Medicare B CONNECTION

medicare.fcso.com

FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction N Providers

October 2018

In this issue

New local coverage determinations process

Provider type affected

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

Provider action needed

Change request (CR) 10901 notifies MACs that, in accordance with Section 4009 of H.R. 34-21st Century Cures Act (Public Law No: 114-255), the Centers for Medicare & Medicaid Services (CMS) is updating the *Medicare Program Integrity Manual* with detailed changes to the local coverage determination (LCD) process. You should ensure that your staffs are aware of these changes.

Background

Through feedback received in the proposed 2018 physician fee schedule (PFS) rule (82 FR 33950), and through meetings and correspondence; stakeholders, including providers and healthcare associations, have provided CMS with valuable insight regarding modernization of the LCD process.

Most stakeholders acknowledged that the local coverage process is an important means to provide decisions related to the items and services that benefit Medicare's beneficiaries and to ensure beneficiary access to life saving and medically necessary products and procedures. However, there is concern about

See **PROCESS**, page 7

Contents

Find out first: Subscribe to First Coast *eNews*

Subscribe to First Coast Service Options *eNews*, to learn the latest Medicare news and critical program changes affecting the provider community. Join as many lists as you wish, in English or Spanish, and customize your subscription to fit your specific needs, line of business, specialty, or topics of interest. So, *subscribe to eNews, and stay informed.*

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

Publication staff:

Marielba Cancel
Terri Drury
Maria Murdoch
Mark Willett
Robert Petty

Fax comments about this publication to:

Medicare Publications
904-361-0723

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

About the Medicare B Connection

The *Medicare B Connection* is a comprehensive publication developed by First Coast Service Options Inc. (First Coast) for Part B providers in Florida, Puerto Rico, and the U.S. Virgin Islands and is distributed on a monthly basis.

Important notifications that require communication in between publications will be posted to the First Coast Medicare provider education website at *https://medicare.fcso.com*. In some cases, additional unscheduled special issues may be posted.

Who receives the *Connection*

Anyone may view, print, or download the *Connection* from our provider education website(s). Providers who cannot obtain the *Connection* from the internet are required to register with us to receive a complimentary hardcopy.

Distribution of the *Connection* in hardcopy is limited to providers who have billed at least one Part B claim to First Coast Medicare during the twelve months prior to the release of each issue. Providers meeting these criteria are eligible to receive a complimentary copy of that issue, if a technical barrier exists that prevents them from obtaining it from the internet and they have returned a completed registration form to us.

Registration forms must be submitted annually or when you experience a change in circumstances that impacts your electronic access.

For additional copies, providers may purchase a separate annual subscription (see order form in the back of this issue). All issues published since 1997 may be downloaded from the internet, free of charge.

We use the same mailing address for all correspondence, and cannot designate that the *Connection* be sent to a specific person/department within a provider's office. To ensure continued receipt of all Medicare correspondence, providers must keep their addresses current with the Medicare provider enrollment department. Please remember that address changes must be done using the appropriate CMS-855.

Publication format

The *Connection* is arranged into distinct sections.

- The **Claims** section provides claim submission requirements and tips.
- The **Coverage/Reimbursement** section discusses specific CPT® and HCPCS procedure codes. It is arranged by categories (not specialties). For example, "Mental Health" would present coverage information of interest to psychiatrists, clinical psychologists and clinical social workers, rather than listing articles separately under individual provider specialties. Also presented in this section are changes to the Medicare physician fee schedule, and other pricing issues.

- The section pertaining to **Electronic Data Interchange** (EDI) submission also includes information pertaining to the Health Insurance Portability and Accountability Act (HIPAA).
- The **Local Coverage Determination** section features summaries of new and revised local coverage determinations (LCDs) developed as a result of either local medical review or comprehensive data analysis initiatives.
- The **General Information** section includes fraud and abuse, and national provider identifier topics, plus additional topics not included elsewhere.
- In addition to the above, other sections include:
- **Educational Resources**, and
- **Contact information** for Florida, Puerto Rico, and the U.S. Virgin Islands.

The *Medicare B Connection* represents formal notice of coverage policies

Articles included in each edition represent formal notice that specific coverage policies either have or will take effect on the date given. Providers are expected to read, understand, and abide by the policies outlined in this document to ensure compliance with Medicare coverage and payment guidelines.

Never miss an appeals deadline again

When it comes to submitting a claims appeal request, *timing is everything*. Don't worry – you won't need a desk calendar to count the days to your submission deadline. Try our *"time limit" calculators on our Appeals of claim decisions page*. Each calculator will *automatically calculate* when you must submit your request based upon the date of either the initial claim determination or the preceding appeal level.

Medicare Part B advance beneficiary notices

Medicare Part B allows coverage for services and items deemed medically reasonable and necessary for treatment and diagnosis of the patient.

