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

In this issue

Update of Publication 100-04, Chapter 18 - preventive and screening services, and Chapter 35 – IDTF

Provider type affected

This *MLN Matters*® article is intended for independent diagnostic testing laboratories (IDTFs) billing Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

What you need to know

Change request (CR) 10735 updates *Medicare Claims Processing Manual*, Chapter 18 - *Preventive and Screening Services* and Chapter 35 - *Independent Diagnostic Testing Facility (IDTF)* to include requirements and payment policies for screening mammography services furnished by IDTFs. CR 10735 does not convey any policy changes. Instead, it just documents current policy in the *Medicare Claims Processing Manual*.

Background

If an IDTF furnishes any type of mammography service (screening or diagnostic), it must have a Food and Drug Administration (FDA) certification to perform such services. However, an entity that only performs diagnostic mammography services should not be enrolled as an IDTF.

Screening mammographies (including those that are self-referred) are payable by Medicare when performed in and by an IDTF entity.

Additional information

The official instruction, CR 10735, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4071CP.pdf*.

If you have questions, your MACs may have more information. Find their website at *https://go.cms.gov/MAC-website-list*.

Document history

Date of change	Description
June 8, 2018	Initial article released.

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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.

Publication staff:

Marielba Cancel
Terri Drury
Maria Murdoch
Mark Willett
Robert Petty

Fax comments about this publication to:

Medicare Publications
904-361-0723

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.

Ambulatory Surgical Center

July update of the ASC payment system

Provider type affected

This *MLN Matters*® article is intended for ambulatory surgical centers (ASCs) billing Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 10788 informs MACs about updates to the ASC payment system for July 2018. Be sure your billing staffs are aware of these changes.

Background

Change request (CR) 10788 describes changes to and billing instructions for various payment policies implemented in the July 2018 ASC payment system update. As appropriate, this notification also includes updates to the Healthcare Common Procedure Coding System (HCPCS). Included in CR 10788 are 2018 payment rates for separately payable drugs and biologicals, including descriptors for newly created Level II HCPCS codes for drugs and biologicals (ASC DRUG) files. The CR also includes a July 2018 ASC payment rates for covered surgical and ancillary services (ASCFS) update file. CR 10788 is not issuing a "no ASC code pair" file. The key changes are as follows:

1. Bilateral indicator for HCPCS code C9749

In the April 2018 outpatient prospective payment system (OPPS) update (Transmittal 4005, CR 10515, dated March 20, 2018), the Centers for Medicare & Medicaid Services (CMS) announced the establishment of HCPCS code C9749 (Repair of nasal vestibular lateral wall stenosis with implant(s)), effective April 1, 2018. CMS is clarifying that this code describes an inherently bilateral procedure, and that for unilateral procedures; ASCs need to report either modifier 73 or 74. Modifiers 73 and 74 are only used to indicate discontinued procedures for which anesthesia is planned or provided.

2. Drugs, biologicals, and radiopharmaceuticals

a. Drugs and biologicals with payments based on average sales price (ASP) effective April 1, 2018

For 2018, payment for non-pass-through drugs, biologicals, and therapeutic radiopharmaceuticals continues to be made at a single rate of ASP + six percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological, or therapeutic radiopharmaceutical. In addition, in 2018, a single payment of ASP + six percent continues to be made for pass-through drugs, biologicals, and therapeutic radiopharmaceuticals to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items.

Payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later-quarter ASP submissions become available. Updated payment rates effective July 1, 2018, and drug price restatements are available in the July 2018 update of ASC Addendum BB, which is at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html*.

b. July 2018 HCPCS codes and dosage descriptors for certain drugs, biologicals, and radiopharmaceuticals effective July 1, 2018

Six new HCPCS codes have been created for reporting drugs and biologicals in the ASC payment system effective July 1, 2018, where there have not previously been specific codes available. These new codes are listed in Table 1.

Table 1 — July 2018 HCPCS codes and dosage descriptors for certain drugs, biologicals, and radiopharmaceuticals effective July 1, 2018

HCPCS code	Long descriptor	Short descriptor	ASC PI
C9030	Injection, copanlisib, 1 mg	Inj copanlisib	K2
C9031	Lutetium Lu 177, dotatate, therapeutic, 1 mCi	Lutetium Lu 177 dotatate, tx	K2
C9032	Injection, voretigene neparvovec-rzyl, 1 billion vector genome	Voretigene neparvovec-rzyl	K2
Q9991	Injection, buprenorphine extended-release (Sublocade), less than or equal to 100 mg	Buprenorph xr 100 mg or less	K2
Q9992	Injection, buprenorphine extended-release (Sublocade), greater than 100 mg	Buprenorphine xr over 100 mg	K2
Q9995	Injection, emicizumab-kxwh, 0.5 mg	inj. emicizumab-kxwh, 0.5 mg	K2

c. Drugs and biologicals based on ASP methodology with restated payment rates

Some drugs and biologicals based on ASP methodology may have payment rates that are corrected retroactively. These retroactive corrections typically occur on a quarterly basis. The list of drugs and biologicals with corrected payment rates will be accessible on the first date of the

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quarter at *https://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/index.html*.

Suppliers who think they may have received an incorrect payment for drugs and biologicals impacted by these corrections may request MAC adjustment of the previously processed claims.

d. Other changes to 2018 HCPCS codes for certain drugs, biologicals, and radiopharmaceuticals effective July 1, 2018

Effective July 1, 2018, HCPCS code Q9993 (Injection, triamcinolone acetonide, preservative-free, extended-release, microsphere formulation, 1 mg) will replace HCPCS code C9469 (Injection, triamcinolone acetonide, preservative-free, extended-release, microsphere formulation, 1 mg). The ASC payment indicator (PI) will remain K2, "Drugs and biologicals paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate." These codes are listed in Table 2 (page XX).

3. Category III CPT® code effective July 1, 2018

The AMA releases Category III CPT® codes twice per year:

- In January, for implementation beginning the following July
- In July, for implementation beginning the following January

For the July 2018 update, CMS is implementing one Category III CPT® code that the AMA released in January 2018 for implementation January 1, 2018. The ASC payment indicator for this code is shown in Table 3. The payment rate for this service is in Addendum BB of the July 2018 ASC addenda at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html*.

Table 3 — Category III CPT® codes effective July 1, 2018

CPT® code	Long descriptor	Short descriptor	ASC PI
0508T	Pulse-echo ultrasound bone density measurement resulting in indicator of axial bone mineral density, tibia	Pls echo us b1 dns meas tib	Z2

4. Reassignment of skin substitute product from the low-cost group to the high-cost group

The payment for skin substitute products that do not qualify for hospital OPPS pass-through status is packaged into the OPPS payment for the associated skin substitute application procedure. This policy is also implemented in the ASC payment system. The skin substitute products are divided into two groups: 1) High-cost skin substitute products and 2) Low-cost skin substitute products for packaging purposes.

The skin substitute product listed in Table 4 has been reassigned from the low-cost skin substitute group to the high-cost skin substitute group based on updated pricing information.

Note: This skin substitute product is packaged and should not be separately billed by ASCs

Table 4 — Reassignment of skin substitute product from the low-cost group to the high-cost group effective July 1, 2018

2018 HCPCS code	2018 short descriptor	2018 ASC PI	Low/high cost skin substitute
Q4178	Floweramniopatch, per sq cm	N1	High

ASCs should not separately bill for packaged skin substitutes (ASC PI=N1). High-cost skin substitute products should only be used in combination with the performance of one of the skin application procedures described by CPT® codes 15271-15278. Low-cost skin substitute products should only be used in combination with the performance of one of the skin application procedures described by HCPCS codes C5271-C5278. All OPPS pass-through skin substitute products (ASC PI=K2) should be billed in combination with one of the skin application procedures described by CPT® codes 15271-15278.

5. Coverage determinations

The fact that a drug, device, procedure or service is assigned a HCPCS code and a payment rate under the ASC payment system does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the program. Medicare administrative contractors (MACs) determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, MACs determine that it is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment.

Additional information

The official instruction, CR 10788, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4067CP.pdf*.

If you have questions, your MACs may have more information. Find their website at *https://go.cms.gov/MAC-website-list*.

Document history

Date of change	Description
June 1, 2018	Initial article released.

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Related CR Transmittal Number: R4067CP
Related Change Request (CR) Number: 10788

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Chiropractic Services

Medicare coverage for chiropractic services – medical record documentation requirements for initial and subsequent visits

***Note**. This article was revised June 18, 2018, to delete the word "always" from the line for item 5 (Treatment plan) under "Documentation requirements for the initial visit." All other information remains the same. This information was previously published in the March 2016 Medicare B Connection, pages 7-10.*

Provider type affected

This *MLN Matters*® special edition article is intended for chiropractors and other practitioners who submit claims to Medicare administrative contractors (MACs) for chiropractic services provided to Medicare beneficiaries.

This article is part of a series of special edition (SE) articles prepared for chiropractors by the Centers for Medicare & Medicaid Services (CMS) in response to the request for educational materials at the September 24, 2015, special open door forum titled: "Improving Documentation of Chiropractic Services". Other articles in the series are SE1602, which details the use of the AT modifier on chiropractic claims and SE1603, which identifies other useful resources to help chiropractors bill Medicare correctly for covered services.

Provider action needed

CMS is providing this special edition article to help clarify the CMS policy regarding Medicare coverage of chiropractic services for Medicare beneficiaries and documentation requirements for the beneficiary's initial visit and subsequent visits to the chiropractor.

Be aware of these policies along with any local coverage determinations (LCDs) for these services in your area that might limit circumstances under which Medicare pays for active/corrective chiropractic services.

Background

In 2014, the comprehensive error testing program (CERT) that measures improper payments in the Medicare fee-for-service (FFS) program reported a 54 percent error rate on claims for chiropractic services. The majority of those errors were due to insufficient documentation or other documentation errors.

