Medicare B CONNECTION
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FIRST COAST SERVICE OPTIONS, INC.
A Newsletter for MAC Jurisdiction N Providers
February 2018

In this issue

NGACO year three benefit enhancements

Note: *This article was revised January 23, 2018, to reflect the revised change request (CR) 10044 issued November 22, 2017. In the article, the CR release date, transmittal number, and the web address of the CR are revised. All other information remains the same. This information was previously published in the August 2017 Medicare B Connection, page 23-24.*

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 services provided to Medicare beneficiaries.

Provider action needed

CR 10044 provides instruction to MACs to implement two new benefit enhancements for performance year three (2018) of the NGACO model. MACs will process and pay claims for asynchronous telehealth and post-discharge home visit waiver services when those services meet the appropriate payment requirements as outlined in CR 10044. Make sure your billing staff is aware of these changes.

Background

The aim of the NGACO model is to improve the quality of care, population health outcomes, and patient experience for the beneficiaries who choose traditional Medicare fee-for-service (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.

In order to emphasize high-value services and support the ability of ACOs to manage the care of beneficiaries, the Centers for Medicare & Medicaid Services (CMS) is issuing the authority under Section 1115A of the Social Security Act (the Act) (Section 3021 of the Affordable Care Act) to conditionally waive certain Medicare payment requirements as part of the NGACO model.

Asynchronous telehealth

CMS is expanding the current telehealth waiver to include asynchronous (also known as “storeand-forward”) telehealth in the specialties of teledermatology and teleophthalmology. Asynchronous telehealth includes the transmission of recorded health history (for example, retinal scanning and digital images) through a secure

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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 *https://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.

April quarterly update to correct coding initiative edits

Provider type affected

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

Provider action needed

Change request (CR) 10472 includes the normal update to the National Correct Coding Initiative (NCCI) procedure-to-procedure (PTP) edits. This update applies to Chapter 23, Section 20.9 of the *Medicare Claims Processing Manual*. Please make sure your billing staffs are aware of these updates.

Background

The Centers for Medicare & Medicaid Services (CMS) developed the NCCI to promote national correct coding methodologies and to control improper coding that leads to inappropriate payments in Part B claims.

Version 24.1 will include all previous versions and updates from January 1, 1996, to the present. In the past, NCCI was organized in two tables – column one/column two correct coding edits and mutually exclusive code (MEC) edits. To simplify the use of NCCI edit files (two tables), 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 the outpatient code editor (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.** Refer to the CMS NCCI webpage for additional information at *https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html*

The coding policies developed are based on coding conventions defined in the *American Medical Association's Current Procedural Terminology 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.

Additional information

The official instruction, CR 10472, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R3963CP.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/*.

Document history

Date of change	Description
February 2, 2018	Initial article released.

MLN Matters® Number: MM10472
Related CR Release Date: February 2, 2018
Related CR Transmittal Number: R3963CP
Related Change Request (CR) Number: 10472
Effective Date: April 1, 2018
Implementation Date: April 2, 2018

Where do I find...

Looking for something specific and don't know where to find it? Find out how to perform routine tasks or locate information that visitors frequently visit our site to accomplish or find. Check out the "Where do I find" page.

Drugs & Biologicals

April 2018 update of drug and biological code changes

Note: Editorial corrections made May 23, 2018, to the related CR transmittal number.

Provider type affected

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

What you need to know

The HCPCS code set is updated on a quarterly basis. Change request (CR) 10454 informs MACs of the April 2018 updates of specific biosimilar biological product HCPCS code, modifiers used with these biosimilar biologic products and an autologous cellular immunotherapy treatment. Be sure your staffs are aware of these updates.

Background

CR 10454 describes updates associated with the following biosimilar biological product HCPCS codes and modifiers. The April 2018 HCPCS file includes three new HCPCS codes: Q5103, Q5104, and Q2041 Also, the April 2018 HCPCS file includes a revision to the descriptor for HCPCS code Q5101.

Effective for services as of April 1, 2018, The April 2018 HCPCS file includes these revised/new HCPCS codes:

- HCPCS code: Q5101
  - Short description: Injection, zarxio
  - Long description: Injection, filgrastim-sndz, biosimilar, (zarxio), 1 microgram
- HCPCS code: Q5103
  - Short description: Injection, inflectra
  - Long description: Injection, infliximab-dyyb, biosimilar, (inflectra), 10 mg
  - Type of service (TOS) code: 1,P
  - Medicare physician fee schedule database (MPFSDB) status indicator: E
- HCPCS code: Q5104
  - Short description: Injection, renflexis
  - Long description: Injection, infliximab-abda, biosimilar, (renflexis), 10 mg
  - TOS code: 1, P
  - MPFSDB status indicator: E
- HCPCS code:Q2041
  - Short description: Axicabtagene ciloleucel car+
  - Long description: Axicabtagene Ciloleucel, up to 200 million autologous Anti-CD19 CAR T Cells, Including leukapheresis and dose preparation procedures, per infusion
  - TOS code: 1
  - MPFSDB status indicator: E

Effective for claims with dates of service on or after April 1, 2018, HCPCS code Q5102 (which describes both currently available versions of infliximab biosimilars) will be replaced with two codes, Q5103 and Q5104. Thus, Q5102 Injection, infliximab, biosimilar, 10 mg, will be discontinued, effective March 31, 2018.

Also, beginning on April 1, 2018, modifiers that describe the manufacturer of a biosimilar product (for example, ZA, ZB and ZC) will no longer be required on Medicare claims for HCPCS codes for biosimilars. However, please note that HCPCS code Q5102 and the requirement to use biosimilar modifiers remain in effect for dates of service prior to April 1, 2018.

Medicare Part B policy changes for biosimilar biological products were discussed in the 2018 physician fee schedule (PFS) final rule at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1676-F.html*. Effective January 1, 2018, newly approved biosimilar biological products with a common reference product will no longer be grouped into the same billing code. The rule also stated that instructions for new codes for biosimilars that are currently grouped into a common payment code and the use of modifiers would be issued.

Additional information

The official instruction, CR 10454, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R3966CP.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/*.

Document history

Date of change	Description
February 2, 2018	Initial article released.

MLN Matters® Number: MM10454
Related CR Release Date: February 8, 2018
Related CR Transmittal Number: R3966CP
Related Change Request (CR) Number: 10454
Effective Date: April 1, 2018
Implementation Date: April 2, 2018

Evaluation & Management

E/M service documentation provided by students – manual update

Provider type affected

This *MLN Matters*® article is intended for teaching physicians billing Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 10412 revises the *Medicare Claims Processing Manual* to allow the teaching physician to verify in the medical record any student documentation of components of E/M services, rather than re-documenting the work. Make sure your billing staffs are aware of the changes.

Background

The Centers for Medicare & Medicaid Services (CMS) is revising the *Medicare Claims Processing Manual*, Chapter 12, Section 100.1.1, to update policy on evaluation and management (E/M) documentation to allow the teaching physician to verify in the medical record any student documentation of components of E/M services, rather than re-documenting the work. Students may document services in the medical record. However, the teaching physician must verify in the medical record all student documentation or findings, including history, physical exam and/or medical decision making. The teaching physician must personally perform (or re-perform) the physical exam and medical decision making activities of the E/M service being billed, but may verify any student documentation of them in the medical record, rather than re-documenting this work.

Additional information

The official instruction, CR 10412, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R3971CP.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/*.

Document history

Date of change	Description
February 5, 2017	Initial article released.

MLN Matters® Number: MM10412
Related CR Release Date: February 2, 2018
Related CR Transmittal Number: R3971CP
Related Change Request (CR) Number: 10412
Effective Date: January 1, 2018
Implementation Date: March 5, 2018

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Laboratory/Pathology

Quarterly update for clinical laboratory fee schedule and services subject to reasonable charge payment

Provider type 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) 10445 which informs the MACs about the changes in the April 2018 quarterly update to the clinical laboratory fee schedule (CLFS). Make sure that your billing staffs are aware of these changes.

Background

Effective January 1, 2018, CLFS rates will be based on weighted median private payor rates as required by the Protecting Access to Medicare Act (PAMA) of 2014. For more details, visit PAMA Regulations, at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/PAMA-Regulations.html*. Part B deductible and coinsurance do not apply for services paid under the CLFS.

Access to data file

Internet access to the quarterly CLFS data file will be available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html*. Interested parties, such as the Medicaid State agencies, the Indian Health Service, the United Mine Workers, and the Railroad Retirement Board, should use the Internet to retrieve the quarterly clinical laboratory fee schedule. The file will be available in multiple formats: Excel, text, and comma delimited.

Pricing information

The CLFS includes separately payable fees for certain specimen collection methods (codes 36415, P9612, and P9615). The fees are established in accordance with Section 1833(h)(4)(B) of the Social Security Act.

New codes

The following new codes will be MAC priced, until they are addressed at the annual Clinical Laboratory Public Meeting, which will take place in July, 2018. The following "U" codes shall have HCPCS pricing indicator code - 22 = Price established by A/B MACs Part B (e.G., gap-fills, A/B MACs Part B established panels) instead of pricing indicator - 21 = Price subject to national limitation amount. (code, long descriptor, short descriptor, effective date, type of service (TOS))

0024U Glycosylated acute phase proteins (GlycA), nuclear magnetic resonance spectroscopy, quantitative GLYCA NUC MR SPECTRSC QUAN 1/1/2018 5

0025U Tenofovir, by liquid chromatography with tandem mass spectrometry (LC-MS/MS), urine, quantitative TENOFOVIR LIQ CHROM UR QUAN 1/1/2018 5

0026U Oncology (thyroid), DNA and mRNA of 112 genes, next-generation sequencing, fine needle aspirate of thyroid nodule, algorithmic analysis reported as a categorical result ("Positive, high probability of malignancy" or "Negative, low probability of malignancy") ONC THYR DNA&MRNA 112 GENES 1/1/18 5

0027U JAK2 (Janus kinase 2) (eg, myeloproliferative disorder) gene analysis, targeted sequence analysis exons 12-15 JAK2 GENE TRGT SEQ ALYS 1/1/18 5

0028U CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism) gene analysis, copy number variants, common variants with reflex to targeted sequence analysis CYP2D6 GENE CPY NMR CMN VRNT 1/1/18 5

0029U Drug metabolism (adverse drug reactions and drug response), targeted sequence analysis (ie, CYP1A2, CYP2C19, CYP2C9, CYP2D6, CYP3A4, CYP3A5, CYP4F2, SLCO1B1, VKORC1 and rs12777823) RX METAB ADVRS TRGT SEQ ALYS 1/1/18 5

0030U Drug metabolism (warfarin drug response), targeted sequence analysis (ie, CYP2C9, CYP4F2, VKORC1, rs12777823) RX METAB WARF TRGT SEQ ALYS 1/1/18 5

0031U CYP1A2 (cytochrome P450 family 1, subfamily A, member 2)(eg, drug metabolism) gene analysis, common variants (ie, *1F, *1K, *6, *7) CYP1A2 GENE 1/1/18 5

0032U COMT (catechol-O-methyltransferase)(drug metabolism) gene analysis, c.472G>A (rs4680) variant COMT GENE 1/1/18 5

0033U HTR2A (5-hydroxytryptamine receptor 2A), HTR2C (5-hydroxytryptamine receptor 2C) (eg, citalopram metabolism) gene analysis, common variants (ie, HTR2A rs7997012 [c.614-2211T>C], HTR2C rs3813929 [c.-759C>T] and rs1414334 [c.551-3008C>G]) HTR2A HTR2C GENES 1/1/18 5

0034U TPMT (thiopurine S-methyltransferase), NUDT15 (nudix hydroxylase 15)(eg, thiopurine metabolism), gene analysis, common variants (ie, TPMT *2, *3A, *3B, *3C, *4, *5, *6, *8, *12; NUDT15 *3, *4, *5) TPMT NUDT15 GENES 1/1/18 5

The following new code is effective January 1, 2018:

New code 87634QW is priced at the same rate as code 87634.

