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

In this issue

What SPOT can do for you – use secure messaging to file appeals

Save time and money by corresponding electronically with First Coast

Mailing documents to First Coast Service Options Inc. (First Coast) offices in Jacksonville, FL, is no small expense, particularly when you have to submit additional documentation in support of claim appeals. Between making copies and mailing reams of paper, these costs can add up quickly.

With the availability of portable document formats (PDF) through its *secure messaging tool*, First Coast's SPOT (Secure Provider Online Tool) offers you a more convenient solution for handling correspondence. "The SPOT is the way to go. No more filling out forms and then having to fax or mail them in. By using SPOT, we also received those payments quicker than if we had faxed or mailed the request," said *Kristin Gunn, an experienced medical biller with South Florida Revenue Cycle Specialists*.

The *secure messaging feature* within SPOT allows users to select and submit appeal requests, overpayment forms, and *additional development requests (ADR)* from SPOT to First Coast's e-documentation system. In addition, it also allows users to include support documentation as required.

"I spend 30-45 minutes a day logging appeals in a spreadsheet to track where we were in the process. We handle 20-30 appeals each day. This adds up to a lot of time for me and for my team handling appeals. When SPOT added secure mail to handle appeals too, it was like, wow this is so great. SPOT just keeps getting better," *said Kristin Sierens, a University of Florida/Shands Supervisor*.

Besides *claim redeterminations*, SPOT's secure messaging feature offers access to other Medicare processes, helping to save time and money for both Medicare Part A and Part B providers.

Available secure messaging forms

- Additional claim development response - Respond to ADR requests for prepay claim
- Claim redetermination request - Level 1 appeal request

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Medicare Learning Network®

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

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 (waiver of liability statement on file).

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

Nonassigned claims containing the modifier GA in which the patient has been found liable must have the patient's written consent for an appeal. Refer to the applicable contact section located at the end of this publication for the address in which to send written appeals requests.

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

Provider types affected

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

Provider action needed

Change request (CR) 9911 modifies the Medicare claims processing systems to help providers more readily identify the Qualified Medicare Beneficiary (QMB) status of each patient and to support providers' ability to follow QMB billing requirements.

Beneficiaries enrolled in the QMB program are not liable to pay Medicare cost-sharing for all Medicare A/B claims. CR 9911 adds an indicator of QMB status to Medicare's claims processing systems.

This system enhancement will trigger notifications to providers (through the provider remittance advice) and to beneficiaries (through the Medicare summary notice) to reflect that the beneficiary is enrolled in the QMB program and has no Medicare cost-sharing liability. Make sure that your billing staffs are aware of these changes.

Background

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

Under federal law, Medicare providers may not bill individuals enrolled in the QMB program for Medicare deductibles, coinsurance, or copayments, under any circumstances. (See Sections 1902(n)(3)(B); 1902(n)(3)(C); 1905(p)(3); 1866(a)(1)(A); 1848(g)(3)(A) of the Social Security Act.) State Medicaid programs may pay

providers for Medicare deductibles, coinsurance, and copayments. However, as permitted by federal law, states can limit provider reimbursement for Medicare cost-sharing under certain circumstances.

Nonetheless, Medicare providers must accept the Medicare payment and Medicaid payment (if any, and including any permissible Medicaid cost sharing from the beneficiary) as payment in full for services rendered to an individual enrolled in the QMB program.

CR 9911 aims to support Medicare providers' ability to meet these requirements by modifying the Medicare claims processing system to clearly identify the QMB status of all Medicare patients.

Currently, neither the Medicare eligibility systems (the HIPAA Eligibility Transaction System (HETS)), nor the claims processing systems (the FFS Shared Systems), notify providers about their patient's QMB status and lack of Medicare cost-sharing liability.

Similarly, Medicare summary notices (MSNs) do not inform those enrolled in the QMB program that they do not owe Medicare cost-sharing for covered medical items and services.

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Quarterly provider update

The Centers for Medicare & Medicaid Services (CMS) publishes the quarterly provider update (QPU) at the beginning of each quarter to inform the public about:

- Regulations and major policies currently under development during this quarter.
- Regulations and major policies completed or canceled.
- New/revised manual instructions.

CMS regulations establish or modify the way CMS administers the Medicare program. These regulations impact providers and suppliers providing services to Medicare beneficiaries. Providers may access the QPU by going to the CMS website at *https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/index.html*. Providers may join the CMS-QPU electronic mail to ensure timely notification of all additions to the QPU.

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

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

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

CWF will provide the claims processing systems the QMB indicator if the "through date" falls within a QMB coverage period (one of the occurrences) for inpatient hospital claims (TOB 011x) and religious non-medical health care institution claims (TOB 041x).

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

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

In addition, the MACs will include a claim adjustment reason code of 209 ("Per regulatory or other agreement. The provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected. (Use only with group code OA (Other Adjustment)).

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

Additional information

The official instruction, CR 9911, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3715CP.pdf*.

For more information regarding billing rules applicable to individuals enrolled in the QMB Program, see the *MLN Matters article*, SE1128, at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se1128.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/*.

MLN Matters® Number: MM9911
Related Change Request (CR) #: CR 9911
Related CR Release Date: February 3, 2017
Effective Date: for claims processed on or after October 2, 2017
Related CR Transmittal #: R3715CP
Implementation Date: February 21, 2017

Quarterly update to the National Correct Coding Initiative procedure-to-procedure edits

Provider types affected

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

Provider action needed

Change request (CR) 9970 instructs MACs about the release of the latest package of correct coding initiative (CCI) procedure-to-procedure (PTP) edits, Version 23.1, effective April 1, 2017. The National Correct Coding Initiative (NCCI) developed by the Centers for Medicare & Medicaid (CMS) helps promote national correct coding methodologies and controls improper coding.

The coding policies developed are based on coding conventions defined in the American Medical Association's (AMA's) Current Procedural Terminology® (CPT®) manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practice, and review of current coding practice. Make sure that your billing staffs are aware of these changes.

Background

CMS developed the CCI to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment in Part B claims.

The latest package of CCI procedure-to-procedure (PTP) edits, Version 23.1, effective April 1, 2017, will be available via the CMS data center (CDC). A test file will be available on or about January 31, 2017, and a final file will be available on or about February 14, 2017.