Medicare coverage of chiropractic services is specifically limited to treatment by means of manual manipulation (that is, by use of the hands) of the spine to correct a subluxation. The patient must require treatment by means of manual manipulation of the spine to correct a subluxation, and the manipulative services rendered must have a direct therapeutic relationship to the patient's condition and provide reasonable expectation of recovery or improvement of function. Additionally, manual devices (that is, those that are hand-held with the thrust of the force of the device being controlled manually) may be used by chiropractors in performing manual manipulation of the spine. However, no additional payment is available for use of the device, nor does Medicare recognize an extra charge for the device itself.

Chiropractors are limited to billing three *Current Procedural Terminology* (CPT®) codes under Medicare: 98940 (chiropractic manipulative treatment; spinal, one to two regions), 98941 (three to four regions), and 98942 (five regions).When submitting manipulation claims, chiropractors must use an acute treatment (AT) modifier to identify services that are active/corrective treatment of an acute or chronic subluxation. The AT modifier, when applied appropriately, should indicate expectation of functional improvement, regardless of the chronic nature or redundancy of the problem.

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Effective Date: July 1, 2018
Implementation July 2, 2018

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

Table 2 – Other changes to 2018 HCPCS codes for certain drugs, biologicals, and radiopharmaceuticals effective July 1, 2018

HCPCS code	Long descriptor	Short descriptor	ASC PI	Effective date	Term date
C9469	Injection, triamcinolone acetonide, preservative-free, extended-release, microsphere formulation, 1 mg	Inj triamcinolone acetonide	K2	4/1/18	6/30/18
Q9993	Injection, triamcinolone acetonide, preservative-free, extended-release, microsphere formulation, 1 mg	Inj., triamcinolone ext rel	K2	7/1/18	

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Documentation requirements

The Social Security Act states that "no payment shall be made to any provider of services or other person under this part unless there has been furnished such information as may be necessary in order to determine the amounts due such provider or other person under this part for the period with respect to which the amounts are being paid or for any prior period." See the Social Security Act (*Section 1833(e)*).

In addition, the *Medicare Benefit Policy Manual* requires that the initial visit and all subsequent visits meet specific documentation requirements. See Chapter 15 (*Section 240.1.2*).

Documentation requirements for the initial visit

The following documentation requirements apply for initial visits whether the subluxation is demonstrated by X-ray or by physical examination:

1. **History:** The history recorded in the patient record should include the following:
   - Chief complaint including the symptoms causing patient to seek treatment;
   - Family history if relevant; and
   - Past medical history (general health, prior illness, injuries, or hospitalizations; medications; surgical history).
2. **Present illness:** Description of the present illness including:
   - Mechanism of trauma;
   - Quality and character of symptoms/problem;
   - Onset, duration, intensity, frequency, location, and radiation of symptoms;
   - Aggravating or relieving factors;
   - Prior interventions, treatments, medications, secondary complaints; and
   - Symptoms causing patient to seek treatment.

Note: Symptoms must be related to the level of the subluxation that is cited. A statement on a claim that there is "pain" is insufficient. The location of the pain must be described and whether the particular vertebra listed is capable of producing pain in that area.

3. **Physical exam:** Evaluation of musculoskeletal/nervous system through physical examination. To demonstrate a subluxation based on physical examination, two of the following four criteria (one of which must be asymmetry/misalignment or range of motion abnormality) are required and should be documented:
   - **P - Pain/tenderness:** The perception of pain and tenderness is evaluated in terms of location, quality, and intensity. Most primary neuro-musculoskeletal disorders manifest primarily by a painful response. Pain and tenderness findings may be identified through one or more of the following: observation, percussion, palpation, provocation, etc. Furthermore, pain intensity may be assessed using one or more of the following; visual analog scales, algometers, pain questionnaires, and so forth.
   - **A - Asymmetry/misalignment:** Asymmetry/misalignment may be identified on a sectional or segmental level through one or more of the following: observation (such as, posture and heat analysis), static palpation for misalignment of vertebral segments, diagnostic imaging.
   - **R - Range of motion abnormality:** Changes in active, passive, and accessory joint movements may result in an increase or a decrease of sectional or segmental mobility. Range of motion abnormalities may be identified through one or more of the following: motion palpation, observation, stress diagnostic imaging, range of motion, measurement(s).
   - **T -Tissue tone, texture, and temperature abnormality:** Changes in the characteristics of contiguous and associated soft tissue including skin, fascia, muscle, and ligament may be identified through one or more of the following procedures: observation, palpation, use of instrumentation, test of length and strength.

Note: The P.A.R.T. (Pain/tenderness; Asymmetry/misalignment; Range of motion abnormality; and Tissue tone, texture, and temperature abnormality) evaluation process is recommended as the examination alternative to the previously mandated demonstration of subluxation by X-ray/MRI/CT for services beginning January 1, 2000. The acronym P.A.R.T. identifies diagnostic criteria for spinal dysfunction (subluxation).

4. **Diagnosis**: The primary diagnosis must be subluxation, including the level of subluxation, either so stated or identified by a term descriptive of subluxation. Such terms may refer either to the condition of the spinal joint involved or to the direction of position assumed by the particular bone named. The precise level of the subluxation must be specified by the chiropractor to substantiate a claim for manipulation of the spine. This designation is made in relation to the part of the spine in which the subluxation is identified as shown table on page 10:

In addition to the vertebrae and pelvic bones listed, the Ilii (R and L) are included with the sacrum as an area where a condition may occur which would be appropriate for chiropractic manipulative treatment.

There are two ways in which the level of the subluxation may be specified in patient's record.

- The exact bones may be listed, for example: C 5, 6;
- The area may suffice if it implies only certain bones such as: occipito atlantal (occiput and CI

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(atlas)), lumbo-sacral (L5 and sacrum) sacro-iliac (sacrum and ilium).

Following are some common examples of acceptable descriptive terms for the nature of the abnormalities:

- Off-centered;
- Misalignment;
- Malpositioning;
- Spacing - abnormal, altered, decreased, increased;
- Incomplete dislocation;
- Rotation;
- Listhesis - antero, postero, retro, lateral, spondylo; and
- Motion - limited, lost, restricted, flexion, extension, hypermobility, hypomobility, aberrant.

Other terms may be used. If they are understood clearly to refer to bone or joint space or position (or motion) changes of vertebral elements, they are acceptable.

X-rays

As of January 1, 2000, an X-ray is not required by Medicare to demonstrate the subluxation. However, an X-ray may be used for this purpose if you so choose.

The x-ray must have been taken reasonably close to (within 12 months prior or three months following) the beginning of treatment. In certain cases of chronic subluxation (for example, scoliosis), an older X-ray may be accepted if the beneficiary's health record indicates the condition has existed longer than 12 months and there is a reasonable basis for concluding that the condition is permanent.

A previous CT scan and/or MRI are acceptable evidence if a subluxation of the spine is demonstrated.

5. **Treatment plan**: The treatment plan should include the following:
   - Recommended level of care (duration and frequency of visits);
   - Specific treatment goals; and
   - Objective measures to evaluate treatment effectiveness.

Date of the initial treatment

The patient's medical record

- Validate all of the information on the face of the claim, including the patient's reported diagnosis(s), physician work (CPT® code), and modifiers.
- Verify that all Medicare benefit and medical necessity requirements were met.

Documentation requirements for subsequent visits

The following documentation requirements apply whether the subluxation is demonstrated by X-ray or by physical examination:

1. **History**
   a. Review of chief complaint;
   b. Changes since last visit; and
   c. Systems review if relevant.
2. **Physical examination**
   a. Examination of area of spine involved in diagnosis;
   b. Assessment of change in patient condition since last visit;
   c. Evaluation of treatment effectiveness.
3. **Documentation of treatment given on day of visit.**

Necessity for treatment of acute and chronic subluxation

The patient must have a significant health problem in the form of a neuromusculoskeletal condition necessitating treatment, and the manipulative services rendered must have a direct therapeutic relationship to the patient's condition and provide reasonable expectation of recovery or improvement of function.

The patient must have a subluxation of the spine as demonstrated by x-ray or physical examination, as described below.

Most spinal joint problems fall into the following categories:

- **Acute subluxation**: A patient's condition is considered acute when the patient is being treated for a new injury, identified by x-ray or physical examination as specified above. The result of chiropractic manipulation is expected to be an improvement in, or arrest of progression, of the patient's condition.
- **Chronic subluxation**: A patient's condition is considered chronic when it is not expected to significantly improve or be resolved with further treatment (as is the case with an acute condition); however, the continued therapy can be expected to result in some functional improvement. Once the clinical status has remained stable for a given condition, without expectation of additional objective clinical improvements, further manipulative treatment is considered maintenance therapy and is not covered.

You must place the HCPCS (Healthcare Common Procedure Coding System) modifier AT on a claim when providing active/corrective treatment to treat acute or chronic subluxation. However, the presence of the HCPCS modifier AT may not in all instances indicate that the service is reasonable and necessary.

ICD-10 codes that support medical necessity for chiropractor services

The chiropractic local coverage determinations (LCDs) for MACs include ICD-10 coding information for ICD-10 codes that support the medical necessity for chiropractor services. There may be additional documentation information in your LCD. There are links to the chiropractic LCDs in the *Additional information* section of this article.

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The **Group 1 (primary) codes** are the only covered ICD-10-CM codes that support medical necessity for chiropractor services.

- Primary: ICD-10-CM codes (names of vertebrae)
- The precise level of subluxation must be listed as the primary diagnosis.

