Medicare B Connection

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A Newsletter for MAC Jurisdiction N Providers

September 2018

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Influenza vaccine payment allowances – annual update for 2018-2019 season

Provider type affected

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

Provider action needed

Change request (CR) 10914 informs MACs about payment allowances for influenza virus vaccines, which are updated August 1 of each year. The Centers for Medicare & Medicaid Services (CMS) will post the payment allowances for influenza vaccines that are approved after the release of CR 10914 at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html*. Make sure your billing staffs are aware that the payment allowances are being updated.

Background

The Medicare Part B payment allowance limits for influenza and pneumococcal vaccines are 95 percent of the average wholesale price (AWP), as reflected in the published compendia except where the vaccine is furnished in a hospital outpatient department, rural health clinic (RHC), or federally qualified health center (FQHC). Where the vaccine is furnished in the hospital outpatient department, RHC, or FQHC, payment for the vaccine is based on reasonable cost.

Annual Part B deductible and coinsurance amounts do not apply. All physicians, non-physician practitioners, and suppliers who administer the influenza virus vaccination and the pneumococcal vaccination must take assignment on the claim for the vaccine.

The Medicare Part B payment allowances for dates of service of August 1, 2018, through July 31, 2019, are still pending as of the date of CR 10914 for CPT® codes 90630, 90653, 90654, 90655, 90656, 90657, 90661, 90662, 90672, 90673, 90674, 90682, 90685, 90686, 90687, 90688, 90756, and HCPCS codes Q2035, Q2036, Q2037, and Q2038. Once payment allowances are available, they will be posted at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/*

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

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

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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.

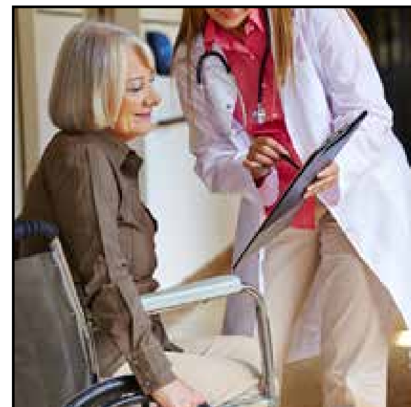
For some services, to ensure that payment is made only for medically necessary services or items, coverage may be limited based on one or more of the following factors (this list is not inclusive):

- 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=45*.



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.

Anesthesia

Bill correct modifiers for medically supervised concurrent anesthesia procedures

First Coast Service Options (First Coast) would like to ensure providers are aware of how to properly bill claims involving an anesthesiologist that is medically supervising more than four concurrent anesthesia procedures. This article outlines First Coast's billing requirements and the steps you must take to receive proper payment for these services.

Medicare allows three base units per procedure when an anesthesiologist is involved in furnishing more than four anesthesia procedures concurrently, or is performing other services while directing the concurrent procedures. An additional time unit is allowed if documentation supports the physician was present at induction.

Claim submission

To receive payment for the three base units, providers must append modifier AD to the claim form along with the anesthesia procedure code. This modifier indicates:

- AD – Medical supervision by a physician; more than four concurrent anesthesia procedures

For payment of an additional time unit along with the three base units, providers must also append modifier 23 with the anesthesia procedure code. This modifier indicates:

- 23 – Unusual anesthesia

By appending modifier 23 with modifier AD, you are attesting that you have the proper documentation on file to support that the provider was present at induction. Providers should bill the AD modifier followed by the 23 modifier.

First Coast does not require providers to submit documentation with these claims.

Review your billing practices to ensure proper payment

If a claim is submitted with modifier AD only, First Coast will only allow three base units in the payment calculation.

Please carefully review your current billing practices to make the appropriate system and process updates within your facility.

Source: *The Centers for Medicare & Medicaid Services (CMS) Internet-Only Manuals (IOMs) Pub. 100-04, Chapter 12, Section 50*
First Coast Anesthesia Provider Specialty Page

Preventive Services

Quarterly influenza virus vaccine code update – January 2019

***Note**: This article was revised September 6, 2018 to reflect the revised change request (CR) 10871 issued September 5. In the article, the CR release date, transmittal number, and the web address for accessing CR 10871 are revised. All other information remains the same. This information was previously published in the August 2018 Medicare B Connection, page 1.*

Provider type affected

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

Provider action needed

CR 10871 provides instructions for payment and edits for Medicare's common working file (CWF) and fiscal intermediary shared system (FISS) to include and update new or existing influenza virus vaccine codes. This update includes one new influenza virus vaccine code: 90689. Please make certain your billing staffs are aware of this update.

Background

Effective for claims processed with dates of service (DOS) on or after January 1, 2019, influenza virus vaccine code 90689 (*Influenza virus vaccine quadrivalent (IIV4), inactivated, adjuvanted, preservative free, 0.25mL dosage, for intramuscular use)* will be payable by Medicare. The short descriptor is VACC IIV4 NO PRSRV 0.25ML IM. This new code will be included on the 2019 Medicare physician fee schedule database file update and the annual Healthcare Common Procedure Coding System (HCPCS) update.

Except as noted below, MACs will use the Centers for Medicare & Medicaid Services (CMS) Seasonal Influenza Vaccines Pricing webpage: *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html* to obtain the payment rate for 90689.The new influenza virus vaccine code 90689 is not retroactive to August 1, 2018. No claims should be accepted for influenza virus vaccine code 90689 between the DOS August 1, 2018, and December 31, 2018. If claims are received in January 2019 with code 90689 for DOS between August 1, 2018, and December 31, 2018, MACs will follow their normal course of action for codes billed prior to their effective date.

See **CODE**, page 6

CODE

from page 5

Payment basis for institutional claims

MACs will pay for influenza virus vaccine code 90689 with a type of service (TOS) of V based on reasonable cost to

- Hospitals (type of bill 12x and 13x)
- Skilled nursing facilities (22x and 23x)
- Home health agencies (34x)
- Hospital-based renal dialysis facilities (72x)
- Critical access hospitals (85x)

MACs will pay for influenza virus vaccine code 90689 with a TOS of V based on the lower of the actual charge or 95 percent of the average wholesale price (AWP), to:

- Indian Service Hospitals (IHS) (12x and 13x)
- Hospices (81x and 82x)
- IHS critical access hospitals (85x)
- Comprehensive outpatient rehabilitation facilities (CORFs) (75x)
- Independent renal dialysis facilities (72x)

Note: In all cases, coinsurance and deductible do not apply.

Additional information

The official instruction, CR 10871, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4127CP.pdf*.

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

Document history

Date of change	Description
September 6, 2018	The article was revised to reflect the revised CR 10871 issued September 5. In the article, the CR release date, transmittal number, and the web address for accessing CR 10871 are revised. All other information remains the same.
August 6, 2018	Initial article released.

MLN Matters® Number: MM10871 *Revised*
Related CR Release Date: September 5, 2018
Related CR Transmittal Number: R4127CP
Related Change Request (CR) Number: 10871
Effective Date: January 1, 2019
Implementation January 7, 2019

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VaccinesPricing.html.

Payment allowances for codes for which products have not yet been approved will be provided when the products have been approved and pricing information becomes available to CMS.

The payment allowances for pneumococcal vaccines are based on 95 percent of the AWP and are updated on a quarterly basis via the quarterly average sales price (ASP) drug pricing files.

Note: MACs will reprocess any previously processed and paid claims for the current flu season that were paid using influenza vaccine payment allowances other than the allowances published in the influenza vaccine pricing website for the 2018/2019 season, that began August 1, 2018. This reprocessing should occur by November 1, 2018.

Additional information

The official instruction, CR 10914, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4124CP.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
September 4, 2018	Initial article released.

MLN Matters® Number: MM10914
Related CR Release Date: August 31, 2018
Related CR Transmittal Number: R4124CP
Related Change Request (CR) Number: 10914
Effective Date: August 1, 2018
Implementation No later than October 1, 2018

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Processing Issues

Overpayments for medically supervised concurrent anesthesia procedures

Issue

First Coast Service Options (First Coast) discovered that claims involving more than four concurrent anesthesia procedures have resulted in overpayments. Medicare allows three base units per procedure when an anesthesiologist is involved in furnishing more than four anesthesia procedures concurrently, or is performing other services while directing the concurrent procedures. An additional time unit may be recognized if the physician can document that he or she was present at induction.