Version 23.1 will include all previous versions and updates from January 1, 1996, to the present. In the past, CCI was organized in two tables: column 1/column 2 correct coding edits and mutually exclusive code (MEC) edits. In order to simplify the use of NCCI edit files (two tables), on April 1, 2012, CMS consolidated these two edit files into the column one/column two correct coding edit file.

Separate consolidations have occurred for the two practitioner NCCI edit files and the two NCCI edit files used for OCE. It will only be necessary to search the column one/column two correct coding edit file for active or previously deleted edits.

CMS no longer publishes a mutually exclusive edit file on its website for either practitioner or outpatient hospital services, since all active and deleted edits will appear in

the single column one/column two correct coding edit file on each website. The edits previously contained in the mutually exclusive edit file are NOT being deleted but are being moved to the column one/column two correct coding edit file.

Additional Information

The official instruction, CR 9970, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3708CP.pdf*.

Refer to the CMS NCCI webpage for additional information at *http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/*.

MLN Matters® Number: MM9970
Related Change Request (CR) #: CR 9970
Related CR Release Date: February 3, 2017
Effective Date: April 1, 2017
Related CR Transmittal #: R3708CP
Implementation Date: April 3, 2017

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Evaluation & Management

Medicare outpatient observation notice instructions

Provider types affected

This *MLN Matters*® article is intended for hospitals, including critical access hospitals (CAHs) submitting claims to Medicare administrative contractors (MACs) for outpatient observation services provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 9935 updates Chapter 30 of the *Medicare Claims Processing Manual* to include the Medicare outpatient observation notice (MOON), CMS-10611, and related instructions.

Providers should use the MOON to inform Medicare beneficiaries when they are an outpatient receiving observation services, and are not an inpatient of the hospital or a critical access hospital (CAH). The instructions included in Chapter 30 provide guidance for proper issuance of the MOON. The updated Chapter 30 is attached to CR 9935.

Background

The MOON is mandated by the Federal Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act), passed August 6, 2015. This law amended Section 1866(a)(1) of the Social Security Act by adding new subparagraph (Y) that requires hospitals and CAHs to provide written notification and an oral explanation of such notification to individuals receiving observation services as outpatients for more than 24 hours at the hospitals or CAHs.

Scope

Hospitals and CAHs must provide the MOON to beneficiaries in original Medicare (fee-for-service) who receive observation services as outpatients for more than 24 hours. (**Note**: MA plans are to follow MOON instructions outlined in CR 9935/Section 400 of Chapter 30 of the *Medicare Claims Processing Manual*.

All beneficiaries receiving services in hospitals and CAHs must receive a MOON no later than 36 hours after observation services as an outpatient begin.

For purposes of these instructions, the term “beneficiary,” means either beneficiary or representative, when a representative is acting for a beneficiary.

This also includes beneficiaries in the following circumstances:

- Beneficiaries who do not have Part B coverage
- Beneficiaries who are subsequently admitted as an inpatient prior to the required delivery of the MOON
- Beneficiaries for whom Medicare is either the primary or secondary payer

The statute expressly provides that the MOON be

delivered to beneficiaries receiving observation services as an outpatient for more than 24 hours. In other words, the MOON should not be delivered to all beneficiaries receiving outpatient services. The MOON is intended to inform beneficiaries who receive observation services for more than 24 hours that they are outpatients receiving observation services and not inpatients, and the reasons for such status, and must be delivered no later than 36 hours after observation services begin.

However, hospitals and CAHs may deliver the MOON to an individual receiving observation services as an outpatient before such individual has received more than 24 hours of observation services.

Allowing delivery of the MOON before an individual has received 24 hours of observation services affords hospitals and CAHs the flexibility to deliver the MOON consistent with any applicable state law that requires notice to outpatients receiving observation services within 24 hours after observation services begin.

The flexibility to deliver the MOON any time up to, but no later than, 36 hours after observation services begin also allows hospitals and CAHs to spread out the delivery of the notice and other hospital paperwork in an effort to avoid overwhelming and confusing beneficiaries.

Hospitals affected by these instructions

These instructions apply to hospitals as well as CAHs per Section 1861(e) and Section 1861(mm) of the Social Security Act.

Medicare outpatient observation notice

The MOON is subject to the Paperwork Reduction Act (PRA) process and approved by the Office of Management and Budget (OMB).

OMB-approved notices may only be modified as per its accompanying form instructions, as well as per guidance in this section of the manual. Unapproved modifications cannot be made to the OMB-approved, standardized

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MOON. The notice and accompanying form instructions are available at *https://www.cms.gov/Medicare/Medicare-General-Information/BNI*.

Alterations to the notice

In general, the MOON must remain two pages, except as needed for the additional information field discussed below or to include state-specific information below.

Hospitals and CAHs subject to State law observation notice requirements may attach an additional page to the MOON to supplement the *Additional information* section in order to communicate additional content required under state law, or may attach the notice required under state law to the MOON. The pages of the notice can be two sides of one page or one side of separate pages, but must not be condensed to one page.

Hospitals may include its business logo and contact information on the top of the MOON. Text may not be shifted from page 1 to page 2 to accommodate large logos, address headers, or any other information.

Completing the MOON

Hospitals must use the OMB-approved MOON (CMS-10611). Hospitals must type or write the following information in the corresponding blanks of the MOON:

- Patient name
- Patient number
- Reason patient is an outpatient

Hospital delivery of the MOON

Hospitals and CAHs must provide both the standardized written MOON, as well as oral notification. Oral notification must consist of an explanation of the standardized written MOON. The format of such oral notification is at the discretion of the hospital or CAH, and may include, but is not limited to, a video format. However, a staff person must always be available to answer questions related to the MOON, both in its written and oral delivery formats.

The hospital or CAH must ensure that the beneficiary or representative signs and dates the MOON to demonstrate that the beneficiary or representative received the notice and understands its contents. Use of assistive devices may be used to obtain a signature.

Electronic issuance of the MOON is permitted. If a hospital or CAH elects to issue a MOON viewed on an electronic screen before signing, the beneficiary must be given the option of requesting paper issuance over electronic issuance if that is what the beneficiary prefers.