The groups 2, 3, and 4 ICD-10-CM codes support the medical necessity for diagnoses and involve short, moderate, and long term treatment:

- **Group 2 codes**: Category I - ICD-10-CM diagnosis (diagnoses that generally require **short term treatment**)
- **Group 3 codes**: Category II - ICD-10-CM diagnosis (diagnoses that generally require **moderate term treatment**)
- **Group 4 codes**: Category III - ICD-10-CM diagnosis (diagnoses that may require **long term treatment**)

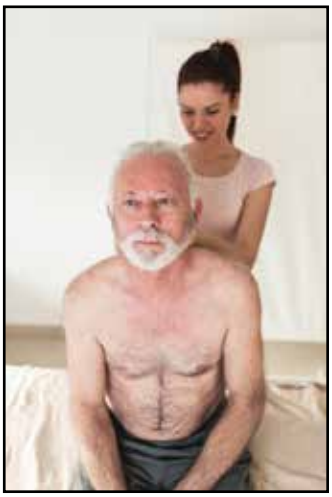
ICD-10 Codes that DO NOT Support Medical Necessity are **all** ICD-10-CM codes **not** listed in LCDs under *ICD-10-CM Codes That Support Medical Necessity*.

Additional information

If you have questions, your MACs may have more information. Find their website at *https://go.cms.gov/MAC-website-list*.

To review MM3449, Revised Requirements for Chiropractic Billing of Active/Corrective Treatment and Maintenance Therapy, Full Replacement of CR 3063 go to: *MM3449*.

Other articles in this series on chiropractic services are *SE1602*, which discusses the use of the AT modifier and *SE1603*, which lists a wide array of other materials to assist chiropractors in delivering covered services to Medicare beneficiaries and correctly billing for those services.



Document history

- June 18, 2018– The article was revised to delete the word “always” from the line for item 5 (Treatment plan) under *Documentation requirements for the initial visit*. All other information remains the same.
- March 16, 2016 – Initial article released.

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Effective Date: N/A
Implementation N/A

Area of spine	Names of vertebrae	Number of vertebrae	Short form or other name	Subluxation ICD-10 code
Neck	Occiput Cervical Atlas Axis	7	Occ, CO C1-C7 C1 C2	M99.00 M99.01
Back	Dorsal or Thoracic Costovertebral Costotransverse	12	D1-D12 T1-T12 R1-R12 R1-R12	M99.02
Low Back	Lumbar	5	L1-L5	M99.03
Pelvis	Ilii, R and L (I, Si)		I, Si	M99.05
Sacral	Sacrum, Coccyx		S, SC	M99.04

Drugs & Biologicals

July 2018 quarterly ASP Medicare Part B drug pricing files and revisions to prior quarterly pricing files

Provider type affected

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

Provider action needed

Change request (CR) 10667 instructs MACs to download and implement the July 2018 and, if released, the revised April, 2018, January 2018, October 2017, and July 2017 ASP drug pricing files for Medicare Part B drugs via the Centers for Medicare & Medicaid Services (CMS) data center (CDC). Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after July 2, 2018, with dates of service July 1, 2018, through September 30, 2018. Make sure that your billing staffs are aware of these changes.

Background

The average sales price (ASP) methodology is based on quarterly data submitted by manufacturers to CMS. CMS supplies MACs with the ASP and not otherwise classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the outpatient prospective payment system (OPPS) are incorporated into the outpatient code editor (OCE) through separate instructions that are available in Chapter 4, Section 50 of the *Medicare Claims Processing Manual* at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf*.

- File: July 2018 ASP and ASP NOC -- effective dates of service: July 1, 2018, through September 30, 2018
- File: April 2018 ASP and ASP NOC -- effective for dates of service of April 1, 2018, through June 30, 2018
- File: January 2018 ASP and ASP NOC -- effective for dates of service of January 1, 2018, through March 31, 2018
- File: October 2017 ASP and ASP NOC -- effective for dates of service of October 1, 2017, through December 31, 2017
- File: July 2017 ASP and ASP NOC -- effective for dates of service of July 1, 2017, through September 30, 2017

For any drug or biological not listed in the ASP or NOC drug pricing files, your MACs will determine the payment allowance limits in accordance with the policy described in the *Medicare Claims Processing Manual*, Chapter 17, Section 20.1.3 at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c17.pdf*.

For any drug or biological not listed in the ASP or NOC drug pricing files that is billed with the KD modifier, MACs will determine the payment allowance limits in accordance with instructions for pricing and payment changes for infusion drugs furnished through an item of durable medical equipment on or after January 1, 2017, associated with the passage of the 21st Century Cures Act which is available at *https://www.gpo.gov/fdsys/pkg/PLAW-114publ255/pdf/PLAW-114publ255.pdf*.

Additional information

The official instruction, CR 10667, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4061CP.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Medicare/Medicare-Contracting/FFSProvCustSvcGen/MAC-Website-List.html*.

Document history

Date of change	Description
May 25, 2018	Initial article released.

MLN Matters® Number: MM10667
Related CR Release Date: May 25, 2018
Related CR Transmittal Number: R4061CP
Related Change Request (CR) Number: 10667
Effective Date: July 1, 2018
Implementation July 2, 2018

Durable Medical Equipment

New Q code for in-line cartridge containing digestive enzyme(s)

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) 10626 instructs MACS to add Healthcare Common Procedure Coding System (HCPCS) code Q9994 to the Level II HCPCS code set effective July 1, 2018. Make sure your billing staffs are aware of these changes.

Background

The HCPCS is divided into two principal subsystems, referred to as Level I and Level II. Level I is comprised of the *Current Procedural Terminology* (CPT®), a numeric coding system maintained by the American Medical Association (AMA) to identify medical services and procedures furnished by physicians and other health care professionals. The Level II HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT® codes.

Policy change

Q9994 is added to the Level II HCPCS code set effective July 1, 2018:

- Long Description: In-line cartridge containing digestive enzyme(s) for enteral feeding, each
- Short Description: Enzyme cartridge enteral nut

The billing jurisdiction for this code will be DME MAC.

Additional information

The official instruction, CR 10626, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4063CP.pdf*.

If you have questions, your MACs may have more information. Find their website at *https://go.cms.gov/MAC-website-list*.

Document history

Date of change	Description
June 1, 2018	Initial article released.

MLN Matters® Number: MM10626
Related CR Release Date: June 1, 2018
Related CR Transmittal Number: R4063CP
Related Change Request (CR) Number: 10626
Effective Date: July 1, 2018
Implementation July 2, 2018

July quarterly update for 2018 DMEPOS fee schedule

Provider type affected

This *MLN Matters*® article is intended for providers and suppliers submitting claims to durable medical equipment Medicare administrative contractors (DME MACs) for DME, prosthetics, orthotics, and supplies (DMEPOS) items or services paid under the DMEPOS fee schedule.

Provider action needed

Change request (CR) 10707 provides the July 2018 Medicare DMEPOS fee schedule quarterly update listing fee schedule amounts for non-rural and rural areas. Additionally, the parenteral and enteral nutrition (PEN) fee schedule file includes state fee schedule amounts for enteral nutrition items and national fee schedule amounts for parental nutrition items. Also, the files for this update include the July 2018 DMEPOS rural ZIP code file containing the third quarter 2018 rural ZIP code changes.

Background

Sections 1834(a), (h), and (i) of the Social Security Act (the Act) require payment for DME, prosthetic devices, orthotics, prosthetics, and surgical dressings be completed on a fee schedule basis. Further, payment on a fee schedule basis is a regulatory requirement at 42 *Code of Federal Regulations* (CFR) §414.102, for parenteral and enteral nutrition, splints, casts and intraocular lenses (IOLs) inserted in a physician's office.

Additionally, Section 1834(a)(1)(F)(ii) of the Act mandates adjustments to the fee schedule amounts for certain items furnished on or after January 1, 2016, in areas that are not competitive bid areas, based on information from competitive bidding programs (CBPs) for DME. Section 1842(s) (3)(B) of the Act provides authority for adjusting the fee schedule amount for enteral nutrients, equipment and supplies (enteral nutrition) based on information from CBPs.

See **DMEPOS**, page 13

DMEPOS

from page 12

The methodologies for adjusting DMEPOS fee schedule amounts under this authority are established at 42 CFR §414.210(g). The DMEPOS and PEN fee schedule files contain Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the adjustments, as well as codes that are not subject to the fee schedule CBP adjustments.

Additional information on adjustments to the fee schedule amounts based on information from CBPs is available in Transmittal 3551, CR 9642, dated June 23, 2016 and Transmittal 3416, CR 9431, dated November 23, 2015. You can find the MLN Matters® articles associated with these CRs at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9642.pdf* and *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9431.pdf* respectively.

The ZIP code associated with the address used for pricing a DMEPOS claim determines the rural fee schedule payment applicability for codes with rural and non-rural adjusted fee schedule amounts. ZIP codes for non-continental metropolitan statistical areas (MSA) are not included in the DMEPOS rural ZIP code file. The DMEPOS rural ZIP code file is updated on a quarterly basis as necessary.

Key changes in this update are as follows:

Interim final rule with comment period (CMS-1687-IFC)

The interim final rule with comment period (CMS-1687-IFC) titled "Transitional 50/50 blended rates to provide relief in rural areas and non-contiguous areas" was published in the *Federal Register* Friday, May 11, 2018. The IFC amends the regulations to increase the fee schedule amounts for items furnished from June 1, 2018, through December 31, 2018, in rural areas and non-contiguous areas (Alaska, Hawaii, and United States territories) not subject to the CBP. This change requires new 2018 rural and non-contiguous fee schedules be calculated for HCPCS codes for certain DME and PEN adjusted using competitive bidding information effective June 1, 2018. The new rural and non-contiguous fee schedule amounts are based on a blend of 50 percent of the adjusted fee schedule amount and 50 percent of the unadjusted fee schedule amounts updated by the covered item updates specified in Sections 1834(a)(14) and 1842(s)(B) of the Act. For areas other than rural or non-continuous areas, the fee schedules for DME and PEN codes with adjusted fee schedule amounts will continue to be based on 100 percent of the adjusted fee schedule amounts from June 1, 2018, through December 31, 2018.

