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

In this issue

New physician specialty code for medical genetics and genomics

Provider type affected

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

Provider action needed

This article is based on change request (CR) 10457 which informs MACs that CMS has established a new physician specialty code for medical genetics and genomics (D3). Make sure that your billing staffs are aware of these changes.

Background

Physicians self-designate their Medicare physician specialty on the Medicare enrollment application (CMS-855I or CMS-855O) or Internet-based provider enrollment, chain and ownership system (PECOS) when they enroll in the Medicare program. Medicare physician specialty codes describe the specific/unique types of medicine that physicians (and certain other suppliers) practice. The Centers for Medicare & Medicaid Services (CMS) uses specialty codes for programmatic and claim processing purposes. CMS has established a new physician specialty code for medical genetics and genomics. The new code is D3. MACs will accept and recognize the new code of D3.

Additional information

CR 10457 revises *The Medicare Financial Management Manual*, Chapter 6, and the *Medicare Claims Processing Manual*, Chapter 26, to reflect this new specialty code. The revised manual sections are attached to CR 10457.

The official instruction, CR 10457, issued to your MAC regarding this change via two transmittals. The first updates the *Medicare Financial Management Manual* and it is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R304FM.pdf*. The second updates the *Medicare Claims Processing Manual* and it is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4039CP.pdf*.

See **SPECIALTY**, page 17

Contents

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

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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.

Drugs & Biologicals

July 2018 update of drug and biological code changes

***Note**: This article was revised May 14, 2018, to reflect a revised change request (CR), issued May 11. In the article, a sentence is added to show that Part B payment for Q9995 includes the clotting factor furnishing fee. Also, the CR release date, transmittal number, and the web address of the CR are revised. All other information is the same. This information was previously published in the April 2018 Medicare B Connection, page 8.*

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

CR 10624 informs MACs of updated drug/biological Healthcare Common Procedure Coding System (HCPCS) codes. The HCPCS code set is updated on a quarterly basis. The July 2018 HCPCS file includes four new HCPCS codes: Q9991, Q9992, Q9993, and Q9995. Please make sure your billing staffs are aware of these updates.

Background

The July 2018 HCPCS file includes four new HCPCS codes, which are payable by Medicare, effective for claims with dates of service on or after July 1, 2018. Part B payment for HCPCS code Q9995 will include the clotting factor furnishing fee. These codes are:

- **Q9991**
  - Short description: Buprenorph xr 100 mg or less
  - Long description: Injection, buprenorphine extended-release (sublocade), less than or equal to 100 mg
  - Type of service (TOS) code: 1
  - Medicare physician fee schedule data base (MPFSDB) status indicator: E
- **Q9992**
  - Short description: Buprenorphine xr over 100 mg
  - Long description: Injection, buprenorphine extended-release (sublocade), greater than 100 mg
  - TOS code: 1
  - MPFSDB status indicator: E
- **Q9993**
  - Short description: Inj., triamcinolone ext rel
  - Long description: Injection, triamcinolone acetonide, preservative-free, extended-release, microsphere formulation, 1 mg
  - TOS code: 1,P
  - MPFSDB status indicator: E
- **Q9995**
  - Short description: Inj. emicizumab-kxwh, 0.5 mg
  - Long description: Injection, emicizumab-kxwh, 0.5 mg
  - TOS code: 1
  - MPFSDB status indicator: E

Additional information

The official instruction, CR 10624, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4048CP.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
May 14, 2018	This article was revised to reflect a revised CR issued May 11. In the article, a sentence is added to show that Part B payment for Q9995 includes the clotting factor furnishing fee. Also, the CR release date, transmittal number, and the web address of the CR are revised. All other information is the same.
April 20, 2018	Initial article released.

MLN Matters® Number: MM10624 *Revised*
Related CR Release Date: May 11, 2018
Related CR Transmittal Number: R4048CP
Related Change Request (CR) Number: 10624
Effective Date: July 1, 2018
Implementation July 2, 2018

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) 10642 informs MACs about the changes in the July 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 clinical laboratory fee schedule.

Access to data file

Under normal circumstances, CMS will make the updated CLFS data file available to MACs approximately six weeks prior to the beginning of each quarter. For example, the updated file will typically be made available for download and testing on or before approximately May 15 for the July 1 release. 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*.

Other 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 CLFS. It 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 contractor priced until they are addressed at the annual clinical laboratory public meeting, which will take place in July 2018. The following "U" codes will 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, type of service (TOS), short descriptor, long descriptor)

The following new codes are effective April 1, 2018:

- 0035U TOS 5; short descriptor—Neuro csf prion prtn qual; long descriptor—Neurology (prion disease), cerebrospinal fluid, detection of prion protein by quaking-induced conformational conversion, qualitative
- 0036U TOS 5; short descriptor—Xome tum & nml spec seq alys; long descriptor—Exome (ie, somatic mutations), paired formalin-fixed paraffin-embedded tumor tissue and normal specimen, sequence analyses
- 0037U TOS 5; short descriptor—Trgt gen seq dna 324 genes; long descriptor—Targeted genomic sequence analysis, solid organ neoplasm, DNA analysis of 324 genes, interrogation for sequence variants, gene copy number amplifications, gene rearrangements, microsatellite instability and tumor mutational burden
- 0038U TOS 5; short descriptor—Vitamin d srm microsamp quan; long descriptor—Vitamin D, 25 hydroxy D2 and D3, by LC-MS/MS, serum microsample, quantitative
- 0039U TOS 5; short descriptor—Dna antb 2strand hi avidity; long descriptor—Deoxyribonucleic acid (DNA) antibody, double stranded, high avidity
- 0040U TOS 5; short descriptor—Bcr/abl1 gene major bp quan; long descriptor—BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis, major breakpoint, quantitative
- 0041U TOS 5; short descriptor—B brgdrferi antb 5 prtn igm; long descriptor—Borrelia burgdorferi, antibody detection of 5 recombinant protein groups, by immunoblot, IgM
- 0042U TOS 5; short descriptor—B brgdrferi antb 12 prtn igg; long descriptor—Borrelia burgdorferi, antibody detection of 12 recombinant protein groups, by immunoblot, IgG

See **CLFS**, page 7

CLFS

from page 6

- 0043U TOS 5; short descriptor—Tbrf b grp antb 4 prtn igm; long descriptor—Tick-borne relapsing fever Borrelia group, antibody detection to 4 recombinant protein groups, by immunoblot, IgM
- 0044U TOS 5; short descriptor—Tbrf b grp antb 4 prtn igg; long descriptor—Tick-borne relapsing fever Borrelia group, antibody detection to 4 recombinant protein groups, by immunoblot, IgG0024U Glycosylated acute phase proteins (GlycA), nuclear magnetic resonance spectroscopy, quantitative
- 0012M TOS 5; short descriptor—Onc mrna 5 gen rsk urthl ca; long descriptor—Oncology (urothelial), mRNA, gene expression profiling by real-time quantitative PCR of five genes (MDK, HOXA13, CDC2 [CDK1], IGFBP5, and XCR2), utilizing urine, algorithm reported as a risk score for having urothelial carcinoma
- 0013M TOS 5; short descriptor—Onc mrna 5 gen recr urthl ca; long descriptor—Oncology (urothelial), mRNA, gene expression profiling by real-time quantitative PCR of five genes (MDK, HOXA13, CDC2 [CDK1], IGFBP5, and CXCR2), utilizing urine, algorithm reported as a risk score for having recurrent urothelial carcinoma

The following new code is effective January 1, 2018:

- 0011M TOS 5; short descriptor—Onc prst8 ca mrna 12 gen alg; long descriptor—Oncology, prostate cancer, mRNA expression assay of 12 genes (10 content and 2 housekeeping), RT-PCR test utilizing blood plasma and/or urine, algorithms to predict high-grade prostate cancer risk

Notes

- In instances where Medicare-covered CLFS procedure codes do not yet appear on the quarterly CLFS file or the quarterly integrated outpatient code editor (I/OCE) update, MACs will locally price the codes until they appear on the CLFS file and/or, for Part A claims, the I/OCE.
- MACs will not search their files to either retract payment or retroactively pay claims; however, they should adjust claims that you bring to their attention.

