

C Medicare B CONNECTION

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A Newsletter for MAC Jurisdiction N Providers

December 2018



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Summary of policies in the 2019 MPFS final rule and the telehealth originating site facility fee payment

Provider type affected

This MLN Matters Article is intended for physicians and other providers who submit claims to Medicare Administrative Contractors (MACs) for services paid under the Medicare Physician Fee Schedule (MPFS) and provided to Medicare beneficiaries.

Provider action needed

CR 11063 provides a summary of policies in the Calendar Year (CY) 2019 MPFS Final Rule and announces the Telehealth Originating Site Facility Fee payment amount and makes other policy changes related to Medicare Part B payment. These changes are applicable to services furnished in CY 2019. Make sure your billing staffs are aware of these updates.

Background

Section 1848(b)(1) of the Social Security Act (the Act) requires the Secretary to establish by regulation a fee schedule of payment amounts for physicians' services

for the subsequent year. The Centers for Medicare & Medicaid Services (CMS) final rule (Regulation number CMS-1693-F) that updates payment policies and Medicare payment rates for services furnished by physicians and Nonphysician Practitioners (NPPs) that are paid under the MPFS in CY 2019 went on display on November 1, 2018. The final rule also addresses public comments on Medicare payment policies proposed earlier this year. The following summarizes the key provisions of this final rule.

Streamlining Evaluation and Management (E/M) Payment and Reducing Clinician Burden

For CY 2019 and CY 2020, CMS will continue the current coding and payment structure for E/M office/outpatient visits and practitioners should continue to use either the 1995 or 1997 E/M documentation guidelines to document E/M office/outpatient visits billed to Medicare. For CY 2019 and beyond, CMS is finalizing the following policies:

- Elimination of the requirement to document the medical necessity of a home visit in lieu of an office visit

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WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Medicare B Connection

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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.

Publication staff:

Marielba Cancel
Terri Drury
Maria Murdoch
Mark Willett
Robert Petty

Fax comments about this publication to:

Medicare Publications
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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=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.

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- For established patient office/outpatient visits, when relevant information is already contained in the medical record, practitioners may choose to focus their documentation on what has changed since the last visit, or on pertinent items that have not changed, and need not re-record the defined list of required elements if there is evidence that the practitioner reviewed the previous information and updated it as needed. Practitioners should still review prior data, update as necessary, and indicate in the medical record that they have done so.
- CMS is clarifying that for E/M office/outpatient visits, for new and established patients for visits, practitioners need not re-enter in the medical record information on the patient's chief complaint and history that has already been entered by ancillary staff or the beneficiary. The practitioner may simply indicate in the medical record that he or she reviewed and verified this information.
- Removal of potentially duplicative requirements for notations in medical records that may have previously been included in the medical records by residents or other members of the medical team for E/M visits furnished by teaching physicians

Beginning in CY 2021, CMS will further reduce burden with the implementation of payment, coding, and other documentation changes. Payment for E/M office/outpatient visits will be simplified and payment would vary primarily based on attributes that do not require separate, complex documentation. Specifically for CY 2021, CMS is finalizing the following policies:

- Reduction in the payment variation for E/M office/outpatient visit levels by paying a single rate for E/M office/outpatient visit levels 2 through 4 for established and new patients while maintaining the payment rate for E/M office/outpatient visit level 5 in order to better account for the care and needs of complex patients
- Permitting practitioners to choose to document E/M office/outpatient level 2 through 5 visits using Medical Decision Making (MDM) or time instead of applying the current 1995 or 1997 E/M documentation guidelines, or alternatively practitioners could continue using the current framework
- Beginning in CY 2021, for E/M office/outpatient levels 2 through 5 visits, CMS will allow for flexibility in how visit levels are documented— specifically a choice to use the current framework, MDM, or time. For E/M office/outpatient level 2 through 4 visits, when using MDM or current framework to document the visit, CMS will also apply a minimum supporting documentation standard associated with level 2 visits. For these cases, Medicare would require information to support a level 2 E/M office/outpatient visit code for history, exam and/or MDM.
- When time is used to document, practitioners will



document the medical necessity of the visit and that the billing practitioner personally spent the required amount of time face-to-face with the beneficiary.

- Implementation of add-on codes that describe the additional resources inherent in visits for primary care and particular kinds of non-procedural specialized medical care, though they would not be restricted by physician specialty. These codes would only be reportable with E/M office/outpatient level 2 through 4 visits, and their use generally would not impose new per-visit documentation requirements.
- Adoption of a new “extended visit” add-on code for use only with E/M office/outpatient level 2 through 4 visits to account for the additional resources required when practitioners need to spend extended time with the patient.

CMS believes these policies will allow practitioners greater flexibility to exercise clinical judgment in documentation, so they can focus on what is clinically relevant and medically necessary for the beneficiary. CMS intends to engage in further discussions with the public to potentially further refine the policies for CY 2021.