Because the revised rural and non-contiguous fee schedule amounts are based in part on unadjusted fee schedule amounts, the fees for certain items included in the 2008 original round one CBP, denoted with the HCPCS pricing modifier, are added back to the fee schedule file only for items furnished in rural and non-contiguous

areas. Background information and a list of the applicable KE HCPCS codes was issued in Transmittal 1630, CR 6270, dated November 7, 2008. (See the related *MLN Matters*® article MM6270 at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6270.pdf*.) Beginning June 1, 2018, through December 31, 2018, the rural and non-contiguous KE fee schedule amounts will be based on a blend of 50 percent of the adjusted fee schedule amount and 50 percent of the unadjusted KE fee schedule amount updated by the covered item updates specified in Sections 1834(a)(14) and 1842(s)(B) of the Act. The non-rural fees for these KE codes will be populated with zeros on the fee schedule file since KE is not a valid option for areas without blended fees.

For certain accessories used with base equipment included in the CBP in 2008 (for example, power wheelchairs, walkers, and negative pressure wound therapy pumps), the unadjusted fee schedule amounts include a 9.5 percent reduction in accordance with Federal law if these accessories were also included in the 2008 CBP. The 9.5 percent fee reduction only applies to these accessories when they are furnished for use with the base equipment included in the 2008 CBP. Beginning June 1, 2018, in cases where accessories included in the 2008 CBP are furnished for use with base equipment that was not included in the 2008 CBP (for example, manual wheelchairs, canes and aspirators), for beneficiaries residing in rural or non-contiguous, non-competitive bid areas, suppliers should append the KE modifier to the HCPCS code for the accessory. Suppliers should not use the KE modifier with accessories that were included in the 2008 CBP and furnished for use with base equipment that was not included in the 2008 CBP when these accessories are furnished to beneficiaries residing in non-rural, non-competitive bid areas.

Also, because the IFC results in a change to the 2018 fee schedule amounts for the various classes of oxygen and oxygen equipment, the annual oxygen budget neutrality adjustment for 2018 is recomputed and the adjustments to the stationary oxygen equipment, mandated by regulations at section 414.226(c)(6), will be applied to the fees on the June 1, 2018 file.

See **DMEPOS**, page 14

DMEPOS

from page 13

DMEPOS and PEN fee schedule files containing the revised rural and non-contiguous 50/50 blend fees were transmitted in May to the Part B and DME MACs for the June 1, 2018, implementation. However, the DMEPOS institutional claim (FI) fee schedule file was not updated with the revised rural and non-contiguous 50/50 blend in June. The July 2018 DMEPOS fee schedule FI file will incorporate the 50/50 blend rural and non-contiguous fees with a June 1, 2018, effective date. As part of the July 2018 DMEPOS fee schedule file update, HHHMACs shall adjust any impacted 50/50 blend claims processed for dates of service between June 1, 2018, and June 30, 2018, that are brought to their attention by the supplier.

MACs will not search for and adjust claims for HCPCS codes with revised 50/50 blend fees appearing on the July 2018 DMEPOS FI file with effective dates of June 1, 2018, for dates of service June 1, 2018, through June 30, 2018. However, they will adjust these claims when you bring them to their attention for dates of service June 1, 2018, through June 30, 2018.

Other changes

As part of this update, the fee schedules for HCPCS code Q0477 (power module patient cable for use with electric or electric/pneumatic ventricular assist device, replacement only) are revised and effective for dates of service on or after January 1, 2018. If you resubmit impacted claims, MACs will adjust previously processed claims for code Q0477 with dates of service on or after January 1, 2018.

The fee schedules public use files (PUFs) will be available for state Medicaid agencies, managed care organizations, and other interested parties shortly after the release of the data files at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html*.

Additional information

The official instruction, CR 10707, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4072CP.pdf*.

If you have questions, your MACs may have more information. Find their website at *https://go.cms.gov/MAC-website-list*.

Document history

Date of change	Description
June 11, 2018	Initial article released.

MLN Matters® Number: MM10707
Related CR Release Date: June 8, 2018
Related CR Transmittal Number: R4072CP
Related Change Request (CR) Number: 10707
Effective Date: January 1, 2018, for fees for code Q0477; June 1, 2018, for CMS-1687-IFC-related rural and blended fees; July 1, 2018, for all other changes
Implementation July 2, 2018

IDTF

from page 1

MLN Matters® Number: MM10735
Related CR Release Date: June 8, 2018
Related CR Transmittal Number: R4071CP
Related Change Request (CR) Number: 10735
Effective Date: July 9, 2018

Implementation July 9, 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.

Evaluation and Management

E/M service documentation provided by students – manual update

***Note**: This article was revised June 1, 2018, to reflect an updated change request (CR) that corrected typos in the CR and part of the manual update under Section 100.1.1. The transmittal number, CR released date and link to the transmittal also changed. All other information is unchanged. This information was previously published in the February 2018 Medicare A Connection, page 14.*

Provider type affected

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

Provider action needed

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

Background

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

Additional information

The official instruction, CR 10412, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4068CP.pdf*.

If you have questions, your MACs may have more information. Find their website at *https://go.cms.gov/MAC-website-list*.

Document history

Date of change	Description
June 1, 2018	This article was revised to reflect an updated CR that corrected typos in the CR and part of the manual update under Section 100.1.1. The transmittal number, CR released date and link to the transmittal also changed.
February 5, 2018	Initial article released.

MLN Matters® Number: MM10412 *Revised*
Related CR Release Date: May 31, 2018
Related CR Transmittal Number: R4068CP
Related Change Request (CR) Number: 10412
Effective Date: January 1, 2018
Implementation March 5, 2018

Medicare Physician Fee Schedule Database

July update to the 2018 Medicare physician fee schedule database

Provider type affected

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

Provider action needed

Change request (CR) 10644 amends payment files issued to MACs based upon 2018 Medicare physician fee schedule (MPFS) final rule. Make sure your billings staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) issued payment files to the MACs based upon the 2018 Medicare physician fee schedule (MPFS) final rule, published in the *Federal Register* November 15, 2017, to be effective for services furnished between January 1, 2018, and December 31, 2018.

CR 10644 presents a summary of the changes for the July update to the 2018 MPFSDB. Unless otherwise stated, these changes are effective for dates of service on and after January 1, 2018. The following tables show those changes.

CPT®/HCPCS & mod	Action
G0511	Change PC/TC indicator to "0"
G0512	Change PC/TC indicator to "0"
G0460*	Change status = A, work RVU = 2.25, non-facility PE RVU = 2.89, facility PE RVU = .94, malpractice RVU = .34, mult proc = 2, bilat surg = 0, asst surg = 1, co-surg = 0, team surge = 0, global days = 000
71045	Facility and non-facility PE RVU changed to 0.42
71045 TC	Facility and non-facility PE RVU changed to 0.35

* The work RVU of G0460 was valued at the work RVU of one billing of *Current Procedural Terminology* (CPT®) code 11042 (1.01) plus two billings of CPT® code 11045 (0.50), along with a single billing of CPT® codes 99195 (0.00) and 38213 (0.24) to cover the lab portion of the work. The direct PE inputs were crosswalked from CPT® code 11042 along with the inclusion of additional clinical labor, supplies, and equipment based on CMS determination of what would be typical and medically necessary for the procedure.

The following "Q" codes are effective for services performed on or after July 1, 2018, (see MM10624 for additional information).

Code	Action
Q9991	Procedure status = E; there are no RVUs, payment policy indicators do not apply
Q9992	Procedure status = E; there are no RVUs, payment policy indicators do not apply
Q9993	Procedure status = E; there are no RVUs, payment policy indicators do not apply
Q9995	Procedure status = E; there are no RVUs, payment policy indicators do not apply

The following new CPT® category III codes have been added for dates of service July 1, 2018, and after:

Code	Short descriptor	Long descriptor
0505T	Ev fempop artl revsc	Endovenous femoral-popliteal arterial revascularization, with transcatheter placement of intravascular stent graft(s) and closure by any method, including percutaneous or open vascular access, ultrasound guidance for vascular access when performed, all catheterization(s) and intraprocedural roadmapping and imaging guidance necessary to complete the intervention, all associated radiological supervision and interpretation, when performed, with crossing of the occlusive lesion in an extraluminal fashion
0506T	Mac pgmt opt dns meas hfp	Macular pigment optical density measurement by heterochromatic flicker photometry, unilateral or bilateral, with interpretation and report

See **MPFSDB**, page 17

MPFSDB

from page 16

Code	Short descriptor	Long descriptor
0507T	Near ifr 2img mibmn glnd i&r	Near-infrared dual imaging (ie, simultaneous reflective and trans- illuminated light) of meibomian glands, unilateral or bilateral, with interpretation and report
0508T	Pls echo us b1 dns meas tib	Pulse-echo ultrasound bone density measurement resulting in indicator of axial bone mineral density, tibia

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

Note: Policy indicators for new CPT® category III codes 0505T-0508T may be found at the bottom of this page.

Note: Pre, intra and post-operative percentages for CPT® codes 0505T-0508T are all "0.00."

Additional information

The official instruction, CR 10644, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4053CP.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Medicare/Medicare-Contracting/FFSProvCustSvcGen/MAC-Website-List.html*.

Document history

Date of change	Description
May 21, 2018	Initial article released.