To receive payment for the three base units, providers must append modifier AD to the claim form along with the anesthesia procedure code. For payment of an additional time unit along with the three base units, providers must also append modifier 23 with the anesthesia procedure code in the secondary modifier position. By appending modifier 23 with modifier AD, you are attesting that you have the proper documentation on file to support that the provider was present at induction.

First Coast discovered that we processed these claims incorrectly by allowing the base units and time units that were billed. This resulted in overpayments for claims paid from January 1, 2013, through July 20, 2018.

Resolution

First Coast started adjusting the claims August 30, 2018, to recover the overpayments. Providers will receive overpayment demand letters listing the impacted claim(s) to help you reconcile the payment adjustments. The adjustments will also be reflected on your remittance advices.

Status/date resolved

Open

Provider action

You still have your appeal rights. If you have documentation to support that you were present at induction and you weren't paid for the additional time unit, you may appeal the claim(s) and request First Coast to add modifier 23. You don't have to submit the documentation with the appeal. Refer to your overpayment demand letter which outlines the steps you can take if you wish to file an appeal.

For additional information regarding proper billing of claims involving more than four concurrent anesthesia procedures, access the article *Bill correct modifiers for medically supervised concurrent anesthesia procedures*.

Current processing issues

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

General Information

Review of opioid use during the IPPE and annual wellness visit

Provider type affected

This MLN Matters® special edition (SE) article 18004 is intended to emphasize the existing policy for eligible health care professionals who furnish the AWV to Medicare beneficiaries.

What you need to know

Medicare covers the following services for Medicare patients that meet certain eligibility requirements:

- The initial preventive physical examination (IPPE) (also known as the "Welcome to Medicare" preventive visit)
- The annual wellness visit (AWV)

These preventive benefits allow you to assess your patients' health on an annual basis to help you determine if they have any risk factors and if they are eligible for other preventive services and screenings that Medicare covers.

These preventive benefits are a great way for you to detect illnesses in their earliest stages when treatment works best. For example, review of opioid use as an important routine aspect of the patient's medical history is helpful in diagnosing and then treating as appropriate opioid use disorders (OUD). CMS information on reducing opioid misuse is available at *https://www.cms.gov/about-cms/story-page/reducing-opioid-misuse.html*.

Note: Please check the physician fee schedule for the exact amount of reimbursement for your locality and setting. The physician fee schedule is available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PFSlookup/index.html*.

The initial preventative physical exam IPPE ("Welcome to Medicare" preventive visit)

Medicare covers an IPPE for all patients who are newly enrolled in Medicare Part B.

- The patient must receive this service within the first 12 months after the effective date of their Medicare Part B coverage.
- The IPPE is a one-time benefit.
- The IPPE consists of the following:
- Review the patient's medical and social history *(Medicare would like to emphasize that review of*

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OPIOID

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opioid use is a routine component of this element, including OUD. If a patient is using opioids, assess the benefit from other, non-opioid pain therapies instead, even if the patient does not have OUD but is possibly at risk.) Review potential risk factors for depression and other mood disorders

- Review functional ability and level of safety
- Measurement of height, weight, body mass index (BMI), and visual acuity screening
- End-of-life planning (upon agreement of the individual)
- Education, counseling and referral based on the review of previous 5 components
- Education, counseling and referral for other preventive services, including a brief written plan such as a checklist

For more information about the IPPE, please see *Quick Reference Information: The ABCs of the IPPE* at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf* .

The AWV or annual wellness visit

Medicare covers an annual AWV for patients:

- Who are no longer within 12 months of the effective date of their first Part B coverage period and
- Who have not gotten either an IPPE or AWV within the previous 12 months.

Medicare pays for only one **first** AWV. Medicare will pay for a **subsequent** AWV for each patient annually. **Note:** The elements in first and subsequent AWVs, and the codes to bill them, are different.

- The first AWV includes the following elements:
- A health risk assessment
- Establishment of a current list of provider and suppliers
- Review of medical and family history *(Medicare would like to emphasize that review of opioid use is a routine component of this element, including OUD. If a patient is using opioids, assess the benefit from other, non-opioid pain therapies instead, even if the patient does not have OUD but is possibly at risk.)*
- Measurement of height, weight, BMI, and blood pressure
- Review of potential risk factors for depression and other mood disorders
- Review of functional ability and level of safety
    - Detection of any cognitive impairment the patient may have
    - Establishment of a written screening schedule (such as a checklist)
    - Establishment of a list of risk factors
    - Provision of personalized health advice and referral to appropriate health education or other preventive services.
- Subsequent AWVs include the following elements:
    - Review of updated health risk assessment;
    - Update medical and family history **(As mentioned above, Medicare would like to include opioid use in the 'Review of Medical and Family History' element of the AWV. Providers are encouraged to pay close attention to opioid use during this element of the AWV. If a patient is using opioids, assess the benefit from other, non-opioid pain therapies instead, even if the patient does not have OUD but is possibly at risk.)**
    - Update of list of current providers and suppliers;
    - Measurement of weight and blood pressure;
    - Detection of cognitive impairment the patient may have;
    - Update of the written screening schedule (such as a checklist);
    - Update of the list of risk factors; and
    - Provision of personalized health advice and referral to appropriate health education or other preventive services.

Additional information

The *Medicare Learning Network®* has published a variety of additional educational material on Medicare-covered preventive services, including:

- The *Preventive Services MLN* page: *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/PreventiveServices.html*
- *MLN Matters®* articles related to Medicare-covered preventive benefits *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNPrevArticles.pdf*
- THE ABCs OF THE ANNUAL WELLNESS VISIT (AWV): *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AWV_chart_ICN905706.pdf*
- THE ABCs OF THE INITIAL PREVENTIVE PHYSICAL EXAMINATION (IPPE): *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MPS_QRI_IPPE001a.pdf*
- *MLN Matters®* article SE1604 *Medicare Coverage of Substance Abuse Services*: *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se1604.pdf*

For general information about Medicare-covered preventive services, visit the CMS prevention page at *https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/index.html*. For information to share with your Medicare patients, please visit *https://www.medicare.gov*.

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Update to Chapter 15, Pub. 100-08, Certification Statement Policies

Provider type affected

This *MLN Matters*® article is intended for physicians and providers, including home health agencies (HHAs), submitting certain internet-based applications to Medicare administrative contractors (MACs) via the Provider Enrollment Chain and Ownership System (PECOS).

Provider action needed

Change request (CR) 10845 makes modifications to certain provider enrollment certification statement policies. Specifically, you may upload provider enrollment certification statements using PECOS functionality.

CR 10845 makes these modifications via changes to the *Medicare Program Integrity Manual*, Chapter 15, Section 15.5.14.4. The revised manual section is attached to CR 10845. Make sure your billing staff is aware of these changes.

Background

PECOS functionality provides an option to upload paper certification statements. CR 10845 aligns the provider enrollment certification statement policy with this PECOS functionality.

CR 10845 and the accompanying revised portion of the manual requires your MACs to:

- Accept all handwritten signatures for paper forms CMS-855, CMS-20134, CMS-460 and CMS-588 application submissions
- Accept e-signed or uploaded signatures for web-based application submissions. MACs will no longer accept paper certification statements for web-based application submissions (CMS-855 and CMS-20134 only) via mail. If the provider chooses to submit its certification statement via paper rather than through e-signature, it shall do so via PECOS upload functionality
- Not accept stamped signatures
- Accept uploaded, faxed and emailed paper certification statements in response to a development request.
- Begin processing ALL applications upon receipt and shall develop for missing certification statements and all other missing information, including application fee, upon review
- Consider the web-based application date of receipt as the date of the web-based application submission

Note: There is no legislative or regulatory impact associated with CR 10845.

Additional information

The official instruction, CR 10845, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R824PI.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
September 5, 2018	The article was revised to reflect a revised CR 10845 issued the same day. The revised CR did not change any substantive information in the article. Within the article, there is a revised transmittal number, CR release date, and web address for accessing the CR. All other information remains the same.
August 24, 2018	Initial article released.

MLN Matters® Number: MM10845 *Revised*
Related CR Release Date: September 5, 2018
Related CR Transmittal Number: R824PI
Related Change Request (CR) Number: 10845
Effective Date: October 1, 2018
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Additional details on the AWV are available in the *Medicare Benefit Policy Manual*, Chapter 15, Section 280.5 at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf*.