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

- Coverage for a service or item may be allowed only for specific diagnoses/conditions. Always code to the highest level of specificity.
- Coverage for a service or item may be allowed only when documentation supports the medical need for the service or item.
- Coverage for a service or item may be allowed only when its frequency is within the accepted standards of medical practice (i.e., a specified number of services in a specified timeframe for which the service may be covered).

If the provider believes that the service or item may not be covered as medically reasonable and necessary, the patient must be given an acceptable advance notice of Medicare's possible denial of payment if the provider does not want to accept financial responsibility for the service or item. Advance beneficiary notices (ABNs) advise beneficiaries, before items or services actually are furnished, when Medicare is likely to deny payment.

Patient liability notice

The Centers for Medicare & Medicaid Services' (CMS) has developed the Advance Beneficiary Notice of Noncoverage (ABN) (Form CMS-R-131), formerly the "Advance Beneficiary Notice." Section 50 of the *Medicare Claims Processing Manual* provides instructions regarding the notice that these providers issue to beneficiaries in advance of initiating, reducing, or terminating what they believe to be noncovered items or services. The ABN must meet all of the standards found in Chapter 30. Beginning March 1, 2009, the ABN-G and ABN-L was no longer valid; and notifiers must use the revised Advance Beneficiary Notice of Noncoverage (CMS-R-131). Section 50 of the *Medicare Claims Processing Manual* is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c30.pdf#page=44*.

Reproducible copies of Form CMS-R-131 ABNs (in English and Spanish) and other BNI information may be found at *https://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html*.

ABN modifiers

When a patient is notified in advance that a service or item may be denied as not medically necessary, the provider must annotate this information on the claim (for both paper and electronic claims) by reporting modifier GA (waiver of liability statement on file) or GZ (item or service expected to be denied as not reasonable and necessary) with the service or item.

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

Modifier GZ may be used in cases where a signed ABN is not obtained from the patient; however, when modifier GZ is billed, the provider assumes financial responsibility if the service or item is denied.

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

GA modifier and appeals

When a patient is notified in advance that a service or item may be denied as not medically necessary, the provider must annotate this information on the claim (for both paper and electronic claims) by reporting the modifier GA (waiver of liability statement on file).

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

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

Preventive Services

2018-2019 influenza resources for health care professionals

Provider type affected

All health care professionals who order, refer, or provide flu vaccines and vaccine administration to Medicare beneficiaries and submit bills for these services to Medicare administrative contractors (MACs).

Provider action needed

Special edition (SE) *MLN Matters*® article SE18015 provides information about influenza (flu) resources for health care professionals and providers relevant to the 2018-2019 flu season. Health care professionals should:

- Keep this article and refer to it throughout the 2018-2019 flu season.
- Take advantage of each office visit as an opportunity to encourage patients to protect themselves from the flu and serious complications by getting a flu shot.
- Continue to provide the flu shot if you have vaccine available, even after the New Year.
- Remember to immunize yourself and your staff.

Background

The Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare Part B reimburses health care providers for flu vaccines and their administration (Medicare provides coverage of the flu vaccine without any out-of-pocket costs to the Medicare patient. No deductible or copayment/coinsurance applies).

You can help your Medicare patients reduce their risk for contracting seasonal flu and serious complications by using every office visit as an opportunity to recommend they take advantage of Medicare's coverage of the annual flu shot. As a reminder, please help prevent the spread of the flu by immunizing yourself and your staff!

Know what to do about the flu!

Payment rates for 2018-2019

Each year, CMS updates the Medicare Healthcare Common Procedure Coding System (HCPCS) and *Current Procedure Terminology* (CPT®) codes and payment rates for personal flu and pneumococcal vaccines. Payment allowance limits for such vaccines are 95 percent of the average wholesale price (AWP), except where the vaccine is furnished in a hospital outpatient department, rural health clinic (RHC), or federally qualified health center (FQHC). In these cases, the 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 following table contains the applicable Medicare Part B payment allowances for HCPCS and CPT® codes:

Code	Labeler name	Drug name	Payment allowance	Effective date
90653	Seqirus Inc	Fluad (2018/2019)	$54.673	8/1/18 – 7/31/19
90656	Seqirus Inc	Afluria (2018/2019)	$19.773	8/1/18 – 7/31/19
90662	Sanofi Pasteur	Fluzone high-dose (2018/2019)	$53.373	8/1/18 – 7/31/19
90674	Seqirus Inc	Flucelvax Quadrivalent (2018/2019)	$24.047	8/1/18 – 7/31/19
90682	Sanofi Pasteur	Flublok Quadrivalent (2018/2019)	$53.373	8/1/18 – 7/31/19
90685	Sanofi Pasteur	Fluzone Quadrivalent Pediatric (2018/2019)	$21.813	8/1/18 – 7/31/19
90686	Seqirus Inc,	Afluria Quadrivalent (2018/2019), Fluarix Quadrivalent (2018/2019), Flulaval Quadrivalent (2018/2019), Fluzone Quadrivalent (2018/2019) [Preservative Free]	$19.032	
90687	Sanofi Pasteur	Fluzone Quadrivalent Pediatric (2018/2019)	$9.403	
90688	Seqirus Inc,	Afluria Quadrivalent (2018/2019), Flulaval Quadrivalent (2018/2019), Fluzone Quadrivalent (2018/2019)	$17.835	
90756	Seqirus Inc	Flucelvax Quadrivalent (2018/2019)	$22.793	
Q2035	Seqirus Inc	Afluria (2018/2019)	$18.236	

Payment allowance information is still pending as of the date of this article for other CPT® and HCPCS codes.

