Medicare B CONNECTION

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FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction N Providers

August 2016

In this issue

Timely reporting of provider enrollment information changes

Provider types affected

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

Provider action needed

Stop – impact to you

Failure to comply with the requirements to report changes in your Medicare enrollment information could result in the revocation of your Medicare billing privileges. This article does not establish any new or revised policy, but serves as a reminder to comply with existing policy.

Caution – what you need to know

MLN Matters® article SE1617 reinforces the importance of the timely reporting of changes in your Medicare enrollment information.

Go – what you need to do

Comply with the reporting requirements for changes in your enrollment information and avoid disruption of your Medicare claims payments.

Background

In accordance with 42 Code of Federal Regulations (CFR) Section 424.516(d), all physicians, non-physician practitioners (for example, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives, clinical social workers, clinical psychologists, registered dietitians or nutrition professionals) and physician and non-physician practitioner organizations must report the following changes in their enrollment information to your MAC via the internet-based provider enrollment, chain and ownership system (PECOS) or the CMS-855 paper enrollment application within 30 days of the change:

- A change in ownership
- An adverse legal action, or
- A change in practice location.

You must report all other changes to your MAC within 90 days of the change.

If you are a supplier of durable medical equipment, prosthetics, orthotics, and supplies, you must report

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

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Articles included in the *Medicare B Connection* represent formal notice of coverage policies. Policies have or will take effect on the date given. Providers are expected to read, understand, and abide by the policies outlined within to ensure compliance with Medicare coverage and payment guidelines.

About the 'Medicare B Connection'

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

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

Who receives the *Connection*

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

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

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

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

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

Publication format

The *Connection* is arranged into distinct sections.

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

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

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

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

Never miss an appeals deadline again

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

Medicare Part B advance beneficiary notices

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

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

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

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

Patient liability notice

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

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

ABN modifiers

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

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

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

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

GA modifier and appeals

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

Cardiac Services

Widespread probe review for myocardial perfusion imaging

First Coast Service Options Inc. (First Coast) conducted a widespread post payment probe review in response to an aberrant billing pattern identified in Florida for Current Procedural Terminology (CPT®) code 78452 Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection. Services billed with dates of services February 1, 2015, to July 31, 2015, were reviewed to validate documentation supported the medical necessity of myocardial perfusion studies as identified in the local coverage determination cardiovascular nuclear imaging studies.

In addition to CPT® 78452 the following procedure codes and Healthcare Common Procedure Coding System (HCPCS) codes were also included in the widespread probe review:

- CPT® 93015 Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with supervision, interpretation and report.
- CPT® 93016 Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; supervision only, without interpretation and report.
- CPT® 93017 Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; tracing only, without interpretation and report.
- CPT® 93018 Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; interpretation and report only.
- HCPCS A9500 Technetium tc-99m sestamibi, diagnostic, per study dose.
- HCPCS A9502 Technetium tc-99m tetrofosmin, diagnostic, per study dose.
- HCPCS A9505 Thallium tl-201 thallous chloride, diagnostic, per millicurie.

- HCPCS J0153 Injection, adenosine, 1 mg (not to be used to report any adenosine phosphate compounds).
- HCPCS J7050 Infusion, normal saline solution, 250 cc.
- HCPCS J1245 Injection, dipyridamole, per 10 mg.
- HCPCS J2785 Injection, regadenoson, 0.1 mg.
- HCPCS J0280 Injection, aminophyllin, up to 250 mg.

The overall widespread probe error rate was 69.40 percent. Services were denied due to the below findings:

- The documentation did not support medical necessity based on the LCD requirements.
- The documentation did not support evidence that services was ordered and/or furnished by qualified personnel.
- The documentation did not include the SPECT test images.
- The documentation did not include the history and physical, progress note, etc.
- Some services were denied as the medical documentation requested was not received or not received timely.

First Coast recommends providers be familiar with medical necessity indications and documentation requirements for non-emergent cardiology outpatient testing as indicated in the Cardiology non-emergent testing: exercise stress test, stress echo, MPI SPECT, and cardiac PET LCD. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

Laboratory/Pathology

CLFS: Guidance to labs for collecting and reporting data for the private payor rate-based payment system

Provider types affected

This article is intended for Medicare Part B clinical laboratories who submit claims to Medicare administrative contractors (MACs) for services furnished to Medicare beneficiaries.

Provider action needed

This guidance is intended to assist the laboratory community in meeting the new requirements under Section 1834A of the Social Security Act (the "Act") for the Medicare Part B clinical laboratory fee schedule (CLFS). It includes clarifications for determining whether a laboratory meets the requirements to be an "applicable laboratory," the applicable information (that is, private payor rate data) that must be collected and reported to the Centers for Medicare & Medicaid Services (CMS), the entity responsible for reporting applicable information to CMS, the data collection and reporting periods, and the schedule for implementing the new CLFS. CMS will issue additional information about the CLFS data collection system and advanced diagnostic laboratory tests (ADLTs) through separate guidance.

Background

The CLFS was first established in 1984 based on historical charge data. It was updated to only establish payment rates for new tests or to make statutorily-required across-the board updates. Payment for new tests established after 1984 is based on crosswalking or gap-filling methodologies. For crosswalking, an existing test or combination of tests with similar methodology and resources is used as a basis for the payment amount. Gap-filling is used when there is no other test with similar methodology and resources. In this case, MACs develop a payment amount for the test.

Section 1834A of the Act, as established by Section 216 of the Protecting Access to Medicare Act of 2014 (PAMA), requires significant changes to how Medicare pays for clinical diagnostic laboratory tests under the CLFS. The CLFS final rule "Medicare Clinical Diagnostic Laboratory Tests Payment System Final Rule" (CMS-1621-F) was displayed in the *Federal Register* June 17, 2016, and was published June 23, 2016. The CLFS final rule implements Section 1834A of the Act. Under the final rule, private payor rates from applicable laboratories will be the basis for the revised CLFS beginning January 1, 2018.

Based on applicable information (that is, private payor rates) from applicable laboratories, the payment amount for a test on the new CLFS will be equal to the weighted median private payor rate for each test. However, for new tests or when no data is reported for an existing test, crosswalking or gapfilling methodologies will be used to establish a payment amount for the test.

Applicable laboratory

Section 1834A of the Act defines an applicable laboratory as a laboratory with the majority of its Medicare revenues received under the CLFS and/or Medicare physician fee schedule (PFS). It also provides the authority to establish a low volume or low expenditure threshold. Under the final policies for the new Medicare CLFS, an applicable laboratory is a laboratory as defined under the Clinical Laboratory Improvement Amendments (CLIA) that bills Medicare Part B under its own national provider identifier (NPI) and meets the majority of Medicare revenues threshold and the low expenditure threshold. Accordingly, there are four steps in determining whether a laboratory meets the requirements to be an applicable laboratory: 1) Is the laboratory certified under CLIA?, 2) Does the CLIA-certified laboratory bill Medicare Part B under its own NPI?, 3) Does the laboratory meet the majority of Medicare revenues threshold?, and 4) Does the laboratory meet the low expenditure threshold?

Step 1: CLIA certification

The CLIA applies to all laboratories performing testing on human specimens for a health purpose. To be paid under Medicare, a laboratory must be a CLIA-certified laboratory. Therefore, the first step in identifying an applicable laboratory is to determine whether the laboratory is CLIA certified. The CLIA regulatory definition of a laboratory is codified in regulation in 42 CFR 493.2. Note that a facility that receives any CLIA certificate (including a CLIA certificate of waiver) is considered a laboratory as defined at 42 CFR 493.2.

Step 2: NPI

The second step is to determine whether the CLIA-certified laboratory bills Medicare Part B under its own NPI. The NPI is the standard unique health identifier used by health care providers for billing Medicare and other payors. The NPI is assigned by the National Plan and Provider Enumeration System in 45 CFR 162. The laboratory's own billing NPI is used as the mechanism for defining an applicable laboratory.

Step 3: Majority of Medicare revenues threshold

For a CLIA-certified laboratory that bills Medicare Part B under its own NPI to be an applicable laboratory, it must meet the majority of Medicare revenues threshold. A laboratory, by its own billing NPI, meets the majority of Medicare revenues threshold if it receives more than 50 percent of its total Medicare revenues from payments under the Medicare CLFS and/or Medicare PFS. The CLFS and PFS are included under Medicare Part B, also known as original Medicare or fee-for-service (FFS) Medicare.