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

Document history

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Hurricane Maria and Medicare disaster-related U.S. Virgin Islands and Puerto Rico claims

***Note:** This article was revised September 13 to advise providers that the public health emergency (PHE) declaration and Section 1135 waiver authority for the U.S. Virgin Islands were renewed again September 11. All other information is unchanged. This information was previously published in the August 2018 Medicare B Connection, pages 14-16.*

Provider type affected

This *MLN Matters®* special edition article is intended for providers and suppliers who submit claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries in the United States Virgin Islands and the Commonwealth of Puerto Rico who were affected by Hurricane Maria.

Provider information available

On September 18, 2017, pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, President Trump declared that, as a result of the effects of Hurricane Maria, an emergency exists in the United States Virgin Islands and the Commonwealth of Puerto Rico. Also on September 19, 2017, Secretary Price of the Department of Health & Human Services declared that a public health emergency (PHE) exists in the United States Virgin Islands and the Commonwealth of Puerto Rico and authorized waivers and modifications under Section 1135 of the Social Security Act (the Act), retroactive to September 16, 2017, for the United States Virgin Islands and retroactive to September 17, 2017, for the Commonwealth of Puerto Rico.

The PHE declaration and Section 1135 waiver authority for the U.S. Virgin Islands were renewed December 15, 2017, renewed again March 15, 2018, June 13, 2018, and again September 11, 2018. The PHE and Section 1135 waiver authority for Puerto Rico were extended to March 15, 2018, and were extended again on March 16, 2018, to June 13, 2018. **The PHE and Section 1135 waiver authority for Puerto Rico expired June 13, 2018.**

On September 19, 2017, the Administrator of the Centers for Medicare & Medicaid Services (CMS) authorized waivers under Section 1812(f) of the Social Security Act for the United States Virgin Islands and the Commonwealth of Puerto Rico, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of Hurricane Maria in 2017.

Under Section 1135 or 1812(f) of the Social Security Act, the CMS has issued several blanket waivers in the impacted geographical areas of the United States Virgin Islands and the Commonwealth of Puerto Rico. These waivers will prevent gaps in access to care for beneficiaries impacted by the emergency. Providers do not need to apply for an individual waiver if a blanket waiver has been issued. Providers can request an individual Section 1135 waiver, if there is no blanket waiver, by following the instructions available at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Requesting-an-1135-Waiver-Updated-11-16-2016.pdf*.

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

Background

Section 1135 and Section 1812(f) Waivers

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

1. Change request (CR) 6451 (Transmittal 1784, Publication 100-04) issued July 31, 2009, applies to items and services furnished to Medicare beneficiaries within the United States Virgin Islands from September 16, 2017, and the Commonwealth of Puerto Rico from September 17, 2017, for the duration of the emergency. In accordance with CR 6451, use of the “DR” condition code and the “CR” modifier are mandatory on claims for items and services for which Medicare payment is conditioned on the presence of a “formal waiver” including, but not necessarily limited to, waivers granted under either Section 1135 or Section 1812(f) of the Act.
2. The most current information can be found at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Past-Emergencies/Hurricanes-and-tropical-storms.html*. Medicare FFS Questions & Answers (Q&As) posted on that web page and also referenced below are applicable for items and services furnished to Medicare beneficiaries within the United States Virgin Islands and the Commonwealth of Puerto Rico. These Q&As are displayed in two files:
   - One file addresses policies and procedures that are applicable without any Section 1135 or other formal waiver. These policies are always applicable in any kind of emergency or disaster, including the current emergency in the United States Virgin Islands and the Commonwealth of Puerto Rico.
   - Another file addresses policies and procedures that are applicable only with approved Section 1135 waivers or, when applicable, approved Section 1812(f) waivers. These Q&As are applicable for approved Section 1135 blanket waivers and approved individual 1135 waivers requested by providers and are effective September 16, 2017, for the United States Virgin Islands and September 17, 2017, for the Commonwealth of Puerto Rico.

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

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

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

Blanket waivers issued by CMS

Under the authority of Section 1135 (or, as noted below, Section 1812(f)), CMS has issued blanket waivers in the affected area of **the United States Virgin Islands and Commonwealth of Puerto Rico**. Individual facilities do not need to apply for the following approved blanket waivers:

Skilled nursing facilities

- Section 1812(f): Waiver of the requirement for a 3-day prior hospitalization for coverage of a skilled nursing facility (SNF) stay provides temporary emergency coverage of SNF services without a qualifying hospital stay, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of Hurricane Maria in the United States Virgin Islands and the Commonwealth of Puerto Rico in 2017. In addition, for certain beneficiaries who recently exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period. (Blanket waiver for all impacted facilities)
- 42 CFR 483.20: Waiver provides relief to Skilled Nursing Facilities on the timeframe requirements for minimum data set assessments and transmission. (Blanket waiver for all impacted facilities)

Home health agencies

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

Critical access hospitals

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

Housing acute care patients in excluded distinct part units

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

Care for Excluded Inpatient Psychiatric Unit Patients in the Acute Care Unit of a Hospital

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

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

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

Emergency durable medical equipment, prosthetics, orthotics, and supplies for Medicare beneficiaries impacted by an emergency or disaster

As a result of Hurricane Maria, CMS has determined it is appropriate to issue a blanket waiver to suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) where DMEPOS is lost, destroyed, irreparably damaged, or otherwise rendered unusable. Under this waiver, the face-to-face requirement, a new physician's order, and new medical necessity documentation are not required for replacement. Suppliers must still include a narrative description on the claim explaining the reason why the equipment must be replaced and are reminded to maintain documentation indicating that the DMEPOS was lost, destroyed, irreparably damaged or otherwise rendered unusable as a result of the hurricane.

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For more information refer to the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies for Medicare Beneficiaries Impacted by an Emergency or Disaster fact sheet at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Emergency-DME-Beneficiaries-Hurricanes.pdf*.

Appeal administrative relief for areas affected by Hurricane Maria

If you were affected by Hurricane Maria and are unable to file an appeal within 120 days from the date of receipt of the remittance advice (RA) that lists the initial determination or will have an extended period of non-receipt of remittance advices that will impact your ability to file an appeal, please contact your Medicare administrative contractor.

Replacement prescription fills

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

Applicability of reporting requirements for inpatient psychiatric facilities, skilled nursing facilities, home health agencies, hospices, inpatient rehabilitation facilities, ambulatory surgical centers, and renal dialysis facilities affected by Hurricane Maria

CMS is granting exceptions under certain Medicare quality reporting and value-based purchasing programs to inpatient psychiatric facilities, skilled nursing facilities, home health agencies, hospices, inpatient rehabilitation facilities, renal dialysis facilities, and ambulatory surgical centers located in areas affected by Hurricane Maria due to the devastating impact of the storm. These providers will be granted exceptions without having to submit an Extraordinary Circumstances Exceptions (ECE) request if they are located in one of the 78 Puerto Rico municipios or one of the three U.S. Virgin Islands county-equivalents, all of which have been designated by the *Federal Emergency Management Agency (FEMA)* as a major disaster municipio or county-equivalent.

The scope and duration of the exception under each Medicare quality reporting program is described in the memorandum that CMS posted *September 25, 2017*, however, all of the exceptions are being granted to assist these providers while they direct their resources toward caring for their patients and repairing structural damages to facilities.

Requesting an 1135 waiver

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

Additional information

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

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

Providers may also want to review the CMS Emergency and Preparedness webpage at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/EPRO-Home.html*.

Providers may also want to view the Survey and Certification Frequently Asked Questions at *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/index.html*.

Document history

Date of change	Description
September 13, 2018	The article was revised September 13, 2018, to advise providers that the PHE declaration and Section 1135 waiver authority for the U.S. Virgin Islands were renewed again September 11, 2018. All other information is unchanged.
July 25, 2018	This article was revised to advise providers that the PHE declaration and Section 1135 waiver authority for the U.S. Virgin Islands were renewed again June 13, 2018. The PHE and Section 1135 waiver authority for Puerto Rico expired June 13, 2018. The article was updated October 2, 2017, to include the section 'Applicability of reporting requirements for inpatient psychiatric facilities, skilled nursing facilities, home health agencies, hospices, inpatient rehabilitation facilities, ambulatory surgical centers, and renal dialysis facilities affected by Hurricane Maria.' All other information remains the same.
October 2, 2017	The article was updated October 2, 2017, to include the section 'Applicability of reporting requirements for inpatient psychiatric facilities, skilled nursing facilities, home health agencies, hospices, inpatient rehabilitation facilities, ambulatory surgical centers, and renal dialysis facilities affected by Hurricane Maria.' All other information remains the same.
September 21, 2017	Initial article released.