The following new codes are effective April 1, 2018:

New code 0001UQW is priced at the same rate as 0001U.

New code 0002UQW is priced at the same rate as 0002U.

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New code 0003UQW is priced at the same rate as 0003U.
New code 0005UQW is priced at the same rate as 0005U.
New code 0006UQW is priced at the same rate as 0006U.
New code 0007UQW is priced at the same rate as 0007U.
New code 0008UQW is priced at the same rate as 0008U.
New code 0009UQW is priced at the same rate as 0009U.
New code 0010UQW is priced at the same rate as 0010U
New code 0011UQW is priced at the same rate as 0011U
New code 0012UQW is priced at the same rate as 0012U
New code 0013UQW is priced at the same rate as 0013U
New code 0014UQW is priced at the same rate as 0014U
New code 0016UQW is priced at the same rate as 0016U
New code 0017UQW is priced at the same rate as 0017U
New code 81105QW is priced at the same rate as 81105
New code 81106QW is priced at the same rate as 81106
New code 81107QW is priced at the same rate as 81107
New code 81108QW is priced at the same rate as 81108
New code 81109QW is priced at the same rate as 81109
New code 81110QW is priced at the same rate as 81110
New code 81111QW is priced at the same rate as 81111
New code 81112QW is priced at the same rate as 81112
New code 81120QW is priced at the same rate as 81120
New code 81121QW is priced at the same rate as 81121
New code 81175QW is priced at the same rate as 81175
New code 81176QW is priced at the same rate as 81176
New code 81230QW is priced at the same rate as 81230
New code 81231QW is priced at the same rate as 81231
New code 81232QW is priced at the same rate as 81232
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New code 81283QW is priced at the same rate as 81283
New code 81328QW is priced at the same rate as 81328
New code 81334QW is priced at the same rate as 81334
New code 81335QW is priced at the same rate as 81335
New code 81346QW is priced at the same rate as 81346
New code 81361QW is priced at the same rate as 81361
New code 81362QW is priced at the same rate as 81362
New code 81363QW is priced at the same rate as 81363
New code 81364QW is priced at the same rate as 81364
New code 81448QW is priced at the same rate as 81448
New code 81520QW is priced at the same rate as 81520
New code 81521QW is priced at the same rate as 81521
New code 81541QW is priced at the same rate as 81541
New code 81551QW is priced at the same rate as 81551
New code 86008QW is priced at the same rate as 86008
New code 86794QW is priced at the same rate as 86794
New code 87662QW is priced at the same rate as 87662

Deleted codes

The following codes are deleted effective January 1, 2018:

Existing code 0004U is to be deleted
Existing code 0015U is to be deleted
Existing code 81280 is to be deleted
Existing code 81281 is to be deleted
Existing code 81282 is to be deleted

Code update

Existing code 80410 had an incorrect crosswalk (multiplier of 1 instead of 3) in the annual CLFS file, and is corrected with this CR in the quarterly file, effective January 1, 2018.

Additional information

The official instruction, CR 10445, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R3973CP.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/*.

Document history

Date of change	Description
January 12, 2018	Initial article released.

MLN Matters® Number: MM10445
Related CR Release Date: February 8, 2018
Related CR Transmittal Number: R3973CP
Related Change Request (CR) Number: 10445
Effective Date: January 1, 2018, for new HCPCS codes, otherwise April 1, 2018
Implementation Date: April 2, 2018

Codes subject to and excluded from CLIA edits

Note: *This article was revised on February 9, 2018, to reflect an updated change request (CR). That CR added HCPCS code G0475 as a code that is subject to CLIA edits effective, April 13, 2015 (see bold paragraph in the "Background" section.). All other information remains the same. This information was previously published in the January 2018 Medicare B Connection, page 31-34.*

Provider type affected

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

Provider action needed

CR 10446 informs providers and MACs about the new Healthcare Common Procedure Coding System (HCPCS) codes for 2018 that are subject to and excluded from Clinical Laboratory Improvement Amendments (CLIA) edits. Make sure your billing staffs are aware of these updates.

Background

The HCPCS codes that are considered a laboratory test under CLIA change each year. MACs are informed about the new HCPCS codes that are both subject to CLIA edits and excluded from CLIA edits.

The following HCPCS codes were discontinued December 31, 2017:

- 83499 - Hydroxyprogesterone, 20 (synthetic hormone) level
- 84061 -Phosphatase (enzyme) level for forensic examination
- 86185 - Immunologic analysis for detection of antigen
- 86243 - Measurement of Fc receptor
- 86378 - Migration inhibitory factor
- 86729 - Lympho venereum antibody
- 86822 - Lymphocyte culture primed
- 87277 - Legionella micdadei ag if
- 87470 - Bartonella dna dir probe
- 87477 - Lyme dis dna quant
- 87515 - Hepatitis b dna dir probe
- 88154 - Cytopath c/v select

The following HCPCS codes were added February 1, 2017, and are subject to CLIA edits. These codes require a facility to have either a CLIA certificate of registration (certificate type code 9), a CLIA certificate of compliance (certificate type code 1), or a CLIA certificate of accreditation (certificate type code 3). A facility without a valid, current, CLIA certificate, with a current CLIA certificate of waiver (certificate type code 2) or with a current CLIA certificate for provider-performed microscopy procedures (certificate type code 4) cannot be paid for these tests.

- 0001U - Red blood cell antigen typing, DNA, human erythrocyte antigen gene analysis of 35 antigens from 11 blood groups, utilizing whole blood, common RBC alleles reported
- 0002U - Oncology (colorectal), quantitative assessment of three urine metabolites (ascorbic acid, succinic acid and carnitine) by liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring acquisition, algorithm reported as likelihood of adenomatous polyps
- 0003U - Oncology (ovarian) biochemical assays of five proteins (apolipoprotein A-1, CA 125 II, follicle stimulating hormone, human epididymis protein 4, transferrin), utilizing serum, algorithm reported as a likelihood score

The following HCPCS codes were added May 1, 2017, and are subject to CLIA edits. These codes require a facility to have either a CLIA certificate of registration (certificate type code 9), a CLIA certificate of compliance (certificate type code 1), or a CLIA certificate of accreditation (certificate type code 3). A facility without a valid, current, CLIA certificate, with a current CLIA certificate of waiver (certificate type code 2) or with a current CLIA certificate for provider-performed microscopy procedures (certificate type code 4) cannot be paid for these tests.

- 0004U – Infectious disease (bacterial), DNA, 27 resistance genes, PCR amplification and probe hybridization in microarray format (molecular detection and identification of AmpC, carbapenemase and ESBL coding genes), bacterial culture colonies, report of genes detected or not detected, per isolate
- 0005U - Oncology (prostate) gene expression profile by real-time RT-PCR of 3 genes (ERG, PCA3, and SPDEF), urine, algorithm reported as risk score

The following HCPCS codes were added August 1, 2017, and are subject to CLIA edits. These codes require a facility to have either a CLIA certificate of registration (certificate type code 9), a CLIA certificate of compliance (certificate type code 1), or a CLIA certificate of accreditation (certificate type code 3). A facility without a valid, current, CLIA certificate, with a current CLIA certificate of waiver (certificate type code 2) or with a current CLIA certificate for provider-performed microscopy procedures (certificate type code 4) cannot be paid for these tests.

- 0006U – Prescription drug monitoring, 120 or more drugs and substances, definitive tandem mass spectrometry with chromatography, urine, qualitative report of presence (including quantitative levels, when detected) or absence of each drug or substance with description and severity of potential interactions, with identified substances, per date of service
- 0007U - Drug test(s), presumptive, with definitive confirmation of positive results, any number of drug

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classes, urine, includes specimen verification including DNA authentication in comparison to buccal DNA, per date of service

- 0008U - Helicobacter pylori detection and antibiotic resistance, DNA, 16S and 23S rRNA, gyrA, pbp1, rdxA and rpoB, next generation sequencing, formalin-fixed paraffin embedded or fresh tissue, predictive, reported as positive or negative for resistance to clarithromycin, fluoroquinolones, metronidazole, amoxicillin, tetracycline and rifabutin
- 0009U - Oncology (breast cancer), ERBB2 (HER2) copy number by FISH, tumor cells from formalin fixed paraffin embedded tissue isolated using image-based dielectrophoresis (DEP) sorting, reported as ERBB2 gene amplified or non-amplified
- 0010U - Infectious disease (bacterial), strain typing by whole genome sequencing, phylogenetic-based report of strain relatedness, per submitted isolate
- 0011U - Prescription drug monitoring, evaluation of drugs present by LC-MS/MS, using oral fluid, reported as a comparison to an estimated steady-state range, per date of service including all drug compounds and metabolites
- 0012U - Germline disorders, gene rearrangement detection by whole genome next-generation sequencing, DNA, whole blood, report of specific gene rearrangement(s)
- 0013U - Oncology (solid organ neoplasia), gene rearrangement detection by whole genome next-generation sequencing, DNA, fresh or frozen tissue or cells, report of specific gene rearrangement(s)
- 0014U - Hematology (hematolymphoid neoplasia), gene rearrangement detection by whole genome next-generation sequencing, DNA, whole blood or bone marrow, report of specific gene rearrangement(s);
- 0015U - Drug metabolism (adverse drug reactions), DNA, 22 drug metabolism and transporter genes, real-time PCR, blood or buccal swab, genotype and metabolizer status for therapeutic decision support
- 0016U - Oncology (hematolymphoid neoplasia), RNA, BCR/ABL1 major and minor breakpoint fusion transcripts, quantitative PCR amplification, blood or bone marrow, report of fusion not detected or detected with quantitation
- 0017U - Oncology (hematolymphoid neoplasia), JAK2 mutation, DNA, PCR amplification of exons 12-14 and sequence analysis, blood or bone marrow, report of JAK2 mutation not detected or detected

The following HCPCS codes are new for 2018 and are subject to CLIA edits. These codes require a facility to have either a CLIA certificate of registration (certificate type code 9), a CLIA certificate of compliance (certificate type code 1), or a CLIA certificate of accreditation (certificate type code 3). A facility without a valid, current, CLIA certificate, with a current CLIA certificate of waiver (certificate type code 2) or with a current CLIA certificate for provider-performed microscopy procedures (certificate type code 4) cannot be paid for these tests.