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To determine whether a laboratory meets the majority of Medicare revenues threshold, the laboratory must look to its final paid claims received by its own billing NPI during the data collection period. See the *Applicable information* section for additional guidance on final paid claims.

The three steps to determine whether a laboratory meets the majority of Medicare revenues threshold are:

- First, sum the CLFS and PFS payment amounts received by the laboratory's own billing NPI during the data collection period. The revenues from the CLFS include payments for all laboratory services under the CLFS. The revenues from the PFS include all payments from all services paid under the PFS (for instance, laboratory services and services that are not laboratory services such as pathology services, evaluation and management services, and radiology services). The sum of CLFS and PFS revenues is the numerator of the majority of Medicare revenues threshold equation.
- Next, sum the total Medicare revenues received by the laboratories own billing NPI during the data collection period. Total Medicare revenues include the sum of all FFS payments under Medicare Parts A and B, Medicare advantage payments under Medicare Part C, prescription drug payments under Medicare Part D, and any associated Medicare beneficiary deductible or coinsurance for services furnished during the data collection period. The sum of total Medicare revenues is the denominator of the majority of Medicare revenues threshold equation.
- Finally, divide the sum of CLFS and PFS revenues by the sum of total Medicare revenues received during the data collection period. We provide additional information on the data collection period below.

If the Medicare revenues received from the CLFS and/or PFS are greater than 50 percent of the total Medicare revenues for the laboratory's billing NPI, the laboratory meets the majority of Medicare revenues threshold.

The majority of Medicare revenues threshold equation is:

CLFS revenues (for billing NPI) + PFS revenues (for billing NPI)/total Medicare revenues (for billing NPI) > 50 percent

Step 4: Low expenditure threshold

An applicable laboratory must meet the low expenditure requirements. A laboratory (as defined under the CLIA regulations) meets the low expenditure threshold if, by its own billing NPI, receives at least $12,500 in **Medicare** revenues from the **CLFS** (under Medicare Part B) during the data collection period. To meet the low expenditure threshold, the laboratory must look to its **final paid claims** received by its own billing NPI during the data collection period.

To determine whether the laboratory meets the low expenditure threshold, sum all final payments for the laboratory's own billing NPI received from Medicare CLFS services during the data collection period (completed under Step 3: Majority of Medicare revenues threshold). It is important to note that the low expenditure threshold applies only to **CLFS services**. It does **not** include revenues received under the PFS. In other words, to meet the low expenditure threshold, the laboratory's own billing NPI must receive at least $12,500 under only the CLFS during the data collection period.

The low expenditure threshold equation is:

Medicare CLFS revenues (for billing NPI) = > $12,500

These are examples on how the majority of Medicare revenues threshold and low expenditure threshold are applied to the CLIA-certified laboratory's own billing NPI for purposes of determining whether the laboratory is an applicable laboratory:

Example 1: A laboratory organization includes five CLIA-certified laboratories. Each CLIA-certified laboratory has its **own unique NPI** and bills the Medicare program (and other payors) for laboratory tests separately under **each NPI**. In this example, the majority of Medicare revenues threshold and low expenditure threshold are applied to each NPI in the laboratory organization. That is, individually determine whether each laboratory meets the majority of revenues threshold and low expenditure threshold. Even though all five laboratories may be under the same tax identification number (TIN), each is considered a separate laboratory for purposes of determining an applicable laboratory because each bills Medicare Part B for laboratory tests using its own unique NPI.

Example 2: A laboratory organization includes five CLIA-certified laboratories. Each CLIA-certified laboratory has the **same NPI** and bills for laboratory tests under the same NPI for each of its CLIA-certified laboratories. In this example, the majority of Medicare revenues threshold and low expenditure threshold are applied based on the combined revenues of all CLIA-certified laboratories in the organization that use the same billing NPI. In other words, for purposes of applying the applicable laboratory thresholds, all five CLIA-certified laboratories in the laboratory organization are considered a single laboratory because they all bill Medicare Part B using the same NPI.

Example 3: A laboratory organization includes five CLIA-certified laboratories. Each CLIA-certified laboratory has its **own unique NPI**. However, **only one laboratory's NPI is used for billing** all laboratory tests furnished by all five laboratories in the laboratory organization. In this example, the majority of Medicare revenues threshold and low expenditure threshold are applied to the **one NPI** used for billing all tests furnished by the laboratory organization.

Example 4: An entity consists of five physician offices and one CLIA-certified laboratory. All five physician offices and the CLIA-certified laboratory are assigned the **same NPI** and bill for services under the same NPI. In this example, the majority of Medicare revenues threshold and low expenditure threshold are applied based on the combined revenues of all components of the entity that bill for services under the same NPI. In other words, since the physician offices and CLIA-certified laboratory all have the

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same NPI and bill Medicare Part B under the same NPI, the entity is considered a single laboratory for purposes of applying the majority of Medicare revenues threshold and low expenditure threshold.

Example 5: An entity consists of five physician offices and one CLIA-certified laboratory. Each of the five physician offices and the CLIA-certified laboratory have **unique NPIs**. The laboratory bills for laboratory tests under its **own unique NPI**. In this example, the majority of Medicare revenues threshold and low expenditure threshold are only applied to the CLIA-certified laboratory's own billing NPI.

Example 6: A CLIA-certified hospital outreach laboratory that performs laboratory services for non-hospital patients is assigned its **own unique NPI** separate from the hospital's NPI. The hospital outreach laboratory bills Medicare Part B for laboratory tests furnished to non-hospital patients using its own unique NPI. In this example, the majority of Medicare revenues threshold and low expenditure threshold are applied to the **NPI of the hospital outreach laboratory** and not to the hospital's NPI.

Example 7: A CLIA-certified hospital laboratory that performs laboratory services primarily for its hospital inpatients and hospital outpatients has the **same NPI as the hospital**. Laboratory services performed for non-hospital patients are billed using the hospital's NPI. In this example, the majority of Medicare revenues threshold and low expenditure threshold are applied to the **NPI of the entire hospital**. In this circumstance, it is unlikely that the hospital laboratory qualifies as an applicable laboratory because the majority of Medicare revenues for the NPI are received from the hospital inpatient prospective payment system and/or hospital outpatient prospective payment system, not from the CLFS and/or PFS.

Applicable laboratory summary

An applicable laboratory is defined as a CLIA-certified laboratory (which includes a facility that receives a CLIA certificate of waiver) and, using its own billing NPI, meets the majority of Medicare revenues threshold (that is, greater than 50 percent of total Medicare revenues derived from the **CLFS and/or PFS**) and low expenditure threshold (at least $12,500 in revenue **from only the CLFS**). In other words, to qualify as an applicable laboratory, the CLIA-certified laboratory must be assigned an NPI and have its services billed to Medicare Part B under that NPI. The laboratory does not qualify as an applicable laboratory if no services are billed to Medicare Part B under its own NPI because no revenues attributed to the NPI are assigned to the laboratory.

Both the majority of Medicare revenues threshold and low expenditure threshold are applied to the CLIA-certified laboratory's own billing NPI based on **final claims paid** during a data collection period. If the laboratory's own billing NPI receives more than 50 percent of its total Medicare revenues under the CLFS and/or PFS and at least $12,500 from the CLFS during the data collection period, the laboratory is considered an applicable laboratory. Applicable information (that is, private payor rate data) from applicable laboratories must be collected during the data collection period and reported by reporting entities to CMS during the data reporting period.

The applicable information reported to CMS will be used to establish payment rates under the new CLFS. All CLIA-certified laboratories (that is, both applicable laboratories and laboratories that are not applicable laboratories) are subject to the new Medicare Part B CLFS payment rates when they are established and implemented January 1, 2018.

Applicable information

The applicable laboratory along with its reporting entity (we provide more information about reporting entities below) are responsible for collecting applicable information and reporting that data to CMS.

Applicable information includes three major components:

1) The specific HCPCS code associated with the test
2) The private payor rate for each test for which **final** payment has been made during the data collection period
3) The associated volume for each test

Private payor defined

The term "private payor" is defined as:

1) A health insurance issuer and a group health plan (as defined in Section 2791 of the Public Health Service Act)
2) A Medicare advantage plan under Part C
3) A Medicaid managed care organization (MCO) (as defined in Section 1903(m) of the Act)

Note: Applicable information does **not** include information on tests for which payment is made on a capitated basis, where payments do not reflect specific HCPCS code-level amounts (see below for additional information on payments made on a capitated basis). Therefore, private payor rates from Medicaid MCO plans are considered applicable information only to the extent that the individual HCPCS code for the test, private payor rate specific to the test, and the volume paid at the specific rate for the test can be identified.