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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.

Find fees faster: Try First Coast's fee schedule lookup

Find the fee schedule information you need fast - with First Coast's fee schedule lookup, located at *https://medicare.fcso.com/Fee_lookup/fee_schedule.asp*. This exclusive online resource features an intuitive interface that allows you to search for fee information by procedure code. Plus, you can find any associated local coverage determinations (LCDs) with just the click of a button.

Retired LCDs

Allergen immunotherapy – retired Part B LCD

LCD ID number: L33804 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) and related "Coding Guidelines" for allergen immunotherapy are being retired based on the development of the new LCD and "Coding Guidelines" for allergen immunotherapy (L37800).

Effective date

This LCD retirement is effective for services rendered **on or after October 18, 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*.

Destruction of internal hemorrhoid(s) by infrared coagulation (IRC) – retired Part A and Part B LCD

LCD ID number: L33571 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on data analysis review of the local coverage determination (LCD), 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 August 22, 2018.** LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Revisions to LCDs

Allergen immunotherapy – new Part B LCD

LCD ID number: L37800 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for allergen immunotherapy was developed to address coverage criteria, coding requirements, documentation requirements, and utilization parameters for allergen immunotherapy. The LCD also addresses providers eligible to perform this service. Furthermore, in creating this new LCD, the current LCD for allergen immunotherapy (L33804) will be retired when this new LCD becomes effective.

Effective date

This new LCD is effective for services rendered **on or after October 18, 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*.

Cardiology — non-emergent outpatient testing: exercise stress test, stress echo, MPI SPECT, and cardiac PET – revision to the Part A and Part B LCD

LCD ID number: L36209 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for cardiology–non-emergent outpatient testing: exercise stress test, stress echo, MPI SPECT, and cardiac PET was revised to update the "CMS National Coverage Policy" section of the LCD for-*Medicare Claims Processing Manual*, Pub.100-04, Chapter 13, adding Sections 50, 60.11, and 60.9. Also, the "Limitations" section was revised as follows: "The CMS Manual System, Pub. 100-08, *Program Integrity Manual*, Chapter 13, Section 13.5.1, outlines that "reasonable and necessary" services are "ordered and furnished by qualified personnel"."

In addition, the "ICD-10 Codes that Support Medical Necessity" section of the LCD for each group of ICD-10-CM diagnosis codes was updated.

For Group 1 codes, ICD-10-CM diagnosis code Z01.810 was added for CPT® codes 93015, 93016, 93017, and 93018.

For Group 2 codes, the following ICD-10-CM diagnosis codes were added: I01.0-I01.9, I02.0, I11.0-I11.9, I13.0-I13.2, I21.01-I21.9, I21.A1-I21.A9, I22.0-I22.9, I24.1, I26.01-I26.99, I27.0-I27.9, I70.92, R01.0-R01.2, R06.00-R06.09, R06.2-R06.4, R06.81-R06.9, R55, R94.39, T36.0X5A-T36.0X5S, T36.1X5A-T36.1X5S, T36.2X5A-T36.2X5S, T36.3X5A-T36.3X5S, T36.4X5A-T36.4X5S, T36.5X5A-T36.5X5S, T36.6X5A-T36.6X5S, T36.7X5A-T36.7X5S, T36.8X5A-T36.8X5S, T36.95XA-T36.95XS, T37.0X5A-T37.0X5S, T37.1X5A-T37.1X5S, T37.2X5A-T37.2X5S, T37.3X5A-T37.3X5S, T37.4X5A-T37.4X5S, T37.5X5A-T37.5X5S, T37.8X5A-T37.8X5S, T37.95XA-T37.95XS, T38.4X5A-T38.4X5S, T38.5X5A-T38.5X5S, T39.015A-T39.015S, T39.095A-T39.095S, T39.1X5A-T39.1X5S, T39.2X5A-T39.2X5S, T39.315A-T39.315S, T39.395A-T39.395S, T39.4X5A-T39.4X5S, T39.8X5A-T39.8X5S, T39.95XA-T39.95XS, T40.0X5A-T40.0X5S, T40.2X5A-T40.2X5S, T40.3X5A-T40.3X5S, T40.4X5A-T40.4X5S, T40.5X5A-T40.5X5S, T40.605A-T40.605S, T40.695A-T40.695S, T40.7X5A-T40.7X5S, T40.905A-T40.905S, T40.995A-T40.995S, T41.5X5A-T41.5X5S, T42.0X5A-T42.0X5S, T42.1X5A-T42.1X5S, T42.2X5A-T42.2X5S, T42.3X5A-T42.3X5S, T42.4X5A-T42.4X5S, T42.5X5A-T42.5X5S, T42.6X5A-T42.6X5S, T42.75XA-T42.75XS, T42.8X5A-T42.8X5S, T43.015A-T43.015S, T43.025A-T43.025S, T43.1X5A-T43.1X5S, T43.205A-T43.205S, T43.215A-T43.215S, T43.225A-T43.225S, T43.295A-T43.295S, T43.3X5A-T43.3X5S, T43.4X5A-T43.4X5S, T43.505A-T43.505S, T43.595A-T43.595S, T43.605A-T43.605S, T43.615A-T43.615S, T43.625A-T43.625S, T43.635A-T43.635S, T43.695A-T43.695S, T43.8X5A-T43.8X5S, T43.95XA-T43.95XS, T44.0X5A-T44.0X5S, T45.0X5A-T45.0X5S, T45.1X1A-T45.1X1S, T45.2X5A-T45.2X5S, T45.3X5A-T45.3X5S, T45.4X5A-T45.4X5S, T45.515A-T45.515S, T45.525A-T45.525S, T45.605A-T45.605S, T45.615A-T45.615S, T45.625A-T45.625S, T45.695A-T45.695S, T45.7X5A-T45.7X5S, T45.8X5A-T45.8X5S, T45.95XA-T45.95XS, T47.1X5A-T47.1X5S, T47.2X5A-T47.2X5S, T47.3X5A-T47.3X5S, T47.4X5A-T47.4X5S, T47.5X5A-T47.5X5S, T47.6X5A-T47.6X5S, T47.7X5A-T47.7X5S, T47.8X5A-T47.8X5S, T47.95XA-T47.95XS, T48.0X5A-T48.0X5S, T48.1X5A-T48.1X5S, T48.205A-T48.205S, T48.295A-T48.295S, T48.3X5A-T48.3X5S, T48.4X5A-T48.4X5S, T48.5X5A-T48.5X5S, T48.6X5A-T48.6X5S, T48.905A-T48.905S, T48.995A-T48.995S, T49.0X5A-T49.0X5S, T49.1X5A-T49.1X5S, T49.2X5A-T49.2X5S, T49.3X5A-T49.3X5S, T49.4X5A-T49.4X5S, T49.5X5A-T49.5X5S, T49.6X5A-T49.6X5S, T49.7X5A-T49.7X5S, T49.8X5A-T49.8X5S, T49.95XA-T49.95XS, T50.3X5A-T50.3X5S, T50.4X5A-T50.4X5S, T50.5X5A-T50.5X5S, T50.6X5A-T50.6X5S, T50.7X5A-T50.7X5S, T50.8X5A-T50.8X5S, T50.A15A-T50.A15S, T50.A25A-T50.A25S, T50.A95A-T50.A95S, T50.B15A-T50.B15S, T50.B95A-T50.B95S, T50.Z15A-T50.Z15S, T50.Z95A-T50.Z95S, T50.905A-T50.905S, T50.995A-T50.995S, T88.52XA-T88.52XS, and Z01.810 for CPT® codes 93350, 93351 and 93352 . ICD-10-CM diagnosis codes I25.10-I25.799, I25.811-I25.812, I25.84, I25.89, and I25.9 were removed and replaced with ICD-10-CM diagnosis code range I25.10-I25.9 for CPT® codes 93350, 93351 and 93352.