After consideration of concerns raised by commenters in response to the proposed rule, CMS is not finalizing aspects of the proposal that would have:

- Reduced payment when E/M office/outpatient visits are furnished on the same day as procedures
- Established separate coding and payment for podiatric E/M visits
- Standardized the allocation of practice expense Relative Value Unit (RVUs) for the codes that describe these services

Modernizing Medicare Physician Payment by Recognizing Communication Technology- Based Services

CMS is finalizing its proposals to pay separately for two newly defined physicians' services furnished using

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communication technology:

- Brief communication technology-based service, for example, virtual check-in (Healthcare Common Procedure Coding System (HCPCS) code G2012)
- Remote evaluation of recorded video and/or images submitted by an established patient (HCPCS code G2010)

CMS is also finalizing policies to pay separately for new coding describing chronic care remote physiologic monitoring (Current Procedural Terminology (CPT) codes 99453, 99454, and 99457) and interprofessional internet consultation (CPT codes 99451, 99452, 99446, 99447, 99448, and 99449).

Expanding the Use of Telehealth Services for the Treatment of Opioid Use Disorder and Other Substance Use Disorders

Through an interim final rule with comment period, CMS is implementing a provision from the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act that removes the originating site geographic requirements and adds the home of an individual as a permissible originating site for telehealth services furnished for purposes of treatment of a substance use disorder or a co-occurring mental health disorder for services furnished on or after July 1, 2019.

Providing Practice Flexibility for Radiologist Assistants

CMS is revising the physician supervision requirements so that diagnostic tests performed by a Radiologist Assistant (RA) that meets certain requirements, that would otherwise require a personal level of physician supervision as specified in its regulations, may be furnished under a direct level of physician supervision to the extent permitted by state law and state scope of practice regulations.

Discontinue Functional Status Reporting Requirements for Outpatient Therapy

CMS is finalizing its proposal to discontinue the functional status reporting requirements for services furnished on or after January 1, 2019.

Outpatient Physical Therapy and Occupational Therapy Services Furnished by Therapy Assistants

The Bipartisan Budget Act of 2018 requires payment for services furnished in whole or in part by a therapy assistant at 85 percent of the applicable Part B payment amount for the service effective January 1, 2022. In order to implement this payment reduction, the law requires CMS to establish a new modifier by January 1, 2019, and CMS to detail its plans to accomplish this in the final rule.

CMS is finalizing its proposal to establish two new modifiers – one for Physical Therapy Assistants (PTA) and

another for Occupational Therapy Assistants (OTA) – when services are furnished in whole or in part by a PTA or OTA. However, CMS is finalizing the new modifiers as “payment” rather than as “therapy” modifiers, based on comments from stakeholders. These will be used alongside of the current PT and OT modifiers, instead of replacing them, which retains the use of the three existing therapy modifiers to report all PT, OT, and Speech Language Pathology (SLP) services, that have been used since 1998 to track outpatient therapy services that were subject to the therapy caps.

CMS is also finalizing a de minimis standard under which a service is furnished in whole or in part by a PTA or OTA when more than 10 percent of the service is furnished by the PTA or OTA, instead of the proposed definition that applied when a PTA or OTA furnished any minute of a therapeutic service. The new therapy modifiers for services furnished by PTAs and OTAs are not required on claims until January 1, 2020.

Practice Expense (PE): Market-Based Supply and Equipment Pricing Update

CMS is finalizing the proposal to adopt updated direct PE input prices for supplies and equipment. While CMS is adopting most of the prices for supplies and equipment as recommended by the contractor and included in the proposed rule, in the case of particular items, CMS is finalizing refinements to the proposed prices based on feedback from commenters. CMS is also finalizing its proposal to phase-in use of these new prices over a 4-year period beginning in CY 2019 to ensure a smooth transition.

Payment Rates for Non-excepted Off-campus Provider-Based Hospital Departments Paid Under the PFS

Section 603 of the Bipartisan Budget Act of 2015 requires that certain items and services furnished by certain off-campus hospital outpatient provider-based departments are no longer paid under the Hospital Outpatient Prospective Payment System (OPPS) and are instead paid under the applicable payment system. In CY 2017, CMS finalized the PFS as the applicable payment system for most of these items and services.

Since CY 2017, payment for these items and services furnished in non-excepted off-campus provider-based departments has been made under the PFS using a PFS Relativity Adjuster based on a percentage of the OPPS payment rate. The PFS Relativity Adjuster in CY 2018 is 40 percent, meaning that non-excepted items and services are paid 40 percent of the amount that would have been paid for those services under the OPPS. CMS is finalizing that the PFS Relativity Adjuster remain at 40 percent for CY 2019. CMS believes that this PFS Relativity Adjuster encourages fairer competition between hospitals and physician practices by promoting greater payment

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alignment between outpatient care settings.

Medicare Telehealth Services

For CY 2019, CMS is finalizing its proposals to add HCPCS codes G0513 and G0514 (Prolonged preventive service(s)) to the list of telehealth services.