MLN Matters® Number: MM10644
Related CR Release Date: May 18, 2018
Related CR Transmittal Number: R4053CP
Related Change Request (CR) Number: 10644
Effective Date: January 1, 2018
Implementation July 2, 2018

HCPCS/mod	0505T	0506T	0506T-26	0506T-TC	0507T	0507T-26	0507T-TC	0508T	0508T-26	0508T-TC
Status	C	C	C	C	C	C	C	C	C	
Muti	0	7	7	7	7	7	7	7	7	7
Bilat	0	0	0	0	0	0	0	0	0	0
Asst Surg	0	0	0	0	0	0	0	0	0	0
Co-surg	0	0	0	0	0	0	0	0	0	0
Team surg	0	0	0	0	0	0	0	0	0	0
PC/TC	0	1	1	1	1	1	1	1	1	1
Global	YYY	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
Diag supv	09	09	09	01	09	09	01	09	09	01
Diag imag	99	99	99	99	99	99	99	99	99	99

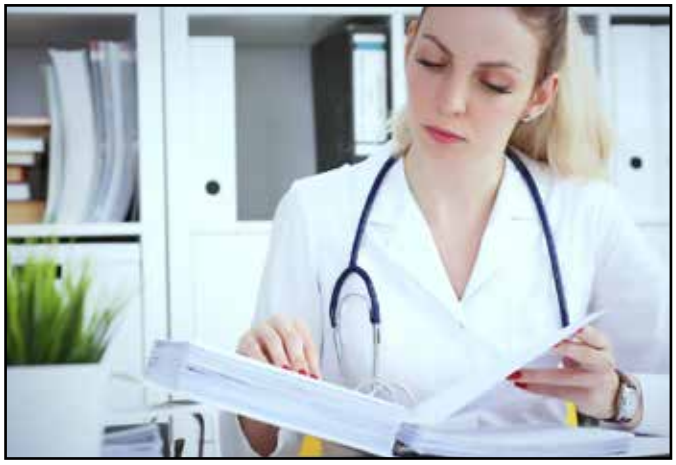
Avoid issues completing the PWK fax/mail coversheet

First Coast Service Options' (First Coast's) claims department encourages you to avoid submitting invalid or unnecessary PWK (5010 paperwork segment) fax/mail coversheets. If a coversheet is received containing inaccurate, incomplete, or invalid information, the coversheet will be either faxed or mailed back to the originating source, but without the documentation. Coversheets returned in this manner should not be resent; instead, the provider should await an additional documentation request (ADR) before submitting the documentation again to First Coast.

PWK issues

In some cases, the coversheets and additional documentation are not able to be appropriately attached to a claim due to several reasons. The following list has been developed to assist you in avoiding these situations.

1. PWK coversheet is received, completed accurately with documentation, but the claim was submitted without the indicators in the PWK loop.
   - This will not allow us to assign the documentation in the system to the appropriate claim. If the claim requires documentation, an ADR letter will be sent and providers will need to respond to the letter.
2. PWK coversheet is received with the related documentation attached and a copy of our additional documentation request (ADR) letter. Again, the PWK loop indicators are not on the claim.
   - There are two issues here: 1) without the PWK loop completed, the claim will not suspend to look for any anticipated documentation. Most importantly 2) the claim has already suspended for additional documentation; therefore, providers only need to respond to the ADR letter with appropriate documentation.
3. PWK coversheet is received with a request for an appeal/redetermination in the information box.
   - The PWK process may only be used on initial claim submission. PWK cannot be used to bypass the standard appeals process. Please use the appropriate level of the appeals process if your claim has been denied or you need to make adjustments/corrections. Appeal requests submitted via the PWK fax/mail process will not be acknowledged.
4. In all of these instances, since the PWK fax/mail coversheet and/or claim is not being submitted correctly or with the correct information, the supporting documentation submitted to us is not being utilized to adjudicate the claim. Also, since in most cases this is outside of the standards for PWK, providers affected by these scenarios will not receive a response concerning the outcome or lack thereof.
5. Our internal claims area is being negatively impacted as well as our electronic storage capacity is being overwhelmed by unneeded, unusable documentation. Providers affected by this will more than likely never receive any indication of the negative impacts this is having on their claims.



Reminders

Here are some items to verify before faxing or mailing your form:

- Verify you have indicated the ACN (attachment control number [submitted in the PWK06 segment]), DCN (document control number [Part A]), ICN (internal control number [Part B]), the beneficiary's Medicare ID, billing provider's name and NPI (national provider identifier) on the fax/mail coversheet.
- Include an address to mail the coversheet to, in case we are unable to fax it back to the originating number.
- **Fax users**: ensure to send your PWK fax coversheet and documentation to the appropriate locality fax line. **Example**: Claims for providers in Puerto Rico should be faxed to the Puerto Rico fax line; claims for Florida providers to the Florida fax line; etc. If a coversheet is received into the incorrect Faxination account, we will be unable to locate the claim.
- Do not send in documentation without the completed fax/mail coversheet.
- Do not use the PWK coversheet for any reason other than the PWK process.
- Do not modify the fax/mail coversheets.

Remittance advice remark code, claims adjustment reason code, MREP and PC Print update

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) 10620 updates the remittance advice remark code (RARC) and claims adjustment reason code (CARC) lists and instructs Medicare shared system maintainers (SSMs) to update Medicare Remit Easy Print (MREP) and PC Print. Be sure your staff are aware of these changes and obtain the updated MREP and PC Print software if they use that software.

Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) instructs health plans to conduct standard electronic transactions adopted under HIPAA using valid standard codes. Medicare policy states that CARCs and RARCs, as appropriate, which provide either supplemental explanation for a monetary adjustment or policy information that generally applies to the monetary adjustment, are required in the remittance advice and coordination of benefits transactions.

The Centers for Medicare & Medicaid Services (CMS) instructs MACs to conduct updates based on the code update schedule that occurs three times per year – around March 1, July 1, and November 1. CMS provides CR 10620 as a code update notification indicating when updates to CARC and RARC lists are made available on the Washington Publishing Company (WPC) website. Medicare's SSMs have the responsibility to implement code deactivation, making sure that any deactivated code is not used in original business messages and allowing the deactivated code in derivative messages. SSMs must make sure that Medicare does not report any deactivated code on or after the effective date for deactivation as posted on the WPC website. If any new or modified code has an effective date past the implementation date specified in CR 10620, MACs must implement on the date specified on the WPC website available at *http://wpc-edi.com/Reference/*.

A discrepancy between the dates may arise because the WPC website is only updated three times per year and may not match the CMS release schedule. For CR 10620, MACs and SSMs must get the complete list for both CARC and RARC from the WPC website to obtain the comprehensive lists for both code sets and determine the changes that are included on the code list since the last code update referenced in CR 10489.

Additional information

The official instruction, CR 10620, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4057CP.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: MM10620
Related CR Release Date: May 18, 2018
Related CR Transmittal Number: R4057CP
Related Change Request (CR) Number: 10620
Effective Date: October 1, 2018
Implementation October 1, 2018

New Part B edit for duplication of diagnosis codes on hard copy claims

Medicare is implementing systems changes to ensure that all Part B 837 coordination of benefits/Medicare crossover claims **do not** include duplicate diagnosis codes. Part B providers:

Effective July 2, 2018, CMS-1500 hard copy claims should not list the same diagnosis code twice within item 21, or your Medicare administrative contractor **will return these claims as unprocessable** with claim adjustment reason code 16, remittance advice remark code (RARC) M76, and alert RARC N211.

Claim status category and claim status codes update

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) 10777 updates, as needed, the claim status and claim status category codes used for the Accredited Standards Committee (ASC) X12 276/277 health care claim status request and response and ASC X12 277 health care claim acknowledgment transactions. Make sure your billing staffs are aware of these updates.

Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all covered entities to use only claim status and claim status category codes approved by the National Code Maintenance Committee in the ASC X12 276/277 health care claim status request and response transaction standards adopted under HIPAA for electronically submitting health care claims status requests and responses. These codes explain the status of submitted claim(s). Proprietary codes may not be used in the ASC X12 276/277 transactions to report claim status. The National Code Maintenance Committee meets at the beginning of each ASC X12 trimester meeting (January/February, June, and September/October) and makes decisions about additions, modifications, and retirement of existing codes. The committee allows the industry six months for implementation of newly added or changed codes.

The codes sets are available at *http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-category-codes/* and *http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-codes/*. Included in the code lists are specific details, including the date when a code was added, changed, or deleted.

All code changes approved during the June 2018 committee meeting shall be posted on these sites on or about July 1, 2018.

The Centers for Medicare & Medicaid Services (CMS) will issue future updates to these codes, as needed. MACs must update their claims systems to ensure that the current version of these codes is used in their claim status responses.

These code changes are used in editing of all ASC X12 276 transactions processed on or after the date of implementation and to be reflected in the ASC X12 277 transactions issued on and after the date of implementation of CR 10777.

The CMS' Medicare contractors must comply with the requirements contained in the current standards adopted under HIPAA for electronically submitting certain health care transactions, among them the ASC X12 276/277 health care claim status request and response transaction standards adopted under HIPAA for electronically submitting health care claims status requests and response. These contractors must use valid claim status and claim status category codes when sending ASC X12 277 health care claim status responses. They must also use valid claim status and claim status category codes when sending ASC X12 277 healthcare claim acknowledgments. References in CR 10777 to "277 responses" and "claim status responses" encompass both the ASC X12 277 health care claim status response and the ASC X12 277 healthcare claim acknowledgment transactions.

Additional information

The official instruction, CR 10777, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4066CP.pdf*.

If you have questions, your MACs may have more information. Find their website at *https://go.cms.gov/MAC-website-list*.

Document history

Date of change	Description
June 1, 2018	Initial article released.

MLN Matters® Number: MM10777
Related CR Release Date: June 1, 2018
Related CR Transmittal Number: R4066CP
Related Change Request (CR) Number: 10777
Effective Date: October 1, 2018
Implementation October 1, 2018

IDTF

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MLN Matters® Number: MM10735
Related CR Release Date: June 8, 2018
Related CR Transmittal Number: R4071CP
Related Change Request (CR) Number: 10735
Effective Date: July 9, 2018

Implementation July 9, 2018

Processing Issue

System edit has been turned off for certain EKG services

Issue

A system edit has been turned off that was rejecting and denying claims for certain electrocardiographic (EKG) services.

Resolution

Medicare administrative contractors (MACs) will reprocess impacted claims.