- 81105 - Human Platelet Antigen 1 genotyping (HPA-1), ITGB3 (integrin, beta 3 [platelet glycoprotein IIIa], antigen CD61 [GPIIIa]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura) gene analysis, common variant, HPA-1a/b (L33P)
- 81106 - Human Platelet Antigen 2 genotyping (HPA-2), GP1BA (glycoprotein Ib [platelet], alpha polypeptide [GPIba]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura) gene analysis, common variant, HPA-2a/b (T145M)
- 81107 - Human Platelet Antigen 3 genotyping (HPA-3), ITGA2B (integrin, alpha 2b [platelet glycoprotein IIb of IIb/IIIa complex], antigen CD41 [GPIIb]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura) gene analysis, common variant, HPA-3a/b (I843S)
- 81108 - Human Platelet Antigen 4 genotyping (HPA-4), ITGB3 (integrin, beta 3 [platelet glycoprotein IIIa], antigen CD61 [GPIIIa]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura) gene analysis, common variant, HPA-4a/b (R143Q)
- 81109 - Human Platelet Antigen 5 genotyping (HPA-5), ITGA2 (integrin, alpha 2 [CD49B, alpha 2 subunit of VLA-2 receptor] [GPIa]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura) gene analysis, common variant (eg, HPA-5a/b (K505E))
- 81110 - Human Platelet Antigen 6 genotyping (HPA-6w), ITGB3 (integrin, beta 3 [platelet glycoprotein IIIa, antigen CD61] [GPIIIa]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura) gene analysis, common variant, HPA-6a/b (R489Q)
- 81111 - Human Platelet Antigen 9 genotyping (HPA-9w), ITGA2B (integrin, alpha 2b [platelet glycoprotein IIb of IIb/IIIa complex, antigen CD41] [GPIIb]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura) gene analysis, common variant, HPA-9a/b (V837M)
- 81112 - Human Platelet Antigen 15 genotyping (HPA-15), CD109 (CD109 molecule) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura) gene analysis, common variant, HPA-15a/b (S682Y)
- 81120 -IDH1 (isocitrate dehydrogenase 1 [NADP+], soluble) (eg, glioma), common variants (eg, R132H, R132C)
- 81121 - IDH2 (isocitrate dehydrogenase 2 [NADP+], mitochondrial) (eg, glioma), common variants (eg, R140W, R172M)
- 81175 - ASXL1 (additional sex combs like 1, transcriptional regulator) (eg, myelodysplastic syndrome, myeloproliferative neoplasms, chronic myelomonocytic leukemia) gene analysis; full gene sequence

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- 81176 - ASXL1 (additional sex combs like 1, transcriptional regulator) (eg, myelodysplastic syndrome, myeloproliferative neoplasms, chronic myelomonocytic leukemia) gene analysis; targeted sequence analysis (eg, exon 12)
- 81230 - CYP3A4 (cytochrome P450 family 3 subfamily A member 4) (eg, drug metabolism) gene analysis, common variant(s) (eg, *2, *22)
- 81231 - CYP3A5 (cytochrome P450 family 3 subfamily A member 5) (eg, drug metabolism) gene analysis, common variants (eg, *2, *3, *4, *5 *6, *7)
- 81232 - DPYD (dihydropyrimidine dehydrogenase) (eg, 5-fluorouracil/5-FU and capecitabine drug metabolism) gene analysis, common variant(s) (eg, *2A, *4, *5, *6)
- 81238 - F9 (coagulation factor IX) (eg, hemophilia B) full gene sequence
- 81247 - G6PD (glucose-6-phosphate dehydrogenase) (eg, hemolytic anemia, jaundice) gene analysis; common variant(s) (eg, A, A-)
- 81248 - G6PD (glucose-6-phosphate dehydrogenase) (eg, hemolytic anemia, jaundice) gene analysis; known familial variant(s)
- 81249 - G6PD (glucose-6-phosphate dehydrogenase) (eg, hemolytic anemia, jaundice) gene analysis; full gene sequence
- 81258 - HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis; known familial variant
- 81259 - HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis; full gene sequence
- 81269 - HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis; duplication/deletion variants
- 81283 - IFNL3 (interferon, lambda 3) (eg, drug response) gene analysis, rs12979860 variant
- 81328 - SLCO1B1 (solute carrier organic anion transporter family, member 1B1) (eg, adverse drug reaction) gene analysis, common variant(s) (eg, *5)
- 81334 - RUNX1 (runt related transcription factor 1) (eg, acute myeloid leukemia, familial platelet disorder with associated myeloid malignancy) gene analysis, targeted sequence analysis (eg, exons 3-8)
- 81335 - TPMT (thiopurine S-methyltransferase) (eg, drug metabolism) gene analysis, common variants (eg, *2, *3)
- 81346 - TYMS (thymidylate synthetase) (eg, 5-fluorouracil/5-FU drug metabolism) gene analysis, common variant(s) (eg, tandem repeat variant)
- 81361 - HBB (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia, hemoglobinopathy); common variant(s) (eg, HbS, HbC, HbE)
- 81362 - HBB (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia, hemoglobinopathy); known familial variant(s)
- 81363 - HBB (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia, hemoglobinopathy); duplication/deletion variant(s)
- 81364 - HBB (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia, hemoglobinopathy); full gene sequence
- 81448 - Hereditary peripheral neuropathies panel (eg, Charcot-Marie-Tooth, spastic paraplegia), genomic sequence analysis panel, must include sequencing of at least 5 peripheral neuropathy-related genes (eg, BSCL2, GJB1, MFN2, MPZ, REEP1, SPAST, SPG11, and SPTLC1)
- 81520 - Oncology (breast), mRNA gene expression profiling by hybrid capture of 58 genes (50 content and 8 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a recurrence risk score
- 81521 - Oncology (breast), mRNA, microarray gene expression profiling of 70 content genes and 465 housekeeping genes, utilizing fresh frozen or formalin-fixed paraffin-embedded tissue, algorithm reported as index related to risk of distant metastasis
- 81541 – Oncology (prostate), mRNA gene expression profiling by real-time RTPCR of 46 genes (31 content and 15 housekeeping), utilizing formalin-fixed paraffin embedded tissue, algorithm reported as a disease-specific mortality risk score • 81551 - Oncology (prostate), promoter methylation profiling by real-time PCR of 3 genes (GSTP1, APC, RASSF1), utilizing formalin-fixed paraffin embedded tissue, algorithm reported as a likelihood of prostate cancer detection on repeat biopsy
- 86008 - Allergen specific IgE; quantitative or semiquantitative, recombinant or purified component, each
- 86794 - Zika virus, IgM
- 87634 - Infectious agent detection by nucleic acid (DNA or RNA); respiratory syncytial virus, amplified probe technique
- 87662 - Infectious agent detection by nucleic acid (DNA or RNA); Zika virus, amplified probe technique

The following HCPCS codes are mentioned in change request 10445 (*Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment*) as new codes and with the effective date of January 1, 2018. These codes are subject to CLIA edits. The HCPCS codes listed below require a facility to have either a CLIA certificate of

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registration (certificate type code 9), a CLIA certificate of compliance (certificate type code 1), or a CLIA certificate of accreditation (certificate type code 3). A facility without a valid, current, CLIA certificate, with a current CLIA certificate of waiver (certificate type code 2) or with a current CLIA certificate for provider-performed microscopy procedures (certificate type code 4) must not be permitted to be paid for these tests.

- 0024U - Glycosylated acute phase proteins (GlycA), nuclear magnetic resonance spectroscopy, quantitative GLYCA NUC MR SPECTRSC QUAN
- 0025U - Tenofovir, by liquid chromatography with tandem mass spectrometry (LCMS/MS), urine, quantitative TENOFOVIR LIQ CHROM UR QUAN
- 0026U - Oncology (thyroid), DNA and mRNA of 112 genes, next-generation sequencing, fine needle aspirate of thyroid nodule, algorithmic analysis reported as a categorical result ("Positive, high probability of malignancy" or "Negative, low probability of malignancy") ONC THYR DNA&MRNA 112 GENES
- 0027U - JAK2 (Janus kinase 2) (eg, myeloproliferative disorder) gene analysis, targeted sequence analysis exons 12-15 JAK2 GENE TRGT SEQ ALYS
- 0028U - CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism) gene analysis, copy number variants, common variants with reflex to targeted sequence analysis CYP2D6 GENE CPY NMR CMN VRNT
- 0029U - Drug metabolism (adverse drug reactions and drug response), targeted sequence analysis (ie, CYP1A2, CYP2C19, CYP2C9, CYP2D6, CYP3A4, CYP3A5, CYP4F2, SLCO1B1, VKORC1 and rs12777823) RX METAB ADVRS TRGT SEQ ALYS
- 0030U - Drug metabolism (warfarin drug response), targeted sequence analysis (ie, CYP2C9, CYP4F2, VKORC1, rs12777823) RX METAB WARF TRGT SEQ ALYS
- 0031U - CYP1A2 (cytochrome P450 family 1, subfamily A, member 2)(eg, drug metabolism) gene analysis, common variants (ie, *1F, *1K, *6, *7) CYP1A2 GENE
- 0032U - COMT (catechol-O-methyltransferase)(drug metabolism) gene analysis, c.472G>A (rs4680) variant COMT GENE
- 0033U - HTR2A (5-hydroxytryptamine receptor 2A), HTR2C (5-hydroxytryptamine receptor 2C) (eg, citalopram metabolism) gene analysis, common variants (ie, HTR2A rs7997012 [c.614-2211T>C], HTR2C rs3813929 [c.-759C>T] and rs1414334 [c.551-3008C>G]) HTR2A HTR2C GENES
- 0034U - TPMT (thiopurine S-methyltransferase), NUDT15 (nudix hydroxylase 15)(eg, thiopurine metabolism), gene analysis, common variants (ie, TPMT *2, *3A, *3B, *3C, *4, *5, *6, *8, *12; NUDT15 *3, *4, *5) TPMT NUDT15 GENES

The HCPCS code, G0475 [HIV antigen/antibody, combination assay, screening], was effective 4/13/2015, and is subject to CLIA edits. HCPCS code G0475 was not mentioned in previous *HCPCS Codes Subject to and Excluded from CLIA Edits* recurring transmittals. This HCPCS code requires a facility to have either a CLIA certificate of registration (certificate type code 9), a CLIA certificate of compliance (certificate type code 1), or a CLIA certificate of accreditation (certificate type code 3). A facility without a valid, current, CLIA certificate, with a current CLIA certificate of waiver (certificate type code 2) or with a current CLIA certificate for provider-performed microscopy procedures (certificate type code 4) must not be permitted to be paid for these tests.

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

Additional information

The official instruction, CR 10446, issued to your MAC regarding this change is available at

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R3975CP.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/*.