These specific private payor claims data are **included** as applicable information:

- **Laboratory tests associated with the CLFS**. Applicable information includes the specific HCPCS code for the test, each different private payor rate for the test, and the volume associated with each private payor rate for the test. You can find a list of laboratory tests associated with the CLFS and therefore subject to the data collection and data reporting requirements at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/PAMA-Regulations.html*.
- **Final amount paid by a private payor for laboratory tests after all private payor price concessions are applied**. Applicable laboratories should look to

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their paid claims data from the billing NPI for which final payment was made during the data collection period. If a private payor pays a laboratory for a test but subsequent post-payment activities during the data collection change that initial payment amount, the final payment is the private payor rate for purposes of determining applicable information. For example, if an initial claim was paid in error 3 months before a data collection period and then corrected, with final payment made by the private payor during the data collection period, the final corrected payment amount for the test is considered the private payor rate for purposes of determining applicable information. However, if an initial claim was paid in error during a data collection period and then corrected, with final payment made after the data collection period, the payment amount is not a private payor rate for purposes of applicable information and, therefore, is not reported to CMS.

- **Payments from secondary insurance payors**. Final payments from secondary insurance payors are considered in calculating private payor rates if the final payment was made during the data collection period.
- **Any patient cost sharing amounts, if applicable**. For purposes of applicable information, the private payor rate for a test should include any patient cost sharing responsibilities required by the private payor (for instance, patient deductible and/or coinsurance amounts). In other words, the private payor rate is 100 percent of the private payor's fee schedule amount for the test.
- **Multiple payment rates for the same test**. If an applicable laboratory receives more than one payment rate from the same private payor for the same test or more than one payment rate from different private payors for the same test, each unique payment rate along with the associated volume for the test code at each such rate is included as applicable information. In this case, the reporting entity must report each unique payment rate and the associated volume for the test at each such rate.
- **Appeals resolved during the data collection period**. Payment rates (and the associated volume of tests) for claims under appeal are included as applicable information if the final payment amount is determined and paid by the private payor during the data collection period. For example, if a laboratory filed an appeal for a test furnished prior to a data collection period and the appeal was resolved so that final payment for the test was made during the data collection period, the final rate paid is considered applicable information.
- **Non-contracted amounts for out-of-network laboratories or services**. Applicable information includes private payor rates for out-of-network laboratories as long as the final payment for the laboratory test was made by the private payor during the data collection period. Non-contracted amounts paid to laboratories include any patient cost sharing amounts (for example, deductible and coinsurance responsibilities, if applicable).

These specific private payor claims data are excluded from applicable information:

- **Private payor rates for laboratory test codes paid only under the PFS**. If a laboratory test code is not paid under the CLFS and is paid under the PFS, the test code, private payor rate, and the test volume associated with the private payor rate is not applicable information.
- **Price concessions applied by a laboratory**. A laboratory's decision to waive a patient's deductible, copay, and/or coinsurance responsibility for a given test(s) must not be factored into the determination of the private payor rate for a test. Although laboratories may provide concessions to patients, it does not reflect the rates paid by private payors. As noted above, the private payor rate is 100 percent of the private payor's fee schedule amount for the test.
- **Information about denied payments**. When a private payor denies payment for a laboratory test, payments of $0.00 or "zero dollars" are not considered a private payor rate for purposes of determining applicable information under the new CLFS. Laboratories should not report "zero dollars" for a laboratory test code where a private payor has denied payment within a data collection period.
- **Unresolved appeals**. Where a laboratory test claim is still under review by the private payor or is under appeal during a data collection period, the amount that has already been paid is not considered a final payment rate and therefore is not considered applicable information. Additionally, if the appeal was settled during the data collection period but final payment was not made by the private payor until after the data collection period, the payment amount is not considered applicable information.
- **Payments made on a capitated basis**. Generally, a capitated payment is made for health care services based on a set amount for each enrolled beneficiary in the plan for a given period of time, regardless of whether the particular beneficiary receives services during the period covered by the payment. Payment is typically made on a capitated basis under a managed care arrangement. As there is no way to determine payment specifically for a given test, it cannot be reported as applicable information. Therefore, applicable information does not include information about a test for which payment is made on a capitated basis.
- **Payments where the associated test volume cannot be determined**. As discussed above, the associated volume of tests performed corresponding to each private payor rate is a component of the definition of applicable information. Where the associated volume of tests performed corresponding to each private payor rate cannot be discerned by a

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laboratory from the private payor's remittance, those payment amounts are not considered applicable information and should not be reported to CMS.

- **Remittances where the payor has grouped individual HCPCS code payments into an encounter or claim level payment**. When a private payor groups payments for individual HCPCS codes into a single encounter or claim-level payment that is not represented by another HCPCS code, those payments are not applicable information. In other words, if individual HCPCS codes are billed by the laboratory and the payor bundles the individual HCPCS codes into groups not represented by other HCPCS codes, the payor's bundled payment amount is not considered applicable information.

Note: In general, if a laboratory cannot correlate a private payor payment amount and the associated volume paid at that rate to a specific HCPCS code, that amount is not a private payor rate for purposes of applicable information. Estimated private payor rates and volumes are also not considered applicable information.

Schedule for data collection and reporting

The first data collection period (the period where applicable information for an applicable laboratory is obtained from claims for which the laboratory received final payment during the period) is from January 1, 2016, through June 30, 2016. A six-month window follows the data collection period and precedes the data reporting period (the period where applicable information must be submitted to CMS). The first data reporting period will be from January 1, 2017, through March 31, 2017.

During the six-month window between the end of the data collection period and the beginning of the data reporting period, laboratories and reporting entities should assess whether the applicable laboratory thresholds are met. That is, determine whether each billing NPI-level component of the TIN meets the majority of Medicare revenues threshold and low expenditure threshold from final paid claims during the data collection period. Applicable laboratories and their reporting entity should also use this time to review and validate applicable information before it is reported to CMS.

For most clinical diagnostic laboratory tests (CDLTs) paid on the CLFS, the data collection and reporting schedule will be repeated every three years. For instance, the first data collection period is January 1, 2016, through June 30, 2016. The first six-month window is July 1, 2016, through December 31, 2016, and the first data reporting period is January 1, 2017, through March 31, 2017. The first data collection and reporting cycle will be used to determine CLFS payment rates for 2018 through 2020.

The second data collection period will begin on January 1, 2019, and end June 30, 2019, with the six-month window starting July 1, 2019, and ending December 31, 2019. The second data reporting period is January 1, 2020, through March 31, 2020. Applicable information from the second data reporting period will be used to determine CLFS payment rates for 2021 through 2023. This data collection and reporting cycle continues every third subsequent year.

This table illustrates the data collection and reporting periods for CDLTs.

Data collection and reporting periods for CDLTs

Data collection period	Six-month window	Data reporting period	Used for CLFS rate years
1/1–6/30/16	7/1–12/31/16	1/1–3/31/17	2018–2020
1/1–6/30/19	7/1–12/31/19	1/1–3/31/20	2021 – 2023
Continues every third subsequent calendar year	Continues every third subsequent calendar year	Continues every third subsequent calendar year	New CLFS rate every third year

While reporting is required every three years for CDLTs (that are not ADLTs), reporting entities must report applicable information annually for ADLTs, except for ADLTs in an initial data collection period (in which case a reporting entity will report by the end of the second quarter of the new ADLT initial period). As noted previously, we will issue additional information about ADLTs through separate guidance.

Reporting entity

The mechanics of reporting applicable information to CMS is separate from the actual definition of an applicable laboratory. The TIN-level entity must report applicable information individually for all its NPI-level components that are applicable laboratories.

As noted above, an applicable laboratory is a CLIA-certified laboratory and, using its billing NPI, meets the majority of Medicare revenues threshold and low expenditure threshold. These are examples of reporting entities that must report applicable information **individually** for all NPI-level components that are applicable laboratories:

Example 1: A TIN-level entity consists of five CLIA-certified laboratories. Each laboratory bills using its **own unique NPI** and all five CLIA-certified laboratories **individually** meet both the majority of Medicare revenues threshold and low expenditure threshold. This TIN-level entity consists of **five unique applicable laboratories**. In this case, the reporting entity reports applicable information associated with each individual NPI that is an applicable laboratory (not collectively for all NPIs that are applicable laboratories under the TIN). The reporting entity separates the applicable information by each NPI and submits applicable information during the data reporting period for five applicable laboratories.