See **FLU**, page 6

FLU

from page 5

Once payment allowances are available, CMS will post them at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html*.

For 2018/2019, there is a new CPT® code (90689), for which the applicable dates of service (DOS) are January 1, 2019, through July 31, 2019. The payment rate for 90689 is pending. The new influenza virus vaccine code 90689 is not retroactive to August 1, 2018. No claims will be accepted for influenza virus vaccine code 90689 for DOS between August 1, 2018, through December 31, 2018. If MACs receive claims 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.

Providers are encouraged to review MM10871 (Quarterly Influenza Virus Vaccine Code Update – January 2019) for more information about 90689, available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10871.pdf*. Background on influenza vaccine payment allowances is in MM10914, available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10914.pdf*.

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 allowanced 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

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

Educational products for health care professionals

The *Medicare Learning Network* (*MLN*®) has developed a variety of educational resources to help you understand Medicare guidelines for seasonal flu vaccines and their administration.

1. MLN® influenza-related products for health care professionals

- MEDICARE PART B IMMUNIZATION BILLING: SEASONAL INFLUENZA VIRUS, PNEUMOCOCCAL, AND HEPATITIS B educational tool - *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/qr_immun_bill.pdf*
- Medicare Preventive Services educational tool – *https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html*
- MASS IMMUNIZERS AND ROSTER BILLING FOR INFLUENZA VIRUS AND PNEUMOCOCCAL VACCINATIONS booklet – *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Mass_Immunize_Roster_Bill_factsheet_ICN907275.pdf*

2. Other CMS resources

- Provider Resources webpage – *https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/ProviderResources.html*
- Immunizations webpage – *https://www.cms.gov/Medicare/Prevention/Immunizations/Overview.html*
- Prevention Services webpage – *https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/index.html*
- *Medicare Benefit Policy Manual* – Chapter 15, Section 50.4.4.2 – Immunizations *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf*
- *Medicare Claims Processing Manual* – Chapter 18, Preventive and Screening Services *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf*

3. Other resources

The following non-CMS resources are useful information and tools for the 2018 – 2019 flu season:

- **Advisory Committee on Immunization Practices** – *https://www.cdc.gov/vaccines/acip/index.html*
- **Centers for Disease Control and Prevention** – *https://www.cdc.gov/flu*
- **Flu.gov** – *https://www.flu.gov*
- **Food and Drug Administration** – *https://www.fda.gov*
- **Immunization Action Coalition** – *https://www.immunize.org*
- **Indian Health Services** – *https://www.ihs.gov*
- **National Alliance for Hispanic Health** – *https://www.hispanichealth.org*
- **National Foundation For Infectious Diseases** – *https://www.nfid.org/influenza*
- **National Library of Medicine and NIH Medline Plus** – *https://medlineplus.gov/immunization.html*
- **National Vaccine Program** – *https://www.hhs.gov/nvpo*
- **Office of Disease Prevention and Health Promotion** – *https://healthfinder.gov/FindServices/Organizations/Organization/HR2013/office-of-disease-prevention-and-health-promotion-us-department-of-health-and-human-services*
- **World Health Organization** – *https://www.who.int/en*

Document history

Date of change	Description
September 24, 2018	Initial article released.

MLN Matters® Number: SE18015
Related CR Release Date: September 24, 2018
Related CR Transmittal Number: N/A
Related Change Request (CR) Number: N/A
Effective Date: N/A
Implementation N/A

General Coverage

PROCESS

from page 1

the lack of local coverage process transparency, including notifying stakeholders of proposed revisions to, and drafting of, new LCDs.

Additional stakeholder concerns include: ineffective MAC processes for soliciting from, and providing to, stakeholders feedback on information provided during open public meetings, a lack of non-physician representation on contractor advisory committees (CACs), and concerns that CAC meetings are not open to the public.

In CR 10901, the revisions to the *Medicare Program Integrity Manual*, Chapter 13, CMS is revising instructions to MACs, reflecting policy process changes in response to the new statutory (21st century Cures Act) requirements and to the stakeholder comments. These changes will help to increase transparency, clarity, consistency, reduce provider burden and enhance public relations while retaining the ability to be responsive to local clinical and coverage policy concerns.