Additional information

The official instruction, CR 10642, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4045CP.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
May 14, 2018	Initial article released.

MLN Matters® Number: MM10642
Related CR Release Date: May 11, 2018
Related CR Transmittal Number: R4045CP
Related Change Request (CR) Number: 10642
Effective Date: July 1, 2018
Implementation July 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.

Therapy Services

Supervised exercise therapy for symptomatic peripheral artery disease

***Note**: The article was revised May 14, 2018, to reflect a revised change request (CR) issued May 11. The CR was revised to remove place of service code edit requirements. The article was revised accordingly. Also, in the article, the CR release date, transmittal numbers and the web address of the CR are revised. The article was revised May 15, 2018, to clarify that one of the requirements of the SET program is it must be conducted in a hospital outpatient setting or in a physician's office. All other information remains the same. This information was originally published in the April 2018 Medicare B Connection, pages 13-15.*

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

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 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

See **PAD**, page 9

PAD

from page 8

- 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 *https://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 *https://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:

- 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*

See **PAD**, page 10

PAD

from page 9

Claims Processing Manual and it is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4049CP.pdf*. The second updates the *NCD Manual* and it is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R207NCD.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
May 15, 2018	The article was revised to clarify that one of the requirements of the SET program is it must be conducted in a hospital outpatient setting or in a physician's office. All other information remains the same.
May 14, 2018	The article was revised to reflect a revised CR issued May 11. The CR was revised to remove place of service code edit requirements. The article was revised accordingly. Also, in the article, the CR release date, transmittal numbers and the Web address of the CR are revised. All other information remains the same.
April 11, 2018	The article was revised to clarify that the SET program must be provided in a physician's office (POS code 11). All other information remains the same.
April 5, 2018	The article was revised to reflect a revised CR. The MAC implementation date, CR release date, transmittal numbers and the web addresses of the transmittals were revised. In addition, the article and CR were revised to delete POS codes 19 and 22 as acceptable places of service for CPT® 93668. All other information remains the same.

Date of change	Description
March 5, 2018	The article was revised to reflect a revised CR. The MAC implementation date, CR release date, transmittal numbers and the Web addresses of the transmittals were revised. All other information remains the same.
February 6, 2018	Initial article released.

MLN Matters® Number: MM10295 *Revised*
Related CR Release Date: May 11, 2018
Related CR Transmittal Number: R207NCD and R4049CP
Related Change Request (CR) Number: 10295
Effective Date: May 25, 2017
Implementation Date: July 2, 2018

ADR status search is here

Users of the Secure Provider Online Tool (SPOT) have a more focused and detailed look at pending and received additional development requests (ADR) with the launch of the new medical review *ADR status lookup functionality*. The new lookup function is located under the Claims navigation at the top of every page, and lets users search for the review status of claims for which an ADR letter was sent related to medical review. **Note**: This function is for medical review ADRs only, not all ADRs.

General Coverage

ICD-10 and other coding revisions to NCDs

Provider type affected

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

Provider action needed

Change request (CR) 10622 constitutes a maintenance update of International Classification of Diseases, 10th Revision (ICD-10) conversions and other coding updates specific to national coverage determinations (NCDs). These NCD coding changes are the result of newly available codes, coding revisions to NCDs released separately, or coding feedback received. Please follow the link below for the NCD spreadsheets included with this CR: *https://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/CR10622.zip*.

Background

Previous NCD coding changes appear in ICD-10 quarterly updates that are available at *https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html*, along with other CRs implementing new policy NCDs. Edits to ICD-10 and other coding updates specific to NCDs, will be included in subsequent quarterly releases as needed.

No policy-related changes are included with these updates. Any policy-related changes to NCDs continue to be implemented via the current, long-standing NCD process.

Coding (as well as payment) is a separate and distinct area of the Medicare program from coverage policy/criteria. Revisions to codes within an NCD are carefully and thoroughly reviewed and vetted by the Centers for Medicare & Medicaid Services (CMS) and are not intended to change the original intent of the NCD. The exception to this is when coding revisions are released as official implementation of new or reconsidered NCD policy following a formal national coverage analysis.

Note: The translations from ICD-9 to ICD-10 are not consistent one-to-one matches, nor are all ICD-10 codes appearing in a complete general equivalence mappings (GEMs) mapping guide or other mapping guides appropriate when reviewed against individual NCD policies. In addition, for those policies that expressly allow MAC discretion, there may be changes to those NCDs based on current review of those NCDs against ICD-10 coding. For these reasons, there may be certain ICD-9 codes that were once considered appropriate prior to ICD-10 implementation that are no longer considered acceptable.

CR 10622 makes coding and clarifying adjustments to the following NCDs:

- NCD 110.18 Aprepitant
- NCD 150.3 Bone mineral density studies
- NCD 190.11 Prothrombin time/international normalized ratio (PT/INR)
- NCD 220.6.16 Positron emission tomography (PET) for infection/inflammation
- NCD 220.6.17 PET for solid tumors
- NCD 220.13 Percutaneous image-guided breast biopsy

When denying claims associated with the attached NCDs, except where otherwise indicated. A/B MACs will use:

- Group code PR (patient responsibility) assigning financial responsibility to the beneficiary (if a claim is received with occurrence code 32, or with occurrence code 32 and a GA modifier, indicating a signed advance beneficiary notice (ABN) is on file).
- 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). For modifier GZ, use CARC 50 and Medicare summary notice (MSN) 8.81 per instructions in CR 7228/TR 2148.

Additional information

The official instruction, CR 10622, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R2076OTN.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
May 9, 2018	Initial article released.

MLN Matters® Number: MM10622
Related CR Release Date: May 4, 2018
Related CR Transmittal Number: R2076OTN
Related Change Request (CR) Number: 10622
Effective Date: October 1, 2018
Implementation October 1, 2018

Comprehensive ESRD care (CEC) model telehealth – implementation

Provider type affected

This *MLN Matters*® article is intended for physicians, providers, and suppliers billing Medicare administrative contractors (MACs) and participating in the comprehensive ESRD care (CEC) model for telehealth services provided to Medicare end-stage renal disease (ESRD) beneficiaries associated with the CEC model.

Provider action needed

Change request (CR) 10314 details the CEC model telehealth program and how it will be implemented. Make sure your billing staffs are aware of this initiative.