Example 2: A TIN-level entity consists of five CLIA-certified laboratories, each billing for services under its

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own unique NPI. However, only three of the laboratories **individually** meet both the majority of Medicare revenues threshold and low expenditure threshold while the remaining two laboratories do not individually meet the low expenditure threshold. In other words, two of the five CLIA-certified laboratories receive less than $12,500 of revenue under the CLFS during the data collection period. This TIN-level entity **consists of three unique applicable laboratories**. In such case, the reporting entity will report applicable information associated with each individual NPI that is an applicable laboratory, but will not report information on the two individual NPIs of the laboratories that are not applicable laboratories. The reporting entity separates the applicable information by each NPI and submits applicable information during the data reporting period for three applicable laboratories.

Example 3: A TIN-level entity consists of five CLIA-certified laboratories and each laboratory has the same NPI and bills Medicare Part B under the **same NPI**. Collectively, the five CLIA-certified laboratories meet the majority of Medicare revenues threshold and low expenditure threshold. This TIN-level entity consists of **one applicable laboratory**. In such case, the reporting entity reports applicable information for all laboratories associated with the same NPI as a **single applicable laboratory**. In other words, in this example, the five CLIA-certified laboratories are considered one applicable laboratory for purposes of reporting applicable information because they all have the same NPI and all bill Medicare Part B under the same NPI.

The TIN-level entity along with its applicable laboratory entities should establish their own approach for ensuring that the TIN-level entity can report applicable information to CMS. To that end, applicable laboratories and their reporting entity should determine the best approach to collect applicable information from final paid claims data and for submitting applicable information to CMS during the data reporting period.

Voluntary reporting is not permitted

The reporting entity reports only applicable information for NPI-level components that are applicable laboratories (that is, NPIs that meet the definition of an applicable laboratory). Reporting entities do not report applicable information for NPIs that do **not** meet the definition of an applicable laboratory.

Example: A TIN-level entity consists of four NPI-level entities. Three of the NPI-level entities meet the definition of an applicable laboratory, and one NPI-level entity does not meet the definition of an applicable laboratory. In this case, the reporting entity reports applicable information to CMS for only the three NPI-level entities that are applicable laboratories.

Reporting applicable information is not discretionary

Reporting entities must report all applicable information for its NPI-level components that are applicable laboratories. Reporting entities do **not** have the discretion to selectively omit reporting certain applicable information.

Example: An applicable laboratory has various final paid claims for laboratory tests from the data collection period that are only in "hard copy" paper format. The reporting entity along with its applicable laboratory perceives that reporting applicable information derived from the paper claims has minimal impact on the final payment rate calculated for the tests. In such case, the reporting entity **cannot** selectively omit reporting applicable information due to the perception that reporting such applicable information may not influence the final weighted median private payor rate for a given test. In this example, the reporting entity must report the applicable information obtained from the "paper-based" claims to CMS during the data reporting period.

Reporting entity summary

Applicable information, which is used to set payment amounts under the new CLFS, must be reported by the TIN-level entity for its NPI components that are applicable laboratories during the data reporting period. As discussed above, applicable information includes the specific HCPCS code for each test, the final payment rate that was paid by each private payor for the test during a data collection period, and the associated volume for each test. Voluntary reporting of applicable information derived from laboratories that are **not** applicable laboratories and omitting certain applicable information from laboratories that **are** applicable laboratories is not permissible. If the laboratory meets the definition of an applicable laboratory, the applicable information for that laboratory must be reported to CMS during the data reporting period.

Implementation schedule

This is the schedule for implementing the new CLFS:

- First data collection period for determining 2018 CLFS payment rates: January 1 through June 30, 2016.
- First data reporting period for reporting entities to report private payor rate data to CMS for determining 2018 CLFS payment rates: January 1 through March 31, 2017.
- Annual laboratory public meeting for new tests: Mid-July 2017. CMS will use cross-walking or gap-filling to set rates for new tests for which there is no private payor data collected for the 2018 CLFS.

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- CMS publishes preliminary CLFS rates for 2018: Early September 2017. The public will have approximately 30 days, through early October 2017, to submit comments on the preliminary 2018 rates.
- CMS makes final 2018 CLFS rates available on the CMS website: Early November 2017.
- Implementation date of new CLFS: January 1, 2018.

Additional information

For more information about the new private payor rate-based payment system including the CLFS final rule, related press release and fact sheet, frequently asked questions on our final policies, and a PowerPoint slide presentation of the new CLFS, visit *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/PAMA-Regulations.html*.

If you have questions about requirements for the new CLFS, please email them to the CLFS Inquiries mailbox at *CLFS_Inquiries@cms.hhs.gov*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html*.

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Medicare Physician Fee Schedule Database

October update to the Medicare physician fee schedule database

Provider types affected

This *MLN Matters*® article is intended for physicians, provider and suppliers submitting claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries and subject to the Medicare physician fee schedule database (MPFSDB).

Provider action needed

This article is based on change request (CR) 9749, which informs you that payment files were issued to MACs based upon the MPFS final rule. This change request amends those payment files. Make sure that your billing staffs are aware of these changes.

Background

Section 1848(c)(4) of the Social Security Act authorizes the Secretary to establish ancillary policies necessary to implement relative values for physicians' services. Unless otherwise stated, the changes included in the October update to the 2016 MPFSDB are effective for dates of service on and after January 1, 2016.

The key changes for the October update are the following:

CPT®/HCPCS code	Action
G0436	Procedure status = I (Effective for services on or after 10-1-2016.)
G0437	Procedure status = I (Effective for services on or after 10-1-2016.)
44799	Procedure status = C; Global surgery days = YYY
32666	Bilateral indicator = 1

The HCPCS codes listed below have been added to the MPFSDB effective for dates of service on and after October 1, 2016. All of these new codes were communicated through other instructions. Please consult those instructions for the description and other information.

Code	Action
G0490	Procedure status = X; there are no RVUs; all policy indicators = concept does not apply
G9679	Procedure status = X; there are no RVUs; all policy indicators = concept does not apply
G9680	Procedure status = X; there are no RVUs; all policy indicators = concept does not apply
G9681	Procedure status = X; there are no RVUs; all policy indicators = concept does not apply
G9682	Procedure status = X; there are no RVUs; all policy indicators = concept does not apply
G9683	Procedure status = X; there are no RVUs; all policy indicators = concept does not apply
G9684	Procedure status = X; there are no RVUs; all policy indicators = concept does not apply

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Code	Action
G9685	Procedure status = A; RVUs = Work 3.86, non-facility 1.55, facility 1.55, MP 0.29
G9686	Procedure status = A; RVUs = Work 1.50, non-facility 0.61, facility 0.61, MP 0.10

The following payment policy indicators apply to G9685 and G9686: multiple surgery = 0, bilateral surgery = 0, assistant at surgery = 0, co-surgeons = 0, team surgeons = 0, PC/TC = 0, physician supervision of diagnostic procedures = 09, and diagnostic imaging family = 99. The global surgery says = XXX.

New code G0498, listed below, has been added to the MPFSDB effective for dates of service on and after January 1, 2016. The procedure status is C and there are no RVUs. The following payment policy indicators apply to G0498: multiple surgery = 0, bilateral surgery = 0, assistant at surgery = 0, co-surgeons = 0, team surgeons = 0, PC/TC = 5, physician supervision of diagnostic procedures = 09, and diagnostic imaging family = 99. The global surgery days = YYY.

Code	Short descriptor	Long descriptor
G0498	Chemo extend iv infus w/ pump	Chemotherapy administration, intravenous infusion technique; initiation of infusion in the office/other outpatient setting using office/other outpatient setting pump/supplies, with continuation of the infusion in the community setting (e.g., home, domiciliary, rest home or assisted living) using a portable pump provided by the office/other outpatient setting, includes follow up office/other outpatient visit at the conclusion of the infusion.

Additional information

The official instruction, CR 9749, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3594CP.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html*.