For Group 3 codes, the following ICD-10 CM diagnoses codes were added: I11.0-I11.9, I13.0-I13.2, I21.01-I21.9, I21.A1-I21.A9, I22.0-I22.9, and R55 for CPT codes 78451, 78452, 78453, and 78454.

For Group 4 codes, the following ICD-10-M diagnosis codes were added: I11.0-I11.9, I13.0-I13.2, I21.01-I21.9, I21.A1-I21.A9, I22.0-I22.9, I24.8, I24.9, I70.211-I70.269, I70.92, R55, R94.31, R94.39, T36.0X5A-T36.0X5S, T36.1X5A-T36.1X5S, T36.2X5A-T36.2X5S, T36.3X5A-T36.3X5S, T36.4X5A-T36.4X5S, T36.5X5A-T36.5X5S, T36.6X5A-T36.6X5S, T36.7X5A-T36.7X5S, T36.8X5A-T36.8X5S, T36.95XA-T36.95XS, T37.0X5A-T37.0X5S, T37.1X5A-T37.1X5S, T37.2X5A-T37.2X5S, T37.3X5A-T37.3X5S, T37.4X5A-T37.4X5S, T37.5X5A-T37.5X5S, T37.8X5A-T37.8X5S, T37.95XA-T37.95XS, T38.0X5A-T38.0X5S, T38.1X5A-T38.1X5S, T38.2X5A-T38.2X5S, T38.4X5A-T38.4X5S, T38.5X5A-T38.5X5S, T38.6X5A-T38.6X5S, T38.7X5A-T38.7X5S, T38.805A-T38.805S, T38.815A-T38.815S, T38.895A-T38.895S, T38.905A-T38.905S, T38.995A-T38.995S, T39.015A-T39.015S, T39.095A-T39.095S, T39.1X5A-T39.1X5S, T39.2X5A-T39.2X5S, T39.315A-T39.315S, T39.395A-T39.395S,

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T39.4X5A-T39.4X5S, T39.8X5A-T39.8X5S, T39.95XA-T39.95XS, T40.0X5A-T40.0X5S, T40.2X5A-T40.2X5S, T40.3X5A-T40.3X5S, T40.4X5A-T40.4X5S, T40.5X5A-T40.5X5S, T40.605A-T40.605S, T40.695A-T40.695S, T40.7X5A-T40.7X5S, T40.905A-T40.905S, T40.995A-T40.995S, T41.5X5A-T41.5X5S, T42.0X5A-T42.0X5S, T42.1X5A-T42.1X5S, T42.2X5A-T42.2X5S, T42.3X5A-T42.3X5S, T42.4X5A-T42.4X5S, T42.5X5A-T42.5X5S, T42.6X5A-T42.6X5S, T42.75XA-T42.75XS, T42.8X5A-T42.8X5S, T43.015A-T43.015S, T43.025A-T43.025S, T43.1X5A-T43.1X5S, T43.205A-T43.205S, T43.215A-T43.215S, T43.225A-T43.225S, T43.295A-T43.295S, T43.3X5A-T43.3X5S, T43.4X5A-T43.4X5S, T43.505A-T43.505S, T43.595A-T43.595S, T43.605A-T43.605S, T43.615A-T43.615S, T43.625A-T43.625S, T43.635A-T43.635S, T43.695A-T43.695S, T43.8X5A-T43.8X5S, T43.95XA-T43.95XS, T44.0X5A-T44.0X5S, T44.1X5A-T44.1X5S, T44.2X5A-T44.2X5S, T44.3X5A-T44.3X5S, T44.4X5A-T44.4X5S, T44.5X5A-T44.5X5S, T44.6X5A-T44.6X5S, T44.7X5A-T44.7X5S, T44.8X5A-T44.8X5S, T44.905A-T44.905S, T44.995A-T44.995S, T45.0X5A-T45.0X5S, T45.1X1A-T45.1X1S, T45.1X5A-T45.1X5S, T45.2X5A-T45.2X5S, T45.3X5A-T45.3X5S, T45.4X5A-T45.4X5S, T45.515A-T45.515S, T45.525A-T45.525S, T45.605A-T45.605S, T45.615A-T45.615S, T45.625A-T45.625S, T45.695A-T45.695S, T45.7X5A-T45.7X5S, T45.8X5A-T45.8X5S, T45.95XA-T45.95XS, T46.0X5A-T46.0X5S, T46.1X5A-T46.1X5S, T46.2X5A-T46.2X5S, T46.3X5A-T46.3X5S, T46.4X5A-T46.4X5S, T46.5X5A-T46.5X5S, T46.6X5A-T46.6X5S, T46.7X5A-T46.7X5S, T46.8X5A-T46.8X5S, T46.905A-T46.905S, T46.995A-T46.995S, T47.0X5A-T47.0X5S, T47.1X5A-T47.1X5S, T47.2X5A-T47.2X5S, T47.3X5A-T47.3X5S, T47.4X5A-T47.4X5S, T47.5X5A-T47.5X5S, T47.6X5A-T47.6X5S, T47.7X5A-T47.7X5S, T47.8X5A-T47.8X5S, T47.95XA-T47.95XS, T48.0X5A-T48.0X5S, T48.1X5A-T48.1X5S, T48.205A-T48.205S, T48.295A-T48.295S, T48.3X5A-T48.3X5S, T48.4X5A-T48.4X5S, T48.5X5A-T48.5X5S, T48.6X5A-T48.6X5S, T48.905A-T48.905S, T48.995A-T48.995S, T49.0X5A-T49.0X5S, T49.1X5A-T49.1X5S, T49.2X5A-T49.2X5S, T49.3X5A-T49.3X5S, T49.4X5A-T49.4X5S, T49.5X5A-T49.5X5S, T49.6X5A-T49.6X5S, T49.7X5A-T49.7X5S, T49.8X5A-T49.8X5S, T49.95XA-T49.95XS, T50.0X5A-T50.0X5S, T50.1X5A-T50.1X5S,

T50.2X5A-T50.2X5S, T50.3X5A-T50.3X5S, T50.4X5A-T50.4X5S, T50.5X5A-T50.5X5S, T50.6X5A-T50.6X5S, T50.7X5A-T50.7X5S, T50.8X5A-T50.8X5S, T50.A15A-T50.A15S, T50.A25A-T50.A25S, T50.A95A-T50.A95S, T50.B15A-T50.B15S, T50.B95A-T50.B95S, T50.Z15A-T50.Z15S, T50.Z95A-T50.Z95S, T50.905A-T50.905S, T50.995A-T50.995S, T88.52XA-T88.52XS, Z01.810, Z08 and Z09 for CPT® codes 78459, 78491, and 78492. ICD-10-CM diagnosis codes I25.10-I25.119, I25.3-I25.42, and I25.700-I25.812 were removed and replaced with ICD-10-CM diagnosis code range I25.10-I25.9 for CPT® codes 78459, 78491, and 78492. ICD-10-CM diagnosis code range I44.30-I45.5 was removed and replaced with ICD-10-CM diagnosis code range I44.30-I45.6 for CPT® codes 78459, 78491, and 78492.

Effective date

This revision to the LCD is effective for claims processed **on or after September 13, 2018**, for services rendered **on or after November 9, 2017.** LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Duplex scan of lower extremity arteries – revision to the Part A and Part B LCD

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

The local coverage determination (LCD) for duplex scan of lower extremity arteries was revised to change diagnosis code range S85.001A-S85.999S to diagnosis code ranges S85.001A-S85.299S and S85.801A-S85.999S. Diagnosis code range S85.301A-S85.599S was added in error. In addition, the LCD was revised to add the following language "<0.9 at rest), it must be accompanied by another appropriate indication before proceeding to more sophisticated or complete studies, except in patients with severely elevated ankle blood pressure" to the "Coverage Indications, Limitations and/or Medical Necessity" section of the LCD, in the second paragraph under "Limitations", as it was omitted in error.

Effective date

The LCD revision related to diagnosis is effective for claims processed **on or after September 18, 2018**, for services rendered **on or after October 1, 2015**. 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*.

Electrocardiography – revision to the Part A and Part B LCD

LCD ID number: L33669 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for electrocardiography was revised to change diagnosis code T36.4X5A to diagnosis code range T36.4X5A-T36.4X5S, diagnosis code T45.515A to diagnosis code range T45.515A-T45.515S, and diagnosis code T50.B95A to diagnosis code range T50.B95A-T50.B95S, as they were omitted in error.