Background

Section 1115A) of the Social Security Act (the Act) (added by Section 3021 of the Affordable Care Act (ACA) (42 USC 1315a) authorizes the Center for Medicare and Medicaid Innovation (CMMI) to test innovate health care payment and service-delivery models that have the potential to lower Medicare, Medicaid, and the Child Health Insurance Program (CHIP) spending while maintaining or improving the quality of beneficiaries' care.

The CEC model is designed to identify, test, and evaluate new ways to improve care for Medicare beneficiaries with ESRD. Through the CEC model, the Centers for Medicare & Medicaid Services (CMS) will partner with health care providers and suppliers to test the effectiveness of a new payment and service delivery model in providing beneficiaries with person-centered, high-quality care. The model builds on accountable care organization (ACO) experience from the pioneer ACO model, next generation ACO model, and the Medicare shared savings program to test ACOs for ESRD beneficiaries.

More than 600,000 Americans have ESRD and require life-sustaining dialysis treatments several times per week. Many beneficiaries with ESRD suffer from poorer health outcomes, often the result of underlying disease complications and multiple co-morbidities. These can lead to high rates of hospital admission and readmissions, as well as a mortality rate that is higher than that of the general Medicare population.

According to United States Renal Data System, in 2014, ESRD beneficiaries comprised less than 1 percent of the Medicare population, but accounted for an estimated 7.2 percent of total Medicare Fee-For-Service (FFS) spending, totaling more than $32.8 billion.

Because of their complex health needs, beneficiaries often require visits to multiple providers and follow multiple care plans, all of which can be challenging for beneficiaries if care is not coordinated. The CEC Model seeks to create incentives to enhance care coordination and to create a person-centered, coordinated care experience, and to ultimately improve health outcomes for this population.

In the CEC model, dialysis clinics, nephrologists and other providers collaborate to create an ESRD seamless care organization (ESCO) to coordinate care for matched beneficiaries. ESCOs are accountable for clinical quality outcomes and financial outcomes measured by Medicare Part A and B spending, including all spending on dialysis services for their aligned ESRD beneficiaries. This model encourages dialysis providers to think beyond their traditional roles in care delivery and supports them as they provide patient-centered care that will address beneficiaries' health needs, both in and outside of the dialysis clinic.

The CEC model includes separate financial arrangements for larger and smaller dialysis organizations. Large dialysis organizations (LDOs), defined as having 200 or more dialysis facilities, will be eligible to receive shared savings payments. These LDOs will also be liable for shared losses and will have higher overall levels of risk compared with their smaller counterparts.

Non-large dialysis organizations (Non-LDOs) include chains with fewer than 200 dialysis facilities, independent dialysis facilities, and hospital-based dialysis facilities. Non-LDOs will have the option of participating in a one-sided track where they will be able to receive shared savings payments, but will not be liable for payment of shared losses, or participating in a track with higher risk and the potential for shared losses. The one-sided track is offered in recognition of the non-LDOs more limited resources.

The CEC model began October 1, 2015, and will run until December 31, 2020. The CEC model conducted a solicitation in 2016 to add more ESCOs for performance year two of the model, beginning January 1, 2017. The CEC model has no current plans for another round of solicitations.

The CEC model LDO payment track and non-LDO two-sided payment track are considered advance payment models (APMs) regarding the quality payment program.

The CEC model will implement design elements with implications for the FFS system for its third performance year that includes benefit enhancements to give ACOs the tools to direct care and engage beneficiaries in their own care. The model also offers increased monitoring to account for different financial incentives and the provision of enhanced benefits. The model's quality requirements are similar to shared savings program (SSP) and pioneer, modified as needed to take into account unique aspects of dialysis care, in keeping with the agencies initiatives to unify and streamline quality measurement and requirements.

Telehealth waiver

In order to emphasize high-value services and support the ability of ESCOs to manage the care of beneficiaries, CMS plans to design policies and use the authority under Section 1115A of the Social Security Act (Section 3021

See **CEC**, page 13

CEC

from page 12

of the Affordable Care Act) to conditionally waive certain Medicare payment requirements as part of the CEC model.

CMS will make available to qualified ESCOs a waiver of the originating site requirement for services provided via telehealth. This benefit enhancement will allow beneficiaries to receive qualified telehealth services in non-rural locations and locations that are not specified by statute, such as homes and dialysis facilities. The waiver will apply only to eligible aligned beneficiaries receiving services from ESCO providers.

An aligned beneficiary will be eligible to receive telehealth services through this waiver if the services are otherwise qualified with respect to:

1) The service provided, as designated by *Current Procedural Terminology* (CPT®) or Healthcare Common Procedure Coding System (HCPCS) codes, and

2) The remote site.

MACs will apply claims processing edit logic, audit, medical review, Medicare secondary payor, and fraud and abuse activities, appeals and overpayment processes for CEC claims in the same manner as normal FFS claims.

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 Act, and subsequent additional services specified through regulation with the exception that claims **will not** be allowed for the following telehealth services rendered to aligned beneficiaries located at their residence:

- Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or skilled nursing facilities (SNFs) - HCPCS codes G0406-G0408.
- Subsequent hospital care services, with the limitation of one telehealth visit every three days - CPT® codes 99231-99233.
- Subsequent nursing facility care services, with the limitation of 1 telehealth visit every 30 days - CPT® codes 99307-99310.
- Telehealth consultations, emergency department or initial inpatient - HCPCS codes G0425-G0427.
- Telehealth consultation, critical care, initial - HCPCS code G0508.
- Telehealth consultation, critical care, subsequent - HCPCS code G0509.
- Prolonged service in the inpatient or observation setting requiring unit/floor time beyond the usual service - CPT® codes 99356-99357.

MACs will be ready to process Part B CEC claims for dates of service on or after October 1, 2018. MACs will process CEC telehealth claims (place of service (POS) 02) when providers are ESCO providers and beneficiaries are aligned to the same ESCO for the date of service (DOS) on the claims and contains the demo code 85 and one of the following CPT® or HCPCS codes:

90785, 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90846, 90847, 90951, 90952, 90954, 90955, 90957, 90958, 90960, 90961, 90963, 90964, 90965, 90966, 90967, 90968, 90969, 90970, 96116, 96150, 96151, 96152, 96153, 96154, 96160, 96161, 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99354, 99355, 99406, 99407, 99495, 99496, 99497, 99498, G0108, G0109, G0270, G0396, G0397, G0420, G0421, G0438, G0439, G0442, G0443, G0444, G0445, G0446, G0447, G0459, G0506, G9481, G9482, G9483, G9484, G9485, G9486, G9487, G9488, G9489

For Part A CEC claims when providers are ESCO providers and beneficiaries are aligned to the same ESCO for the date of service (DOS) on the claims submitted on type of bill (TOB) 12x, 13x, 22x, 23x, 71x, 72x, 76x, 77x, or 85x and contains the demo code 85 and one of the following CPT® or HCPCS codes:

90785, 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90846, 90847, 90951, 90952, 90954, 90955, 90957, 90958, 90960, 90961, 90963, 90964, 90965, 90966, 90967, 90968, 90969, 90970, 96116, 96150, 96151, 96152, 96153, 96154, 96160, 96161, 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99354, 99355, 99406, 99407, 99495, 99496, 99497, 99498, G0108, G0109, G0270, G0396, G0397, G0420, G0421, G0438, G0439, G0442, G0443, G0444, G0445, G0446, G0447, G0459, G0506, G9481, G9482, G9483, G9484, G9485, G9486, G9487, G9488, G9489

MACs will not process as CEC telehealth claims that contain the following codes. Claims that contain these codes these codes can be processed following existing claim processing logic:

- HCPCS codes G0406 – G0408.
- CPT® codes 99231 – 99233.
- CPT® codes 99307 – 99310.
- HCPCS codes G0425-G0427
- HCPCS code G0508
- HCPCS code G0509
- CPT® codes 99356-99357

MACs will treat CEC payments the same as Medicare patients for cost reporting purposes.