The 2016 21st Century Cures Act included changes to the LCD process, adding language to 1862(l)(5)(D) of the Social Security Act (the Act) to describe the LCD process. Section 1862(l)(5)(D), of the Act requires each MAC that develops an LCD to make available on their Internet website on the Medicare website, at least 45 days before the effective date of such determination, the following information:

- Such determination in its entirety
- Where and when the proposed determination was first made public
- Hyperlinks to the proposed determination and a response to comments submitted to the MAC with respect to such proposed determination
- A summary of evidence that was considered by the contractor during the development of such determination and a list of the sources of such evidence
- An explanation of the rationale that supports such determination

CMS revamped the format of the manual so that it could be used as a roadmap to understand the steps of the local coverage process, which enable stakeholders to effectively engage in the process. This transparency also carries through to the reconsideration process, which is a process by which stakeholders can request a MAC take a second look at an existing decision using evidence that has developed since its first review.

The manual also sets forth consistent requirements for communication to providers and other stakeholders to occur at predictable milestones so anyone with an interest in the local policy can stay informed as the policy moves through the process.

New LCD process

The key parts of the new LCD process are summarized as follows:

1. The new LCD process may begin with informal meetings in which interested parties within the MAC's jurisdiction can discuss potential LCD requests. These educational meetings, which are not required, can be held either in person, using web-based technologies, or via teleconference, which allow discussions before requestors submit a formal request.
2. New LCD requests

The new LCD request process is a mechanism through which interested parties within a MAC's jurisdiction can request a new LCD. In this process, MACs will consider all new LCD requests from:

- Beneficiaries residing or receiving care in the MAC's jurisdiction
- Health care professionals doing business in the MAC's jurisdiction
- Any interested party doing business in the MAC's jurisdiction

MACs will consider a New LCD Request to be a complete, formal request if the following requirements are met. The request:

- Is in writing and is sent to the MAC via e-mail, facsimile or written letter
- Clearly identifies the statutorily-defined Medicare benefit category to which the requestor believes the item or service applies
- Identifies the language that the requestor wants in an LCD
- Includes a justification supported by peer-reviewed evidence (full copies of published evidence must be included or the request is not valid) • Addresses relevance, usefulness, clinical health outcomes, or the medical benefits of the item or service
- Fully explains the design, purpose, and/or method, as appropriate, of using the item or service for which the request is made.

Within 60 calendar days of the day they receive the request; MACs will review the materials and determine whether the request is complete or incomplete. If the request is complete, the MAC will follow the new LCD process, as described in the revised manual. If, however, the process is incomplete, they will respond, in writing, to the requestor explaining why the request was incomplete.

See **PROCESS**, page 8

PROCESS

from page 7

3. Clinical guidelines, consensus documents, and consultation

During an LCD's development, MACs should (when applicable and available) supplement their research with clinical guidelines, consensus documents, or consultation by experts (recognized authorities in the field), medical associations or other health care professionals for an advisory opinion. They will summarize the opinions they receive as a result of this consultation with healthcare professional expert(s), professional societies, and others prior to the drafting of a proposed or final LCD, and include this information in the proposed or final LCD. Note that acceptance by individual health care providers, or even a limited group of health care providers, does not indicate general acceptance of the item or service by the medical community.

4. Publication of the proposed LCD

The public announcement of a MAC's proposed determination begins with the date the proposed LCD is published on the Medicare coverage database (MCD) at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. Once the proposed LCD is published, MACs will provide a minimum of 45 calendar days for public comment, and will contact the CMS if they determine an extension to the comment period is needed.

These processes shall be used for all LCDs except in the following situations:

- Revised LCD being issued for compelling reasons.
- Revised LCD that makes a non-substantive correction - For example, typographical or grammatical errors that do not substantially change the LCD.
- Revised LCD that makes a non-discretionary coverage update - Contractors shall update LCDs to reflect changes in NCDs or when a conflict with national policy occurs, coverage provisions in interpretive manuals, and payment systems.
- Revise LCD to effectuate an administrative law judge's decision to nullify an existing LCD due to an LCD challenge.

5. Contractor advisory committee (CAC)

The CAC is to be composed of healthcare professionals, beneficiary representatives, and representatives of medical organizations; and is used to supplement the MAC's internal expertise, and to ensure an unbiased and contemporary consideration of "state of the art" technology and science. Additionally, all CAC meetings will be open to the public to attend and observe.

MACs will establish one CAC per state or one per jurisdiction with representation from each state, ensuring that each state has a full committee and the opportunity to discuss the quality of evidence used to make a determination.

The CAC's purpose is to provide a formal mechanism for healthcare professionals to be informed of the evidence used in developing the LCD and promote communications between the MACs and the healthcare community. The CAC is advisory in nature, with the final decision on all issues resting with MACs.

6. Open meeting

After the proposed LCD is made public, MACs will hold open meetings to discuss the review of the evidence and the rationale for the proposed LCD(s) with stakeholders in their jurisdiction. Interested parties (generally those that would be affected by the LCD, including providers, physicians, vendors, manufacturers, beneficiaries, caregivers, etc.) can make presentations of information related to the proposed LCDs. Members of the CAC may also attend these open meetings. MACs must notify the public about the dates and location for the open meeting. MACs have the option of setting up email listservs to announce this information or may use other education methods to adequately inform the public. The listserv or other method should clearly identify the location, dates and telephone/video/on-line conference information for the open meeting to ensure that this information is clearly distinguished from the information for the CAC meetings.