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Related CR Release Date: August 19, 2016
Effective Date: January 1, 2016
Related CR Transmittal #: R3594CP
Implementation Date: October 3, 2016

Mammography coverage and certification of mammography facilities

Providers and suppliers that furnish and bill Medicare for film, digital, or 3-D mammography services are reminded that claims for these mammography services will either deny or reject as unprocessable if:

- There is no FDA certification number reported on the claim
- The facility is not certified for the type of mammogram submitted on the claim (film, digital, or 3-D)
- A facility's certificate is suspended or revoked
- The HCPCS/CPT® code billed does not match the certification on file for the facility, or
- There is no FDA certification number on the MQSA file for the facility listed on the claim

For additional information, providers and suppliers that furnish and bill Medicare for film, digital, or 3-D mammography services can refer to Medicare's internet-only manual (IOM) Publication 100-04, Chapter 18, Section 20, and its subsections found here: *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf*.

Radiology

Multiple procedure payment reduction on the PC of certain diagnostic imaging procedures

Provider types affected

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

Provider action needed

Change request (CR) 9647 informs providers that Section 502(a)(2) of the Consolidated Appropriations Act of 2016 revised the multiple procedure payment reduction (MPPR) for the professional component (PC) of the second and subsequent procedures from 25 percent to 5 percent of the physician fee schedule amount. Make sure that your billing staffs are aware of these changes.

Background

Medicare currently applies the MPPR of 25 percent to the PC of certain diagnostic imaging procedures. The reduction applies to PC-only services, and the PC portion of global services, for the procedures with a multiple surgery value of '4' in the Medicare fee schedule database.

The Centers for Medicare & Medicaid Services (CMS) currently makes full payment for the PC of the highest-priced procedure and payment at 75 percent for the PC of each additional procedure when furnished by the same physician (or physician in the same group practice) to the same patient, in the same session on the same day.

Section 502(a)(2) of the Consolidated Appropriations Act of 2016 revised the MPPR for the PC of the second and subsequent procedures from 25 percent to 5 percent of the physician fee schedule amount. The MPPR on the technical component (TC) of imaging remains at 50 percent.

Effective January 1, 2017, MACs shall pay 95 percent of the fee schedule amount for the PC of each additional procedure furnished by the same physician (or physician in the same group practice) to the same patient, in the same session on the same day.

The current payment, and the payment as of January 1, 2017, is summarized in the example table below:

Table 1: Current vs. revised payments

	Proc 1	Proc 2	Current total payment	Revised total payment
PC	$100	$80	$160 ($100 + (.75 x $80))	$176 ($100 +(.95 x $80))
TC	$500	$400	$700 ($500 + (.50 x $400))	$700 ($500 + (.50 x $400))
Global	$600	$480	$860 ($600 + (.75 x $80) + (.50 x $400))	$876 ($600 + (.95 x $80) + (.50 x $400))

Additional information

The official instruction, CR 9647 issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3578CP.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html*.

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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.

General Coverage

Next generation accountable care organization – implementation

Provider types affected

This *MLN Matters*® article is intended for providers who are participating in next generation accountable care organizations (NGACOs) and submitting claims to Medicare administrative contractors (MACs) for certain skilled nursing facility, telehealth, and post-discharge home visit services to Medicare beneficiaries that would not otherwise be covered by original fee-for-service (FFS) Medicare.

Provider action needed

This *MLN Matters*® special edition article provides information on the NGACO model's benefit enhancement waiver initiatives and supplemental claim processing direction. Make sure that your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) implemented the next generation ACO model (NGACO or the model) January 1, 2016. The model is the first in the next generation of ACO provider-based models that will test opportunities for increased innovation around care coordination and management through greater accountability for the total cost of care.

The aim of the model is to improve the quality of care, population health outcomes, and patient experience for the beneficiaries who choose traditional Medicare FFS through greater alignment of financial incentives and greater access to tools that may aid beneficiaries and providers in achieving better health at lower costs.

Core principles of the model are:

- Protecting Medicare FFS beneficiaries' freedom to seek the services and providers of their choice
- Creating a financial model with long-term sustainability
- Utilizing a prospectively set benchmark that:
  - Rewards quality
  - Rewards both attainment of and improvement in efficiency, and
  - Ultimately transitions away from updating benchmarks based on the ACO's recent expenditures
- Engaging beneficiaries in their care through benefit enhancements that directly improve the patient experience and incentivize coordinated care from ACOs
- Mitigating fluctuations in aligned beneficiary populations and respecting beneficiary preferences through supplementing a prospective claims-based alignment process with a voluntary process, and
- Smoothing ACO cash flow and improving investment capabilities through alternative payment mechanisms.

Additional information on NGACO is available at *https://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/*.

Participants and preferred providers

NGACO defines two categories of providers/suppliers and their respective relationships to the ACO entity: Next generation participants and next generation preferred providers. Next generation participants are the core providers/suppliers in the model. Beneficiaries are aligned to the ACO through the next generation participants and these providers/suppliers are responsible for, among other things, reporting quality through the ACO and committing to beneficiary care improvement. Preferred providers contribute to ACO goals by extending and facilitating valuable care relationships beyond the ACO. For example, preferred providers may participate in certain benefit enhancements. Services furnished by preferred providers will not be considered in alignment and preferred providers are not responsible for reporting quality through the ACO. (see table at end of article)

Three benefit enhancements

In order to emphasize high-value services and support the ability of ACOs to manage the care of beneficiaries, CMS uses the authority under Section 1115A of the Social Security Act (Section 3021 of the Affordable Care Act) to conditionally waive certain Medicare payment requirements as part of the NGACO model. An ACO may choose not to implement all or any of these benefit enhancements.

1. Three-day SNF rule waiver

CMS makes available to qualified NGACOs a waiver of the three-day inpatient stay requirement prior to admission to a SNF or acute-care hospital or critical access hospital (CAH) with swing-bed approval for SNF services

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("swing-bed hospital"). This benefit enhancement allows beneficiaries to be admitted to qualified next generation ACO SNF participants and preferred providers either directly or with an inpatient stay of fewer than three days. The waiver will apply only to eligible aligned beneficiaries admitted to next generation ACO SNF participants and preferred providers.

An aligned beneficiary will be eligible for admission in accordance with this waiver if:

1) The beneficiary does not reside in a nursing home, SNF, or long-term nursing facility and receiving Medicaid at the time of the decision to admit to an SNF, and
2) The beneficiary meets all other CMS criteria for SNF admission, including that the beneficiary must:
   a. Be medically stable
   b. Have confirmed diagnoses (for example, does not have conditions that require further testing for proper diagnosis)
   c. Not require inpatient hospital evaluation or treatment; and
   d. Have an identical skilled nursing or rehabilitation need that cannot be provided on an outpatient basis or through home health services.

NGACOs identify the SNF participant and preferred providers with which they will partner in this waiver through the annual submission of next generation participant and preferred provider lists.

Claims

Next generation model three-day SNF rule waiver claims do not require a demo code to be manually affixed to the claim. When a qualifying stay does not exist, the fiscal intermediary standard system (FISS) checks whether 1) the beneficiary is aligned to an NGACO approved to use the SNF three-day rule waiver; 2) the SNF provider is also approved to use the waiver; and 3) the SNF is a provider for the same NGACO for which the beneficiary is aligned. Once eligibility is confirmed, demo code 74 (for the NGACO model) and indicator value 4 (for the three-day SNF rule waiver) is placed on the claim.

If an eligible NGACO SNF three-day waiver claim includes demo code 62 (for the BPCI model 2 SNF three-day rule waiver), for example, the FISS will not check to validate whether the claim is a valid NGACO SNF three-day rule waiver. CMS has instructed that FISS only validate when no demo code has been affixed and no qualifying three-day inpatient hospital stay has been met.

To assist MACs in troubleshooting provider SNF three-day rule waiver claim questions, CMS instructed the FISS and the multi-carrier system (MCS) maintainers to create screens. The FISS maintainer created a sub-menu of the 6Q – CMS demonstrations screen to allow for inquiry of both the NGACO provider file data and the NGACO beneficiary file data. The screen shows the following data value for this waiver: Three-day SNF waiver = value 4. The MCS maintainer created two screens to allow for SNF three-day rule waiver validation inquiry as listed:

- MCS created screen PROVIDER ACCOUNTABLE CARE ORGANIZATION (ACO) so that MACs would be able to see which ACO a provider is aligned with.
- MCS created screen BENEFICIARY ACCOUNTABLE CARE ORGANIZATION (ACO) so that MACs would be able to see which ACO a beneficiary is aligned with.

2. Telehealth expansion

CMS makes available to qualified NGACOs a waiver of the requirement that beneficiaries be located in a rural area and at a specified type of originating site in order to be eligible to receive telehealth services. This benefit enhancement will allow payment of claims for telehealth services delivered by next generation ACO participants or preferred providers to aligned beneficiaries in specified facilities or at their residence regardless of the geographic location of the beneficiary.