Providers submitting electronic 837 claims should enter DEMO 85 in the REF segment 2300 loop demonstration project identifiers and providers will include qualifier P4. Providers submitting a paper claim should enter demo 85 in the treatment authorization field.

See **CEC**, page 14

CEC

from page 13

Providers should be aware that MACs will return claims if you append demo code 85, and:

- You are not on the CEC participant provider list with a telehealth record type; or
- DOS "from date" is prior to your telehealth effective date, or
- DOS "from date" is after your telehealth termination date, or
- The DOS "from date" is prior to the beneficiary's effective date; or
- The DOS "from date" is after the beneficiary's termination date, or
- The DOS "from date" is more than 90 days after the beneficiary's termination date; or
- The beneficiary was not aligned to the same ESCO with which you are participating, as identified by ESCO ID; or
- The claim is for Part A and the TOB is other than 12x, 13x, 22x, 23x, 71x, 72x, 76x, 77x, and 85x,
- Other, non-telehealth services are billed on the same claim. In these cases, none of the services on the claim are processed.

In returning Part B claims, your MAC will use the following messaging:

- Claims adjustment reason code (CARC) 16: (Claim/service lacks information or has submission/billing error(s) which is needed for adjudication) and
- Remittance advice remark code (RARC) N763 (The demonstration code is not appropriate for this claim; resubmit without a demonstration code.)
- Group code: CO (contractual obligation)

For Part A claims, your MAC will just return the claim to the provider (RTP).

Additional information

The official instruction, CR 10314, issued to your

MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R196DEMO.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
April 27, 2018	Initial article released.

MLN Matters® Number: MM10314
Related CR Release Date: April 27, 2018
Related CR Transmittal Number: R196DEMO
Related Change Request (CR) Number: 10314
Effective Date: October 1, 2018
Implementation Date: October 1, 2018

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Update the identification code qualifier being used in the NM108 data element

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) 10565 provides instructions to the MACs to update the identification code qualifier in data element NM108 currently being used in the 2100 loop, NM1- patient name segment of the 835 guide. This will synchronize the usage of the same qualifier as used/submitted on the claim. Make sure your billing staffs are aware of these instructions.

Background

With the removal of the Social Security number (SSN)-based health insurance claim number (HICN) from Medicare cards and in an effort to synchronize the usage of the same identification code qualifier in the health care claim payment/advice (835) and the professional and institutional (837) health care claim as required by the 835 guide, CR 10565 modifies the identification code qualifier being used in the 835 electronic remit from HN to MI.

Additional information

The official instruction, CR 10565, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R2063OTN.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
April 27, 2018	Initial article released.

MLN Matters® Number: MM10565
Related CR Release Date: April 27, 2018
Related CR Transmittal Number: R2063OTN
Related Change Request (CR) Number: 10565
Effective Date: October 1, 2018 – not based on date of service
Implementation Date: October 1, 2018

CORE 360 uniform use of CARC, RARC and CAGC rule

Provider type affected

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

Provider action needed

Change request (CR) 10566 informs MACs to update their systems based on the CORE 360 Uniform use of claims adjustment reason codes (CARC), remittance advice remark codes (RARC) and claim adjustment group code (CAGC) rule publication. These system updates are based on the Committee on Operating Rules for Information Exchange (CORE) code combination list to be published on or about June 4, 2018. CR 10566 applies to the *Medicare Claims Processing Manual*, Chapter 22, Section 80.2. Make sure that your billing staffs are aware of these changes.

Background

The Department of Health and Human Services (DHHS) adopted the Phase III Council for Affordable Quality Healthcare (CAQH) CORE, electronic funds transfer (EFT) and electronic remittance advice (ERA) operating rule set that was implemented January 1, 2014, under the Affordable Care Act. The Health Insurance Portability and Accountability Act (HIPAA) amended the Act by adding Part C—Administrative Simplification—to Title XI of the Social Security Act, requiring the Secretary of DHHS (the Secretary) to adopt standards for certain transactions to enable health information to be exchanged more efficiently and to achieve greater uniformity in the transmission of health information. Through the Affordable Care Act, Congress sought to promote implementation of electronic transactions and achieve cost reduction and efficiency improvements by creating more uniformity in the implementation of standard transactions. This was done by mandating the adoption of a set of operating rules for each of the HIPAA transactions.

See **CAQH**, page 16

CAQH

from page 15

CR 10566 deals with the regular update in CAQH CORE defined code combinations per operating rule 360 - uniform use of CARC and RARC (835) rule.

CAQH CORE will publish the next version of the code combination list on or about June 4, 2018. This update is based on the CARC and RARC updates as posted at the Washington Publishing Company (WPC) website on or about March 1, 2018. This will also include updates based on market based review that CAQH CORE conducts once a year to accommodate code combinations that are currently being used by health plans including Medicare, as the industry needs them.

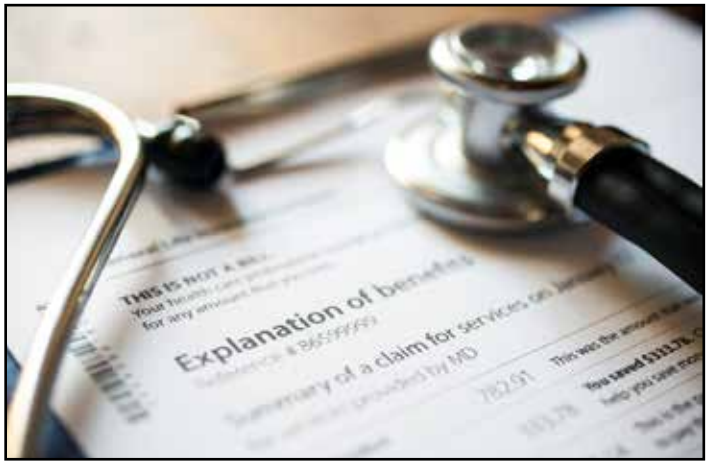
See *http://www.wpc-edi.com/reference* for CARC and RARC updates and *http://www.caqh.org/CORECodeCombinations.php* for CAQH CORE defined code combination updates.

Note: As the Affordable Care Act requires, all health plans including Medicare must comply with CORE 360 Uniform Use of CARCs and RARCs (835) rule or CORE developed maximum set of CARC/RARC and CAGC combinations for a minimum set of four (4) business scenarios. Medicare can use any code combination if the business scenario is not one of the four (4) CORE defined business scenarios. With the four (4) CORE defined business scenarios, Medicare must use the code combinations from the lists published by CAQH CORE.