Regardless of whether a paper or electronic version is issued and regardless of whether the signature is digitally captured or manually penned, the beneficiary must be given a paper copy of the MOON with the required beneficiary specific information inserted, at the time of notice delivery.

Refusal to sign the MOON

If the beneficiary refuses to sign the MOON, and there is no representative to sign on behalf of the beneficiary, the notice must be signed by the staff member of the hospital/CAH who presented the written notification. The staff member's signature must include the name and title of the staff member, a certification that the notification was presented, and the date and time the notification was presented. The staff member annotates the *Additional information* section of the MOON to include the staff member's signature and certification of delivery. The date and time of refusal is considered to be the date of notice receipt.

MOON delivery to representatives

The MOON may be delivered to a beneficiary's appointed representative. A beneficiary may designate an appointed representative via the "Appointment of Representative" form, the CMS-1696, which can be found at *https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf*. See Chapter 29, Section 270.1 of the *Medicare Claims Processing Manual* at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c29.pdf* for more information on appointed representatives.

The MOON may also be delivered to an authorized representative. Generally, an authorized representative is an individual who, under state or other applicable law, may make health care decisions on a beneficiary's behalf (for example, the beneficiary's legal guardian, or someone appointed in accordance with a properly executed durable medical power of attorney). Notification to a beneficiary who has been deemed legally incompetent is typically made to an authorized representative of the beneficiary.

However, if a beneficiary is temporarily incapacitated, a person (typically, a family member or close friend) whom the hospital or CAH has determined could reasonably represent the beneficiary, but who has not been named in any legally binding document, may be a representative for the purpose of receiving the MOON.

Such a representative should act in the beneficiary's best interests and in a manner that is protective of the beneficiary and the beneficiary's rights. Therefore, a representative should have no relevant conflict of interest with the beneficiary.

In instances where the notice is delivered to a representative who has not been named in a legally binding document, the hospital or CAH should annotate the MOON with the name of the staff person initiating the contact, the name of the person contacted, and the date, time, and method (in person or telephone) of the contact.

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Note: There is an exception to the in-person notice delivery requirement. If the MOON must be delivered to a representative who is not physically present to receive delivery of the notice, the hospital/CAH is not required to make an off-site delivery to the representative. The hospital/CAH must complete the MOON as required and telephone the representative.

- The information provided telephonically should include all contents of the MOON.
- Note the date and time the hospital or CAH communicates (or makes a good faith attempt to communicate) this information telephonically to the representative is considered the receipt date of the MOON.
- Annotate the *Additional information* section to reflect that all of the information indicated above was communicated to the representative.
- Annotate the *Additional information* section with the name of the staff person initiating the contact, the name of the representative contacted by phone, the date and time of the telephone contact, and the telephone number called.

A copy of the annotated MOON should be mailed to the representative the day telephone contact is made. A hard copy of the MOON must be sent to the representative by certified mail, return receipt requested, or any other delivery method that can provide signed verification of delivery (for example: FedEx or UPS). The burden is on the hospital or CAH to demonstrate that timely contact was attempted with the representative and that the notice was delivered.

If the hospital or CAH and the representative both agree, the hospital or CAH may send the notice by fax or e-mail; however, the hospital or CAH's fax and e-mail systems must meet the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy and security requirements.

Ensuring beneficiary comprehension

The OMB-approved standardized MOON is available in English and Spanish. If the individual receiving the notice is unable to read its written contents and/or comprehend the required oral explanation, hospitals and CAHs must employ their usual procedures to ensure notice comprehension. Usual procedures may include, but are not limited to, the use of translators, interpreters, and assistive technologies.

Hospitals and CAHs are reminded that recipients of federal financial assistance have an independent obligation to provide language assistance services to individuals with Limited English Proficiency (LEP) consistent with Section 1557 of the Affordable Care Act and Title VI of the Civil Rights Act of 1964.

In addition, recipients of federal financial assistance have an independent obligation to provide auxiliary aids and services to individuals with disabilities free of charge,

consistent with Section 1557 of the Affordable Care Act and Section 504 of the Rehabilitation Act of 1973.

Completing the additional information field of the MOON

This section may be populated with any additional information a hospital wishes to convey to a beneficiary. Such information may include, but is not limited to:

- Contact information for specific hospital departments or staff members
- Additional content required under applicable state law related to notice of observation services
- Part A cost-sharing responsibilities if a beneficiary is admitted as an inpatient before 36 hours following initiation of observation services
- The date and time of the inpatient admission if a patient is admitted as an inpatient prior to delivery of the MOON
- Medicare accountable care organization information
- Hospital waivers of the beneficiary's responsibility for the cost of self-administered drugs
- Any other information pertaining to the unique circumstances regarding the particular beneficiary

If a hospital or CAH wishes to add information that cannot be fully included in the *Additional information* section, an additional page may be attached to the MOON.

Notice retention for the MOON

The hospital or CAH must retain the original signed MOON in the beneficiary's medical record. The beneficiary should receive a paper copy of the MOON that includes all of the required information. Electronic notice retention is permitted.

Intersection with state observation notices

Hospitals and CAHs in states that have state-specific observation notice requirements may add state-required information to the *Additional information* field, attach an additional page, or attach the notice required under state law to the MOON.

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Prompt payment interest rate revision

Medicare must pay interest on clean claims if payment is not made within the applicable number of calendar days (i.e., 30 days) after the date of receipt. The applicable number of days is also known as the payment ceiling. For example, a clean claim received March 1, 2016, must be paid before the end of business March 31, 2016.

The interest rate is determined by the applicable rate on the day of payment. This rate is determined by the Treasury Department on a six-month basis, effective every January and July 1. Providers may access the Treasury Department web page *https://www.fiscal.treasury.gov/fsservices/gov/pmt/promptPayment/rates.htm* for the correct rate. The interest period begins on the day after payment is due and ends on the day of payment. The new rate of 2.5 percent is in effect through June 30, 2017.

Interest is not paid on:

- Claims requiring external investigation or development by the Medicare contractor
- Claims on which no payment is due
- Claims denied in full
- Claims for which the provider is receiving periodic interim payment
- Claims requesting anticipated payments under the home health prospective payment system.

