization and Medicaid & CHIP Telehealth Toolkit Supplement:

In an effort to provide greater transparency on telehealth access in Medicaid and CHIP, CMS released, for the first time, a preliminary Medicaid and CHIP data snapshot on telehealth utilization during the PHE. This snapshot shows, among other things, that there have been more than 34.5 million services delivered via telehealth to Medicaid and CHIP beneficiaries between March and June of this year, representing an increase of more than 2,600% when compared to the same period from the prior year. The data also shows that adults ages 19-64 received the most services delivered via telehealth, although there was substantial variance across both age groups and states.

To further drive telehealth, CMS released a new supplement to its *State Medicaid & CHIP Telehealth Toolkit: Policy Considerations for States Expanding Use of Telehealth, COVID-19 Version* that provides numerous new examples and insights into lessons learned from states that implemented telehealth changes. The *updated supplemental information* is intended to help states strategically think through how they explain and clarify to providers and other stakeholders which policies are temporary or permanent. It also helps states identify services that can be accessed through telehealth, which providers may deliver those services, the ways providers may use in order to deliver services through telehealth, as well as the circumstances under which telehealth can be reimbursed once the PHE expires.

The toolkit includes approaches and tools states can use to communicate with providers on utilizing telehealth for patient care. It updates and consolidates in one place the FAQs and resources for states to consider as they begin planning beyond the temporary flexibilities provided in response to the pandemic.

View the Medicaid and CHIP data *snapshot* on telehealth utilization during the PHE.

Keep updated...

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

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
First Coast Service Options
Part B Claims and Claims ADR FL P.O. Box 2009
Mechanicsburg, PA 17055-0709

Redeterminations
Medicare Part B Redetermination
P.O. Box 3411
Mechanicsburg, PA 17055-1850

Redetermination of overpayments
First Coast Service Options Inc.
Overpayment Redetermination, Review Request
P.O. Box 3411
Mechanicsburg, PA 17055-1850

Reconsiderations
C2C Innovative Solutions Inc.
QIC Part B South
P.O. Box 45300
Jacksonville, FL 32232-5300

General inquiries
General inquiry request
P.O. Box 3411
Mechanicsburg, PA 17055-1850
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 17050

Medical Affairs
First Coast Service Options
Medical Affairs
2020 Technology Parkway
Suite 100
Mechanicsburg, PA 17050-9419
medicalaffairs@guidewellsource.com

Medicare secondary payer
First Coast Service Options
Part B Claims and Claims ADR FL P.O. Box 2009
Mechanicsburg, PA 17055-0709

Electronic data interchange (EDI)
First Coast Service Options Inc.
Attention: JN EDI
PO Box 3703
Mechanicsburg, PA 17055-1861

Overpayments
First Coast Service Options
JN Part B Florida Debt Recovery and Check Mail
P.O. Box 3092
Mechanicsburg, PA 17055-1810

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

Fraud and abuse
First Coast Service Options Inc.
JN Part A and B Complaint Processing Unit P.O. Box 3419
Mechanicsburg, PA 17055-1859

Freedom of Information Act requests
JN FOIA requests
P.O. Box 3425
Mechanicsburg, PA 17055-1825

Overnight mail and/or special courier service
First Coast Service Options Inc.
Attention: (Dept. or Work Type)
2020 Technology Parkway
Suite 100
Mechanicsburg, Pa 17050-9419

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

First Coast Service Options Inc.
Part B Claims VI
P.O. Box 2004
Mechanicsburg, PA 17055-0704

Redeterminations

First Coast Service Options
JN Redeterminations Part A/B
P.O. Box 3412
Mechanicsburg, PA 17055-1851

Redetermination of overpayments

First Coast Service Options Inc.
Overpayment Redetermination, Review Request
P.O. Box 3412
Mechanicsburg, PA 17055-1851

Reconsiderations

C2C Innovative Solutions Inc.
QIC Part B South
P.O. Box 45300
Jacksonville, FL 32232-5300

General inquiries

General inquiry request
P.O. Box 3411
Mechanicsburg, PA 17055-1850
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 17050

Medical Affairs

First Coast Service Options
Medical Affairs
2020 Technology Parkway
Suite 100
Mechanicsburg, PA 17050-9419
medicalaffairs@guidewellsource.com

Medicare secondary payer

First Coast Service Options Inc.
Part B Claims VI
P.O. Box 2004
Mechanicsburg, PA 17055-0704

Electronic data interchange (EDI)

First Coast Service Options Inc.
Attention: JN EDI
PO Box 3703
Mechanicsburg, PA 17055-1861

Overpayments

First Coast Service Options
JN Part B Puerto Rico and Virgin
Islands Debt Recovery and Check Mail
P.O. Box 3121
Mechanicsburg, PA 17055-1831

Medicare Education and Outreach

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

Fraud and abuse

First Coast Service Options Inc.
JN Part A and B Complaint Processing Unit P.O. Box 3419
Mechanicsburg, PA 17055-1859

Freedom of Information Act requests

JN FOIA requests
P.O. Box 3425
Mechanicsburg, PA 17055-1825

Special courier service

First Coast Service Options Inc.
Attention: (Dept. or Work Type)
2020 Technology Parkway, Suite 100
Mechanicsburg, Pa 17050-9419

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

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
First Coast Service Options
Part B Claims and Claims ADR PR/VI P.O. Box 2004
Mechanicsburg, PA 17055-070

Redeterminations
First Coast Service Options
JN Redeterminations Part A/B
P.O. Box 3412
Mechanicsburg, PA 17055-1851

Redetermination of overpayments
First Coast Service Options Inc.
Overpayment Redetermination, Review Request
P.O. Box 3412
Mechanicsburg, PA 17055-1851

Reconsiderations
C2C Innovative Solutions Inc.
QIC Part B South
P.O. Box 45300
Jacksonville, FL 32232-5300

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General inquiry request
P.O. Box 3411
Mechanicsburg, PA 17055-1850
EDOC-CS-PRINQB@fcso.com
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CMS-855 Applications
P. O. Box 3409
Mechanicsburg, PA 17055-1849

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Suite 100
Mechanicsburg PA 17050

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E-learning Center
First Coast University

Beneficiaries
Centers for Medicare & Medicaid Services
medicare.gov

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

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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		
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First Coast Service Options Inc.
P.O. Box 3411 - Mechanicsburg, PA 17055-1850

Attention Billing Manager