Additional information

The official instruction, CR 10566, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4054CP.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
May 18, 2018	Initial article released.

MLN Matters® Number: MM10566
Related CR Release Date: May 18, 2018
Related CR Transmittal Number: R4054CP
Related Change Request (CR) Number: 10566
Effective Date: October 1, 2018
Implementation October 1, 2018

New MBI lookup available

The Secure Provider Online Tool (SPOT) is able to look up the new Medicare beneficiary identifiers (MBIs) belonging to all Medicare beneficiaries. This allows providers to enter information on a beneficiary and receive that beneficiary's new MBI. In preparation for the new Medicare cards, distribution of cards to those who live in Florida, Puerto Rico, and the U.S. Virgin Islands began in June.

Medicare cost report e-filing (MCReF)

Provider type affected

This *MLN Matters*® article is intended for cost report staff submitting annual Medicare cost reports (MCRs) to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 10611 informs MACs and providers of the new MCR e-filing (MCReF) system available for electronic transmission of cost reports. Medicare Part A providers file an annual MCR with the Centers for Medicare & Medicaid Services (CMS). The reports are filed with a MAC assigned to each provider. The MCR is used to determine the providers' Medicare reimbursable costs. MACs may suspend payments to providers that fail to file their MCR on the due date. Make sure your cost report staffs are aware of the new MCReF system.

Background

In accordance with *Chapter 1, Section 104 of the Provider Reimbursement Manual, Part II* (PRM-II), providers that continue to participate in the Medicare Program are required to submit a cost report within five months of their cost reporting fiscal year end. For cost reports ending on a day other than the last day of the month, cost reports are due 150 days after the last day of the cost reporting period. Exceptions to this due date for "no Medicare utilization" cost reports are addressed in PRM-II, Section110.A. MACs are required to suspend payments to providers that fail to file their MCR by the due date.

Current Medicare cost-report (MCR) filing and receipt process: Generally, each provider must perform the following steps to properly submit an MCR to their MAC:

- Generate an MCR consisting of a machine-readable file (ECR) and a human-readable file (PDF or equivalent, also referred to as the print image), using CMS-approved MCR vendor software.
- Submit the worksheet S (certification page) signed by an officer or administrator of the provider. A "wet" signature is required for cost reports ending before December 31, 2017; an electronic signature is allowed for cost reports ending on or after December 31, 2017.
- Provide supporting cost report documentation including, but not limited to, the working trial balance, financial statements, Medicare bad debt listing, interns and residents information system data, and so on.
- Submit the MCR package to their MAC via mail (or hand delivery), which account for 91 percent of all MCR submissions, or a hybrid of mail and electronic submissions which account for 9 percent of total submissions. The signed worksheet S must be mailed to the MAC.

Streamlined the MCR filing process:

To streamline the MCR filing process, the 2018 inpatient prospective payment system (IPPS) final rule allows for an electronic signature on the MCR worksheet S (certification page) for cost reports ending on or after December 31, 2017. Additionally, beginning May 1, 2018, CMS will make the MCReF system available to Part A providers for electronic transmission (e-filing) of an MCR package directly to a MAC. A CMS enterprise identity management (EIDM) account is required to use MCReF, which is the same account providers use to order copies of their provider statistical and reimbursement reports (PS&R).

Upon login, providers will be able to select the fiscal year end for which they are filing, upload all corresponding MCR materials as attachments, and submit the documents directly to their MAC. The system will perform a basic review of the attached materials to determine if the MCR is "receivable" (See Attachment A of CR 10611. The Web address of CR 10611 is in the *Additional information* section of this article.). If issues are identified, the provider will immediately receive an error/warning message. If no issues are identified, the provider will receive a confirmation number, as well as an electronic postmark date, which can be used in correspondence regarding the submission. Once the cost report is deemed "receivable," the MAC will perform the acceptability review within 30 days. The MAC will issue a rejection letter if the cost report is rejected.

Medicare cost report e-filing (MCReF) system access:

MCReF will be hosted at the following URL: *https://mcref.cms.gov*. System access to MCReF will be controlled by the EIDM system, as previously noted. Part A provider security officials (SOs) and their backups (BSOs), already

See **MCReF**, page 18

SPECIALTY

from page 1

Document history

Date of change	Description
April 27, 2018	Initial article released.

MLN Matters® Number: MM10457
Related CR Release Date: April 27, 2018
Related CR Transmittal Number: R304FM and R4039CP

Related Change Request (CR) Number: 10457
Effective Date: October 1, 2018
Implementation Date: October 1, 2018

MCReF

from page 17

registered in EIDM for access to CMS PS&R, will inherit access to MCReF by default through their existing account.

Providers that are not registered in EIDM, but wish to gain access to MCReF, must register in EIDM and assign an SO for their organization. New user registration is available at *https://portal.cms.gov/wps/portal/unauthportal/eidm/newuserregistration*.

Note: It is important for providers to keep their EIDM credentials in good standing to avoid problems using MCReF to e-file cost reports and obtaining PS&R. This includes password updates per CMS policy and the timely replacement of SOs due to staffing changes. Issues with maintaining EIDM credentials will not constitute a valid reason for filing a cost report past its due date.

Starting July 2, 2018, providers that wish to e-file their MCR must use MCReF. MAC portals will no longer be an acceptable means of submission. Providers that wish to mail or hand deliver MCRs to MACs, may continue to do so.

Benefits of streamlined MCR processes:

- Increases CMS access to MCR data as submitted by providers to assist with responding to inquiries and remove additional administrative burdens on MACs and CMS.
- Eliminates MAC processes for populating the CMS Healthcare Cost Reporting Information System (HCRIS) – including the submission of 100,000 cost reports to HCRIS and subsequent resubmission.
- Eliminates the need for MACs to enter MCR postmarked date, received date, and HCRIS sent date.
- Enables direct receipt/promotion of IRIS data to its required end-state in STAR (eliminates manually upload IRIS data).
- Large provider chain organizations will electronically submit MCRs to one system instead of transmitting their MCRs to their assigned MAC jurisdiction's portals or physical mailing addresses.
- An MCR submitted through MCReF will be directed automatically to the correct MAC eliminating the risk of submitting the MCR to an incorrect MAC.
- Providers will receive immediate feedback on whether the MCR is received.
- Providers will save time compiling the paperwork (files) needed to create electronic media and mail the MCR package;
- Providers will have until 11:59 p.m. eastern time on the due date to submit the MCR through MCReF.
- MCReF has a simple, straightforward user interface with just one screen.

- Reduces provider confusion due to conflicting MAC "receivability" rules.

Additional information

The official instruction, CR 10611, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R2075OTN.pdf*. A detailed MCReF system overview is attached to the CR. CMS encourages cost report staff to review this overview.

Chapter 1 of the *Provider Reimbursement Manual* is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021935.html*.