Effective date

The LCD revision related to diagnosis is effective for claims processed **on or after October 1, 2018**, for services rendered **on or after October 1, 2015**. 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*.

Emergency and non-emergency ground ambulance services – revision to the Part A and Part B LCD

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

The local coverage determination (LCD) for emergency and non-emergency ground ambulance services was revised in the "Coverage Indications, Limitations, and/ or Medical Necessity" section of the LCD under "The Destination" to add "site of transfer (e.g. airport or helicopter pad) between modes of ambulance transport" as a covered destination for emergency ambulance services.

Effective date

This LCD revision is effective for claims processed **on or after September 19, 2018,** for services rendered **on or after June 28, 2018.** LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Erythropoiesis stimulating agents – revision to the Part A and Part B LCD

LCD ID number: L36276 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 10859 (International Code of Diseases, Tenth Revision [ICD-10] and Other Coding revisions to National Coverage Determinations [NCDs]), the local coverage determination (LCD) for erythropoiesis stimulating agents was revised to remove ICD-10-CM diagnosis code D64.9 from the "ICD-10 Codes that Support Medical Necessity" "Group 3 Codes:" section of the LCD for Healthcare Common Procedure Coding System (HCPCS) codes J0885 and Q5106, as it is on the list of national non-covered diagnoses.

In addition, the LCD was revised to remove revenue code 045X based on updated language in the Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual (IOM).

Effective date

The LCD revision related to CR 10859 is effective for claims processed **on or after September 28, 2018**, for services rendered **on or after January 1, 2017**.

The LCD revision related to revenue code 045X is for claims processed **on or after October 1, 2018**.

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

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

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

Humanitarian use device (HUD) and humanitarian device exemption (HDE) process – revision to the Part A and Part B LCD

LCD ID number: L36238 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on an annual review, the local coverage determination (LCD) for humanitarian use device (HUD) and humanitarian device exemption (HDE) process was revised to add language taken from the 21 CFR Parts 814 to reflect changes recently enacted into law by the 21st Century Cures Act. The phrase ''fewer than 4,000'' has been replaced with ''not more than 8,000'' in the first paragraph under "Background" in the "Coverage Indications, Limitations, and/or Medical Necessity" section of the LCD.

Effective date

This LCD revision is effective for claims processed **on or after August 23, 2018**, for services rendered **on or after June 7, 2017.** LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

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

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

The local coverage determination (LCD) for major joint replacement (hip and knee) was revised to remove diagnosis codes M96.65, T84.020A, T84.020D, T84.020S, T84.021A, T84.021D, T84.021S, Z89.621, and Z89.622, that were included in the "ICD-10 Codes that Support Medical Necessity/Group 2 Codes:/Total Knee Arthroplasty" section of the LCD in error.

Effective date

The LCD revision is effective for claims processed **on or after October 1, 2018**, for services rendered **on or after March 2, 2016**. 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*.

Pegfilgrastim (Neulasta®) – revision to the Part A and Part B LCD

LCD ID number: L33747 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 10834, CR 10898, CR 10900, CR 10923, and CR 10932 (October 2018 Quarterly Updates), the pegfilgrastim (Neulasta®) local coverage determination (LCD) was revised to add Healthcare Common Procedure Coding System (HCPCS) code Q5108 to the "CPT®/HCPCS Codes" section of the LCD.

Effective date

This LCD revision is effective for claims processed **on or after October 1, 2018**, for services rendered **on or after July 12, 2018**. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Additional Information

2019 ICD-10-CM Coding Changes (Part A/B, Part A and Part B)

The 2019 update to the ICD-10-CM diagnosis coding structure is effective for services rendered **on or after October 1, 2018.** First Coast Service Options Inc. (First Coast) medical policy team has evaluated all active local coverage determinations (LCDs) for diagnosis criteria that are impacted by the 2019 ICD-10-CM update. As a reminder, diagnosis codes included in an LCD are surrogate to the indications addressed within the LCD and providers are required to bill the highest level of specificity for the applicable diagnosis code when reporting services. ICD-10-CM diagnosis codes have been added, revised, and deleted. The following is a list of the impacted LCDs. **Note:** The LCDs will be viewable to the public in Medicare Coverage Database on **October 11, 2018.**

Part A/B Combined LCDs

L33256 3D Interpretation and Reporting of Imaging Studies

L36767 Aortography and peripheral angiography

L33274 Botulinum Toxins

L33275 Carboplatin (Paraplatin, Paraplatin-AQ®)

L33278 Cetuximab (Erbitux®)

L36393 Controlled Substance Monitoring and Drugs of Abuse Testing

L33989 Docetaxel (Taxotere®)

L33669 Electrocardiography

L36276 Erythropoiesis Stimulating Agents

L33723 Etoposide (Etopophos®, Toposar®, Vepesid®, VP-16)

L34003 Hepatitis B Surface Antibody and Surface Antigen

L36773 Intensity Modulated Radiation Therapy (IMRT)

L33382 Lumbar Spinal Fusion for Instability and Degenerative Disc Conditions

L33618 Major Joint Replacement (Hip and Knee)

L33689 Mohs Micrographic Surgery (MMS)

L34859 Nerve Conduction Studies and Electromyography

L33695 Non-invasive Extracranial Arterial Studies

L33730 Paclitaxel (Taxol®)

L33747 Pegfilgratim (Neulasta®)

L33252 Psychiatric Diagnostic Evaluation and Psychotherapy Services

L34520 Psychological and Neuropsychological Tests

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

L36342 Screening and Diagnostic Mammography

L34021 Sedimentation Rate, Erythrocyte

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L34022 Serum Phosphorus

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

L33411 Surgical Management of Morbid Obesity

L34031 Total Calcium

L33768 Transthoracic Echocardiography (TTE)

L33766 Visual Field Examination

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

Part A only LCD

L33972 Psychiatric Partial Hospitalization Program

Part B only LCDS

L33904 B-Scan

L33813 Destruction of Malignant Skin Lesions

L33906 Epidural

L33818 Excision of Malignant Skin Lesions

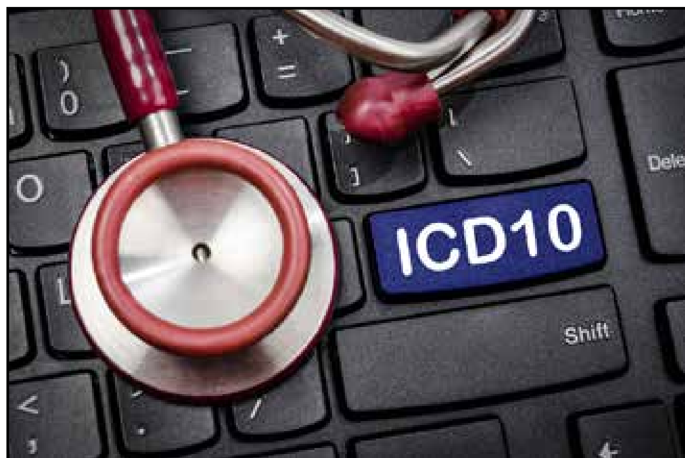
L33907 Hepatic (Liver) Function Panel

L33908 High Sensitivity C-Reactive Protein (hsCRP)

L33912 Injection of Trigger Points

L33933 Peripheral Nerve Blocks

L33937 Proton Beam Radiotherapy



L33977 Transcranial Doppler Studies

Effective date

These LCD revisions are effective for services rendered **on or after October 1, 2018.** LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Quarterly provider update

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

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

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

Upcoming provider outreach and educational events

Topic: Medicare outpatient physical therapy services (A/B)

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

https://medicare.fcso.com/Events/0414762.asp

Topic: Medicare Speaks 2018 Panama City

Date: Wednesday-Thursday, November 7-8
Time: 8:00 a.m.-4:30 p.m. CT
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, https://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® – Special Edition for August 20, 2018

New Medicare Card Mailing Update – Wave 5 Begins, Wave 3 Ends

We started mailing new Medicare cards to people with Medicare who live in Wave 5 states: Alabama, Florida, Georgia, North Carolina, and South Carolina. We continue to mail new cards to people who live in Wave 4 states, as well as nationwide to people who are new to Medicare.