7. Publication of the final determination

After the close of the comment period and the required meetings and consultation, the final LCD and the response to comment (RTC) article will be published on the MCD.

8. Response to public comments

MACs will respond to all comments received during the comment period of the proposed LCD by using the RTC article associated with the LCD. The RTC article is published on the start date of the notice period. The RTC article will remain publicly available indefinitely on the MCD or the MCD archive.

9. Notice period

The date the final LCD is published on the MCD, marks the beginning of the required notice period of at least 45 calendar days before the LCD can take effect. If the notice period is not extended by the MAC, the effective date of the LCD is the 46th calendar day after the notice period began.

Full details of this new process are contained in the updated manual which is an attachment to CR 10901.

LCD reconsideration process

The LCD reconsideration process is a mechanism by which a beneficiary or stakeholder (including a medical professional society or physician) in the MAC's jurisdiction can request a revision to an LCD. The LCD reconsideration process differs from an initial request for an LCD in that it is available only for final effective LCDs. The whole LCD or any provision of the LCD may

See **PROCESS**, page 9

PROCESS

from page 8

be reconsidered. In addition, MACs have the discretion to revise or retire their LCDs at any time on their own initiative. This process is summarized as follows:

1. MACs shall consider all LCD reconsideration requests from:
   - Beneficiaries residing or receiving care in a contractor's jurisdiction
   - Providers doing business in a contractor's jurisdiction
   - Any interested party doing business in a contractor's jurisdiction
2. MACs should only accept reconsideration requests for LCDs published as an effective final. Requests shall **not** be accepted for other documents including:
   - National coverage determinations (NCDs);
   - Coverage provisions in interpretive manuals;
   - Proposed LCDs;
   - Template LCDs, unless or until they are adopted and in effect by the contractor;
   - Retired LCDs;
   - Individual claim determinations
   - Bulletins, articles, training materials; and
   - Any instance in which no LCD exists, i.e., requests for development of an LCD.
3. Process requirements - The requestor shall submit a valid LCD reconsideration request to the appropriate MAC, following instructions on the MAC's web site. Within 60 calendar days of the day the request is received, the MAC shall determine whether the request is valid or invalid. If the request is invalid, the MAC will respond, in writing, to the requestor explaining why the request was invalid. If the request is valid, the MAC will open the LCD and follow the LCD process as outlined in the above for new LCDs or include the LCD on the MAC's waiting list. The MAC shall respond, in writing, to the requestor notifying the requestor of the acceptance, and if applicable, wait-listing, of the reconsideration request.

Other important changes

Other key changes to the manual include the following:

- MACs shall finalize or retire all proposed LCDs within one calendar year of publication date on the MCD.
- Upon further notice from CMS, it will no longer be appropriate to routinely include Current *Procedure Terminology* (*CPT*®) codes or International Classification of Diseases-Tenth Revision-Clinical Modification (ICD-10-CM) codes in the LCDs. All codes will be removed from LCDs and placed in billing & coding articles that are linked to the LCD.

Additional information

The official instruction, CR 10901, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R829PI.pdf*. The complete manual revision is included in CR 10901.

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

As part of the CMS commitment to continuous improvement, CMS invites interested stakeholders to submit feedback on their experience with the revised LCD process. CMS will collect feedback via submissions to *LCDmanual@cms.hhs.gov* and consider additional revisions based on stakeholder feedback.

Document history

Date of change	Description
October 3, 2018	Initial article released.

MLN Matters® Number: MM10901
Related CR Release Date: October 3, 2018
Related CR Transmittal Number: R829PI
Related Change Request (CR) Number: 10901
Effective Date: October 3, 2018
Implementation: January 8, 2019

Processing Issues

Reprocessing Claims for Diagnostic Services by Certain PTs

Some Part B Medicare Administrative Contractors (MACs) denied valid claims submitted by Physical Therapists (PTs) in private practice:

- For professional component or global code for certain CMS-designated diagnostic services involving electromyography, nerve conduction velocity, and sensory evoked potentials with technical component physician supervision indicators of 21, 66, 6A, 77, or 7A
- Furnished by PTs in private practice certified in clinical electrophysiology by the American Board of Physical Therapy Specialties and providing these services in accordance with state law

MACs will reprocess these claims brought to their attention by PTs in private practice. Visit the Physician Fee Schedule website (*https://go.usa.gov/xUtZ5*) for related CMS payment policy and the applicable code list.

General Information

Hurricane Michael and Medicare disaster-related Florida claims

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 state of Florida who were affected by Hurricane Michael.

Provider information available

On October 9, 2018, pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, President Trump declared that, as a result of the effects of Hurricane Michael, an emergency exists in the state of Florida. On October 9, 2018, President Trump declared an emergency exists in Florida as a result of Hurricane Michael. Also, on October 9, 2018, Secretary Azar of the Department of Health & Human Services declared that a public health emergency exists in Florida and authorized waivers and modifications under Section 1135 of the Social Security Act (the Act), retroactive to October 7, 2018, for Florida.