Note: The Medicare contractor reports the amount of interest on each claim on the remittance advice to the provider when interest payments are applicable.

Source: Publication 100-04, Chapter 1, Section 80.2.2

Chronic care management services questions

***Note**: This article was rescinded on January 19, 2017, because CMS has implemented changes to the payment policy for chronic care management (CCM) beginning January 1, 2017.*

Those changes are outlined in the 2017 physician fee schedule (PFS) final rule at https://www.gpo.gov/fdsys/pkg/FR-2016-11-15/pdf/2016-26668.pdf and the new guidance on the PFS care management web page at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Care-Management.html.

This information was previously published in the May 2015 Medicare B Connection, pages 7-12.

MLN Matters® Number: SE1516 *Rescinded*
Related Change Request (CR) #: N/A
Article Release Date: January 19, 2017
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

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Additional information

The official instruction, CR 9935, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3698CP.pdf*.

As mentioned earlier, the notice and accompanying instructions are available at *https://www.cms.gov/Medicare/Medicare-General-Information/BNI*.

If you have any questions, please contact your MAC at their toll-free number.

That number is available at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/*.

Document history

- **January 24, 2017:** Initial issuance
- **February 2, 2017:** The article was revised to reflect a revised CR 9935 issued January 27, 2017. In the article, the CR release date, transmittal number, and the web address for accessing the CR were revised. All other information remains the same.

MLN Matters® Number: MM9935
Related Change Request (CR) #: CR 9935
Related CR Release Date: January 27, 2017
Effective Date: February 21, 2017
Related CR Transmittal #: R3698CP
Implementation Date: February 21, 2017

Laboratory/Pathology

HCPCS subject to and excluded from CLIA edits

Provider types affected

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

Provider action needed

Change request (CR) 9946 informs MACs about the Healthcare Common Procedure Coding System (HCPCS) codes for 2017 that are both subject to, and excluded from, Clinical Laboratory Improvement Amendments (CLIA) edits and includes the HCPCS codes discontinued as of December 31, 2016. Make sure your billing staffs are aware of these CLIA-related changes for 2017.

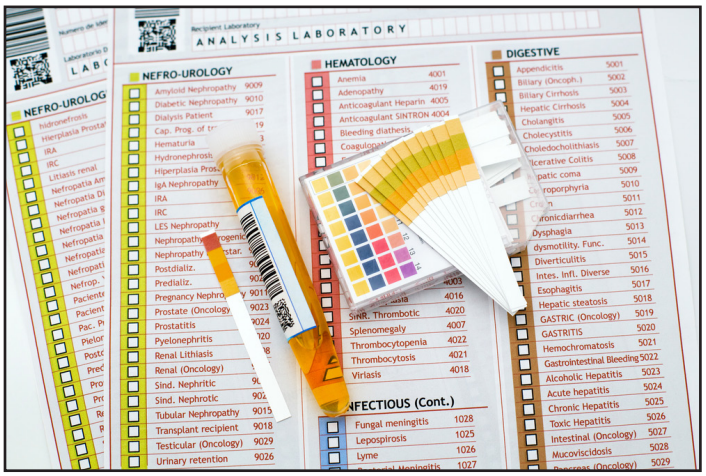
Background

The CLIA regulations require a facility to be appropriately certified for each test performed. To ensure that Medicare and Medicaid only pay for laboratory tests performed in certified facilities, each claim for a HCPCS code that is considered a CLIA laboratory test is currently edited at the CLIA certificate level. The HCPCS codes that are considered a laboratory test under CLIA change each year.

The codes in table 1 were discontinued December 31, 2016.

Table 1: HCPCS codes discontinued December 31, 2016

HCPCS code	Descriptor
80300	Drug screen non tlc devices
80301	Drug screen class list a
80302	Drug screen prsmptv 1 class
80303	Drug screen one/mult class
80304	Drug screen one/mult class
81280	Gene analysis (long QT syndrome) full sequence analysis
81281	Gene analysis (long QT syndrome) known familial sequence variant
81282	Gene analysis (long QT syndrome) duplication or deletion variants
0010M	Oncology (high-grade prostate cancer), biochemical assay of four proteins (total psa, free psa, intact psa and human kallidrein 2 (hk2)) plus patient age, digital rectal examination status, and no history of positive prostate biopsy, utilizing plasma, prognostic algorithm reported as a probability score.



The following HCPCS codes were removed from the Clinical Laboratory Fee Schedule (CR 9909) effective on January 1, 2017:

- G0477 - Drug tests(s), presumptive, any number of drug classes; any number of devices or procedures, (eg immunoassay) capable of being read by direct optical observation only (eg, dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service;
- G0478 – Drug tests(s), presumptive, any number of drug classes; any number of devices or procedures, (eg immunoassay) read by instrument-assisted direct optical observation (eg, dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service; and
- G0479 – Drug tests(s), presumptive, any number of drug classes; any number of devices or procedures by instrumented chemistry analyzers utilizing immunoassay, enzyme assay, TOF, MALDI, LDTD, DESI, DART, GHPC, GC mass spectrometry), includes sample validation when performed, per date of service.

The HCPCS codes listed in table 2 are new for 2017 and subject to CLIA edits. The list does not include new HCPCS codes for waived tests or provider-performed procedures. The HCPCS codes listed in table 2 require a facility to have either a:

1. CLIA certificate of registration (certificate type code 9)
2. CLIA certificate of compliance (certificate type code 1)
3. CLIA certificate of accreditation (certificate type code 3)

The following facilities are not permitted to be paid for the tests in table 2:

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1. A facility without a valid, current, CLIA certificate
2. A facility with a current CLIA certificate of waiver (certificate type code 2)
3. A facility with a current CLIA certificate for provider-performed microscopy procedures (certificate type code 4)

Table 2: New HCPCS codes subject to CLIA edits for 2017

HCPCS code	Descriptor
G0499	Hepatitis b screening in non-pregnant, high risk individual includes hepatitis b surface antigen (hbsag) followed by a neutralizing confirmatory test for initially reactive results, and antibodies to hbsag (anti-hbs) and hepatitis b core antigen (anti-hbc)
G0659	(Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem), excluding immunoassays (eg, IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (eg, alcohol dehydrogenase), performed in a single machine run without drug or class specific calibrations; qualitative or quantitative, all sources, includes specimen validity testing, per day)
80305	Drug test prsmv dir opt obs
80306	Drug test prsmv instrmnt
80307	Drug test prsmv chem anlyzr
81327	Methylation analysis (Septin9)
81413	Test for detecting genes associated with heart disease
81414	Test for detecting genes associated with heart disease
81422	Test for detecting genes associated with fetal disease
81439	Test for detecting genes associated with inherited disease of heart muscle
81539	Measurement of proteins associated with prostate cancer
84410	Testosterone level
87483	Test for detecting nucleic acid of organism causing infection of central nervous system

MACs will not search their files to either retract payment for claims already paid or retroactively pay claims, but will adjust claims that you bring to their attention.