Status/date resolved

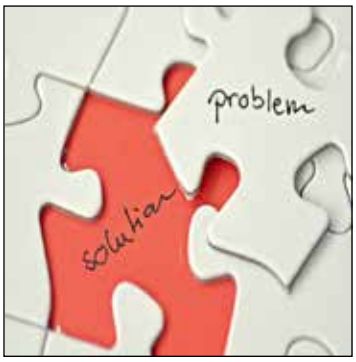
Open

Provider action

None; if you have any questions please contact your MAC provider contact center.

Current processing issues

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



General Information

New Medicare beneficiary identifier (MBI) get it, use it

Provider type affected

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

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) is mailing the new Medicare cards with the MBI in phases by *geographic location*. Here are three ways you and your office staff can get MBIs:

1. Ask your Medicare patients

Ask your Medicare patients for their new Medicare card when they come for care. If they haven't received a new card at the completion of their geographic wave, refer them to 1-800-Medicare (1-800-633-4227).

2. Use the MAC's secure MBI look-up tool

Once the new Medicare card with the MBI has been mailed to your patient, you can look up MBIs for your Medicare patients when they don't or can't give them. *Sign up* for the portal to use the tool. You can use this tool even after the end of the transition period – it doesn't end December 31, 2019.

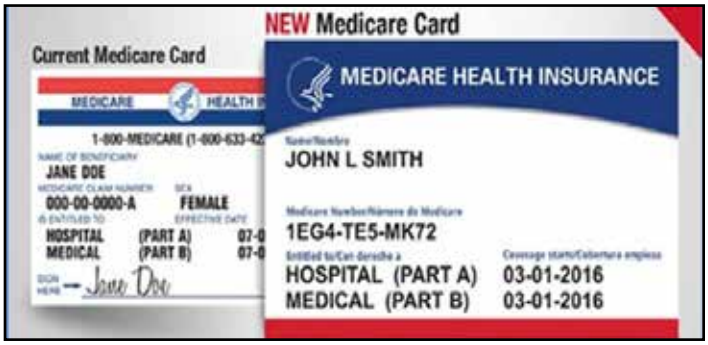
3. Check the remittance advice

Starting in October 2018 through the end of the transition period, we'll also return the MBI on every remittance advice when you submit claims with valid and active health insurance claim numbers (HICNs).

You can start using the MBIs even if the other health care providers and hospitals who also treat your patients haven't. When the transition period ends on December 31, 2019, you must use the MBI for most transactions.

Background

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS to remove Social Security Numbers from all Medicare cards by April 2019. A new, randomly generated Medicare beneficiary identifier, or MBI, is replacing the SSN-based HICN. The new MBI is noticeably different than the HICN. **Just like with the HICN, the MBI hyphens on the card are for illustration purposes: don't include the hyphens or spaces on transactions.**



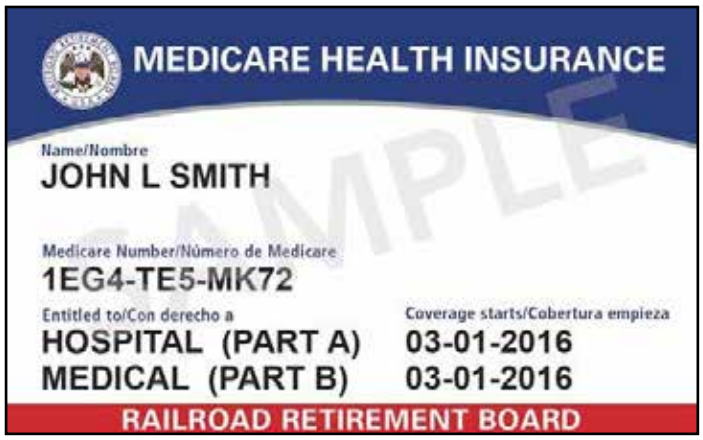
The Railroad Retirement Board (RRB) is also mailing new Medicare cards with the MBI. The RRB logo will be in the upper left corner and "Railroad Retirement Board" at the bottom, but you can't tell from looking at the MBI if your patients are eligible for Medicare because they're railroad retirees. You'll be able to identify them by the RRB logo on their card, and we'll return a Railroad retirement Medicare beneficiary message on the fee-for-service (FFS) MBI eligibility transaction response.

See **MBI**, page 22

MBI

from page 21

RRB issued Medicare card



Use the MBI the same way you use the HICN today. Put the MBI in the same field where you've always put the HICN. This also applies to reporting informational only and no-pay claims. **Don't use hyphens or spaces with the MBI to avoid rejection of your claim.** The MBI will replace the HICN on Medicare transactions including Billing, Eligibility Status, and Claim Status. The effective date of the MBI, like the old HICN, is the date each beneficiary was or is eligible for Medicare. Until December 31, 2019, you can use either the HICN or the MBI in the same field where you've always put the HICN. After that the remittance advice will tell you if we rejected claims because the MBI wasn't used. It will include claim adjustment reason code (CARC) 16, "Claim/service lacks information or has submission/billing error(s)." along with remittance advice remark code (RARC) N382 "Missing/ incomplete/invalid patient identifier".

The beneficiary or their authorized representative can request an MBI change. CMS can also initiate a change to an MBI. An example is if the MBI is compromised. There are different scenarios for using the old or new MBIs:

FFS claims submissions with:

- Dates of service before the MBI change date – use the old or new MBI.
- Span-date claims with a "From Date" before the MBI change date – use the old or new MBI.
- Dates of service that are entirely on or after the effective date of the MBI change – use the new MBI.

FFS eligibility transactions when the:

- Inquiry uses new MBI – we'll return all eligibility data.
- Inquiry uses the old MBI and request date or date range overlap the active period for the old MBI – we'll return all eligibility data. We'll also return the old MBI termination date.
- Inquiry uses the old MBI and request date or date range are entirely on or after the effective date of the new MBI – we'll return an error code (AAA 72) of "invalid member ID."

When the MBI changes, we ask the beneficiary to share the new MBI with you. You can also get the MBI from your MACs secure MBI lookup tool.

Protect the MBI as personally identifiable information (PII); it is confidential like the HICN.

Submit all HICN-based claims by the end of the transition period, December 31, 2019. On January 1, 2020, even for dates of services before this date, you must use MBIs for all transactions; there are a few exceptions when you can use either the HICN or MBI:

- **Appeals** – You can use either the HICN or MBI for claim appeals and related forms.
- **Claim status query** – You can use HICNs or MBIs to check the status of a claim (276transactions) if the earliest date of service on the claim is before January 1, 2020. If you are checking the status of a claim with a date of service on or after January 1, 2020, you must use the MBI.
- **Span-date claims** – You can use the HICN or the MBI for 11x-inpatient hospital, 32x-home health (home health claims and request for anticipated payments [RAPs]) and 41x-religious non-medical health care institution claims if the "From Date" is before the end of the transition period (December 31, 2019). If a patient starts getting services in an inpatient hospital, home health, or religious non-medical health care institution before December 31, 2019, but stops getting those services after December 31, 2019, you may submit a claim using either the HICN or the MBI, even if you submit it after December 31, 2019. Since you submit home health claims for a 60-day payment episode, you can send in the episode's RAP with either the HICN or the MBI, but after the transition period ends on December 31, 2019, you have to use the MBI when you send in the final claim that goes with it.

The MBI does not change Medicare benefits. Medicare beneficiaries may start using their new Medicare cards and MBIs as soon as they get them. Use MBIs as soon as your patients share them. The new cards are effective the date beneficiaries are eligible for Medicare.

Medicare advantage and prescription drug plans continue to assign and use their own identifiers on their health insurance cards. For patients in these plans, continue to ask for and use the plans' health insurance cards.

Additional information

If you have questions, your MACs may have more information. Find their website at *https://go.cms.gov/MAC-website-list*.

The MBI format specifications, which provide more details on the construct of the MBI, are available at *https://www.cms.gov/Medicare/New-Medicare-Card/Understanding-the-MBI.pdf*.

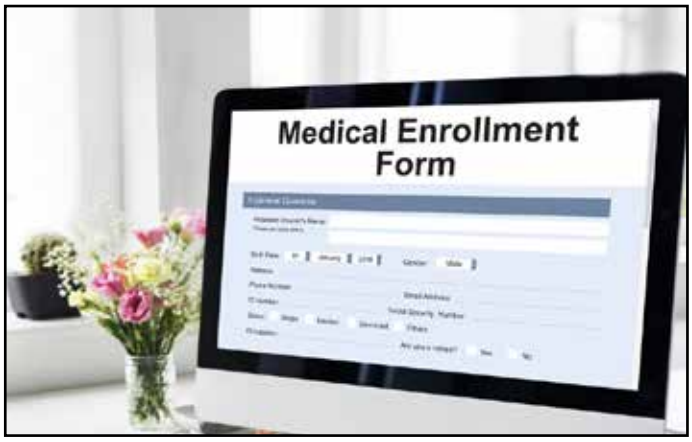
A fact sheet discussing the transition to the MBI and the new cards is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TransitiontoNewMedicareNumbersandCards-909365.pdf*.

See **MBI**, page 23

Provider enrollment – unlicensed residents

Provider type affected

This *MLN Matters*® article is intended for unlicensed resident physicians who need to enroll in the Medicare program through Medicare administrative contractors (MACs). The article is also intended for the providers for whom these residents will practice.



What you need to know

Effective as soon as possible but no later than June 17, 2018, MACs will process CMS Form-855O provider enrollment applications submitted for unlicensed residents if the application submission includes either, 1) a residency contract signed and dated by both an official of the institution and the resident physician or, 2) a letter, on institution letterhead, confirming the applicants status as a resident physician signed and dated by an official of the institution and containing at a minimum the name of the applicant.

MACs shall approve the enrollment if the applicant passes all screening requirements and provides proof of residency as described above.