Document history

Date of change	Description
February 9, 2018	This article was revised to reflect an updated CR. That CR added HCPCS code G0475 as a code that is subject to CLIA edits effective, April 13, 2015 (see page 7 in bold).
January 12, 2018	Initial article released.

MLN Matters® Number: MM10446 *Revised*
Related Change Request (CR) Number: 10446
Related CR Release Date: February 9, 2018
Effective Date: January 1, 2018
Related CR Transmittal Number: R3975CP
Implementation Date: April 2, 2018

Preventive Services

Replacement of mammography codes, waiver of coinsurance and deductible for preventive and other services, and addition of anesthesia and prolonged preventive services

***Note**: This article was revised February 9, 2018, to reposition text under different headers on page 2. All other information is unchanged. This information was previously published in the December 2017 Medicare B Connection, pages 10-11.*

Provider type affected

This *MLN Matters*® article is intended for providers submitting claims to Part A & B Medicare administrative contractors (MACs) for services furnished to Medicare beneficiaries.

Provider action needed

Change request (CR) 10181 provides for the replacement of HCPCS codes G0202, G0204, and G0206 with *Current Procedural Terminology* (CPT®) codes 77067, 77066, and 77065, effective January 1, 2018. CR 10181 also applies the waiver of deductible and coinsurance to 76706, 77067, prolonged preventive services, and anesthesia services furnished in conjunction with and in support of colorectal cancer services. Make sure your billing staffs are aware of these changes.

The language and policy referred to in this article are included in Chapter 18, Sections 20 and 240 (new) of the *Medicare Claims Processing Manual*, which is included as an attachment to CR 10181.

Background

Replacement of mammography HCPCS codes

Effective for claims with dates of service on or after January 1, 2018, the following HCPCS codes are being replaced:

- G0202 - "screening mammography, bilateral (2-view study of each breast), including computer-aided detection Computer-Aided Detection (CAD) when performed"
- G0204 - "diagnostic mammography, including when performed; bilateral" and
- G0206 - "diagnostic mammography, including CAD when performed; unilateral"

These codes are being replaced by the following CPT® codes:

- 77067 - "screening mammography, bilateral (2-view study of each breast), including CAD when performed"
- 77066 - "diagnostic mammography, including (CAD) when performed; bilateral" and
- 77065 - "diagnostic mammography, including CAD when performed; unilateral".

As part of the January 2017 HCPCS code update, code G0389 was replaced by CPT® code 76706. Type of service (TOS) "5" was assigned to 76706, and the coinsurance and deductible were waived.

Effective January 1, 2018, the TOS for 76706 will be changed to "4" as part of the 2018 HCPCS update; the coinsurance and deductible will continue to be waived.

Summary of changes: For claims with dates of service January 1, 2017, through December 31, 2017, report HCPCS codes G0202, G0204, and G0206. For claims with dates of service on or after January 1, 2018, report CPT® codes 77067, 77066, and 77065 respectively.

Prolonged preventive services

Effective for claims with dates of service on or after January 1, 2018, prolonged preventive services will be payable by Medicare when billed as an add-on to an applicable preventive service that is payable from the Medicare physician fee schedule, and both deductible and coinsurance do not apply.G0513 and G0514 for prolonged preventive services will be added as part of January 1, 2018, HCPCS update and the coinsurance and deductible will be waived.

Anesthesia services

Section 4104 of the Affordable Care Act defined the term "preventive services" to include "colorectal cancer screening tests," and as a result, it waives any coinsurance that would otherwise apply under Section 1833(a)(1) of the Social Security Act (the Act) for screening colonoscopies.

In addition, the Affordable Care Act amended Section 1833(b)(1) of the Act to waive the Part B deductible for screening colonoscopies, which includes anesthesia services as an inherent part of the screening colonoscopy procedural service. These provisions are effective for services furnished on or after January 1, 2011.

In the 2018 physician fee schedule (PFS) final rule, the Centers for Medicare & Medicaid Services (CMS) modified reporting and payment for anesthesia services furnished in conjunction with and in support of colorectal cancer screening services. .

Anesthesia services furnished in conjunction with and in support of a screening colonoscopy are reported with CPT® code 00812 (Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy). CPT® code 00812 will be added as part of January 1, 2018, HCPCS update. Effective for claims with dates of service on or after January 1, 2018, Medicare will pay claim lines with new CPT® 00812 and waive the deductible and coinsurance.

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Therapy Services

Supervised exercise therapy for symptomatic peripheral artery disease

Provider type affected

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

Provider action needed

Change request (CR) 10295 informs MACs that effective May 25, 2017, the Centers for Medicare & Medicaid Services (CMS) issued a national coverage determination (NCD) to cover supervised exercise therapy (SET) for beneficiaries with intermittent claudication (IC) for the treatment of symptomatic peripheral artery disease (PAD). Make sure your billing staffs are aware of these changes.

Background

SET involves the use of intermittent walking exercise, which alternates periods of walking to moderate-to-maximum claudication, with rest. SET has been recommended as the initial treatment for patients suffering from IC, the most common symptom experienced by people with PAD.

Despite years of high-quality research illustrating the effectiveness of SET, more invasive treatment options (such as, endovascular revascularization) have continued to increase. This has been partly attributed to patients having limited access to SET programs. There is currently no NCD in effect.

CMS issued the NCD to cover SET for beneficiaries with IC for the treatment of symptomatic PAD. Up to 36 sessions over a 12-week period are covered if all of the following components of a SET program are met:

The SET program must:

- Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication
- Be conducted in a hospital outpatient setting, or a physician's office
- Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD
- Be under the direct supervision of a physician (as defined in Section 1861(r)(1)) of the Social Security Act (the Act), physician assistant, or nurse practitioner/ clinical nurse specialist (as identified in Section 1861(aa)(5) of the Act)) who must be trained in both basic and advanced life support techniques.

Beneficiaries must have a face-to-face visit with the physician responsible for PAD treatment to obtain the referral for SET. At this visit, the beneficiary must receive information regarding cardiovascular disease and PAD risk factor reduction, which could include education, counseling, behavioral interventions, and outcome

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When a screening colonoscopy becomes a diagnostic colonoscopy, anesthesia services are reported with CPT® 00811 (Anesthesia for lower intestinal endoscopic procedures, endoscopy introduced distal to duodenum; not otherwise specified) and with the PT modifier. CPT® 00811 will be added as part of the January 1, 2018, HCPCS update. Effective for claims with dates of service on or after January 1, 2018, Medicare will pay claim lines with new CPT® 00811 and waive only the deductible when submitted with the PT modifier.

Additional information

The official instruction, CR 10181, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3844CP.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/*.

Document history

Date of change	Description
February 9, 2018	Article was revised to reposition text under different headers in the *Background* section (under *Prolonged preventive services* and *Anesthesia services*.
November 24, 2017	Initial article released.

MLN Matters® Number: MM10181
Related CR Release Date: August 18, 2017
Related CR Transmittal Number: R3844CP
Related Change Request (CR) Number: 10181
Effective Date: January 1, 2018
Implementation Date: January 2, 2018

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assessments.

MACs have the discretion to cover SET beyond 36 sessions over 12 weeks and may cover an additional 36 sessions over an extended period of time. MACs shall accept the inclusion of the KX modifier on the claim line(s) as an attestation by the provider of the services that documentation is on file verifying that further treatment beyond the 36 sessions of SET over a 12-week period meets the requirements of the medical policy. SET is non-covered for beneficiaries with absolute contraindications to exercise as determined by their primary attending physician.

Coding requirements for SET

Providers should use *Current Procedural Terminology* (CPT®) 93668 (under peripheral arterial disease rehabilitation) to bill for these services with appropriate International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10) code as follows:

- I70.211 – right leg
- I70.212 – left leg
- I70.213 – bilateral legs
- I70.218 – other extremity
- I70.311 – right leg
- I70.312 – left leg
- I70.313 – bilateral legs
- I70.318 – other extremity
- I70.611 – right leg
- I70.612 – left leg
- I70.613 – bilateral legs
- I70.618 – other extremity
- I70.711 – right leg
- I70.712 – left leg
- I70.713 – bilateral legs
- I70.718 – other extremity

Medicare will deny claim line items for SET services when they do not contain one of the above ICD-10 codes using the following messages:

- Claim adjustment reason code (CARC) 167 – This (these) diagnosis (es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- Remittance advice remark code (RARC) N386: This decision was based on a National Coverage Determination 20.35 (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *www.cms.gov/mcd/search.asp*. If you do not have web access, you may contact the contractor to request a copy of the NCD.
- Group code CO (contractual obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

MACs will accept claims for CPT® 93668 only when services are provided in Place of Service (POS) code 11, 19, or 22. MACs will deny claims for SET if services are not provided in POS 11, 19, or 22, using the following remittance messages:

- CARC 58: Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. **Note**: Refer to the 832 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present.
- RARC N386: This decision was based on a National Coverage Determination 20.35 (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *www.cms.gov/mcd/search.asp*. If you do not have web access, you may contact the contractor to request a copy of the NCD.
- Group code CO (contractual obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

Institutional claims for SET must be submitted on type of bills (TOB) 13x or 85x. MACs will deny line items on institutional claims that are not submitted on TOB 13x or 85x using the following messages:

- CARC 58: “Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. NOTE: Refer to the 832 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present.
- RARC N386: “This decision was based on a National Coverage Determination 20.35 (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *www.cms.gov/mcd/search.asp*. If you do not have web access, you may contact the contractor to request a copy of the NCD.
- Group code CO (contractual obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

Medicare will pay claims for SET services containing CPT® code 93668 on types of bill (TOBs) 13x under OPPS and 85x on reasonable cost, except it will pay claims for SET services containing CPT® 93668 with revenue codes 096x, 097x, or 098x when billed on TOB 85x method II critical access hospitals (CAHs) based on 115 percent of the lesser of the fee schedule amount or the submitted charge.

Medicare will reject claims with CPT® 93668 which exceed 36 sessions within 84 days from the date of the first session when the KX modifier is not included on the claim line OR any SET session provided after 84 days from the date of the first session and the KX modifier is not included on the claim and use the following messages:

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- CARC 96: Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- RARC N640: Exceeds number/frequency approved/allowed within time period.
- Group code CO (contractual obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.
- Group code PR (patient responsibility) assigning financial liability to the beneficiary if a claim is received with a GA modifier indicating a signed ABN is on file.

MACs will deny/reject claim lines for SET exceeding 73 sessions using the following codes:

- CARC 119: Benefit maximum for this time period or occurrence has been reached.
- RARC N386: "This decision was based on a National Coverage Determination 20.35 (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.
- Group code CO (contractual obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.
- Group code PR (patient responsibility) assigning financial liability to the beneficiary if a claim is received with a GA modifier indicating a signed ABN is on file.

Medicare's common working file (CWF) will display remaining SET sessions on all CWF provider query screens (HIQA, HIQH, ELGH, ELGA, and HUQA). The multi-carrier system desktop tool will also display remaining SET sessions in a format equivalent to the CWF HIMR screen(s).