Additional information

The official instruction, CR 9946, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3701CP.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/*.

MLN Matters® Number: MM9946
Related Change Request (CR) #: CR 9946
Related CR Release Date: February 3, 2017
Effective Date: January 1, 2017
Related CR Transmittal #: R3701CP
Implementation Date: April 3, 2017

How can the PDS help my practice?

The Provider Data Summary (PDS) can help you quickly identify potential billing issues through detailed analysis of personal billing patterns in comparison with those of similar providers. Additional information, including a quick-start guide to help you easily get started right away, is available at *http://medicare.fcso.com/PDS/index.asp.*

CMS updates list of new CLIA waived tests

Provider types affected

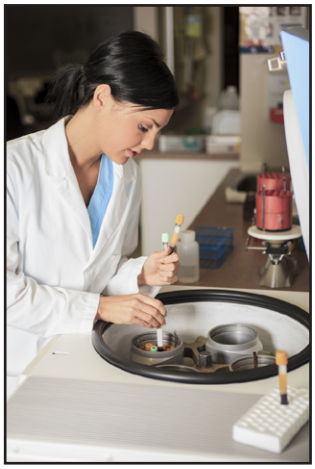
This *MLN Matters*® article is intended for clinical diagnostic laboratories submitting claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 9956 informs MACs of new Clinical Laboratory Improvement Amendments of 1988 (CLIA) waived tests approved by the Food and Drug Administration (FDA).

Since these tests are marketed immediately after approval, the Centers for Medicare & Medicaid Services (CMS) must notify MACs of the new tests so that they can accurately process claims. Make sure that your billing staffs are aware of these CLIA-related changes.

Background



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

Listed below are the latest tests approved by the FDA as waived tests under CLIA. The Current Procedural Terminology (CPT®) codes for the following new tests must have the modifier QW to be recognized as a waived test.

However, the tests mentioned on the first page of the list attached to CR 9956 (CPT® codes: 81002, 81025, 82270, 82272, 82962, 83026, 84830, 85013, and 85651) do not require a QW modifier to be recognized as a waived test.

The CPT® code, effective date and description for the latest tests approved by the FDA as waived tests under CLIA are the following:

- G0477QW [from July 7, 2016, to December 31, 2016], 80305QW [on and after January 1, 2017], July 7, 2016, TransMed Company, CLIA screen in-vitro multi-drug urine test dip card
- G0477QW [from July 7, 2016, to December 31, 2016], 80305QW [on and after January 1, 2017], July 7, 2016, TransMed Company, CLIA screen in-vitro multi-drug urine test dip cup
- 82274QW, G0328QW, July 27, 2016, Pinnacle BioLabs second generation FIT fecal occult blood (FOB) self-test {Cassette}
- G0477QW [from August 11, 2016, to December 31, 2016], 80305QW [on and after January 1, 2017], August 11, 2016, Nobel Medical Inc., AEON multi-drug urine test cup
- G0477QW [from August 11, 2016, to December 31, 2016], 80305QW [on and after January 1, 2017], Nobel Medical Inc., August 11, 2016, AEON Multi-Drug Urine Test Dip Card
- G0477QW [from August 11, 2016, to December 31, 2016], 80305QW [on and after January 1, 2017], August 11, 2016, Nobel Medical Inc., INSTA-SCREEN multi-drug urine test cup
- 82274QW, G0328QW, September 6, 2016, ProAdvantage immunochemical fecal occult blood test
- 87880QW, September 16, 2016, Cardinal health strep A cassette rapid test
- G0477QW [from September 16, 2016, to December 31, 2016], 80305QW [on and after January 1, 2017], September 16, 2016, Premier Biotech, Inc., MDETOX multi-drug urine test cup
- G0477QW [from September 16, 2016, to December 31, 2016], 80305QW [on and after January 1, 2017], September 16, 2016, Premier Biotech, Inc., MDETOX multi-drug urine test card
- 81003QW, October 7, 2016. Moore Medical LLC mooremedical U120 Urine Analyzer
- 87633QW, October 7, 2016, BioFire Diagnostics, FilmArray 2.0 EZ Configuration Instrument (viral and bacterial nucleic acids) {nasopharyngeal swabs}
- 87804QW, October 7, 2016, BioSign Flu A+B {nasal and nasopharyngeal swabs}
- G0477QW [from October 24, 2016, to December 31, 2016], 80305QW [on and after January 1, 2017], October 24, 2016, Identify BioSciences Inc., identifi ulti-panel drug test cups (urine) {cup format}
- G0477QW [from October 25, 2016, to December 31, 2016], 80305QW [on and after January 1, 2017], October 25, 2016, UCP Biosciences, Inc. U-card drug test screen (urine) {card format}
- G0477QW [from October 25, 2016, to December 31, 2016], 80305QW [on and after January 1, 2017], October 25, 2016, UCP Biosciences, Inc. U-cup drug test screen (urine) {cup format}
- G0477QW [from October 26, 2016, to December 31, 2016], 80305QW [on and after January 1, 2017], Intrinsic Interventions Inc., Vista Flow
- 87804QW, November 15, 2016, LifeSign LLC, status flu A+B
- 87804QW, November 21, 2016, Sekisui Diagnostics LLC, OSOM Ultra Flu A&B Test
- G0477QW [from November 23, 2016, to December 31, 2016], 80305QW [on and after January 1, 2017], November 23, 2016, Medical Distribution Group Inc., identify diagnostics drug test cards (UPC Biosciences, Inc.)