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

Document history

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

MLN Matters® Number: MM10611
Related CR Release Date: April 30, 2018
Related CR Transmittal Number: R2075OTN
Related Change Request (CR) Number: 10611
Effective Date: June 12, 2018
Implementation June 12, 2018

Manual updates to replace remittance advice remark code MA61 with N382

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

Change request (CR) 10619 initiates both Medicare manual changes and operational changes related to the new Medicare card. Medicare will replace the use of remittance advice remark code (RARC) MA61, referenced in the *Medicare Claims Processing Manual*, Chapters 1 and 27, with RARC N382 - missing/incomplete/invalid patient identifier (HICN or MBI). Effective for claims processed on or after the effective date of CR 10619, MACs will use N382 in place of MA61 to communicate reject/denials for patient identifiers (HICN or MBI) in all remittance advices and 835 transactions. However, MACs will continue to use RARC MA61 only when/if communicating rejections/denials related to a missing/incomplete/invalid social security number. Make sure your billing staffs are aware of these updates.

Background

With the implementation of the Medicare beneficiary identifier (MBI), references to the health insurance claim number (HICN) will be replaced with a more generic reference (patient identifier). CR 16019 initiates the manual changes and operational changes to accomplish this task.

Additional information

The official instruction, CR 10619, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4047CP.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
May 14, 2018	Initial article released.

MLN Matters® Number: MM10619
Related CR Release Date: May 11, 2018
Related CR Transmittal Number: R4047CP
Related Change Request (CR) Number: 10619
Effective Date: August 13, 2018
Implementation August 13, 2018

Your Feedback Matters

To ensure that our website meets the needs of our provider community, we carefully analyze your feedback and implement changes to better meet your needs. Discover the results of your feedback on our "*Website enhancements*" page. You'll find the latest enhancements to our provider websites and find out how you can share your thoughts and ideas with First Coast's Web team.

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.

New LCD

Emergency and non-emergency ground ambulance services – new Part A and Part B LCD

LCD ID number: L37697 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for emergency and non-emergency ground ambulance services was developed based on the following: data analysis, issues identified by the Office of Inspector General (OIG) and postpayment medical review, and to provide a comprehensive document of all the pertinent Medicare regulations pertaining to ground ambulance services. Furthermore, the existing non-emergency ground ambulance services LCD (L33383) will be retired when this new LCD becomes effective.

Effective date

This new LCD is effective for services rendered **on or after June 28, 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 LCDs

Bone mineral density studies – revision to the Part A and Part B LCD

LCD ID number: L36356 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on an annual review of the local coverage determination (LCD) for bone mineral density studies, it was determined that some of the italicized language in the "Coverage Indications, Limitations, and/or Medical Necessity," "CPT®/HCPCS Codes," and "Utilization Guidelines" sections of the LCD do not represent direct quotation from the Centers for Medicare & Medicaid Services (CMS) sources listed in the LCD; therefore, this LCD is being revised to assure consistency with the CMS sources.

Effective date

The LCD revision is effective for services rendered **on or after May 1, 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.

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Botulinum toxins – revision to the Part A and Part B LCD

LCD ID number: L33274 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on a local coverage determination (LCD) reconsideration request, the botulinum toxins LCD was revised in the "Coverage Indications, Limitations, and/or Medical Necessity" section of the LCD to include the Food and Drug Administration (FDA) indications for Dysport® –the treatment of spasticity in adults and the treatment of lower limb spasticity in pediatric patients two years of age and older. In addition, the accompanying ICD-10-CM diagnosis codes (G11.4, G80.8, G82.21-G82.22, G82.51-G82.52, G83.11-G83.14, I69.041-I69.044, I69.141-I69.144, I69.241-I69.244, I69.341-I69.344, I69.841-I69.844, M62.451-M62.452, M62.461-M62.462, M62.471-M62.472, M62.48, M62.49, M62.831, and M62.838) for these indications were added to the "ICD-10 Codes that Support Medical Necessity" section of the LCD under "Group 2 Codes:" for Healthcare Common Procedure Coding System (HCPCS) code J0586. The "Sources of Information and Basis for Decision" section of the LCD has also been updated.

Effective date

The LCD revision to include the treatment of lower limb spasticity in pediatric patients two years of age and older is effective for claims processed **on or after May 3, 2018**, for services rendered **on or after July 29, 2016.** The LCD revision to include the treatment of spasticity in adults is effective for claims processed **on or after May 3, 2018**, for services rendered **on or after June 14, 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*.

CYP2C19, CYP2D6, CYP2C9, and VKORC1 genetic testing – revision to the Part A and Part B LCD

LCD ID number: L35698 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 10515 (April 2018 Update of the Hospital Outpatient Prospective Payment System [OPPS]) and CR 10445 (Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment), the LCD (CYP2C19, CYP2D6, CYP2C9, and VKORC1 Genetic Testing) was revised to add procedure code 0028U.

Effective date

The LCD revision is effective for claims processed **on or after April 2, 2018**, for services rendered **on or after January 1, 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*.

E&M home and domiciliary visits – revision to the Part B LCD

LCD ID number: L33817 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on an annual review of the local coverage determination (LCD) for E&M home and domiciliary visits, it was determined that some of the italicized language in the "Coverage Indications, Limitations, and/or Medical Necessity" and "Documentation Requirements" sections of the LCD do not represent direct quotation from the Centers for Medicare & Medicaid Services (CMS) sources listed in the LCD; therefore, this LCD is being revised to assure consistency with the CMS sources.

Effective date

The LCD revision is effective for services rendered **on or after May 1, 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*.

G-CSF (Neupogen®, Granix™, Zarxio™) – revision to the Part A and Part B LCD

LCD ID number: L34002 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 10454 (Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes - April 2018 Update), CR 10515 (April 2018 Update of the Hospital Outpatient Prospective Payment System [OPPS]), and CR 10530 (April 2018 update of the Ambulatory Surgical Center [ASC] Payment System), the local coverage determination (LCD) for G-CSF (Neupogen®, Granix™, Zarxio™) was revised to reflect that the descriptor was changed for Healthcare Common Procedure Coding System (HCPCS) code Q5101 in the "CPT®/HCPCS Codes" section of the LCD. In addition, language related to modifier "ZA" with HCPCS code Q5101 was removed as this modifier has been discontinued.

Effective date

The LCD revision is effective for services rendered **on or after April 1, 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*.

Infliximab (Remicade™) – revision to the Part A and Part B LCD

LCD ID number: L33704 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 10488 (Quarterly update to the Medicare Physician Fee Schedule Database [MPFSDB] - April 2018 Update),CR 10454 (Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes - April 2018 Update), CR 10515 (April 2018 Update of the Hospital Outpatient Prospective Payment System [OPPS]), and CR 10530 (April 2018 update of the Ambulatory Surgical Center [ASC] Payment System), the local coverage determination (LCD) for infliximab (Remicade™) was revised to remove Healthcare Common Procedure Coding System (HCPCS) code Q5102 and add HCPCS codes Q5103 and Q5104 in the "CPT®//HCPCS codes" section of the LCD. In addition, the "CPT®/HCPCS codes" section of the LCD was revised to remove language related to modifiers "ZB" and "ZC" with HCPCS code Q5102 as these modifiers have been discontinued.

Effective date

The LCD revision is effective for services rendered **on or after April 1, 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*.

Prostatic urethral lift (PUL) – revision to the Part A and Part B LCD

LCD ID number: L36775 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on reconsideration requests of the prostatic urethral lift (PUL) local coverage determination (LCD), the "Sources of Information and Basis for Decision" section of the LCD was updated to add multiple published sources. The content of the LCD has not been changed in response to the reconsideration requests.