Claims

For those telehealth services originating at the beneficiary's home (in a rural or non-rural geographic setting) place of service (POS) code 12 (home) must be added to the claim.

Claims will ***not*** be allowed for the following telehealth services rendered to aligned beneficiaries located at their residence:

- Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs. Healthcare Common Procedure Coding System (HCPCS) codes G0406-G0408.
- Subsequent hospital care services, with the limitation of one telehealth visit every three days. Current Procedural Terminology (CPT®) codes 99231-99233.
- Subsequent nursing facility care services, with the limitation of one telehealth visit every 30 days. CPT® codes 99307-99310.

For those telehealth services originating in a non-rural area a provider does not need to insert a demonstration code in order for the claim to process successfully.

Notwithstanding these waivers, all telehealth services must be furnished in accordance with all other Medicare coverage and payment criteria, and no additional reimbursement will be made to cover set-up costs, technology purchases, training and education, or other related costs. In particular, the services allowed through telehealth are limited to those described under Section 1834(m)(4)(F) of the Social Security Act and subsequent additional services specified through regulation.

3. Post-discharge home visits

CMS makes available to qualified NGACOs waivers to allow "incident to" claims for home visits to non-homebound aligned beneficiaries by licensed clinicians

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under the general supervision—instead of direct supervision—of next generation participants or preferred providers.

Licensed clinicians, as defined in 42 C.F.R. § 410.26(a)(1), may be any employees, leased employees, or independent contractors who are licensed under applicable state law to perform the ordered services under physician (or other practitioner) supervision. A participant or preferred provider may contract with licensed clinicians to provide this service and the service is billed by the participant or preferred provider.

Claims for these visits will only be allowed following discharge from an inpatient facility (including, for example, inpatient prospective payment system (IPPS) hospitals, critical access hospitals (CAHs), SNFs, inpatient rehabilitation facilities (IRFs) and will be limited to no more than one visit in the first 10 days following discharge and no more than one visit in the subsequent 20 days. Payment of claims for these visits will be allowed as services and supplies that are incident to the service of a physician or other practitioner as described under 42 CFR §410.26. This provision is not generally applicable to home visits; however, for purposes of this payment waiver, CMS intends to use the same definition of general supervision as outlined in this provision.

Claims

Post-discharge home visit service waiver claims must contain one of the following evaluation and management (E/M) CPT® codes:

- 99324-99337
- 99339-99340
- 99341-99350

Providers are not required to add a demonstration code to process these claims.

Additional information

If you have any questions, please contact your MAC at their toll-free number. That number is available at: *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html*.

Additional information about the next generation ACO model is available at: *https://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/*.

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Implementation Date: January 1, 2016

Table 5.1 Types of providers/suppliers and associated functions[1]

Provider type	Alignment	Quality reporting through ACO	Eligible for ACO shared savings	PBP	All-inclusive PBP	Coordinated care reward	Telehealth	three-day SNF rule	Post-discharge home visit
Next generation participant	X	X	X	X	X	X	X	X	X
Preferred provider			X	X	X	X	X	X	X

[1] This table is a simplified depiction of key design elements with respect to next generation participant and preferred provider roles. It does not necessarily imply that this list is exhaustive with regards to possible ACO relationships and activities.

Authorized officials signatures on EDI enrollment and DDE request for access forms

First Coast Service Options Inc. (First Coast) would like to remind providers that only an authorized official or a delegated official, as listed on the CMS 855, can sign the Electronic Data Interchange (EDI) enrollment form, Direct Data Entry (DDE) Access Request form and other EDI forms.

The CMS defines an authorized official as "an appointed official, such as a chief executive officer, chief financial officer, general partner, chairman of the board, or direct owner, to whom the organization has granted the legal authority to enroll it in the Medicare program, to make changes or updates to the organization's status in the Medicare program, and commit the organization to fully abide by the statutes, regulations, and instructions of the Medicare program."

As of March 1, 2016, any DDE Request for Access form or any other EDI forms not signed by an authorized or delegated official will be rejected. A new form will be required.

The EDI forms certification statement states that "by signing the form the signee certifies that he or she have been appointed an authorized individual to whom the provider has granted the legal authority to enroll it in the Medicare Program, to make changes and/or updates to the provider's status in the Medicare program (e.g., new practice locations, change of address, etc.), and to commit the provider to abide by the laws, regulations, and the program instructions of Medicare."

The new EDI forms are designed to be completed online, and can be signed electronically. There are three methods for submitting your EDI forms:

- **Mail**: First Coast Medicare EDI, P.O. Box 44071, Jacksonville, FL 32231-4071
- **Fax**: (904) 361-0470
- **Email**: *MedicareEDI@fcso.com*

Starting September 1, 2016, any EDI form submitted on an outdated form will be rejected. The current DDE Request for Access form was updated on July 6, 2016, and the EDI Enrollment form was revised July 15, 2016. All forms received after 2:00 p.m. ET will have the date of receipt of the next business day. Please allow 10 business days before contacting Medicare EDI for a status of an application.

For questions contact First Coast Medicare EDI Support team at (888) 670-0940.

Source: *IOM 100-04, Chapter 24, Section 30.2.C* and *IOM 100-08, Chapter 15, Section 15.1.1*

Correct your claims on the 'SPOT'

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

General Information

CWF to locate beneficiary record and provide responses to provider queries

Provider types affected

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

Provider action needed

Change request (CR) 9740 informs MACs about the changes to the Medicare's common working file (CWF) to add an auto-search capability to CWF provider queries and eliminate the need for providers to query multiple CWF hosts for Medicare beneficiary eligibility information. Make sure that your billing staffs are aware of these changes, which reduce burden on providers.

Background

Medicare beneficiaries are assigned a primary host at CWF based on their primary address. At the time of querying CWF for eligibility information using CWF provider queries, ELGA, HIQA, ELGH, HIQH, and HUQA, providers may not know the CWF primary host of the Medicare beneficiary. When the CWF primary host of the Medicare beneficiary is not known, Providers must query multiple CWF hosts (up to nine) until they find the host that has the Medicare beneficiary record and get the eligibility information. As the CWF hosts are connected to each other, it is possible for CWF to automatically locate the primary host where the Medicare beneficiary record exists. This will eliminate the need for providers to search and locate the Medicare beneficiary record and may also reduce the number of provider queries received.

Additional information

The official instruction, CR 9740, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1687OTN.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html* under - How Does It Work.

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from front page

any changes in information supplied on the enrollment application within 30 days of the change to the national supplier clearinghouse (NSC) (42 CFR §424.57(c)(2)).

Independent diagnostic testing facilities must report changes in ownership, location, general supervision, and adverse legal actions to your MAC either online, or via the appropriate CMS-855 form, within 30 calendar days of the change. You must report all other changes to your enrollment information within 90 days of the change (42 CFR §410.33(g)(2).

All providers and suppliers not previously identified must report any changes of ownership, including a change in an authorized or delegated official, within 30 days; and all other informational changes within 90 days (42 CFR §424.516(e)).

It is very important that you comply with these reporting requirements. Failure to do so could result in the revocation of your Medicare billing privileges.

Additional information

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html*.

MLN Matters® Number: SE1617
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Reopenings update – changes to Chapter 34

Provider types affected

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

Provider action needed

Change request (CR) 9639 provides updates to Chapter 34, Section 10 of the *Medicare Claims Processing Manual* to remove outdated contractor terminology, clarify remittance advice code reference and to add hyperlinks for regulation and statutory obligations. The updates enhance and clarify operating instructions and language in accordance with regulation and statute. CR 9639 includes no policy changes. Make sure that your billing staffs are aware of these updates.

Background

A reopening is a remedial action taken to change a binding determination or decision that resulted in either an overpayment or an underpayment, even though the determination or decision was correct based on the evidence of record. Reopenings are different from adjustment bills in that adjustment bills are subject to normal claim processing timely filing requirements (that is, filed within one year of the date of service), while reopenings are subject to timeframes associated with administrative finality and are intended to fix an error on a claim for services previously billed (for example, claim determinations may be reopened within one year of the date of the initial determination for any reason, or within one to four years of the date of the initial determination upon a showing of good cause).