Additional information

If you have questions, your MACs may have more information. Find their website at *https://go.cms.gov/MAC-website-list*.

Document history

Date of change	Description
June 8, 2018	Initial article released.

MLN Matters® Number: SE18008
Related CR Release Date: June 8, 2018
Related CR Transmittal Number: N/A
Related Change Request (CR) Number: N/A
Effective Date: N/A
Implementation: N/A

MBI

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Document history

Date of change	Description
June 21, 2018	The article was revised to emphasize the need to submit the MBI without hyphens or spaces to avoid rejection of your claim. All other information remains the same.
May 25, 2018	Initial article released.

MLN Matters® Number: SE18006 *Revised*
Related CR Release Date: June 21, 2018
Related CR Transmittal Number: N/A
Related Change Request (CR) Number: N/A
Effective Date: N/A
Implementation N/A

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.

Provider/supplier reporting of adverse legal actions

Provider type affected

This *MLN Matters*® article is intended to update the Medicare provider and supplier community on what final adverse action(s) need to be timely reported to the Centers for Medicare & Medicaid Services (CMS).

Who should report final adverse action(s)

- Medicare providers or suppliers with new or unreported final adverse action(s)
- Those individuals listed on an application as having managing control or an ownership interest

What final adverse action(s) should be reported

Historically, CMS deemed *Medicare Payment Suspensions* and *CMS-Imposed Medicare Revocations* to be reportable final adverse actions. In an effort to reduce provider and supplier burden, CMS **no longer** requires *Medicare Payment Suspensions* and *CMS-Imposed Medicare Revocations* to be reported.

The updated list of reportable final adverse actions is as follows:

- Felony and misdemeanor conviction(s) within 10 years
- Current or past suspension(s)/revocation(s) of a medical license
- Current or past suspension(s)/revocation(s) of an accreditation
- Current or past suspension(s) or exclusion(s) imposed by the U.S. Department of Health and Human Service's Office of Inspector General (OIG)
- Current or past debarment(s) from participation in any federal executive branch procurement or non-procurement program
- Medicaid exclusion(s), revocation(s) or termination(s) of any billing number
- Any other current or past federal sanction(s)

Please note that all final adverse actions should be reported, regardless of whether any of the records have been expunged or are pending appeal.

When final adverse action(s) be reported

Providers and suppliers shall timely report all new or unreported final adverse actions on any applications submitted to CMS. Final adverse actions must be reported by providers and suppliers within time frames specified in 42 CFR § 424.516.

How final adverse action(s) should be reported

Providers and suppliers shall disclose reportable final adverse legal actions on any CMS-855 or CMS-20134 application submitted to CMS. As it applies, the sections of the application(s) that providers must complete are:

- Section 3
- Section 5B
- Section 6B
- Section 7

If a final adverse action is disclosed on a CMS-855 application, a provider/supplier must attach all applicable documentation related to the adverse action.

Please note that documentation, concerning the final adverse action, must be furnished regardless of whether the adverse action occurred in a state different from that in which the provider/supplier seeks enrollment or is enrolled.

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

Additional information

The official instruction, CR 10558, issued to your MAC is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R797PI.pdf*.

If you have questions, your MACs may have more information. Find their website at *https://go.cms.gov/MAC-website-list*.

Document history

Date of change	Description
June 7, 2018	Initial article released.

MLN Matters® Number: MM10558
Related CR Release Date: June 1, 2018
Related CR Transmittal Number: R797PI
Related Change Request (CR) Number: 10558
Effective Date: April 30, 2018
Implementation April 30, 2018

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

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

Effective and notice dates

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

Electronic notification

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

More information

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

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

Looking for LCDs?

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

Advance beneficiary notice

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

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

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

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

Search capability simplifies LCD lookup

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

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

Click here for more information.

Retired LCDs

Circulating tumor cell testing – retired Part A and Part B LCD

LCD ID number: L33279 (Florida, Puerto Rico/ U.S. Virgin Islands)

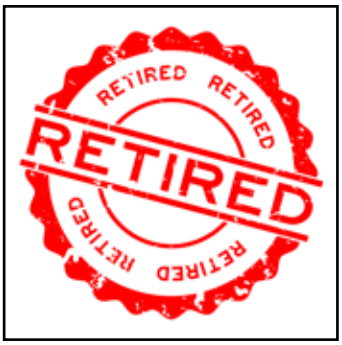
Based on data analysis review of the local coverage determination (LCD) for circulating tumor cell testing, it was determined that the LCD is no longer required and, therefore, is being retired.

Effective date

The retirement of this LCD is effective for services rendered **on or after May 25, 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*.



Lower extremity revascularization – retired Part A and Part B LCD

LCD ID number: DL37404 (Florida, Puerto Rico/U.S. Virgin Islands)

The draft local coverage determination (LCD) for lower extremity revascularization is being retired. The draft LCD was posted for the 45-day comment May 18, 2017 to July 6, 2017. The contractor would like to thank those who submitted comments; however, the contractor has determined that the proposed LCD will be rewritten. Therefore, this proposed LCD is being retired.

Revisions to LCDs

Bisphosphonates (intravenous [IV]) and monoclonal antibodies in the treatment of osteoporosis and their other indications – revision to the Part A and Part B LCD

LCD ID number: L33270 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on an external correspondence and multiple reconsideration requests, the local coverage determination (LCD) for bisphosphonates (intravenous [IV]) and monoclonal antibodies in the treatment of osteoporosis and their other indications was revised to add the Food and Drug Administration (FDA) approved indication "prevention of skeletal-related events in patients with multiple myeloma" to the "FDA indication for XGEVA®" and "Documentation Requirements" sections of the LCD. Also, ICD-10-CM diagnosis codes C90.00, C90.01, C90.02 and M84.50XA – M84.58XS were added to the "ICD-10 Codes that Support Medical Necessity" section of the LCD under "Group 4 Codes" for Healthcare Common Procedure Coding System (HCPCS) code J0897 (Xgeva®) and the "Limitations" section of the LCD was updated to include a statement that "Effective for dates of service on or after 01/04/2018, the FDA has approved denosumab (Xgeva®) for the treatment of skeletal-related events in patients with multiple myeloma." In addition, the statement indicating the requirement of documentation of serum creatinine level prior to the administration of Prolia® was removed from the "Documentation Requirements" section of the LCD under the subtitle "Prolia All Patients." Finally, the "Sources of Information" section of the LCD was also updated.

Effective date

The revision related to the addition of the ICD-10-CM codes, the FDA indication for Xgeva® and sources of information is effective for claims processed **on or after June 21, 2018**, for dates of service **on or after January 4, 2018.**

The revision related to the removal of the statement indicating the requirement of documentation of serum creatinine level prior to the administration of Prolia® and the addition of sources of information is effective for services rendered **on or after June 21, 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*.

Fulvestrant (Faslodex) – revision to the Part A and Part B LCD

LCD ID number: L33998 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on a local coverage determination (LCD) reconsideration request for fulvestrant (Faslodex), the "Coverage Indications, Limitations, and/or Medical Necessity" section of the LCD was revised to add the indications for uterine neoplasms, endometrial carcinoma, and uterine leiomyosarcoma. In addition, ICD-10-CM diagnosis codes C54.0-C54.9 and C55 were added to the "ICD-10 Codes that Support Medical Necessity" section of the LCD for Healthcare Common Procedure Coding System (HCPCS) code J9395. Also, the "Sources of Information and Basis for Decision" section of the LCD was updated.

Effective date

This LCD revision is effective for claims processed **on or after June 14, 2018**, for services rendered **on or after August 1, 2016.** First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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*.

Gemcitabine (Gemzar) – revision to the Part A and Part B LCD

LCD ID number: L33726 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on a local coverage determination (LCD) reconsideration request for gemcitabine (Gemzar), the "Coverage Indications, Limitations, and/or Medical Necessity" section of the LCD was revised to add the indication for bone cancer - osteosarcoma. In addition, ICD-10-CM diagnosis codes C40.01, C40.02, C40.11, C40.12, C40.21, C40.22, C40.31, C40.32, C40.81, C40.82, C41.0, C41.1, C41.2, C41.3, and C41.4 were added to the "ICD-10 Codes that Support Medical Necessity" section of the LCD for Healthcare Common Procedure Coding System (HCPCS) code J9201. Also, the "Sources of Information" section of the LCD was updated.

Effective date

This LCD revision is effective for services rendered **on or after June 14, 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*.

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

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

Based on an internal correspondence, the local coverage determination (LCD) for hyperbaric oxygen (HBO) therapy was revised in the "Coverage Indications, Limitations, and/or Medical Necessity" section of the LCD to remove the requirement for direct supervision of a maximum of five (5) minute response time to the chamber, as direct physician supervision is not defined in terms of time or distance by the Centers for Medicare & Medicaid Services (CMS). In addition, "bowel" was removed from "Specific Conditions" section of the LCD under number nine, as it is not a covered diagnosis code per the National Coverage Determination (NCD) for Hyperbaric Oxygen Therapy (NCD 20.29).

Effective date

This LCD revision is effective for services rendered **on or after May 31, 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*.

Molecular pathology procedures for human leukocyte antigen (HLA) typing – revision to the Part A and Part B LCD

LCD ID number: L34518 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on an annual review of the local coverage determination (LCD) for molecular pathology procedures for human leukocyte antigen (HLA) typing, it was determined that some of the italicized language in the "Coverage Indications, Limitations, and/or Medical Necessity" and "Utilization Guidelines" sections of the LCD do not represent direct quotations from some of 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 22, 2018.** LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Nerve conduction studies and electromyography – revision to the Part A and Part B LCD

LCD ID number: L34859 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on an annual review of the nerve conduction studies and electromyography local coverage determination (LCD), it was determined that the italicized language in the "Coverage Indications, Limitations, and/or Medical Necessity" section of the LCD does 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 manual language. In addition, the "CPT®/HCPCS Codes:" section of the LCD was updated to combine the "Group 1 Codes:" and "Group 2 Codes" to align with the "Group Codes" in the "ICD-10 Codes that Support Medical Necessity" section of the LCD. The effective date of this revision is based on process date.