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- G0477QW [from November 23, 2016, to December 31, 2016], 80305QW [on and after January 1, 2017], November 23, 2016, Medical Distribution Group Inc., identify diagnostics drug test cups (UPC Biosciences, Inc.)
- 87804QW, November 25, 2016, OraSure QuickFlu rapid A+B test {nasal and nasopharyngeal swabs}

The HCPCS code G0477 [Drug tests(s), presumptive, any number of drug classes; any number of devices or procedures, (eg, immunoassay) capable of being read by direct optical observation only (eg, dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service] was discontinued 12/31/2016.

The new HCPCS code 80305 [Drug test(s), presumptive, any number of drug classes, any number of devices or procedures (eg, immunoassay); capable of being read by direct optical observation only (eg, dipsticks, cups, cards, cartridges) includes sample validation when performed, per date of service] was effective 1/1/2017. HCPCS code 80305QW describes the waived testing previously assigned the code G0477QW. All tests in the attachment that previously had HCPCS G0477QW are now assigned 80305QW.

The new waived complexity code 87633QW [Infectious agent detection by nucleic acid (DNA or RNA); respiratory virus (e.g., adenovirus, influenza virus, coronavirus, metapneumovirus, parainfluenza virus, respiratory syncytial virus, rhinovirus), multiplex reverse transcription and amplified probe technique, multiple types or subtypes, 12-25 targets] was assigned for the testing performed by BioFire Diagnostics, FilmArray 2.0 EZ Configuration Instrument (viral and bacterial nucleic acids) {nasopharyngeal swabs}.

The attachment to CR 9956 has been re-organized. HCPCS codes with more than 20 test systems listed in previous transmittal attachments will now not mention the specific waived complexity test system. Instead, there will be a generic test system name and a statement to refer to the FDA waived analytes internet site (*http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfClia/analyteswaived.cfm*) for the specific test system name.

The HCPCS codes mentioned on the attachment that will now only be mentioned in a generic manner are G0477QW (80305QW effective 1/1/2017), 81003QW, 82274QW, G0328QW, 86308QW, 86318QW, and 87880QW.

For these codes, future new waived test transmittals will only mention the specific name of the latest FDA test system in the transmittal and not be included in the attachment.

MACs will not search their files to either retract payment or retroactively pay claims based on these changes. However, MACs should adjust claims that you bring to their attention.

Additional information

The official instruction, CR 9956, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3696CP.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/*.

MLN Matters® Number: MM9956
Related Change Request (CR) #: CR 9956
Related CR Release Date: January 20, 2017
Effective Date: April 1, 2017
Related CR Transmittal #: R3696CP
Implementation Date: April 3, 2017

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. Review *this tutorial* on how to get started correcting claims online.

The SPOT tutorial is available at https://medicare.fcso.com/Help/276733.asp.

Processing Issues

Controlled substance monitoring and drugs of abuse testing – overpayments

Issue

First Coast Service Options Inc. has identified an internal processing issue that resulted in overpayments related to specimen validity testing (SVT).

SVT is an internal laboratory procedure to determine whether the urine specimen has been diluted or adulterated that also assures and protects the laboratory from reporting invalid test results to the ordering physician. SVT must be performed on every specimen by the laboratory. SVT testing relates to specimen integrity and accuracy, and not for direct patient management.

SVT results provide information about the integrity of the urine specimen and does not define/establish criteria for a physician to prescribe/non-prescribe pain medication or dismiss a patient, and as such, is not a separately reimbursable Medicare service.

Resolution

Current Procedural Terminology (CPT®) code 81003 (routine urinalysis) and CPT® code 82570 (urine creatinine), will both be denied when performed on the same date of service as the qualitative drug test (Healthcare Common Procedure Coding System [HCPCS] codes G6030-G6057 [which were deleted effective January 1, 2016] and G0477-G0483 [effective on and after January 1, 2016]).

Status/date resolved

Closed/December 1, 2016.

Provider action

Providers who received payment in error will receive a demand letter requesting the monies back.

Providers do not need to contact customer service; they should follow the instructions in the demand letters.

Current processing issues

Here is a link to a *table of current processing issues* for both Part A and Part B.

Part B services denied due to laboratory NCD edit changes

Issue

Change request (CR) 9806 announces significant changes to 23 national coverage determinations outlined in *Publication 100-03, Sections 190.12 – 190.34 for Laboratory Services* involving ICD-10 diagnosis editing. These changes will be implemented December 5, 2016, for dates of service on and after October 1, 2016.

Therefore, services impacted by these ICD-10 diagnosis changes that have been submitted prior to the December 5 implementation date will be denied.

Resolution

Part B claims submitted prior to December 5 for dates of service on and after October 1, 2016, that denied in error were automatically adjusted after implementation.

Status/date resolved

Closed/December 8, 2016

Provider action

None; claims submitted prior to December 5 for dates of service on and after October 1, 2016, that denied in error were automatically adjusted after implementation.

Current processing issues

Here is a link to a *table of current processing issues* for both Part A and Part B.

Billing clarification of procedure code 96377

The American Medical Association (AMA) issued a new Current Procedural Terminology (CPT®) code 96377 for "Application of on-body injector (includes cannula insertion) for timed subcutaneous injection," effective January 1, 2017.

According to the January 2017 Medicare physician fee schedule update, CPT® code 96377 is not a valid code for Part B providers.

If reported, the service will reject as an invalid code.

To report this service, use CPT® code 96372 (Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular).

CMS issues guidelines for prior authorization

Provider types affected

This *MLN Matters*® article is intended for providers ordering certain DMEPOS items and suppliers submitting claims to Medicare administrative contractors (MACs) for items furnished to Medicare beneficiaries.

What you need to know

Change request (CR) 9940 updates the Centers for Medicare & Medicaid Services (CMS) *Program Integrity Manual* to permit the MACs to conduct prior authorization processes, as so directed by CMS through individualized operational instructions.

As of January 2017, prior authorization of certain durable medical equipment, prosthetic, orthotic, and supply items, frequently subject to unnecessary utilization, is the only permanent (non-demonstration) prior authorization program approved for implementation. Make sure your billing staff is aware of these changes.