The main clarification in CR 9639 is to note that where Medicare medical review staff request documentation from a provider/supplier for a claim, but did not receive it, and issued a denial based on no documentation, the codes used for the denial are as follows:

- **Group code: CO** – contractual obligation
- **Claim adjustment reason code (CARC) 50** – These are non-covered services because this is not deemed a 'medical necessity' by the payer
- **Remittance advice remark code (RARC) M127** – Missing patient medical record for this service).

Additional information

The official instruction, CR 9639 issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3568CP.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html*.

MLN Matters® Number: MM9639
Related Change Request (CR) #: CR 9639
Related CR Release Date: July 29, 2016
Effective Date: September 30, 2016
Related CR Transmittal #: R3568CP
Implementation Date: September 30, 2016

First Coast boosts experience for SPOT users

Live Chat and enhanced alerts added to SPOT

Providers using First Coast's (First Coast Service Options Inc.) Secure Online Provider Tool (SPOT) implemented several communication enhancements Monday, August 15.

These improvements enable SPOT users to remain informed on top issues and easily connect with the SPOT support staff when necessary.

Through Live Chat, First Coast representatives are available 10 a.m. to 2 p.m., Monday through Friday, to help users locate resources on SPOT as well as the First Coast provider website. Representatives will assist with questions such as:

- Updating passwords in your Enterprise Identity Management (EIDM) account
- Completing the remote identity proofing process (RIDP) and multifactor authentication (MFA)
- Creating additional SPOT profiles
- Locating information on the First Coast provider site

Due to Medicare data security restrictions, First Coast representatives do not have access to claims or provider records in SPOT and are not able to answer specific claim or Medicare beneficiary questions. Any issues requiring specific account details will be referred to First Coast's provider contact center.

In addition to Live Chat, First Coast is also added a news and alerts box on the SPOT homepage to help providers stay informed of enhancements and system updates. Providers are also able to connect with a First Coast representative through Twitter (*@TheSPOTPortal*).

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

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

Effective and notice dates

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

Electronic notification

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

More information

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

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

Looking for LCDs?

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

Advance beneficiary notice

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

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

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

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

Learn the secrets to billing Medicare correctly

Who has the power to improve your billing accuracy and efficiency? You do – visit the *Improve Your Billing* section where you'll discover the tools you need to learn how to consistently bill Medicare correctly – the first time.

You'll find First Coast's most popular self-audit resources, including the E/M interactive worksheet, provider data summary (PDS) report, and the comparative billing report (CBR).

Revisions to LCDs

Computerized corneal topography – revision to the Part B LCD

LCD ID number: L33810 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for computerized corneal topography was revised to add ICD-10-CM diagnosis codes H18.51, H18.52, H18.53, H18.54 and H18.55 and diagnosis range H11.811-H11.819 to the "ICD-10 Codes that Support Medical Necessity" section of the LCD.

Effective date

This LCD revision is effective for claims processed **on or after August 8, 2016**, for services rendered **on or after October 1, 2015**.

Claims submitted for computerized corneal topography (procedure code 92025) between October 1, 2015 and August 8, 2016, may have been denied in error when billed with ICD-10 diagnosis code H11.811-H11-819, H18.51, H18.52, H18.53, H18.54, or H18.55.

Claims processed **on or after August 9, 2016**, were adjudicated correctly.

No action is required by providers

Providers whose claims were incorrectly denied do not need to take any action. First Coast Service Options Inc. will perform adjustments to correct the error on all the affected claims. We apologize for any inconvenience this may have caused.

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

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

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

Hyperbaric oxygen (HBO) therapy – revision to the Part A and Part B LCD

LCD ID number: L36504 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for hyperbaric oxygen (HBO) therapy (L36504) was revised to remove the link to the Centers for Medicare & Medicaid Services (CMS) covered diagnoses codes. Since CMS updates the links for national coverage determination (NCD) for hyperbaric oxygen therapy (20.29) with each new change request (CR), a determination was made to remove the link from the LCD and provide an instructional note for stakeholders to locate ICD-10 diagnosis codes and other coding updates specific to NCDs.

Effective date

The effective date for the revision is for dates of service **on and after August 11, 2016**. First Coast Service Options Inc. LCDs are available through the CMS Medicare

coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Check the status of claim redeterminations online

Don't wait up learn the status of your appeal. You may check on its status at your convenience -- online, which enables providers to check the status on active redeterminations to confirm if the appeal has been received by First Coast Service Options.

Mastoidectomy cavity debridement – revision to the Part B LCD

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

The local coverage determination (LCD) for mastoidectomy cavity debridement was revised to add ICD-10-CM diagnosis code H95.02 (Recurrent cholesteatoma of postmastoidectomy cavity, left ear) in the "ICD-10 Codes that Support Medical Necessity" section of the LCD.

Effective date

This LCD revision is effective for claims processed **on or after July 22, 2016**, for services rendered **on or after October 1, 2015**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Multiple Part A/B local coverage determinations (LCDs) revised – article correction

LCD ID number: L33693, L33695, L33696, L33667 (Florida/Puerto Rico/U.S. Virgin Islands)

An article revising multiple local coverage determinations (LCDs) related to CPT® code 93881 and its replacement CPT® code 93882 was previously published on page 31 of the February 2016 Connection. Since that time, it was determined that the incorrect effective date was published in error.

Effective date

The correct effective date should be for claims processed **on or after January 12, 2016**, for services rendered **on or after October 1, 2015**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Pemetrexed – revision to the Part A and Part B LCD

LCD ID number: L33978 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on a reconsideration request, the local coverage determination (LCD) for pemetrexed has been revised to include the off-label indication of malignant peritoneal mesothelioma. Also, the "ICD-10 Codes that Support Medical Necessity" section of the LCD has been updated to include ICD-10-CM diagnosis code C45.1. In addition, the "Sources of Information and Basis for Decision" section of the LCD has been updated.

Effective date

This LCD revision is effective for services rendered **on or after August 18, 2016**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Upcoming provider outreach and educational events

Medicare Part B changes and regulations

Date: Wednesday, September 21
Time: 11:30-1:00 p.m.
Type of Event: Webcast
http://medicare.fcso.com/Events/0338261.asp

Topic: Medicare Speaks 2016 Orlando

Date: Wednesday-Thursday, September 28-29
Time: 7:30 a.m.-4:15 p.m.
Type of Event: Face-to-face
http://medicare.fcso.com/Medicare_Speaks/0343241.pdf

Note: Unless otherwise indicated, all First Coast educational offerings are considered to be "ask-the-contractor" events, "webcast" type of event, designated times are stated as ET, and the focus is to Florida, Puerto Rico, and the U.S. Virgin Islands.

Two easy ways to register

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

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

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

Please Note:

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

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Provider Address: _____

City, State, ZIP Code: _____

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

Never miss a training opportunity

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

Take advantage of 24-hour access to free online training

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

CMS MLN Connects® Provider eNews

The Centers for Medicare & Medicaid Services (CMS) *MLN Connects*® Provider eNews 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 e-News to their membership as appropriate.

MLN Connects® Provider eNews for July 28, 2016

MLN Connects® Provider eNews for July 28, 2016

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News & Announcements

- Overall Hospital Quality Star Ratings: Evaluation of National Distributions
- Million Hearts® Cardiovascular Disease Risk Reduction Model
- New Payment Models and Rewards for Better Care at Lower Cost
- $42 Billion Saved in Medicare and Medicaid Primarily Through Prevention
- SNF Quarterly Reports Available through Nursing Home Compare
- SNF QRP: Requirements for the FY 2018 Reporting Year Fact Sheet Available
- EHR Incentive Programs: Submit Comments on CY 2017 Hospital OPPS and ASC Proposed Rule by September 6
- World Hepatitis Day: Medicare Coverage for Viral Hepatitis

Provider Compliance

- Home Health Care: Proper Certification Required

Claims, Pricers & Codes

- July 2016 OPPS Pricer File Update

Upcoming Events

- ESRD QIP: Reviewing Your Facility's PY 2017 Performance Data Call – August 2
- Special Open Door Forum: Open Payments Notice to Inform Future Rulemaking – August 2
- Medicare Diabetes Prevention Program Webinar – August 9
- IRF Quality Reporting Program Provider Training – August 9 and 10
- PQRS Feedback Reports and Informal Review Process for Program Year 2015 Results Call – August 10
- Comparative Billing Report on IHC and Special Stains Webinar – August 10
- LTCH Quality Reporting Program Provider Training – August 11
- SNF Quality Reporting Program Provider Training – August 24
- Comparative Billing Report on Modifier 25: Physician Assistant Webinar – August 24
- IMPACT Act: Data Elements and Measure Development Call – August 31