On October 9, 2018, the Administrator of the Centers for Medicare & Medicaid Services (CMS) authorized waivers under Section 1812(f) of the Social Security Act for the state of Florida for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of Hurricane Michael in 2018.

Under Section 1135 or 1812(f) of the Social Security Act, CMS has issued several blanket waivers in the impacted geographical areas of the state of Florida. 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 is available at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page.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 on July 31, 2009, applies to items and services furnished to Medicare beneficiaries within the State of Florida from October 7, 2018, for the duration of the emergency. In accordance with CR6451, 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 is available at *https://www.cms.gov/About-CMS/Agency- Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page.html*. Medicare FFS Questions & Answers (Q&As) posted on the waivers and flexibilities page at *https://www.cms.gov/About-CMS/Agency- Information/Emergency/EPRO/Resources/Waivers-and-flexibilities.html*, and also referenced below are applicable for items and services furnished to Medicare beneficiaries within the state of Florida. 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 Florida.

See **MICHAEL**, page 11

MICHAEL

from page 10

- 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 October 7, 2018, for Florida.

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

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

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

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 **Florida**. Individual facilities do not need to apply for the following approved blanket waivers:

Skilled nursing facilities (SNFs)

- Section 1812(f): This waiver of the requirement for a three-day prior hospitalization for coverage of a 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 Michael in the state of Florida. 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 SNFs 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).
- To ensure the correct processing of home health disaster related claims, Medicare administrative contractors (MACs) are allowed to extend the auto-cancellation date of requests for anticipated payment (RAPs).

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 Michael, 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 Michael. (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 Michael, 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 Michael, 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.

See **MICHAEL**, page 12

MICHAEL

from page 11

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

As a result of Hurricane Michael, CMS has determined it is appropriate to issue a blanket waiver to suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) where DMEPOS are 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 were lost, destroyed, irreparably damaged or otherwise rendered unusable as a result of the hurricane.

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*.

Medicare advantage plan or other Medicare health plan beneficiaries

CMS reminds suppliers that Medicare beneficiaries enrolled in a Medicare advantage or other Medicare health plans should contact their plan directly to find out how it replaces DMEPOS damaged or lost in an emergency or disaster. Beneficiaries who do not have their plan's contact information can contact 1-800-MEDICARE (1-800-633-4227) for assistance.

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 disaster or emergency.

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
October 11, 2018	Initial article released.

MLN Matters® Number: SE18021
Related CR Release Date: October 11, 2018
Related CR Transmittal Number: N/A
Related Change Request (CR) Number: N/A
Effective Date: N/A
Implementation N/A

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

Radiation therapy for T1 basal cell and squamous cell carcinomas of the skin – retired Part A and Part B LCD

LCD ID number: L33538 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on data analysis review of the local coverage determination (LCD) for radiation therapy for T1 basal cell and squamous cell carcinomas of the skin, 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 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, please *click here*.

Urinalysis – retired Part A and Part B LCD

LCD ID number: L34029 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on data analysis review of the local coverage determination (LCD) for urinalysis, it was determined that the LCD is no longer required and is being retired. Therefore, the LCD "Coding Guideline" article is also being retired.

Effective date

The retirement of this LCD is effective for services rendered **on or after October 16, 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*.

Revisions to LCDs

Noncovered services – revision to the Part A and Part B LCD

LCD ID number: L33777 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for noncovered services was revised based on change request (CR) 10900/CR 10923/CR 10932 (October 2018 Quarterly Updates). Healthcare Common Procedure Coding System (HCPCS) code C9750 was added to the "CPT®/HCPCS Codes – Group 1 Paragraph:" under the subtitle "Procedures for Part A and Part B" section of the LCD. Also, *Current Procedural Terminology* (CPT®) code 33999+ (Unlisted codes for insertion or removal and replacement of intracardiac ischemia monitoring system) was moved from "CPT®/HCPCS Codes – Group 4 Paragraph: Unlisted Procedure Codes" under the subtitle "Procedures for Part A and Part B" section of the LCD to "CPT®/HCPCS Codes – Group 5 Paragraph: Procedures for Part B only" section of the LCD.

Effective date

This LCD revision is 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*.

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

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

Based on a reconsideration request, the local coverage determination (LCD) for G-CSF (Neupogen®, Granix™, ,Zarxio™, Nivestym™) was revised to add the new FDA approved indications for Granix™ in the "Coverage Indications, Limitations, and/or Medical Necessity" section of the LCD and to update the "Sources of Information" section of the LCD.

Also, based on change request (CR) 10834 (Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes - October 2018 Update), HCPCS code Q5110 (NIVESTYM™ [filgrastim-aafi]) was added to the "CPT®/HCPCS Codes" section of the LCD. In addition, the new Food and Drug Administration (FDA) approved indications for NIVESTYM™ (filgrastim-aafi) were added to the "Coverage Indications, Limitations, and/ or Medical Necessity" section of the LCD and the "Sources of Information" section of the LCD was updated. The "LCD Title" section of the LCD was also updated to include "Nivestym™".