Background

Prior authorization is a process through which a request for provisional affirmation of coverage is submitted to a medical review contractor for review before the item or service is furnished to the beneficiary and before the claim is submitted for processing.

It is a process that permits the submitter/requester (for example, provider, supplier, beneficiary) to send in medical documentation, in advance of the item or service being rendered, and subsequently billed, in order to verify its eligibility for Medicare claim payment.

For any item or service to be covered by Medicare it must:

- Be eligible for a defined Medicare benefit category
- Be medically reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member
- Meet all other applicable Medicare coverage, coding and payment requirements

Contractors shall, at the direction of CMS or other authorizing entity, conduct prior authorizations and alert the requester/submitter of any potential issues with the information submitted.

A prior authorization request decision can be either a provisional affirmative or a non-affirmative decision.

- A provisional affirmative decision is a preliminary finding that a future claim submitted to Medicare for the item or service likely meets Medicare's coverage, coding, and payment requirements.
- A non-affirmative decision is a finding that the submitted information/ documentation does not meet Medicare's coverage, coding, and payment requirements, and if a claim associated with the prior authorization is submitted for payment, it would not be paid. MACs shall provide notification of the reason for the non-affirmation, if a request is non-affirmative,

to the submitter/requester. If a prior authorization request receives a non-affirmative decision, the prior authorization request can be resubmitted an unlimited number of times.

- Prior authorization may also be a condition of payment. This means that claims submitted without an indication that the submitter/requester received a prior authorization decision (that is, unique tracking number (UTN)) will be denied payment.

Each prior authorization program will have an associated operational guide that will be available on the CMS website.

In addition, MACs will educate stakeholders each time a new prior authorization program is launched. That education will include the requisite information and timeframes for prior authorization submissions and the vehicle to be used to submit such information to the MAC.

Prior authorization program for DME MACs

A prior authorization program for certain durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) items that are frequently subject to unnecessary utilization is described in 42 CFR 414.234.

Among other things, this section establishes a master list of certain DMEPOS items meeting inclusion criteria and potentially subject to prior authorization.

CMS will select healthcare common procedure coding system (HCPCS) codes from the prior authorization master list to be placed on the required prior authorization list, and such codes will be subject to prior authorization as a condition of payment.

In selecting HCPCS codes, CMS may consider factors such as geographic location, item utilization or cost, system capabilities, administrative burden, emerging trends, vulnerabilities identified in official agency reports, or other data analysis.

- The prior authorization master list is the list of DMEPOS items that have been identified using the inclusion criteria described in 42 CFR 414.234.

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- Claim reopening request - Clerical reopening form (**Part A**)
- Electronic Data Interchange enrollment form
- General inquiry request - Questions about Medicare program/policies
- Provider Audit & Reimbursement - Documents related to annual cost report filing.(**Part A**)
- Medicare secondary payer (MSP) overpayment form - Voluntary refund of an overpayment for an MSP claim (**Part B**)
- Non-MSP overpayment form - Voluntary refund of an overpayment for a Non-MSP claim (**Part B**)
- Overpayment redetermination request - Appeal of an overpayment decision (**Part B**)

As *one provider discovered*, SPOT allows you to quickly handle an overpayment request. "SPOT made it so easy to resolve the issue. We checked the physician's records to see if we billed an incorrect patient number among other things. Then I checked the eligibility tab on SPOT, checked the date of service. I made a screen print from SPOT and sent it through the secure mail. You hit 'send'. Boom. There it goes. No visits to the post office," said Gunn.

First Coast recently upgraded the secure messaging tool allowing Medicare providers to submit documents using the Adobe® Acrobat PDF. Prior to this improvement, SPOT account holders were required to convert some electronic documents to a tagged image file format (TIFF).

In addition to secure messaging, Medicare providers have several tools available to diagnose, correct, and prevent denied claims.

SPOT gives you the ability to view claims status and patient eligibility information online, conduct detailed data analysis at the claim and provider levels, reopen claims to make clerical corrections on multiple lines, and submit redeterminations and additional development responses (ADRs). First Coast offers SPOT to providers at no charge.

How to get your SPOT account

First Coast *provides a step-by-step guide* to assist you in establishing your SPOT account.

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- The list of required DMEPOS prior authorization items contains those items selected from the prior authorization master list to be implemented in the prior authorization program.

  The list of required DMEPOS prior authorization items will be updated as additional codes are selected for prior authorization.
- CMS may suspend prior authorization requirements generally or for a particular item or items at any time and without undertaking rulemaking.

  CMS provides notification of the suspension of the prior authorization requirements via *Federal Register* notice and posting on the CMS prior authorization website.

The master and required prior authorization lists, as well as other pertinent information and supporting documents regarding this program, are available at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Prior-Authorization-Initiatives/Prior-Authorization-Process-for-Certain-Durable-Medical-Equipment-Prosthetic-Orthotics-Supplies-Items.html*.

Additional information

The official instruction, CR 9940, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R698PI.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/*.

MLN Matters® Number: MM9940
Related Change Request (CR) #: CR 9940
Related CR Release Date: January 20, 2017
Effective Date: February 21, 2017
Related CR Transmittal #: R698PI
Implementation Date: February 21, 2017

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.

Before you file an appeal...

Each month, thousands of medical providers send written inquiries to First Coast Service Options Inc. (First Coast) to check the status of an appealed claim. Unfortunately, many of these appeals and subsequent inquiries are submitted on claims that were ineligible for appeal.

Before you appeal a denied claim, check out *these resources*.

Revisions to LCDs

Evaluation and management services in a nursing facility – revision to the Part A and Part B LCD

LCD ID number: L36230 (Florida, Puerto Rico/U.S. Virgin Islands)

Based on change request (CR) 9754 (October 2016 Integrated Outpatient Code Editor (I/OCE) Specifications) and CR 9749 (Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - October CY 2016 Update), the local coverage determination (LCD) for evaluation and management services in a nursing facility was revised to add HCPCS code G9685 (evaluation and management of a beneficiary's acute change in condition in a nursing facility) to the "CPT®/HCPCS Codes" section of the LCD.

Effective date

This LCD revision is effective for claims processed **on or after January 17, 2017**, for services rendered **on or after October 1, 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*.