We finished mailing cards to people with Medicare who live in Wave 1, 2 and 3 states and territories. If your Medicare patients say they did not get a card, instruct them to:

- Sign into *MyMedicare.gov* to see if we mailed their card. If so, they can print an official card. They must create an account if they do not already have one.
- Call 1-800-MEDICARE (1-800-633-4227). There might be something that needs to be corrected, such as updating their mailing address.

You can also print out and give them a copy of "*Still Waiting for Your New Card?*" or you can *order* copies to hand out.

To ensure your Medicare patients continue to get care, you can use either the former Social Security number-based Health Insurance Claim Number or the new alpha-numeric Medicare Beneficiary Identifier (MBI) for all Medicare transactions through December 31, 2019.

Check this *website* as the mailings progress. Continue to direct your Medicare patients to *Medicare.gov/NewCard* for information about the mailings and to sign up to get email about the status of card mailings in their state.

Information on the transition to the new MBI:

- *New MBI Get It, Use It* MLN Matters® Article
- *Transition to New Medicare Numbers and Cards* MLN Fact Sheet
- *New Medicare Card information* website

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MLN Connects®for August 23, 2018

MLN Connects® for August 23, 2018

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News & Announcements

- New Medicare Card: 0 not O
- Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier
- 2016 PQRS and 2018 Value Modifier Experience Reports
- Patients Over Paperwork: Medicare Physician Fee Schedule Proposed Rule Presentation
- 2019 MIPS Performance Year Virtual Groups Toolkit
- Hospice Compare Quarterly Refresh
- 2016 Inpatient Hospital Utilization and Payment Data
- Hospices: Second Quarter HQRP Update

Provider Compliance

- Medicare Hospital Claims: Avoid Coding Errors — Reminder

Claims, Pricers & Codes

- 2019 MS-DRG Definitions Manual and Software
- Hospice: NOE information in the HETS Transaction

Upcoming Events

- Quality Payment Program Virtual Groups Webinar — August 27
- Person-Centered Approaches to Support Dual Eligibles for Medicare & Medicaid- September 6
- Dementia Care: Opioid Use & Impact for Persons Living with Dementia Call — September 18

Medicare Learning Network Publications & Multimedia

- Additional Search Features on FISS Provider DDE Screen MLN Matters Article — New
- ICD-10 and Other Coding Revisions to NCDs MLN Matters Article — New
- Clarifying Language for Chapters 3 and 5 of the MSP Manual MLN Matters Article — New
- Medicare Coverage of Diabetes Supplies MLN Matters Article — New
- Improvements in Hospice Billing and Claims Processing MLN Matters Article — Revised

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MLN Connects® for August 30, 2018

MLN Connects® for August 30, 2018
View this edition as a PDF

News & Announcements

- New Medicare Card: 0 not O
- Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier
- 2016 PQRS and 2018 Value Modifier Experience Reports
- Patients Over Paperwork: Medicare Physician Fee Schedule Proposed Rule Presentation
- 2019 MIPS Performance Year Virtual Groups Toolkit
- Hospice Compare Quarterly Refresh
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Provider Compliance

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Claims, Pricers & Codes

- 2019 MS-DRG Definitions Manual and Software
- Hospice: NOE information in the HETS Transaction

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- Quality Payment Program Virtual Groups Webinar — August 27
- Person-Centered Approaches to Support Dual Eligibles for Medicare & Medicaid- September 6
- Dementia Care: Opioid Use & Impact for Persons Living with Dementia Call — September 18

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- Clarifying Language for Chapters 3 and 5 of the MSP Manual MLN Matters Article — New
- Medicare Coverage of Diabetes Supplies MLN Matters Article — New
- Improvements in Hospice Billing and Claims Processing MLN Matters Article — Revised

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MLN Connects® for September 6, 2018

MLN Connects® for September 6, 2018
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News & Announcements

- Physician Fee Schedule Year 3 Proposed Rule: Comments due September 10
- QRDA III Implementation Guide: Submit Comments by September 21
- PEPPERs for Short-term Acute Care Hospitals
- Hospice Quality Reporting Program: Training Materials from August Webinar
- Healthy Aging® Month: Discuss Preventive Services with your Patients

Provider Compliance

- CMS Provider Minute Video: The Importance of Proper Documentation — Reminder

Claims, Pricers & Codes

- Average Sales Price Files: October 2018

Upcoming Events

- Quality Payment Program All-Payer Combination Option Overview Webinar — September 12
- New Medicare Card Open Door Forum — September 13
- Dementia Care: Opioid Use & Impact for Persons Living with Dementia Call — September 18
- Medicare Diabetes Prevention Program: New Covered Service Call — September 26

Medicare Learning Network Publications & Multimedia

- Review of Opioid Use during the IPPE and AWV MLN Matters® Article — New
- Update of the Hospital OPPS: October 2018 MLN Matters Article — New
- Physician Fee Schedule Listening Session: Audio Recording and Transcript — New
- Next Generation ACO Model 2019 Benefit Enhancement MLN Matters Article — Revised
- Mass Immunizers and Roster Billing Booklet — Revised

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MLN Connects® for September 13, 2018

MLN Connects® for September 13, 2018
View this edition as a PDF

News & Announcements

- Help Your Medicare Patients Avoid and Report Scams
- Hospice Provider Preview Reports: Review Your Data by October 5
- IRF Provider Preview Reports: Review Your Data by October 8
- LTCH Provider Preview Reports: Review Your Data by October 8
- Open Payments: Key Thresholds for Program Year 2019 Reporting
- Open Payments: Program Year 2019 Teaching Hospital List
- Hand in Hand: A Training Series for Nursing Homes
- Quality Payment Program: Other Payer Advanced APM Resources
- Mapping Medicare Disparities Tool: Hospital View
- Physician Compare: Public Reporting Webinar Materials
- Prostate Cancer Awareness Month

Provider Compliance

- Bill Correctly for Device Replacement Procedures - Reminder

Upcoming Events

- Dementia Care: Opioid Use & Impact for Persons Living with Dementia Call — September 18
- Medicare Diabetes Prevention Program: New Covered Service Call — September 26
- Final Modifications to the Quality of Patient Care Star Rating Algorithm Call — October 3
- Comparative Billing Report on Psychologists Webinar — October 17

Medicare Learning Network Publications & Multimedia

- Billing Requirements Implemented for non-OPPS Providers MLN Matters® Article — New
- Annual Clotting Factor Furnishing Fee: 2019 Update MLN Matters Article — New
- ASC Payment System: October 2018 Update MLN Matters Article — New
- Influenza Vaccine Payment Allowances: Annual Update MLN Matters Article — New
- Influenza Virus Vaccine Code: January 2019 Update MLN Matters Article — Revised
- Certification Statement Policies MLN Matters Article — Revised
- Telehealth Billing Requirements for Distant Site Services MLN Matters Article — Revised
- Complying with Documentation Requirements for Laboratory Services Fact Sheet — Revised
- Global Surgery Booklet— Revised
- Medicare Provider-Supplier Enrollment National Educational Products — Reminder

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MLN Connects® – Special Edition for September 17, 2018

New Medicare Card Mailing Update – Wave 6 Begins, Wave 4 Ends

CMS started mailing new Medicare cards to people with Medicare who live in Wave 6 states: Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Texas, Utah, Washington and Wyoming.

We finished mailing cards to people with Medicare who live in *Waves 1, 2, 3, and now Wave 4 states and territories*.
If your Medicare patients say they did not get a card, ask them to:

Sign into *MyMedicare.gov* to see if we mailed their card. If so, they can print an official card. They must create an account if they do not already have one.

Call 1-800-MEDICARE (1-800-633-4227). There might be something that needs to be corrected, such as updating their mailing address.

You can also print out and give them a copy of *Still Waiting for Your New Card?*, or you can order *copies* to hand out.

To ensure your Medicare patients continue to get care, you can use either the former Social Security number-based Health Insurance Claim Number or the new alpha-numeric Medicare Beneficiary Identifier (MBI) for all Medicare transactions through December 31, 2019.

Check this *website* as the mailings progress. Continue to direct your Medicare patients to *Medicare.gov/NewCard* for information about the mailings and to sign up to get email about the status of card mailings in their state.

We are committed to mailing new cards to all people with Medicare by April 2019.