Effective date

This revision to the LCD is effective for services rendered **on or after May 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*.

Therapy services billed by physicians/nonphysician practitioners – revision to the Part B LCD

LCD ID number: L33961 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on an annual review of the therapy services billed by physicians/nonphysician practitioners local coverage determination (LCD), it was determined that the italicized language in the "Limitations" and "Documentation Requirements" sections of the LCD do not represent direct quotation from the Centers for Medicare & Medicaid Services (CMS) sources. Therefore, this LCD is being revised to assure consistency with the CMS sources.

Effective date

This LCD revision is effective for services rendered **on or after April 17, 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*.

Therapy and rehabilitation services – revision to the Part A and Part B LCD

LCD ID number: L33413 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on an annual review of the therapy and rehabilitation services local coverage determination (LCD), it was determined that the italicized language in the "Coverage Indications, Limitations, and/or Medical Necessity" and "Documentation Requirements" sections of the LCD do not represent direct quotation from the Centers for Medicare & Medicaid Services (CMS) sources. Therefore, this LCD is being revised to assure consistency with the CMS sources.

Effective date

The LCD revision is effective for services rendered **on or after April 24, 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*.

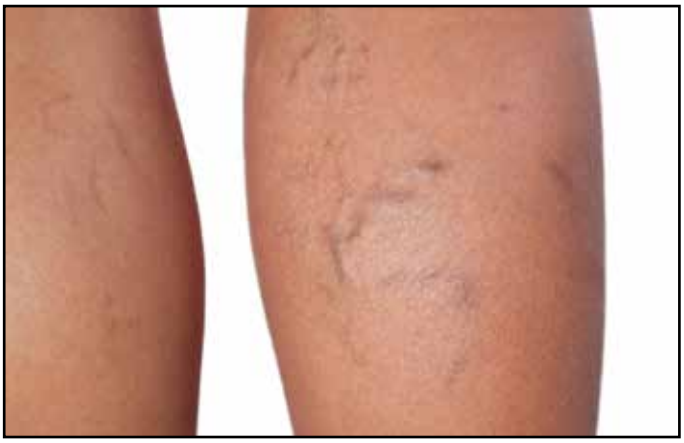
Treatment of varicose veins of the lower extremity – revision to the Part A and Part B LCD

LCD ID number: L33762 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on an annual review of the treatment of varicose veins of the lower extremity local coverage determination (LCD), the "Coverage Indications, Limitations, and/ or Medical Necessity" section of the LCD was revised under "Sclerotherapy" to provide clarification. Also, the "CPT®/HCPCS Codes" section of the LCD under "Group 1 Paragraph" was revised to provide clarification for *Current Procedural Terminology* (CPT®) codes 36470, 36471, 36482, and 36483. In addition, the "Sources of Information" section of the LCD was updated to include multiple published sources from reconsideration requests for CPT® codes 36473 and 36474 (endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical). The content of the LCD has not been changed in response to the reconsideration requests.

Effective date

This revision to the LCD is effective for services rendered **on or after April 17, 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*.

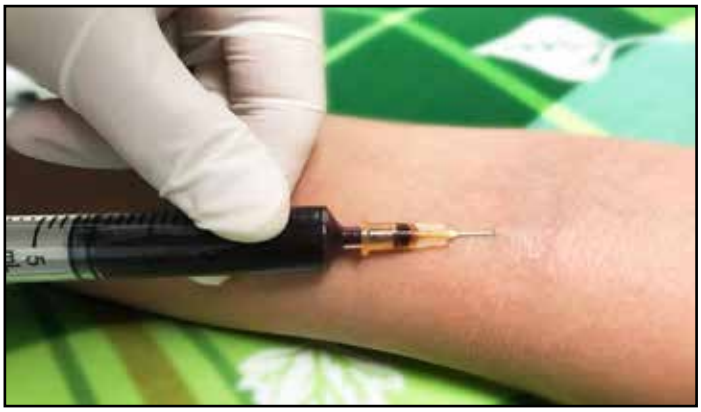
Vitamin D; 25 hydroxy, includes fraction(s), if performed – revision to the Part A and Part B LCD

LCD ID number: L33771 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on an annual review of the local coverage determination (LCD) for vitamin D; 25 hydroxy, includes fraction(s), if performed, it was determined that some of the italicized language in the "Coverage Indications, Limitations, and/or Medical Necessity" section of the LCD does not represent direct quotation from a Centers for Medicare & Medicaid Services (CMS) source listed in the LCD; therefore, this LCD is being revised to assure consistency with the CMS source.

Effective date

The LCD revision is effective for services rendered **on or after May 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, *click here*.

Upcoming provider outreach and educational events

Topic: Medicare Part B changes and regulations

Date: Wednesday, June 13
Time: 11:30 a.m.-1:00 p.m.
Type of Event: Webcast

https://medicare.fcso.com/Events/0402681.asp

Topic: Medicare Speaks 2018 Orlando

Date: Tuesday-Wednesday, June 19-20
Time: 8:00 a.m.-4:30 p.m.
Type of Event: Face-to-face

https://medicare.fcso.com/medicare_speaks/0404327.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 April 26, 2018

MLN Connects® for April 26, 2018
View this edition as a PDF

News & Announcements

- CMS Changes Name of the EHR Incentive Programs and Advancing Care Information to "Promoting Interoperability"
- Protect Medicare and Medicaid: Report Fraud, Waste, and Abuse
- Hospital Inpatient Quality Reporting Program: Submission Deadline May 15
- IRF, LTCH, and SNF Quality Reporting Programs: Submission Deadline May 15
- Open Payments Review and Dispute Data by May 15
- MACRA Funding Opportunity: Deadline Extended to May 30
- STD Awareness Month: Talk, Test, Treat

Provider Compliance

- Proper Use of the KX Modifier for Part B Immunosuppressive Drug Claims – Reminder

Upcoming Events

- Medicare Cost Report e-Filing System Webcast – May 1
- CMS Quality Measures: How They Are Used and

How You Can Be Involved Webinar – May 2

- Quality Payment Program: Answering Your Frequently Asked Questions Call – May 16
- Settlement Conference Facilitation Expansion Call – May 22

Medicare Learning Network Publications & Multimedia

- Quarterly HCPCS Drug/Biological Code Changes: July 2018 Update MLN Matters® Article — New

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MLN Connects® for May 3, 2018

MLN Connects® for May 3, 2018
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News & Announcements

- New Medicare Cards: You Can Use MBIs Right Away
- New Strategy to Fuel Data-driven Patient Care, Transparency
- CMS Encourages Eligible Suppliers to Participate in Expanded Medicare Diabetes Prevention Program Model
- Patients Over Paperwork April Newsletter
- Hospital Quality Reporting Center Spring 2018 Newsletter
- Administrative Simplification: Transactions
- Can't Find An Answer To Your Question?
- Hand Hygiene Day is May 5

Provider Compliance

- Provider Compliance Tips for Ordering Lower Limb Orthoses

Upcoming Events

- Quality Payment Program: Participation Criteria for Year 2 Webinar — May 9
- eCQI Resource Center Demonstration and Annual Update Webinar — May 10
- Quality Payment Program: Answering Your Frequently Asked Questions Call — May 16
- Settlement Conference Facilitation Expansion Call — May 22