Additional information

The official instruction, CR 10295, was issued to your MAC via two transmittals. The first updates the *Medicare Claims Processing Manual* and it is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R3969CP.pdf*. The second updates the *NCD Manual* and it is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R204NCD.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/*.

Document history

Date of change	Description
January 12, 2018	Initial article released.

MLN Matters® Number: MM10295
Related CR Release Date: February 2, 2018
Related CR Transmittal Number: R204NCD and R3969CP
Related Change Request (CR) Number: 10298
Effective Date: May 25, 2017
Implementation Date: April 3, 2018 – MAC edits; July 2, 2018 – full implementation

General Coverage

Next generation accountable care organization – implementation

***Note**: This article was revised January 23, 2018, to revise the "Telehealth expansion" portion of the article and to add Attachment A to the article. This information was previously published in the August 2016 Medicare B Connection, pages 15-17.*

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 5.1 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 ("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:

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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

The telehealth services originating at the beneficiary's home (in a rural or non-rural geographic setting) is billed under the Medicare physician fee schedule (MPFS) with one of nine HCPCS G-codes used for the NGACO and comprehensive joint replacement models telehealth home visits, as listed in Attachment A. The telehealth home visit HCPCS codes are payable for beneficiaries beginning January 1, 2018. Claims submitted for telehealth home visits for the NGACO model will be accepted when the claim contains one of nine of the NGACO specific HCPCS G-Code. CMS is associating the demonstration code 74 with the NGACO initiative. Additional information on billing and payment for the telehealth home visit HCPCS G-codes are available in the MPFS. Future updates to the RVUs and payment for these HCPCS codes will be included in the MPFS final rules and recurring updates each year.

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 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

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

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- 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/*.

Date of change	Description
January 23, 2018	Article revised to revise the telehealth expansion information and to add Attachment A.
November 7, 2017	Article revised to provide a link to MM10044 that provides instruction to MACs to implement two new benefit enhancements for performance year three (calendar year 2018) of the NGACO model.
August 4, 2017	Initial article released

Attachment A

HCPCS code No.	Long descriptor	Short descriptor	RVUs Equal to those of the corresponding office/outpatient E/M visit CPT® code under the MPFS
G9481	Remote in-home visit for the evaluation and management of a new patient for use only in the Medicare-approved comprehensive joint replacement and next generation accountable care organization models, which requires these three key components: ▪ A problem focused history; ▪ A problem focused examination; and ▪ Straightforward medical decision making, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are self-limited or minor. Typically, 10 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology	Remote E/M new pt 10 mins.	99201
G9482	Remote in-home visit for the evaluation and management of a new patient for use only in the Medicare-approved comprehensive joint replacement and next generation accountable care organization models, which requires these three key components: ▪ An expanded problem focused history; ▪ An expanded problem focused examination; ▪ Straightforward medical decision making, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology.	Remote E/M new pt 20 mins.	99202

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HCPCS code No.	Long descriptor	Short descriptor	RVUs Equal to those of the corresponding office/ outpatient E/M visit CPT® code under the MPFS
G9483	Remote in-home visit for the evaluation and management of a new patient for use only in the Medicare-approved comprehensive joint replacement and next generation accountable care organization models, which requires these three key components: ▪ A detailed history; ▪ A detailed examination; ▪ Medical decision making of low complexity, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology	Remote E/M new pt 30 mins	99203
G9484	Remote in-home visit for the evaluation and management of a new patient for use only in the Medicare-approved comprehensive joint replacement and next generation accountable care organization models, which requires these three key components: ▪ A comprehensive history; ▪ A comprehensive examination; ▪ Medical decision making of moderate complexity, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology.	Remote E/M new pt 45 mins	99204
G9485	Remote in-home visit for the evaluation and management of a new patient for use only in the Medicare-approved comprehensive joint replacement and next generation accountable care organization models, which requires these three key components: ▪ A comprehensive history; ▪ A comprehensive examination; ▪ Medical decision making of high complexity, furnished in real time using interactive audio and video technology	Remote E/M new pt 60 mins	99205

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HCPCS code No.	Long descriptor	Short descriptor	RVUs Equal to those of the corresponding office/ outpatient E/M visit CPT® code under the MPFS
G9486	Remote in-home visit for the evaluation and management of an established patient for use only in the Medicare-approved CJR model, which requires at least two of the following three key components: ▪ A problem focused history; ▪ A problem focused examination; ▪ Straightforward medical decision making, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are self-limited or minor. Typically, 10 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology.	Remote E/M new pt 10 mins	99212
G9487	Remote in-home visit for the evaluation and management of an established patient for use only in the Medicare-approved comprehensive joint replacement and next generation accountable care organization models, which requires at least two of the following three key components: ▪ An expanded problem focused history; ▪ An expanded problem focused examination; ▪ Medical decision making of low complexity, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology	Remote E/M new pt 15 mins	99213
G9488	Remote in-home visit for the evaluation and management of an established patient for use only in the Medicare-approved comprehensive joint replacement and next generation accountable care organization models, which requires at least two of the following three key components: ▪ A detailed history; ▪ A detailed examination; ▪ Medical decision making of moderate complexity, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology.	Remote E/M new pt 25 mins	99214

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HCPCS code No.	Long descriptor	Short descriptor	RVUs Equal to those of the corresponding office/ outpatient E/M visit CPT® code under the MPFS
G9489	Remote in-home visit for the evaluation and management of an established patient for use only in the Medicare-approved comprehensive joint replacement and next generation accountable care organization models, which requires at least two of the following three key components: ▪ A comprehensive history; ▪ A comprehensive examination; ▪ Medical decision making of high complexity, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology.	Remote E/M new pt 40 mins	99215

MLN Matters® Number: SE1613
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: January 1, 2016
Related CR Transmittal #: N/A
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.

Processing Issue

NCD 110.21 Erythropoiesis Stimulating Agents (ESAs) in cancer

Issue

Change request (CR) 10318 dated November 9, 2017, addresses edits for NCD 110.21, ESAs in cancer. Those edits are to be implemented on April 2, 2018, and are included in business requirement (BR) 10318.10.

Resolution

Medicare administrative contractors (MACs) are instructed to temporarily deactivate the shared system edits associated with NCD 110.21 from October 1, 2017, until further notice.

Status/date resolved

Open.

Provider action

None.

Current processing issues

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

General Information

Reinstating the QMB indicator in the Medicare fee-for-service claim processing system from CR 9911

Provider type affected

This *MLN Matters*® article is intended for providers and suppliers who submit claims to Part A/B Medicare administrative contractors (MACs).

What you need to know

Effective with change request (CR) 10433, the Centers for Medicare & Medicaid Services (CMS) will reintroduce qualified Medicare beneficiary (QMB) information in the Medicare remittance advice (RA) and Medicare summary notice (MSN). CR 9911 modified the fee-for-service (FFS) systems to indicate the QMB status and zero cost-sharing liability of beneficiaries on RAs and MSNs for claims processed on or after October 2, 2017. On December 8, 2017, CMS suspended CR 9911 to address unforeseen issues preventing the processing of QMB cost-sharing claims by states and other secondary payers outside of the coordination of benefits agreement (COBA) process. CR 10433 remediates these issues by including revised "alert" remittance advice remark codes (RARC) in RAs for QMB claims without adopting other RA changes that impeded claim processing by secondary payers. CR 10433 reinstates all changes to the MSNs under CR 9911. Please make sure your billing staff is aware of these changes.

Background

Federal law bars Medicare providers and suppliers from billing an individual enrolled in the QMB program for Medicare Part A and Part B cost-sharing under any circumstances. (See Sections 1902(n)(3)(B), 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A), and 1848(g)(3)(A) of the Social Security Act.) The QMB program is a State Medicaid benefit that assists low-income Medicare beneficiaries with Medicare Part A and Part B premiums and cost-sharing, including deductibles, coinsurance, and copays. In 2015, 7.2 million individuals (more than one out of 10 beneficiaries) were enrolled in the QMB program.

Providers and suppliers may bill state Medicaid agencies for Medicare cost-sharing amounts. However, as permitted by Federal law, states may limit Medicare cost-sharing payments, under certain circumstances. Be aware, persons enrolled in the QMB program have no legal liability to pay Medicare providers for Medicare Part A or Part B cost-sharing.

System changes to assist providers under CR 9911

To help providers more readily identify the QMB status of their patients, CR 9911 introduced a QMB indicator in the claim processing system for the first time. CR 9911 is part of the CMS ongoing effort to give providers tools to comply with the statutory prohibition on collecting Medicare A/B cost-sharing from QMBs.

Through CR 9911, CMS indicated the QMB status and zero cost-sharing liability of beneficiaries in the RA and MSN for claims processed on or after October 2, 2017. In particular, CR 9911 changed the MSN to include new messages for QMB beneficiaries and reflect $0 cost-sharing liability for the period they are enrolled in QMB. In addition, CMS modified the RA to include new alert RARCs to notify providers to refrain from collecting Medicare cost-sharing because the patient is a QMB (N781 is associated with deductible amounts and N782 is associated with coinsurance).

Additionally, CR 9911 changed the display of patient responsibility on the RA by replacing claim adjustment group code "patient responsibility" (PR) with group code "other adjustment" (OA). CMS zeroed out the deductible and coinsurance amounts associated with claim

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adjustment reason code (CARC) 1 (deductible) and/or 2 (coinsurance) and used CARC 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 the patient if collected. (Use only with group code OA).") However, the changes to the display of patient liability in the RAs for QMB claims caused unforeseen issues affecting the processing of QMB cost-sharing claims directly submitted by providers to states and other payers secondary to Medicare. Providers rely on RAs to bill state Medicaid Agencies and other secondary payers outside the Medicare COBA claims crossover process. States and other secondary payers generally require RAs that separately display the Medicare deductible and coinsurance amounts with the claim adjustment group code "PR" and associated CARC codes and could not process claims involving the RA changes from CR 9911. Barriers to the processing of secondary claims have additional implications for institutional providers that claim bad debt under the Medicare program since they must obtain a Medicaid remittance advice to seek reimbursement for unpaid deductibles and coinsurance as a Medicare bad debt for QMBs.

To address these issues, on December 8, 2017, CMS suspended the CR 9911 system changes causing the claim processing systems to suspend the RA and MSN changes for QMB claims under CR 9911.

Reintroduction of QMB information in the MA and MSN under CR 10433

Effective with CR 10433, the claim processing systems will reintroduce QMB information in the RA without impeding claim processing by secondary payers.

The RA for QMB claims will retain the display of patient liability amounts needed by secondary payers to process QMB cost-sharing claims. CMS systems shall output claim adjustment group code "PR" along with CARC 1 and/or 2, as applicable, with monetary values expressed on outbound Medicare 835 electronic remittance advices (ERAs) and on standard paper remittance advices (SPRs), as applicable. Medicare's shared systems shall discontinue the practice of outputting claim adjustment group code OA with CARC 209 and reflecting the CARC 1 and 2 monetary amounts as zero.