Additional Information

Updating the address for ADR letters

Did you know you can update your address for additional documentation requests (ADRs)? First Coast Service Options Inc. (First Coast) sometimes requires a clinical review of documentation to determine the medical necessity of services. It is the goal of First Coast to ensure that providers are properly reimbursed for medically reasonable and necessary services. When documentation is required, an ADR is mailed to the provider.

The ADR letter is mailed to a provider's practice address on file with Medicare. For individual providers rendering services in large facilities such as hospitals, however, the ADR letter may be misdirected and not received in time by the appropriate department or individual provider.

Providers in these situations may request First Coast to mail all correspondence (including ADRs) to the pay-to address listed on their Provider Enrollment, Chain and Ownership (PECOS) file.

How to request all correspondence to go to the pay-to address

- If the pay-to address is already on file in PECOS:
  - Submit a letter on company letterhead requesting all correspondence be sent to the pay-to address on file. The letter must be signed by a person in an official role (authorized or delegated official) for the billing provider.
- If the pay-to address is NOT already on file in PECOS:
  - Submit a change of information using the appropriate paper CMS-855 enrollment application or internet-based PECOS to update the pay-to address. Include a letter on company letterhead requesting all correspondence be sent to the pay-to address being updated with the enrollment application. The letter must be signed by a person in an official role (authorized or delegated official) for the billing provider.

Note: Please keep in mind that once completed, ALL correspondence from First Coast will be sent to this address. This includes situations where the provider has more than one practice location; all correspondence for all practice locations will be sent to the designated pay-to address you selected once First Coast makes the change.

The letter and application, if applicable, may be mailed to:

Provider Enrollment

P.O. Box 44021

Jacksonville, FL 32231-4021

Upcoming provider outreach and educational events

Medicare Part B changes and regulations (Part B)

Date: Wednesday, March 15
Time: 10:00 a.m.-11:00 a.m.
Type of Event: Webcast
https://medicare.fcso.com/Events/0366071.asp

Ask-the-contractor teleconference (ACT): Physical therapy services (Part B)

Date: Wednesday, March 22
Time: 11:30-1:00 p.m.
Type of Event: Webcast
https://medicare.fcso.com/Events/0365062.asp

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

Two easy ways to register

Online – Visit our provider training website at *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®

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

MLN Connects® for February 2, 2017

MLN Connects® for February 2, 2017

View this edition as a PDF

News & Announcements

- Clinical Laboratories: Prepare Now to Report Lab Data through March 31
- Updated Clinical Laboratory Fee Schedule Website
- Teaching Hospitals Receiving FTE Resident Caps Due to Hospital Closures
- February is American Heart Month

Provider Compliance

- Hospital Discharge Day Management Services

Upcoming Events

- Understanding and Promoting the Value of Chronic Care Management Services Call — February 21
- Looking Ahead: The IMPACT Act in 2017 Call — February 23

Medicare Learning Network® Publications & Multimedia

- Telehealth Services Fact Sheet — Revised
- Inpatient Rehabilitation Facility Prospective Payment System Fact Sheet — Revised
- Home Oxygen Therapy Booklet — Revised
- MLN Suite of Products & Resources for Rural Health Providers Educational Tool — Revised

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MLN Connects® for February 9, 2017

MLN Connects® for February 9, 2017

View this edition as a PDF

News & Announcements

- Clinical Laboratories: Easier to Report Lab Data

Claims, Pricers & Codes

- January 2017 OPPS Pricer File

Upcoming Events

- Understanding and Promoting the Value of Chronic Care Management Services Call — February 21
- Looking Ahead: The IMPACT Act in 2017 Call — February 23

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MLN Connects® for February 16, 2017

MLN Connects® for February 16, 2017

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News & Announcements

Influenza Activity Continues: Are Your Patients Protected?

Upcoming Events

- Understanding and Promoting the Value of Chronic Care Management Services Call — February 21
- What's New with Physician Compare Webinar — February 21 and 23
- Looking Ahead: The IMPACT Act in 2017 Call — February 23

Medicare Learning Network® Publications & Multimedia

- Medicare Home Health Benefit Booklet — Revised
- Medicare Costs at a Glance: 2017 Educational Tool — Revised
- CMS Provider Minute Video: Nasal Endoscopy — Reminder

The Medicare Learning Network®, MLN Connects®, and MLN Matters® are registered trademarks of the U.S. Department of Health and Human Services (HHS).

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

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877-660-1759 (speech and hearing impaired)

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888-670-0940

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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

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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

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

General inquiries

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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,

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532 Riverside Avenue
Jacksonville, FL 32202-4914

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https://www.cms.gov

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

Beneficiaries

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

Order form for Medicare Part B materials

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

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

Item	Acct Number	Cost per item	Quantity	Total cost
Part B subscription – The Medicare Part B jurisdiction N publications, in both Spanish and English, are available free of charge online at *http://medicare.fcso.com/Publications_B/index.asp* (English) or *http://medicareespanol.fcso.com/Publicaciones/* (Español). Nonprovider entities or providers who need additional copies may purchase an annual subscription. This subscription includes all issues published from October 2016 through September 2017.	40300260	$33		
2017 fee schedule – The Medicare Part B Physician and Nonphysician Practitioner Fee Schedules, effective for services rendered January 1 through December 31, 2017, are available free of charge online at *http://medicare.fcso.com/Data_files/* (English) or *http://medicareespanol.fcso.com/Fichero_de_datos/* (Español). Additional copies are available for purchase. The fee schedules contain payment rates for all localities. These items do not include the payment rates for injectable drugs, clinical lab services, mammography screening, or DMEPOS items. **Note:** Requests for hard copy paper disclosures will be completed as soon as CMS provides the direction to do so. Revisions to fees may occur; these revisions will be published in future editions of the Medicare Part B publication.	40300270	$12		
Language preference: **English** [ ] **Español** [ ]				
Please write legibly			Subtotal	$
			Tax (***add % for your area***)	$
			Total	$

Mail this form with payment to:
First Coast Service Options Inc.
Medicare Publications
P.O. Box 406443
Atlanta, GA 30384-6443

Contact Name: _____

Provider/Office Name: _____

Phone: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

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