See **Connects®**, page 28

MLN Connects® for May 10, 2018

MLN Connects® for May 10, 2018
View this edition as a PDF

News & Announcements

- First CMS Rural Health Strategy
- Direct Provider Contracting RFI — Submit Comments by May 25
- Provider Documentation Manual: Home Use of Oxygen — Submit Comments on Draft by May 31
- Hospital Compare Preview Reports Available through June 2
- eCQM Annual Update
- Hospital Quality Reporting: 2019 QRDA I Implementation Guide, Schematron, and Sample Files
- 2018 Measure Development Plan Annual Report
- National Women's Health Week Kicks off on Mother's Day

Provider Compliance

- Reporting Changes in Ownership — Reminder

Upcoming Events

- Quality Payment Program: Answering Your Frequently Asked Questions Call — May 16
- Managing Older Adults with Substance Use Disorders Webinar — May 16
- FY 2019 IPPS Proposed Rule: eCQM Reporting Webinar — May 16

- Settlement Conference Facilitation Expansion Call — May 22
- Qualified Medicare Beneficiary Program Billing Requirements Call — June 6

Medicare Learning Network Publications & Multimedia

- Inexpensive or Routinely Purchased DME Payment Classification for SGD and Accessories MLN Matters® Article — New
- Medicare Cost Report E-Filing MLN Matters® Article — New
- MCReF System Webcast: Audio Recording and Transcript — New

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CONNECTS

from page 27

- Comparative Billing Report on Critical Care Services Webinar — June 6

Medicare Learning Network Publications & Multimedia

- New Physician Specialty Code for Medical Genetics and Genomics MLN Matters® Article — New
- Processing Instructions to Update the Identification Code Qualifier Being Used in the NM108 Data Element MLN Matters® Article — New
- Revisions to the Telehealth Billing Requirements for Distant Site Services MLN Matters® Article — New
- Enhancements to Processing of Hospice Routine Home Care Payments MLN Matters® Article — New
- Comprehensive ESRD Care Model Telehealth - Implementation MLN Matters® Article — New
- Removal of KH Modifier from Capped Rental Items MLN Matters® Article — New
- Acute Care Hospital IPPS Booklet — Revised

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MLN Connects® for May 17, 2018

MLN Connects® for May 17, 2018

View this edition as a PDF

News & Announcements

- New Medicare Card: MBI Look-up Tool Clarification and RRB Mailing
- Enhanced "Drug Dashboards" to Increase Transparency on Drug Prices
- CMS Safeguards Patient Access to Certain Medical Equipment and Services in Rural and Other Non-contiguous Communities
- Quality Payment Program: Check 2018 MIPS Clinician Eligibility at the Group Level
- Medicare Diabetes Prevention Program Resources
- Hospital Outpatient Quality Reporting Spring 2018 Newsletter
- Talk to Your Patients about Mental Health

Provider Compliance

- Cochlear Devices Replaced Without Cost: Bill Correctly — Reminder

Upcoming Events

- Settlement Conference Facilitation Expansion Call — May 22
- Qualified Medicare Beneficiary Program Billing Requirements Call — June 6

Medicare Learning Network Publications & Multimedia

- ICD-10 and Other Coding Revisions to National Coverage Determinations MLN Matters Article — New
- Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment MLN Matters Article — New
- Updates to Publication 100-04 to Replace RARC MA61 with N382 MLN Matters Article — New
- IPPS and LTCH PPS Extensions per the ACCESS Act MLN Matters Article — New
- Supervised Exercise Therapy for Symptomatic PAD MLN Matters Article — Revised
- Quarterly HCPCS Drug/Biological Code Changes – July 2018 Update MLN Matters Article — Revised
- Medicare Preventive Services National Educational Products — Revised
- Power Mobility Devices Booklet — Reminder
- Advance Beneficiary Notice of Noncoverage Interactive Tutorial Educational Tool — Reminder
- Medicare Advance Written Notices of Noncoverage Booklet — Reminder
- Long-Term Care Hospital Prospective Payment System Booklet — Reminder
- Medicare Disproportionate Share Hospital Fact Sheet — Reminder
- Hospital-Acquired Conditions and Present on Admission Indicator Reporting Provision Fact Sheet — Reminder

Quarterly provider update

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

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

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

Phone numbers

Customer service

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

Education event registration hotline

904-791-8103 (NOT toll-free)

Electronic data interchange (EDI)

888-670-0940

Electronic funds transfers (EFT) (CMS-588)

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

Fax number (for general inquiries)

904-361-0696

Interactive voice response (IVR) system

877-847-4992

Provider enrollment

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

The SPOT help desk

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

Addresses

Claims

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

Redeterminations

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

Redetermination of overpayments

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

Reconsiderations

C2C Innovative Solutions, Inc.
Part B QIC South Operations
ATTN: Administration Manager
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 3409
Mechanicsburg, PA 17055-1849

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

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

Phone numbers

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

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

Electronic data interchange (EDI)
888-670-0940

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

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

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

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

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

Addresses

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

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

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

Reconsiderations
C2C Innovative Solutions, Inc.
Part B QIC South Operations
ATTN: Administration Manager
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-FLINQB@fcso.com>>*
Online form: *https://medicare.fcso.com/Feedback/161670.asp*

Provider enrollment
Provider Enrollment
P.O. Box 3409
Mechanicsburg, PA 17055-1849

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

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

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

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

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

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

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

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

Websites

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

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
Centers for Medicare & Medicaid Services

https://www.medicare.gov

Phone numbers

Customer service

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

Education event registration hotline

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

Electronic data interchange (EDI)

888-875-9779

Electronic funds transfers (EFT) (CMS-588)

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

General inquiries

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

Interactive voice response (IVR) system

877-847-4992

Provider enrollment

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

The SPOT help desk

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

Addresses

Claims

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

Redeterminations

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

Redetermination of overpayments

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

Reconsiderations

C2C Innovative Solutions, Inc.
Part B QIC South Operations
ATTN: Administration Manager
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 3409
Mechanicsburg, PA 17055-1849

Medical policy

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

Medicare secondary payer

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

Electronic data interchange (EDI)

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

Overpayments

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

Medicare Education and Outreach

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

Fraud and abuse

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

Freedom of Information Act requests

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

Special courier service

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

Websites

Provider

First Coast Service Options Inc. (First Coast), your CMS-contracted Medicare administrative contractor
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https://www.cms.gov

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

Beneficiaries

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

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2018 fee schedule – The Medicare Part B Physician and Nonphysician Practitioner Fee Schedules, effective for services rendered January 1 through December 31, 2018, are available free of charge online at *https://medicare.fcso.com/Data_files/* (English) or *https://medicareespanol.fcso.com/Fichero_de_datos/* (Español). Additional copies are available for purchase. The fee schedules contain payment rates for all localities. These items do not include the payment rates for injectable drugs, clinical lab services, mammography screening, or DMEPOS items. **Note:** Requests for hard copy paper disclosures will be completed as soon as CMS provides the direction to do so. Revisions to fees may occur; these revisions will be published in future editions of the Medicare Part B publication.	40300270	$12		
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