Effective date

The LCD revision related to assuring consistency with the CMS manual language is effective for services rendered **on or after May 31, 2018.**

The LCD revision related to aligning the "Group Codes" is effective for claims processed **on or after May 31, 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*.

Scanning computerized ophthalmic diagnostic imaging (SCODI) – revision to the Part A and Part B LCD

LCD ID number: L33751 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on a local coverage determination (LCD) reconsideration request, the scanning computerized ophthalmic diagnostic imaging (SCODI) LCD was revised in the "Bibliography" section of the LCD to include multiple published sources. The content of the LCD has not been changed in response to the reconsideration request.

Effective date

The LCD revision is effective for services rendered **on or after May 31, 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*.

Upcoming provider outreach and educational events

Topic: Medicare Part B changes and regulations

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

https://medicare.fcso.com/Events/0409582.asp

Topic: Medicare Speaks 2018 Panama City

Date: Wednesday-Thursday, November 7-8
Time: 8:00 a.m.-4:30 p.m.
Type of Event: Face-to-face

https://medicare.fcso.com/medicare_speaks/0404329.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 May 24, 2018

MLN Connects® for May 24, 2018
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News & Announcements

- MIPS Promoting Interoperability Performance Category
- Provider Documentation Manual on Home Use of Oxygen: Submit Comments on Draft by May 31
- Proposals for New Measures for Promoting Interoperability Program: Deadline June 29
- Targeted Probe and Educate Video
- Hospice Compare Quarterly Refresh
- CQM Annual Update
- Break Free from Osteoporosis

Provider Compliance

- Medicare Hospital Claims: Avoid Coding Errors — Reminder

Claims, Pricers & Codes

- FY 2019 ICD-10-PCS Procedure Codes

Upcoming Events

- Hospice Quality Reporting Program Data Submission and Reporting Webinar — May 30
- DMEPOS Dietary Related Items, Templates and CDEs Special Open Door Forum — May 31
- Qualified Medicare Beneficiary Program Billing Requirements Call — June 6
- MIPS Promoting Interoperability Performance Category Webinar — June 12

Medicare Learning Network Publications & Multimedia

- RARC, CARC, MREP, and PC Print Update MLN Matters Article — New
- Implement Operating Rules - Phase III ERA EFT: CORE 360 Uniform Use of CARC, RARC and CAGC Rule - Update from CAQH CORE MLN Matters Article — New
- Removal of KH Modifier from Capped Rental Items MLN Matters Article — Revised
- Changes to the ESRD Claim to Accommodate Dialysis Furnished to Beneficiaries with AKI MLN Matters Article — Revised
- World of Medicare Web-Based Training Course — Revised
- Your Office in the World of Medicare Web-Based Training Course — Revised
- Your Institution in the World of Medicare Web-Based Training Course — Revised

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.

MLN Connects® for May 31, 2018

MLN Connects® for May 31, 2018

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News & Announcements

- New Medicare Card Project — Card Mailing Update
- MIPS: Submit Quality Measures for Consideration by June 1
- 2016 Physician and Other Supplier PUF
- 2016 Referring Provider DMEPOS PUF

Provider Compliance

- Provider Minute Video: The Importance of Proper Documentation

Upcoming Events

- Qualified Medicare Beneficiary Program Billing Requirements Call — June 6
- Medicare Diabetes Prevention Program: Supplier Enrollment Call — June 20
- IMPACT Act: Frequently Asked Questions Call — June 21

Medicare Learning Network Publications & Multimedia

- New Medicare Beneficiary Identifier: Get It, Use It MLN Matters Article — New
- Quarterly Update to the Medicare Physician Fee Schedule Database MLN Matters Article — New
- Quarterly Update for the DMEPOS CBP MLN Matters Article — New
- Quarterly ASP Part B Drug Pricing Files and Revisions to Prior Files MLN Matters Article — New
- MCReF System Webcast: Video Presentation — New
- Quality Payment Program Call: Audio Recording and Transcript — New
- Diagnosis Code Update for Add-on Payments for Blood Clotting Factor Administered to Hemophilia Inpatients MLN Matters Article — Revised

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MLN Connects® for June 7, 2018

MLN Connects® for June 7, 2018

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News & Announcements

- New Medicare Card: MBI Look-up Tool Available through your MAC
- Declines in Hospital-Acquired Conditions Save 8,000 Lives and $2.9 Billion
- 2017 Quality Payment Program Year 1 Submission Results
- DMEPOS Prior Authorization List Additions
- Draft QRDA III Implementation Guide: Submit Comments by June 20
- IRF and LTCH Provider Preview Reports: Review Your Data by June 30
- SNF Provider Preview Report: Review Your Data by June 30
- Hospice Provider Preview Reports: Review Your Data by June 30
- Eligible Hospitals: Submit a Hardship Exception Application by July 1
- PEPPER for Short-term Acute Care Hospitals
- View Your MIPS Preliminary Performance Feedback Data
- Physician Compare Downloadable Database: 2016 Performance Scores

Provider Compliance

- Bill Correctly for Device Replacement Procedures — Reminder

Upcoming Events

- MIPS Promoting Interoperability Performance Category Webinar — June 12
- CMS Quality Measures: Development, Implementation, and You Webinar — June 13 or 14
- Medicare Diabetes Prevention Program: Supplier Enrollment Call — June 20
- IMPACT Act: Frequently Asked Questions Call — June 21
- Home Health Agencies: Quality of Patient Care Star Ratings Algorithm Call — June 27
- Ground Ambulance Providers and Suppliers: Data Collection System Listening Session — June 28
- Comparative Billing Report on Knee Orthoses Referring Providers Webinar — July 11

Medicare Learning Network Publications & Multimedia

- New Q Code for In-Line Cartridge Containing Digestive Enzyme(s) MLN Matters Article — New
- July 2018 Update of the Ambulatory Surgical Center Payment System MLN Matters Article — New
- Claim Status Category and Claim Status Codes Update MLN Matters Article — New
- Settlement Conference Facilitation Call: Audio Recording and Transcript — New
- E/M Service Documentation Provided by Students MLN Matters Article — Revised

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MLN Connects® for June 14, 2018

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News & Announcements

- CMS Opioids Roadmap
- LTCH and IRF Compare Refresh
- Antipsychotic Drug Use in Nursing Homes: Trend Update
- Men's Health Week Ends on Father's Day

Provider Compliance

- Billing for Stem Cell Transplants — Reminder

Claims, Pricers & Codes

- FY 2019 ICD-10-CM Diagnosis Codes

Upcoming Events

- Medicare Diabetes Prevention Program: Supplier Enrollment Call — June 20
- IMPACT Act: Frequently Asked Questions Call — June 21
- Home Health Agencies: Quality of Patient Care Star Ratings Algorithm Call — June 27
- Ground Ambulance Providers and Suppliers: Data Collection System Listening Session — June 28

Medicare Learning Network Publications & Multimedia

- Improvements in Hospice Billing and Claims Processing MLN Matters Article — New
- Provider Enrollment: Unlicensed Residents MLN Matters Article — New
- Update of the Hospital OPPS: July 2018 MLN Matters Article — New
- I/OCE Specification Version 19.2: July 2018 MLN Matters Article — New
- Quarterly Update for the DMEPOS CBP: October 2018 MLN Matters Article — New
- Medicare Claims Processing Manual Update, Chapters 18 and 35: IDTF MLN Matters Article — New
- Provider/Supplier Reporting of Adverse Legal Actions MLN Matters Article — New
- Transition to New Medicare Numbers and Cards Fact Sheet — Revised
- CMS Web Wheel Educational Tool — Revised
- Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians Web-based Training — Reminder
- Remittance Advice Resources and FAQs Booklet — Reminder

MLN Connects® for June 21, 2018

MLN Connects® for June 21, 2018
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News & Announcements

- New Medicare Cards May Have QR Codes
- Continuous Glucose Monitors: Changes Impacting Medicare Coverage
- Quality Payment Program Look-Up Tool Updated
- Quality Payment Program Website Includes 2018 MIPS Measures and Activities
- Hospice Provider Preview Reports: Review Your Data by June 30
- IRF and LTCH Provider Preview Reports: Review Your Data by July 1
- SNF Provider Preview Report: Review Your Data by July 1
- CMS Leverages Medicaid Program to Combat the Opioid Crisis

Provider Compliance

- Payment for Outpatient Services Provided to Beneficiaries Who Are Inpatients of Other Facilities — Reminder

Upcoming Events

- Home Health Agencies: Quality of Patient Care Star Ratings Algorithm Call — June 27
- Ground Ambulance Providers and Suppliers: Data Collection System Listening Session — June 28

Medicare Learning Network Publications & Multimedia

- July Quarterly Update for 2018 DMEPOS Fee Schedule MLN Matters Article — New
- Qualified Medicare Beneficiary Call: Audio Recording and Transcript — New

Phone numbers

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

Education event registration hotline

904-791-8103 (NOT toll-free)

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888-670-0940

Electronic funds transfers (EFT) (CMS-588)

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877-660-1759 (TTY)

Fax number (for general inquiries)

904-361-0696

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877-847-4992

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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
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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

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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
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https://www.medicare.gov

Phone numbers

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Electronic data interchange (EDI)
888-670-0940

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

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

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

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

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

Addresses

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

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

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

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C2C Innovative Solutions, Inc.
Part B QIC South Operations
ATTN: Administration Manager
PO Box 45300
Jacksonville, FL 32232-5300

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

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

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

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

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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
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Jacksonville, FL 32231-5073

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Jacksonville, FL 32202-4914

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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)

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904-361-0407 (FAX)

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877-660-1759 (TTY)

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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,

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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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