Information on the transition to the new MBI:

New MBI Get It, Use It MLN Matters® Article

Transition to New Medicare Numbers and Cards Fact Sheet

New Medicare Card information website

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MLN Connects® – Special Edition for September 19, 2018

New Medicare Card – Progress Updates

CMS continues to successfully mail newly-designed Medicare cards with the new Medicare number and we are excited to share important progress updates with you.

As of August 31, we mailed nearly 35 million cards and continue to mail more every day. We are processing claims and eligibility requests with the Medicare Beneficiary Identifier (MBI), showing that providers are successfully using the new number.

We started mailing new cards to people with Medicare who live in Wave 6 states this week and finished mailing cards to people who live in Waves 1, 2, 3 and 4 states. Because card mailing is progressing so well, we updated the *mailing schedule* to include an approximate start date for the last wave, and we are on track to finish mailing new cards to all people with Medicare before April 2019.

With our ongoing focus on fraud and protecting the identities of people with Medicare, we are continuously adjusting and improving our mailing strategy to make sure we are mailing new cards to accurate addresses and using the highest levels of fraud protection throughout the mailing. To do this, we are:

- Using trusted industry tools and standards to verify addresses
- Comparing each address against multiple information sources to ensure we are mailing to the right person and the right address
- Mailing cards to people with Medicare when we have high confidence in their identity and address

If your Medicare patients say they did not get a card after their mailing wave ends, ask them to:

- Call 1-800-MEDICARE (1-800-633-4227) where we can verify their identity, check their address, and help them get their new card
- Continue to use their current card to get health care services until they get their new card

Your Medicare patients should continue to protect their new number to prevent medical identity theft and health care fraud. We will continue to raise awareness about potential scams and how they can prevent fraud through our outreach and launched a national fraud prevention campaign in September before Medicare Open Enrollment.

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MLN Connects® for September 20, 2018

MLN Connects® for September 20, 2018
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News & Announcements

- CMS Proposes to Lift Unnecessary Regulations and Ease Burden on Providers
- Hospital Quality Reporting System Open for CY 2018 eCQM Data
- eCQM Value Sets: Updates for 2019 Reporting and Performance Periods
- MIPS Targeted Review Request: Deadline Extended to October 15
- Quality Payment Program: MIPS Resources
- Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier

Provider Compliance

- Billing for Stem Cell Transplants — Reminder

Claims, Pricers & Codes

- ASP Pricing Files and Coverage for Drugs

Upcoming Events

- Medicare Diabetes Prevention Program: New Covered Service Call — September 26
- FY 2019 IPPS/LTCH PPS Final Rule Webinar— September 26
- Final Modifications to the Quality of Patient Care Star Rating Algorithm Call — October 3
- Provider Compliance Focus Group Meeting — October 5
- Submitting Your Medicare Part A Cost Report Electronically Webcast — October 15
- Home Health Quality Reporting Program In-Person Training Event — November 6 and 7

Medicare Learning Network Publications & Multimedia

- IMRT Planning Services Editing MLN Matters Article — New
- Payment Policy Changes Affecting Hospice Aggregate Cap Calculation and Designation of Hospice Attending Physicians MLN Matters Article — New
- Medicare Claims Processing Manual, Chapter 23: Update MLN Matters Article — New
- Procedure Coding: Using the ICD-10-PCS Web-Based Training — New
- ICD-10 and Other Coding Revisions to NCDs MLN Matters Article — Revised
- HCPCS Drug/Biological Code Changes: October 2018 Update MLN Matters Article — Revised
- Hurricane Maria and Medicare Disaster Related U.S Virgin Islands and Commonwealth of Puerto Rico Claims MLN Matters Article — Revised
- Preventive Services Poster Educational Tool — Revised
- Medicare Fraud & Abuse Poster — Revised

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Phone numbers

Customer service

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

Education event registration hotline

904-791-8103 (NOT toll-free)

Electronic data interchange (EDI)

888-670-0940

Electronic funds transfers (EFT) (CMS-588)

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

Fax number (for general inquiries)

904-361-0696

Interactive voice response (IVR) system

877-847-4992

Provider enrollment

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

The SPOT help desk

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

Addresses

Claims

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

Redeterminations

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

Redetermination of overpayments

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

Reconsiderations

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

General inquiries

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

Email: *EDOC-CS-FLINQB@fcso.com>>*
Online form: *https://medicare.fcso.com/Feedback/161670.asp*

Provider enrollment

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

Special or overnight deliveries
Provider Enrollment
2020 Technology Parkway Suite 100
Mechanicsburg, PA 17055-1849

Medical policy

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

Medicare secondary payer

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

Electronic data interchange (EDI)

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

Overpayments

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

Medicare Education and Outreach

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

Fraud and abuse

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

Freedom of Information Act requests

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

Overnight mail and/or special courier service

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

Websites

Provider

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

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

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

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

Beneficiaries

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

Phone numbers

Customer service

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

Education event registration hotline

904-791-8103 (NOT toll-free)

Electronic data interchange (EDI)

888-670-0940

Electronic funds transfers (EFT) (CMS-588)

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

Fax number (for general inquiries)

904-361-0696

Interactive voice response (IVR) system

877-847-4992

Provider enrollment

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

The SPOT help desk

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

Addresses

Claims

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

Redeterminations

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

Redetermination of overpayments

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

Reconsiderations

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

General inquiries

First Coast Service Options Inc.
P.O. Box 45098
Jacksonville, FL 32232-5098
Email: *EDOC-CS-FLINQB@fcso.com>>*
Online form: *https://medicare.fcso.com/Feedback/161670.asp*

Provider enrollment

CMS-855 Applications
P. O. Box 3409
Mechanicsburg, PA 17055-1849

Special or overnight deliveries
Provider Enrollment
2020 Technology Parkway Suite 100
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 45013
Jacksonville, FL 32232-5013

Medicare Education and Outreach

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

Fraud and abuse

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

Freedom of Information Act requests

FOIA USVI
P.O. Box 45073
Jacksonville, FL 32231-5073

Special courier service

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

Websites

Provider

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

https://medicare.fcso.com

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Centers for Medicare & Medicaid Services

https://www.cms.gov

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

Beneficiaries

Centers for Medicare & Medicaid Services

https://www.medicare.gov

Phone numbers

Customer service

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

Education event registration hotline

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

Electronic data interchange (EDI)

888-875-9779

Electronic funds transfers (EFT) (CMS-588)

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

General inquiries

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

Interactive voice response (IVR) system

877-847-4992

Provider enrollment

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

The SPOT help desk

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

Addresses

Claims

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

Redeterminations

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

Redetermination of overpayments

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

Reconsiderations

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

General inquiries

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

Email: *EDOC-CS-PRINQB@fcso.com>*
Online form: *https://medicare.fcso.com/Feedback/161670.asp*

Provider enrollment

CMS-855 Applications
P. O. Box 3409
Mechanicsburg, PA 17055-1849

Special or overnight deliveries
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2020 Technology Parkway Suite 100
Mechanicsburg, PA 17055-1849

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

Medicare secondary payer

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

Electronic data interchange (EDI)

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

Overpayments

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

Medicare Education and Outreach

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

Fraud and abuse

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

Freedom of Information Act requests

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

Special courier service

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

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https://www.cms.gov

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

Beneficiaries

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

Order form for Medicare Part B materials

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

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

Item	Acct Number	Cost per item	Quantity	Total cost
Part B subscription – The Medicare Part B jurisdiction N publications, in both Spanish and English, are available free of charge online at https://medicare.fcso.com/Publications_B/index.asp (English) or https://medicareespanol.fcso.com/Publicaciones/ (Español). Nonprovider entities or providers who need additional copies may purchase an annual subscription. This subscription includes all issues published from October 2018 through September 2019.	40300260	$33		
2017 fee schedule – The Medicare Part B Physician and Nonphysician Practitioner Fee Schedules, effective for services rendered January 1 through December 31, 2017, are available free of charge online at 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		
Language preference: **English** [ ] **Español** [ ]				
Please write legibly			Subtotal	$
			Tax (***add % for your area***)	$
			Total	$

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

Contact Name: ______________________________

Provider/Office Name: ______________________________

Phone: ______________________________

Mailing Address: ______________________________

City: ______________ State: ______________ ZIP: ______________

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