The shared systems shall include the revised alert RARCs N781 and N782 in association with CARCs 1 and/or 2 on the RA. These RARCs designate that the beneficiary is enrolled in the QMB program and may not be billed for Medicare cost sharing amounts. Additionally, for QMB claims, the Part A and B shared systems shall include the revised alert RARC N781 in association with CARC 66 (blood deductible). The revised alert RARCs are as follows:

- N781 - Alert: Patient is a Medicaid/ Qualified Medicare Beneficiary. Review your records for any wrongfully collected deductible. This amount may be billed to a subsequent payer.
- N782 – Alert: Patient is a Medicaid/ Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance. This amount may be billed to a subsequent payer.

CR 10433 reestablishes all CR 9911 changes to the MSN by including QMB messages and reflecting $0 cost-sharing liability for the period beneficiaries are enrolled in QMB.

Additional information

The official instruction, CR 10433, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R3965CP.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/*.

Document history

Date of change	Description
February 2, 2018	Initial article released.

MLN Matters® Number: MM10433
Related CR Release Date: February 2, 2018
Related CR Transmittal Number: R3965CP
Related Change Request (CR) Number: 10433
Effective Date: July 1, 2018
Implementation Date: For claims processed on or after July 2, 2018

Hurricane Nate and Medicare disaster-related Alabama, Florida, Louisiana, and Mississippi claims

***Note**: This article was revised on January 19, 2018, to advise providers that the public health emergency declaration and Section 1135 waiver authority has expired as noted below. All other information remains the same. This information was previously published in the October 2017 Medicare B Connection, pages 13-15.*

Provider type affected

This *MLN Matters*® special edition article is intended for providers and suppliers who submit claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries in the states of Alabama, Florida, Louisiana, and Mississippi, who were affected by Hurricane Nate.

Provider information available

Pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, President Trump declared that, as a result of the effects of Hurricane Nate, an emergency exists in Alabama, Florida, Louisiana, and Mississippi.

On October 8, 2017, Acting Secretary Wright of the Department of Health & Human Services declared that a public health emergency exists in the states of Louisiana retroactive to October 5, 2017; Mississippi, and Alabama retroactive to October 6, 2017; and Florida retroactive to October 7, 2017, and authorized waivers and modifications under §1135 of the Social Security Act.

The Public Health Emergency declaration and Social Security Act waivers including the Section 1135 waiver authority expired as follows:

- The authority expired on January 2, 2018, for Louisiana.
- The authority expired on January 3, 2018, for Alabama and Mississippi.
- The authority expired on January 4, 2018, for Florida.

On October 10, 2017, the Administrator of the Centers for Medicare & Medicaid Services (CMS) authorized waivers under §1812(f) of the Social Security Act for the States of Louisiana retroactive to October 5, 2017; Mississippi, and Alabama retroactive to October 6, 2017; and Florida retroactive to October 7, 2017, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of Hurricane Nate in 2017. These waivers will prevent gaps in access to care for beneficiaries impacted by the emergency. Providers do not need to apply for an individual waiver if a blanket waiver has been issued. Providers can request an individual Section 1135 waiver, if there is no blanket waiver, by following the instructions available at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Requesting-an-1135-Waiver-Updated-11-16-2016.pdf*.

The most current waiver information can be found at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Hurricanes.html*. See the *Background* section of this article for more details.

Background

Section 1135 and Section 1812(f) Waivers

As a result of the aforementioned declaration, CMS has instructed the MACs as follows:

Change request (CR) 6451 (Transmittal 1784, Publication 100-04) issued on July 31, 2009, applies to items and services furnished to Medicare beneficiaries within the within Alabama, Florida, Louisiana and Mississippi for the duration of the emergency. In accordance with CR 6451, use of the “DR” condition code and the “CR” modifier are mandatory on claims for items and services for which Medicare payment is conditioned on the presence of a “formal waiver” including, but not necessarily limited to, waivers granted under either Section 1135 or Section 1812(f) of the Act.

The most current information can be found at *https://www.cms.gov/emergency* posted in the downloads section at the bottom of the Emergency Response and Recovery webpage.

Also referenced below are Q&As that are applicable for items and services furnished to Medicare beneficiaries within the Alabama, Florida, Louisiana, and Mississippi. These Q&As are displayed in two files:

- One file addresses policies and procedures that are applicable **without** any Section 1135 or other formal waiver. These policies are always applicable in any kind of emergency or disaster, including the current emergency in Alabama, Florida, Louisiana and Mississippi.
- Another file addresses policies and procedures that are applicable **only with** approved Section 1135 waivers or, when applicable, approved Section 1812(f) waivers. These Q&As are applicable for approved Section 1135 blanket waivers and approved individual 1135 waivers requested by providers for Alabama, Florida, Louisiana, and Mississippi.

In both cases, the links below will open the most current document. The date included in the document filename will change as new information is added, or existing information is revised.

a. Q&As applicable **without any Section 1135** or other formal waiver are available at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Consolidated_Medicare_FFS_Emergency_QsAs.pdf*.

b. Q&As applicable **only with a Section 1135** waiver or, when applicable, a Section 1812(f) waiver, are available at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/MedicareFFS-EmergencyQsAs1135Waiver.pdf*.

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Blanket waivers for Alabama, Florida, Louisiana, and Mississippi

Under the authority of Section 1135 (or, as noted below, Section 1812(f)), CMS has issued the following blanket waivers in the affected areas of Alabama, Florida, Louisiana and Mississippi. Individual facilities do not need to apply for the following approved blanket waivers.

Skilled nursing facilities

- Section 1812(f): Waiver of the requirement for a three-day prior hospitalization for coverage of a skilled nursing facility (SNF) stay provides temporary emergency coverage of SNF services without a qualifying hospital stay, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of Hurricane Nate in Alabama, Florida, Louisiana, and Mississippi in 2017. In addition, for certain beneficiaries who recently exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period. (Blanket waiver for all impacted facilities).
- 42 CFR 483.20: Waiver provides relief to skilled nursing facilities on the timeframe requirements for minimum data set assessments and transmission. (Blanket waiver for all impacted facilities)

Home health agencies

42 CFR 484.20(c)(1): This waiver provides relief to home health agencies on the timeframes related to OASIS transmission (Blanket waiver for all impacted agencies)

Critical access hospitals

This action waives the requirements that critical access hospitals limit the number of beds to 25, and that the length of stay be limited to 96 hours (Blanket waiver for all impacted hospitals).

Housing acute care patients in excluded distinct part units

CMS has determined it is appropriate to issue a blanket waiver to IPPS hospitals that, as a result of Hurricane Nate, need to house acute care inpatients in excluded distinct part units, where the distinct part unit's beds are appropriate for acute care inpatient. The IPPS hospital should bill for the care and annotate the patient's medical record to indicate the patient is an acute care inpatient being housed in the excluded unit because of capacity issues related to the hurricane. (Blanket waiver for all IPPS hospitals located in the affected areas that need to use distinct part beds for acute care patients as a result of the hurricane.)

Durable medical equipment

- As a result of Hurricane Nate, CMS has determined it is appropriate to issue a blanket waiver to suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) where DMEPOS is lost, destroyed, irreparably damaged, or otherwise rendered unusable. Under this waiver, the face-to-face requirement, a new physician's order, and new medical necessity documentation are not required for replacement. Suppliers must still include a narrative description on the claim explaining the reason why the equipment must be replaced and are reminded to maintain documentation indicating that the DMEPOS was lost, destroyed, irreparably damaged or otherwise rendered unusable as a result of the hurricane.
- As a result of Hurricane Nate, CMS is temporarily extending the 10-business day deadline to provide notification of any subcontracting arrangements. During the temporary extension period, affected contract suppliers will have 30-business days to provide notice to the competitive bidding implementation contractor of any subcontracting arrangements. CMS will notify DMEPOS competitive bidding contract suppliers via e-mail when this temporary extension expires. All other competitive bidding program requirements remain in force. **Note**: CMS will provide notice of any changes to reporting timeframes for future events.
- For more information refer to the *Durable Medical Equipment, Prosthetics, Orthotics, and Supplies for Medicare Beneficiaries Impacted by an Emergency or Disaster* fact sheet at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Emergency-DME-Beneficiaries-pdf*.

Replacement prescription fills

Medicare payment may be permitted for replacement prescription fills (for a quantity up to the amount originally dispensed) of covered Part B drugs in circumstances where dispensed medication has been lost or otherwise rendered unusable by damage due to the emergency.

Care for excluded inpatient psychiatric unit patients in the acute care unit of a hospital

CMS has determined it is appropriate to issue a blanket waiver to IPPS and other acute care hospitals with excluded distinct part inpatient psychiatric units that, as a result of Hurricane Nate, need to relocate inpatients from the excluded distinct part psychiatric unit to an acute care bed and unit. The hospital should continue to bill for inpatient psychiatric services under the inpatient psychiatric facility prospective payment system for such patients and annotate the medical record to indicate the patient is a psychiatric inpatient being cared for in an acute care bed because of capacity or other exigent circumstances related to the hurricane. This waiver may be utilized where the hospital's acute care beds are appropriate for psychiatric patients and the staff and environment are conducive to safe care. For psychiatric patients, this includes assessment of the acute care bed and unit location to ensure those patients at risk of harm to self and others are safely cared for.

See **HURRICANE**, page 28

HURRICANE

from page 27

Care for excluded inpatient rehabilitation unit patients in the acute care unit of a hospital

CMS has determined it is appropriate to issue a blanket waiver to IPPS and other acute care hospitals with excluded distinct part inpatient Rehabilitation units that, as a result of Hurricane Nate, need to relocate inpatients from the excluded distinct part Rehabilitation unit to an acute care bed and unit. The hospital should continue to bill for inpatient rehabilitation services under the inpatient rehabilitation facility prospective payment system for such patients and annotate the medical record to indicate the patient is a rehabilitation inpatient being cared for in an acute care bed because of capacity or other exigent circumstances related to the hurricane. This waiver may be utilized where the hospital's acute care beds are appropriate for providing care to rehabilitation patients and such patients continue to receive intensive rehabilitation services.

These temporary emergency policies would apply to the timeframes specified in the waiver(s) issued under Section 1135 of the Act in connection with the effect of Hurricane Nate in Alabama, Florida, Louisiana, and Mississippi. More information is available in the 1135 waiver letter, which is posted in the Downloads section at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Hurricanes.html*.

Requesting an 1135 waiver

Information for requesting an 1135 waiver, when a blanket waiver hasn't been approved, can be found at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Requesting-an-1135-Waiver-Updated-11-16-2016.pdf*.

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/Research-Statistics-Data-and-Systems/*

Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/.

The Centers for Disease Control and Prevention released *ICD-10-CM coding advice* to report healthcare encounters in the hurricane aftermath.

Document history

Date of change	Description
January 19, 2018	The article was revised to include information on the expiration of the public health emergency declaration and Section 1135 waiver authority.
October 11, 2017	Initial article released.

MLN Matters® Number: SE17034 *Revised*
Article Release Date: January 19, 2018
Related CR Transmittal Number: N/A
Related Change Request (CR) Number: N/A
Effective Date: N/A
Implementation Date: N/A

Disclaimer: This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT® only copyright 2016 American Medical Association.