Medicare Learning Network® Publications & Multimedia

- Protecting Patient Personal Health Information MLN Matters Article – New
- SNF Quality Reporting Program Call: Audio Recording and Transcript – New
- Medicare Coverage of Items and Services Furnished to Beneficiaries in Custody under a Penal Authority Fact Sheet – Revised
- Electronic Mailing Lists: Keeping Health Care Professionals Informed Fact Sheet – Revised
- SNF Billing Reference Fact Sheet – Reminder
- Suite of Products & Resources for Compliance Officers Educational Tool – Reminder
- Suite of Products & Resources for Educators & Students Educational Tool – Reminder
- Suite of Products & Resources for Inpatient Hospitals Educational Tool – Reminder
- Suite of Products & Resources for Billers & Coders Educational Tool – Reminder

MLN Connects® Provider eNews for August 4, 2016

MLN Connects® Provider eNews for August 4, 2016

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News & Announcements

- Hospital IPPS and LTCH PPS Final Rule Policy and Payment Changes for FY 2017
- SNFs: Final FY 2017 Payment and Policy Changes
- Hospice Benefit: Final FY 2017 Payment and Policy Changes
- IRFs: Final FY 2017 Payment and Policy Changes
- Inpatient Psychiatric Facilities: Final FY 2017 Payment and Policy Changes
- CMS Announces Next Phase in Largest-ever Initiative to Improve Primary Care in America
- CMS Extends, Expands Fraud-Fighting Enrollment Moratoria Efforts in Six States
- First Release of the Overall Hospital Quality Star Rating on Hospital Compare
- Home Health Agencies: New PEPPER Available
- Partial Hospitalization Programs: New PEPPER Available
- Physician Compare: 2014 Quality Data Available
- Teaching Hospital Closures: Apply for Resident Slots by October 31, 2016
- PQRS: EIDM Accounts Required to Access Feedback Reports and 2015 Annual QRURs
- Replacement of Accessories for Beneficiary-Owned CPAP Device or RAD
- Administrative Simplification Statutes and Regulations
- ICD-10 Coding Resources
- Vaccines are Not Just for Kids

Provider Compliance

- Hospital Discharge Day Management Services

Upcoming Events

- PQRS Feedback Reports and Informal Review Process for Program Year 2015 Results Call – August 10
- Data Collection on Resources Used in Furnishing Global Services Information Session – August 11
- IMPACT Act: Data Elements and Measure Development Call – August 31
- National Partnership to Improve Dementia Care and QAPI Call – September 15

Medicare Learning Network® Publications & Multimedia

- Remittance Advice Information: An Overview Fact Sheet – Reminder
- Medicare Costs at a Glance: 2016 Educational Tool – Revised

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® Provider eNews for August 11, 2016

MLN Connects® Provider eNews for August 11, 2016
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News & Announcements

- Medicare Announces Participants in Effort to Improve Access, Quality of Care in Rural Areas
- Affordable Care Act Payment Model Continues to Improve Care, Lower Costs
- ESRD QIP PY 2020 Proposed Rule: New Fact Sheet and Video
- CMS to Release a CBR on Positive Airway Pressure Devices, Respiratory Assist Devices and Accessories in August
- TEP on IMPACT Act Quality Measures: Nominations due August 21

Provider Compliance

- Preventive Services

Claims, Pricers & Codes

- ICD-10 GEMS for 2017 Available

Upcoming Events

- ESRD QIP PY 2020 Proposed Rule Call-In Session – August 16
- Global Surgery Proposed Data Collection Town Hall – August 25
- IMPACT Act: Data Elements and Measure Development Call – August 31
- National Partnership to Improve Dementia Care and QAPI Call – September 15

Medicare Learning Network® Publications & Multimedia

- Timely Reporting of Provider Enrollment Information Changes MLN Matters® Article – New
- IRFs: Improving Documentation Positively Impacts CERT Web-Based Training Course – New
- Physician Compare Call: Addendum – New
- RHCs HCPCS Reporting Requirement and Billing Updates MLN Matters® Article – Revised
- MLN Guided Pathways Provider Specific Medicare Resources Booklet – Revised
- PECOS Technical Assistance Contact Information Fact Sheet – Revised

MLN Connects® Provider eNews for August 18, 2016

MLN Connects® Provider eNews for August 18, 2016
View this edition as a PDF

News & Announcements

- CMS Updates Nursing Home Five-Star Quality Ratings
- IMPACT Act Standardized Assessment Data: Comments due August 26
- Medicare Outpatient Observation Notice: Public Comment Period Ends September 1
- Open Payments: Limited Time for Physicians to Dispute 2015 Data
- Programs of All-Inclusive Care for the Elderly
- Administrative Simplification: Adopted Standards and Operating Rules

Provider Compliance

- Nasal Endoscopy

Claims, Pricers & Codes

- 2017 ICD-10-CM and ICD-10-PCS Code Updates
- Hospice Claim Adjustments Will Correct Routine Home Care Day Count

Upcoming Events

- IRF and LTCH Quality Reporting Program: Public Reporting Webinar – August 23
- Global Surgery Proposed Data Collection Town Hall – August 25
- IMPACT Act: Data Elements and Measure Development Call – August 31
- SNF Quality Reporting Program Webcast – September 14
- National Partnership to Improve Dementia Care and QAPI Call – September 15

Medicare Learning Network® Publications & Multimedia

- Medicare Part B Clinical Laboratory Fee Schedule: Guidance to Laboratories for Collecting and Reporting Data for the Private Payor Rate-Based Payment System MLN Matters Article – New
- ESRD QIP Call: Audio Recording and Transcript – New
- Health Insurance Portability and Accountability Act (HIPAA) EDI Standards Web-Based Training Course – Revised

Phone numbers

Customer service

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

Education event registration hotline

904-791-8103 (NOT toll-free)

Electronic data interchange (EDI)

888-670-0940

Electronic funds transfers (EFT) (CMS-588)

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

Fax number (for general inquiries)

904-361-0696

Interactive voice response (IVR) system

877-847-4992

Provider enrollment

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

The SPOT help desk

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

Addresses

Claims

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

Redeterminations

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

Redetermination of overpayments

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

Reconsiderations

C2C Innovative Solutions, Inc.
Part B QIC South Operations
ATTN: Administration Manager
P.O. Box 183092
Columbus, Ohio 43218-3092

General inquiries

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

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

Provider enrollment

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

Medical policy

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

Medicare secondary payer

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

Electronic data interchange (EDI)

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

Overpayments

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

Medicare Education and Outreach

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

Fraud and abuse

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

Freedom of Information Act requests

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

Overnight mail and/or special courier service

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

Websites

Provider

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

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

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

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

Beneficiaries

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

Phone numbers

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

Education event registration hotline
904-791-8103 (NOT toll-free)

Electronic data interchange (EDI)
888-670-0940

Electronic funds transfers (EFT) (CMS-588)
866-454-9007
877-660-1759 (TTY)

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

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

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

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

Addresses

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

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

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

Reconsiderations
C2C Innovative Solutions, Inc.
Part B QIC South Operations
ATTN: Administration Manager
P.O. Box 183092
Columbus, Ohio 43218-3092

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

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

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

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

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

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

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

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

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

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

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

Websites

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

http://medicare.fcso.com

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

Centers for Medicare & Medicaid Services

https://www.cms.gov

First Coast University

http://www.fcsouniversity.com/

Beneficiaries
Centers for Medicare & Medicaid Services

https://www.medicare.gov

Phone numbers

Customer service

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

Education event registration hotline

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

Electronic data interchange (EDI)

888-875-9779

Electronic funds transfers (EFT) (CMS-588)

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

General inquiries

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

Interactive voice response (IVR) system

877-847-4992

Provider enrollment

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

The SPOT help desk

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

Addresses

Claims

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

Redeterminations

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

Redetermination of overpayments

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

Reconsiderations

C2C Innovative Solutions, Inc.
Part B QIC South Operations
ATTN: Administration Manager
P.O. Box 183092
Columbus, Ohio 43218-3092

General inquiries

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

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

Provider enrollment

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

Medical policy

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

Medicare secondary payer

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

Electronic data interchange (EDI)

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

Overpayments

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

Medicare Education and Outreach

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

Fraud and abuse

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

Freedom of Information Act requests

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

Special courier service

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

Websites

Provider

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

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

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

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

Beneficiaries

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

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