Effective date

The LCD revision related to Granix™ is effective for claims processed **on or after October 1, 2018**, for services rendered **on or after August 6, 2018**.

The LCD revision related to Nivestym™ is effective for services rendered **on or after October 1, 2018.**

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

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

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

Noncovered services – revision to the Part A and Part B LCD

LCD ID number: L33777 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for noncovered services was revised based on a reconsideration request. *Current Procedural Terminology* (CPT®) code 0449T (insertion of aqueous drainage device, without extraocular reservoir, internal approach, into the subconjunctival space; initial device) was removed from the LCD. Also, the "Sources of Information and Basis for Decision" article was updated to include multiple published sources from reconsideration requests received for CPT® codes 0449T and 0450T. In addition, the "Sources of Information and Basis for Decision" article was updated to include multiple published sources from a reconsideration request received for CPT® codes 0466T, 0467T, 0468T, and 64568 (hypoglossal nerve stimulation therapy); the content of the LCD has not been changed in response to this reconsideration request.

Effective date

This LCD revision is effective for services rendered **on or after October 25, 2018.** LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Upcoming provider outreach and educational events

Topic: Medicare Part B changes and regulations

Date: Thursday, November 29
Time: 11:30 a.m.-1:00 p.m.
Type of Event: Webcast

https://medicare.fcso.com/Events/0415565.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® for September 27, 2018

MLN Connects® for September 27, 2018
View this edition as a PDF

News & Announcements

- New Medicare Card: MBI on Remittance Advice October 1
- Quality Payment Program: Funding for Quality Measure Development
- Patients Over Paperwork September Newsletter
- 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
- QRURs and PQRS Feedback Reports: Access Ends December 31
- 2019 Eligible Hospital eCQM Flows
- Connected Care Toolkit
- Development of a Disability Index
- Hurricane Resources from ASPR TRACIE
- Medicare Appeals Council: New Decision Format
- National Cholesterol Education Month and World Heart Day

Provider Compliance

- Improper Payment for Intensity-Modulated Radiation Therapy Planning Services

Claims, Pricers & Codes

- FY 2019 IPPS and LTCH PPS Claims Hold

Upcoming Events

- 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

Medicare Learning Network Publications & Multimedia

- New Waived Tests MLN Matters® Article — New
- HCPCS Drug/Biological Code Changes: October Update 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

MLN Connects® for October 4, 2018

MLN Connects® for October 4, 2018

View this edition as a PDF

News & Announcements

- New Medicare Card: Replacement Card
- MIPS Targeted Review Request: Deadline October 15
- MIPS Virtual Groups: Election Period Open through December 31
- MIPS: List of Quality Measures Impacted by ICD-10 Updates
- LTCH Compare Refresh
- IRF Compare Refresh
- ABNs and Dual Eligible Beneficiaries: Special Guidelines
- Sickle Cell Disease Data Highlight
- Enteral Device Connectors that Reduce Patient Injury
- October is National Breast Cancer Awareness Month

Provider Compliance

- Outpatient Services Payment: Beneficiaries Who Are Inpatients of Other Facilities — Reminder

Upcoming Events

- Submitting Your Medicare Part A Cost Report Electronically Webcast — October 15
- Patient Relationship Categories and Codes Webcast — October 17

Medicare Learning Network Publications & Multimedia

- Influenza Resources for Health Care Professionals: 2018-2019 MLN Matters Article — New
- HPSA Bonus Payments: 2019 Annual Update MLN Matters Article — New
- Laboratory NCD Edit Software: Changes for January 2019 MLN Matters Article — New
- AWV, IPPE, and Routine Physical – Know the Differences Educational Tool — New
- Dementia Care Call: Audio Recording and Transcript — New
- Looking for Educational Materials?

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

MLN Connects® for October 11, 2018

MLN Connects® for October 11, 2018

View this edition as a PDF

News & Announcements

- New Medicare Card: Destroy the Old Card
- CMS to Strengthen Oversight of Medicare's Accreditation Organizations
- Participants in New Value-Based Bundled Payment Model
- Medicare Diabetes Prevention Program: New Covered Service
- Part A Providers: MCReF System Enhancement
- Protect Your Patients from Influenza this Season

Provider Compliance

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

Claims, Pricers & Codes

- Reprocessing Claims for Diagnostic Services by Certain PTs

Upcoming Events

- Submitting Your Medicare Part A Cost Report Electronically Webcast — October 15
- Patient Relationship Categories and Codes Webcast — October 17
- Physician Compare: Preview Period and Public Reporting Webcast — October 30