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NGACO

from page 1

electronic communications system to a practitioner, usually a specialist, who uses the information to evaluate the case or render a service outside of a real-time interaction. Asynchronous telecommunications system in single media format does not include telephone calls, images transmitted via facsimile machines, and text messages without visualization of the patient (electronic mail). Photographs must be specific to the patients' condition and adequate for rendering or confirming a diagnosis or treatment plan.

Payment will be permitted for telemedicine when asynchronous telehealth in single or multimedia formats, is used as a substitute for an interactive telecommunications system for dermatology and ophthalmology services. Distant-site practitioners will bill for these new services using new codes, and the distant-site practitioner must be an NGACO participant or preferred provider.

Asynchronous telehealth based on intra-service plus five minutes post-service time

- **Code 1:** G9868– Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation, for use under the next generation ACO model, less than 10 minutes.
- **Code 2:** G9869– Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation, for use under the next generation ACO model, 10-20 minutes.
- **Code 3**: G9870 – Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation, for use under the next generation ACO model, 20 or more minutes.

Additional information

The official instruction, CR 10044, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R187DEMO.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/*

MonitoringPrograms/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/.

Document history

Date of change	Description
August 4, 2017	Initial article released
January 23, 2018	The article was revised to reflect the revised CR 10044 issued November 22, 2017. In the article, the CR release date, transmittal number, and the web address of the CR are revised. All other information is the same.

MLN Matters® Number: MM10044 *Revised*
Related Change Request (CR) Number: 10044
Related CR Release Date: November 22, 2017
Effective Date: January 1, 2018
Related CR Transmittal Number: R187DEMO
Implementation Date: January 2, 2018

New Medicare cards

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, requires the Centers for Medicare & Medicaid Services (CMS) to remove Social Security numbers (SSNs) from all Medicare cards by April 2019. A new Medicare beneficiary identifier (MBI) will replace the SSN-based health insurance claim number (HICN) on the new Medicare cards for Medicare transactions like billing, eligibility status, and claim status.

The new Medicare cards will be mailed between April 2018 and April 2019. Resources are available to prepare you for this change at *https://medicare.fcso.com/Claim_submission_guidelines/0380240.asp*.

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 *https://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 *https://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 *https://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.

Search capability simplifies LCD lookup

Providers in need of a quick and direct method to locate local coverage determinations (LCDs) by procedure code have a simple way to do so by using First Coast Service Options' website search functionality.

Providers can simply enter a procedure code, keyword, or ICD-10 code into the website search bar and search "LCDs only" to find the matching results. This search function replaces the multiple steps currently required by other methods, and lets providers locate the corresponding LCDs by using First Coast's own LCD data.

Click here for more information.

Retired LCDs

Multiple Part A and Part B LCDs being retired

LCD ID number: L33985, L33990, L33991, L34013 (Florida, Puerto Rico/U.S. Virgin Islands)

Based on an annual review and data analysis review of the following local coverage determinations (LCDs), it was determined that these LCDs are no longer required and, therefore, are being retired.

L33985 – Transplantation Immune Cell Function Assay (ImmuKnow®)

L33990 – Doxorubicin HCl

L33991 – Endoscopic and Percutaneous Lysis of Epidural Adhesions

L34013 – Lung Volume Reduction Surgery

Effective date

The retirement of these LCDs is effective for services rendered **on or after February 15, 2018.** LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Tympanometry – retired Part B LCD

LCD ID number: L33963 (Florida, Puerto Rico/U.S. Virgin Islands)

Based on an annual review and data analysis review of the local coverage determination (LCD) for tympanometry, it was determined that this LCD is no longer required and, therefore, is being retired.

Effective date

The retirement of this LCD is effective for services rendered **on or after February 15, 2018.** LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Revisions to LCD

Major joint replacement (hip and knee) – revision to the Part A and Part B LCD

LCD ID number: L33618 (Florida, Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for major joint replacement (hip and knee) was revised to add ICD-10-CM diagnosis code Z47.32 to the "ICD-10-CM Diagnosis Codes for Total Hip Arthroplasty" section of the LCD and ICD-10-CM diagnosis code Z47.33 to the "ICD-10-CM Diagnosis Codes for Total Knee Arthroplasty" section of the LCD. Also, the "Sources of Information and Basis for Decision" section of the LCD was updated. In addition, based on an annual review of the LCD, it was determined that some of the italicized language in the "Documentation Requirements" section of the LCD does not represent direct quotation from the Centers for Medicare & Medicaid Services (CMS) sources listed in the LCD; therefore, this LCD was revised to assure consistency with the CMS sources.

Effective date

This LCD revision is effective for services rendered **on or after February 15, 2018.** LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Multiple Part A/B and Part B local coverage determination revisions

First Coast Service Options Inc. has revised the "ICD-10 Codes that Support Medical Necessity" section of multiple local coverage determinations (LCDs) to include an explanation that all the codes within an ICD-10-CM diagnosis code asterisked range from the first code to the last code apply.

The following is a list of the impacted LCDs:

Part A/B Combined LCDs

L33270 Bisphosphonates (Intravenous [IV]) and Monoclonal Antibodies in the Treatment of Osteoporosis and Their Other Indications

L36356 Bone mineral density studies

L33273 Bortezomib (Velcade®)

L33274 Botulinum Toxins

L33669 Electrocardiography

L36276 Erythropoiesis Stimulating Agents

L33661 Flow Cytometry

L33726 Gemcitabine (Gemzar®)

L34912 Genetic Testing for Lynch Syndrome

L33538 Radiation Therapy for T1 Basal Cell and Squamous Cell Carcinomas of the Skin

L34021 Sedimentation Rate, Erythrocyte

L36035 Spinal Cord Stimulation for Chronic Pain

L33410 Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiation Therapy (SBRT)

L33771 Vitamin D; 25 hydroxy, includes fraction(s), if performed

L33774 Wireless Capsule Endoscopy

Part B only LCDs

L33804 Allergen Immunotherapy

L33810 Computerized Corneal Topography

L33941 Routine Foot Care

L33963 Tympanometry

L33967 Vitamin B12 Injections

Effective date

All the LCD revisions above except for Tympanometry are effective for claims processed **on or after February 8, 2018**. The LCD revision for Tympanometry is effective for claims processed **on or after February 8, 2018**, for services rendered **on or after September 23, 2002**. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Reduction mammaplasty – revision to the Part B LCD

LCD ID number: L33939 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on an annual review of the reduction mammaplasty local coverage determinations (LCD), it was determined that the italicized language in the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD does not represent direct quotation from the Centers for Medicare & Medicaid Services (CMS) national coverage determination (NCD) for breast reconstruction following mastectomy (NCD 140.2). Therefore, this LCD is being revised to assure consistency with the NCD.

The following statement was removed:

Medicare will consider reduction mammaplasty reasonable and necessary when performed to achieve symmetry following removal and/or reconstruction of a breast due to malignancy.

The following statements were added:

Reconstruction of the affected and the contralateral unaffected breast following a medically necessary mastectomy is considered a relatively safe and effective noncosmetic procedure. Accordingly, program payment may be made for breast reconstruction surgery following removal of a breast for any medical reason.

Program payment may not be made for breast reconstruction for cosmetic reasons. (Cosmetic surgery is excluded from coverage under §l862(a)(l0) of the Act.)

Effective date

The LCD revision is effective for services rendered **on or after February 8, 2018.** LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

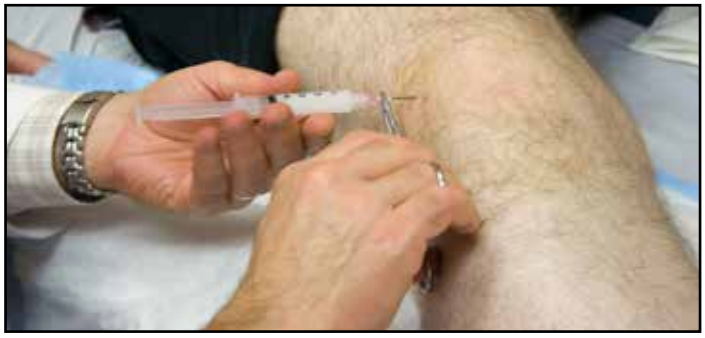
Viscosupplementation therapy for knee – revision to the Part A and Part B LCD

LCD ID number: L33767 (Florida, Puerto Rico/ U.S. Virgin Islands)

The "Utilization Guidelines" section of the local coverage determination (LCD) for viscosupplementation therapy for knee was revised to clarify the drugs that are administered as a single intra-articular injection per course of treatment and the drugs that are administered as an intra-articular injection over multiple weeks per course of treatment. In addition, a single course of treatment should be given no more than once every six months.

Effective date

This LCD revision is effective for claims processed **on or after February 8, 2018.** LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.



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

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

Additional Information

ASC inappropriate use of modifier 50

Bilateral surgical procedures furnished by certified ambulatory surgical centers (ASCs) may be covered under Part B. While use of the 50 modifier is not prohibited according to Medicare billing instructions, the modifier is not recognized for payment purposes and if used by ASCs, may result in incorrect payment.

As stated in Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 14 - Ambulatory Surgical Centers, Section 40.5 - Payment for Multiple Procedures, a procedure performed bilaterally in one operative session is reported as two procedures, either as a single unit on two separate lines or with "2" in the units field on one line. The multiple procedure reduction of 50 percent applies to all bilateral procedures subject to multiple procedure discounting. For example, if lavage by cannulation; maxillary sinus (antrum puncture by natural ostium) (CPT® code 31020) is performed bilaterally in one operative session, report 31020 on two separate lines or with "2" in the units field. Depending on whether the claim includes other services to which the multiple procedure discounts applies, the contractor applies the multiple procedure reduction of 50 percent to the payment for at least one of the CPT® code 31020 payment rates.

Therefore, bilateral procedures furnished in ASCs should be reported as either a single unit on two separate lines (appending the RT and LT modifiers) or with "2" in the units field on one line, in order for the bilateral procedures to be paid correctly. The multiple procedure reduction of 50 percent will apply to all bilateral procedures subject to multiple procedure discounting. Effective for services rendered **on or after March 26, 2018**, claims by ASCs inappropriately billed with a modifier 50 will be rejected.

Destruction of paravertebral facet joint nerve(s) – clarification of article/revision to the Part B LCD/"Coding Guideline" article

LCD ID number: L33814 (Florida, Puerto Rico/ U.S. Virgin Islands)

The following article was previously published in the September 2017 Connection (pg. 51). Further clarification pertaining to ambulatory surgical centers (ASCs) has been included in this article.