Medicare Learning Network Publications & Multimedia

- LCDs MLN Matters Article — New
- Ensuring OC 22 is Billed Correctly on SNF Inpatient Claims MLN Matters Article — New
- HCPCS Codes for SNF CB: 2019 Annual Update MLN Matters Article — New
- Medicare Diabetes Prevention Program Call: Audio Recording and Transcript — New
- Medicare Preventive Services National Educational Products Listing — Revised

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

MLN Connects® – Special Edition for October 11, 2018

Hurricane Michael and Medicare Disaster Related Florida Claims MLN Matters Article — New

The President declared a state of emergency for the state of Florida, and the HHS Secretary declared a Public Health Emergency, which allows for CMS programmatic waivers based on Section 1135 of the Social Security Act. An MLN Matters Special Edition Article on *Hurricane Michael and Medicare Disaster Related Florida Claims* is available. Learn about blanket waivers CMS issued for the impacted geographical areas. These waivers will prevent gaps in access to care for beneficiaries impacted by the emergency.

MLN Connects® – Special Edition for October 12, 2018

Hurricane Michael and Medicare Disaster Related Florida and Georgia Claims MLN Matters Article — Revised

The President declared a state of emergency for the states of Florida and Georgia, and the HHS Secretary declared a Public Health Emergency, which allows for CMS programmatic waivers based on Section 1135 of the Social Security Act. A revised MLN Matters Special Edition Article on *Hurricane Michael and Medicare Disaster Related Florida Claims* is available. Learn about blanket waivers CMS issued for the impacted geographical areas. These waivers will prevent gaps in access to care for beneficiaries impacted by the emergency. This article was revised to add information regarding the emergency declared for the state of Georgia.

MLN Connects® – Special Edition for October 15, 2018

Important New Medicare Card Mailing Update — Wave 7 Begins, Wave 5 Ends

CMS has started *mailing* new Medicare cards to people with Medicare who live in Wave 7 states and territories including: Kentucky, Louisiana, Michigan, Mississippi, Missouri, Ohio, Puerto Rico, Tennessee, and the Virgin Islands.

We are finished mailing cards to people with Medicare who live in states within Waves 1 through 4 and now Wave 5. If someone with Medicare who lives in one of these states says they did not get a card, you should instruct them to:

- Sign into *MyMedicare.gov* to see if we mailed their card. If so, they can print an official card. They will need to create an account if they do not already have one.
- Call 1-800-MEDICARE (1-800-633-4227) where we can verify their identity, check their address, and help them get their new card.

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

People with Medicare should continue to protect their new number to prevent medical identity theft and health care fraud, especially during Medicare Open Enrollment. View and share our new *Guard your Medicare card video*, which reminds people with Medicare to beware of scams. There are also new fraud prevention products on our new Medicare card *Outreach & Education* webpage for you to share with people with Medicare:

- *Drop-in article* (also in *Spanish*) and *Public Service Announcement script* reminding people to be wary of scams
- *Flyer* (also in *Spanish*) with fraud prevention tips during Open Enrollment

Continue to direct people with Medicare to *Medicare.gov/NewCard* for information about the mailings and to sign up to get emails about the status of card mailings in their state.

MLN Connects® for October 18, 2018

MLN Connects® for October 18, 2018

View this edition as a PDF

News & Announcements

- Hand in Hand: A Training Series for Nursing Homes
- MIPS Quality Data Submitted via Claims: 2018 Performance Feedback
- Quality Payment Program: 2018 CME Modules, Infographics, and Scoring Guide
- 2019 QRDA III Implementation Guide, Schematron, and Sample Files
- Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier

Provider Compliance

- Cardiac Device Credits: Medicare Billing — Reminder

Claims, Pricers & Codes

- 2019 MS-DRG Definitions Manual and Software

Upcoming Events

- Hospital Reporting: Successful eCQM Submission for CY 2018 Webinar — October 24
- Physician Compare: Preview Period and Public Reporting Webcast — October 30

Medicare Learning Network Publications & Multimedia

- Systematic Validation Edits for OPPS Providers MLN Matters® Article — New
- IPPS and LTCH PPS: FY 2019 Changes MLN Matters Article — New
- Home Health Star Ratings Call: Audio Recording and Transcript — New
- Annual Wellness Visit Booklet — Revised
- Initial Preventive Physical Examination Educational Tool — Revised

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

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

Centers for Medicare & Medicaid Services

https://www.cms.gov

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

Beneficiaries

Centers for Medicare & Medicaid Services

https://www.medicare.gov

Phone numbers

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

Education event registration hotline
904-791-8103 (NOT toll-free)
904-361-0407 (FAX)

Electronic data interchange (EDI)
888-875-9779

Electronic funds transfers (EFT) (CMS-588)
877-715-1921
877-660-1759 (TTY)

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

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

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

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

Addresses

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

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

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

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

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

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

Provider enrollment
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 45040
Jacksonville, FL 32231-5040

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

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

Freedom of Information Act requests
FOIA Puerto Rico
P.O. Box 45092
Jacksonville, FL 32232-5092,

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

Websites

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

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

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

Contact Name: _____

Provider/Office Name: _____

Phone: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

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