Based on an external correspondence asking for clarification on when repeat paravertebral facet joint destruction can be performed, the local coverage determination (LCD) for destruction of paravertebral facet joint nerve(s) was revised to add clarifying language to the "Indications and Limitations of Coverage and/ or Medical Necessity" and the "Utilization Guidelines" sections of the LCD. The language will read as follows: Repeat paravertebral facet joint destruction is not medically necessary when performed at the same anatomic site (side and spinal level) within six months of a prior treatment. (So one bilateral or R(L) then L(R) same level is allowed in six months and then can be repeated in the subsequent six months). In addition, coding guidelines were created and attached to the LCD to provide instructions for the appropriate use of modifiers and add-on codes for paravertebral facet joint destruction services (*Current Procedural Terminology* [CPT®]) codes 64633-64636). For each episode of care, the appropriate modifier must be used for identifying the side of the spinal level being treated (i.e. RT, LT, 50 (modifier 50 is not reportable by ASCs). Physician services billed without a modifier indicating the side of the spinal level treated will be rejected.

Of note, ASCs cannot report modifier 50 for any Healthcare Common Procedure Coding System (HCPCS)/ CPT® code. ASCs must report two procedures either as a single unit on two separate lines (appending the RT and LT modifiers) or with "2" in the units field on one line when bilateral services are performed on the same date of service.

In addition, the destruction of paravertebral facet joint nerve(s) "Coding Guidelines" article was revised to include the above clarification related to ASCs

Effective date

This LCD/"Coding Guidelines" article revision is effective for claims processed **on or after February 8, 2018,** for services rendered **on or after October 16, 2017.** LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Self-administered drug (SAD) list – revision to the Part A and Part B article

LCD ID number: A52571 (Florida, Puerto Rico/ U.S. Virgin Islands)

The Centers for Medicare & Medicaid Services (CMS) provide instructions to contractors regarding Medicare payment for drugs and biologicals incident to a physician's service. The instructions also provide contractors with a process for determining if an injectable drug is usually self-administered and therefore not covered by Medicare. Guidelines for the evaluation of drugs for the list of excluded self-administered injectable drugs incident to a physician's service are in the *Medicare Benefit Policy Manual*, Pub. 100-02, Chapter 15, Section 50.2.

Effective for services rendered **on or after April 2, 2018,** Haegarda® (c1 esterase inhibitor subcutaneous [human]) (J3490/J3590) has been added to the Medicare administrative contractor (MAC) Jurisdiction N (JN) self-administered drug (SAD) list.

The evaluation of drugs for addition to the SAD list is an ongoing process. Providers are responsible for monitoring the SAD list for the addition or deletion of drugs.

The First Coast Service Options Inc. (First Coast) SAD list is available at: *https://medicare.fcso.com/Self-administered_drugs/*.

Upcoming provider outreach and educational events

Topic: Medicare Part B changes and regulations

Date: Thursday, March 15
Time: 11:30 a.m.-1:00 p.m.
Type of Event: Webcast

https://medicare.fcso.com/Events/0396642.asp

Topic: Ask-the-contractor teleconference (ACT): Medicare provider enrollment process (A/B)

Date: Thursday, March 22
Time: 11:30 a.m.-1:00 p.m.
Type of Event: Webcast

https://medicare.fcso.com/Events/0399040.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 *https://gm1.geolearning.com/geonext/fcso/opensite.geo*, 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 *MLN Connects*® to its membership as appropriate.

MLN Connects® for January 25, 2018

MLN Connects® for January 25, 2018

View this edition as a PDF

News & Announcements

- VA, HHS Announce Partnership to Strengthen Prevention of Fraud, Waste and Abuse Efforts
- CMS Updates Open Payments Data
- Improved Open Payments Data Website
- IRF and LTCH Quality Reporting Programs: Submission Deadline February 15
- Panel on Development of Potentially Preventable Hospitalization Measures for HHAs: Nominations due February 22
- SNF Quality Reporting Program: Submission Deadline Extended to May 15
- Hospice Quality Reporting Program: Quality Measure User's Manual Version 2
- Continue Seasonal Influenza Vaccination through January and Beyond

Provider Compliance

- Reporting Changes in Ownership — Reminder

Upcoming Events

- Low Volume Appeals Settlement Option Call – February 13
- Home Health Review and Correct Reports Webinar — March 6

Medicare Learning Network Publications & Multimedia

- Low Volume Appeals Settlement Call: Video Presentation — New
- Hurricane Nate and Medicare Disaster Related Alabama, Florida, Louisiana and Mississippi Claims *MLN Matters*® Article — Updated
- Swing Bed Services Fact Sheet — Revised

MLN Connects® – Special Edition for January 26, 2018

In this Edition:

- Therapy Cap Claims Rolling Hold
- New Medicare Card: Web Updates
- New Medicare Card: When Will My Medicare Patients Receive Their Cards?

Therapy Cap Claims Rolling Hold

CMS is immediately releasing for processing *held therapy claims* with the KX modifier with dates of receipt beginning January 1-10; CMS will also implement a "rolling hold" to minimize impact if legislation to extend the outpatient therapy caps exceptions process is enacted.

New Medicare Card: Web Updates

To help you prepare for the transition to the Medicare Beneficiary Identifier (MBI) on Medicare cards beginning April 1, 2018, review the new information about remittance advices.

Beginning in October 2018, through the *transition period*, when providers submit a claim using a patient's valid and active Health Insurance Claim Number (HICN), CMS will return both the HICN and the MBI on every remittance advice. Here are examples of different remittance advices:

- *Medicare Remit Easy Print* (Medicare Part B providers and suppliers)
- *PC Print for Institutions*
- Standard Paper Remits: *FISS (Medicare Part A/ Institutions)*, *MCS (Medicare Part B/Professionals)*, *VMS (Durable Medicare Equipment)*

Find more new information on the New Medicare Card provider webpage.

New Medicare Card: When Will My Medicare Patients Receive Their Cards?

Starting April 2018, CMS will begin mailing new Medicare cards to all people with Medicare on a flow basis, based on geographic location and other factors. Learn more about the *Mailing Strategy*. Also starting April 2018, your patients will be able to check the status of card mailings in their area on *Medicare.gov*.

For More Information:

- *Mailing Strategy*
- Questions from Patients? *Guidelines*
- New Medicare Card *overview* and *provider* web pages

MLN Connects® for February 1, 2018

MLN Connects® for February 1, 2018
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News & Announcements

- Medicare Diabetes Prevention Program: Supplier Enrollment Open
- Targeted Probe and Educate: New Resources
- MIPS Clinicians: 2017 Extreme and Uncontrollable Circumstances Policy
- Quality Payment Program: Patient-facing Encounters Resources
- Eligible Hospitals and CAHs: Get Help with Attestation on QNet
- Find Medicare FFS Payment Regulations
- February is American Heart Month

Provider Compliance

- Cochlear Devices Replaced Without Cost: Bill Correctly — Reminder

Upcoming Events

- Low Volume Appeals Settlement Option Call – February 13
- Home Health Review and Correct Reports Webinar — March 6

Medicare Learning Network Publications & Multimedia

- Next Generation Accountable Care Organization - Implementation MLN Matters® Article — Revised
- DMEPOS Quality Standards Educational Tool — Revised
- Home Oxygen Therapy Booklet — Revised
- Looking for Educational Materials?

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News & Announcements

- Patients over Paperwork: January Newsletter
- Open Payments Registration
- MIPS: Call for Advancing Care Information Measures and Improvement Activities
- Quality Payment Program: Advanced APM Table
- Hospice Quality Reporting Program Resources
- LTCH Quality Reporting Program: Materials from December Training
- SNF QRP Quality Measure and Review and Correct Report: Calculation Error
- Home Health Review and Correct Report: Correction
- Influenza Activity Continues: Are Your Patients Protected?

Provider Compliance

- Medicare Hospital Claims: Avoid Coding Errors — Reminder

Upcoming Events

- Low Volume Appeals Settlement Option Call — February 13
- What's New with Physician Compare Webinar — February 21 or 22
- Comparative Billing Report on Opioid Prescribers Webinar — February 21 or March 7
- ESRD QIP: Final Rule for CY 2018 Call — February 22

Medicare Learning Network Publications & Multimedia

- E/M Service Documentation Provided by Students MLN Matters Article — New
- Medicare Enrollment Resources Educational Tool — Revised
- Medicare Part B Immunization Billing Educational Tool — Reminder

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News & Announcements

- MIPS Reporting Deadlines Fast Approaching: 10 Things to Do and Know
- Quality Payment Program: Performance Scores for 2017 Claims Data
- Diabetic Self-Management Training Accreditation Program: New Webpage and Helpdesk
- Measures of Hospital Harm: Comment by February 16
- EHR Incentive Program: Accepting Proposals for New Measures by June 29
- New Option for Submission of Medicare Cost Reports

Provider Compliance

- Home Health Care: Proper Certification Required — Reminder

Claims, Pricers & Codes

- January 2018 OPPS Pricer File

Upcoming Events

- Improving Accessibility of Provider Settings Webinar — February 21
- ESRD QIP: Final Rule for CY 2018 Call — February 22
- 2018 QCDR Measures Workgroup Webinar — February 27
- Serving Adults with Disabilities on the Autism Spectrum Webinar — February 28
- MIPS Quality Data Submission Webinar – February 28
- Palliative and Hospice Care for Adults with Disabilities Webinar — March 7
- Low Volume Appeals Settlement Option Update Call — March 13
- Open Payments: The Program and Your Role Call — March 14
- MIPS Attestation for Advancing Care Information and Improvement Activities Webinar — March 14

Medicare Learning Network Publications & Multimedia

- Medicare Enrollment Resources Educational Tool — Revised
- PECOS FAQs Booklet — Revised
- PECOS for DMEPOS Suppliers Booklet — Revised
- Safeguard Your Identity and Privacy Using PECOS Booklet —Revised
- PECOS for Provider and Supplier Organizations Booklet — Revised
- PECOS Technical Assistance Contact Information Fact Sheet — Revised
- Health Professional Shortage Area Physician Bonus Program Fact Sheet — Revised
- Medicare Secondary Payer Booklet – Reminder
- Beneficiaries in Custody under a Penal Authority Fact Sheet — Reminder

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Looking for something specific and don't know where to find it? Find out how to perform routine tasks or locate information that visitors frequently visit our site to accomplish or find. Check out the "Where do I find" page.

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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)

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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
PO Box 45300
Jacksonville, FL 32232-5300

General inquiries

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

Email**:** *EDOC-CS-FLINQB@fcso.com>>*
Online form: *https://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
https://medicare.fcso.com

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

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

E-learning Center
https://gm1.geolearning.com/geonext/fcso/opensite.geo

Beneficiaries

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https://www.medicare.gov

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877-660-1759 (TTY)

Fax number (for general inquiries)
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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
PO Box 45300
Jacksonville, FL 32232-5300

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

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Online form: *https://medicare.fcso.com/Feedback/161670.asp*

Provider enrollment
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Jacksonville, FL 32231-4021

Medical policy
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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

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Jacksonville, FL 32232-5087

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

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Jacksonville, FL 32202-4914

Websites

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https://www.cms.gov

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https://gm1.geolearning.com/geonext/fcso/opensite.geo

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)

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Electronic funds transfers (EFT) (CMS-588)

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

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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
PO Box 45300
Jacksonville, FL 32232-5300

General inquiries

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

Email**:** *EDOC-CS-PRINQB@fcso.com>*
Online form: *https://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

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Jacksonville, FL 32202-4914

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