CMS is also finalizing policies to implement the requirements of the Bipartisan Budget Act of 2018 for telehealth services related to beneficiaries with End-Stage Renal Disease (ESRD) receiving home dialysis and beneficiaries with acute stroke effective January 1, 2019. CMS is finalizing the addition of renal dialysis facilities and the homes of ESRD beneficiaries receiving home dialysis as originating sites, and to not apply originating site geographic requirements for hospital-based or critical access hospital-based renal dialysis centers, renal dialysis facilities, and beneficiary homes, for purposes of furnishing the home dialysis monthly ESRD-related clinical assessments.

CMS is also finalizing policies to add mobile stroke units as originating sites and not to apply originating site type or geographic requirements for telehealth services furnished for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke.

Telehealth origination site facility fee payment amount update

Section 1834(m)(2)(B) of the Act establishes the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001, through December 31, 2002, at \$20. For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased by the percentage increase in the Medicare Economic Index (MEI) as defined in Section

1842(i)(3) of the Act. The MEI increase for 2019 is 1.5 percent. Therefore, for CY 2019, the payment amount for HCPCS code Q3014 (Telehealth originating site facility fee) is 80 percent of the lesser of the actual charge, or \$26.15. (The beneficiary is responsible for any unmet deductible amount and Medicare coinsurance.)

Additional information

The official instruction, CR 11063, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4176CP.pdf>.

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

Document history

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National Provider Enrollment Conference – March 2019

Tuesday, March 12, 2019, from 8:00 a.m. to 5:00 p.m. CT and Wednesday, March 13, 2019, from 8:30 a.m. to 5:00 p.m. CT, Nashville, TN.

Register at <https://www.palmgba.com/events/NPEC2019/> for the CMS National Provider Enrollment Conference at the Nashville Music City Center. Take advantage of this opportunity to interact directly with CMS and Medicare Administrative Contractor provider enrollment experts.

Annual Update to the Per-Beneficiary Therapy Amounts

Provider type affected

This MLN Matters® Article is intended for physicians, therapists, and other providers submitting claims to Medicare Administrative Contractors (MACs), including Home Health & Hospice MACs, for outpatient therapy services provided to Medicare beneficiaries.

Provider action needed

CR 11055 describes the annual per-beneficiary incurred expense amounts now known as the KX modifier thresholds, and related policy updates for CY 2019. These amounts were previously associated with the financial limitation amounts that were more commonly referred to as “therapy caps” before the application of the therapy limits/ caps was repealed when the Bipartisan Budget Act of 2018 (BBA of 2018) was signed into law. Another provision of the BBA of 2018 lowers the threshold of the targeted medical review process as explained in the Background section below.

For CY 2019, the KX modifier threshold amount for physical therapy (PT) and speech-language pathology (SLP) services combined is \$2,040. For occupational therapy (OT) services, the CY 2019 threshold amount is \$2,040. Make sure that your billing staffs are aware of these updates.

Background

Effective for January 1, 2018, section 50202 of the Bipartisan Budget Act of 2018, P.L. 115-123 (BBA of 2018) amended section 1833(g) of the Social Security Act (the Act) to repeal the application of the therapy caps and the therapy caps exceptions process while also retaining and adding limitations to ensure appropriate therapy. The therapy caps or financial limitations originally applied through section 4541(c) of the Balanced Budget Act of 1997, P.L. 105-33 (1997 BBA) are no longer applicable to beneficiaries.

A separate provision of section 50202 of the BBA of 2018 adds section 1833(g)(7)(A) of the Act to preserve the former therapy cap amounts as thresholds above which claims must include the KX modifier to confirm that services are medically necessary as justified by appropriate documentation in the medical record. Claims from suppliers or providers for therapy services above these amounts without the KX modifier are denied. These amounts are now known as the KX modifier thresholds.

Just as with the incurred expenses for the therapy cap amounts, there is one KX modifier threshold amount for physical therapy (PT) and speech-language pathology (SLP) services combined and a separate amount for occupational therapy (OT) services. These per-beneficiary amounts under section 1833(g) of the Act (as amended by 1997 BBA) are updated each year by the Medicare Economic Index (MEI).

For CY 2019, the KX modifier threshold amounts are: (a) \$2,040 for PT and SLP services combined, and (b) \$2,040 for OT services.

Another provision of section 50202 of the BBA of 2018



adds section 1833(g)(7)(B) of the Act which maintains the targeted medical review process (first established through section 202 of the Medicare Access and CHIP Reauthorization Act of 2015), but at a lower threshold than the \$3,700 amount established as part of the therapy caps exceptions process via section 3005 of the Middle Class Tax Relief and Jobs Creation Act of 2012. For CY 2018 (and each successive calendar year until 2028, at which time it is indexed annually by the MEI), this now-terminated Medical Review (MR) threshold amount is \$3,000 for PT and SLP services combined and \$3,000 for OT services.

For more information, please see the pages for Therapy Services of CMS-1693-F on the CMS web page at the following link for PFS Federal Regulation Notices: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html>.

Additional information

The official instruction, CR11055, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4178CP.pdf>.

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

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Hurricane Michael and Medicare disaster-related Florida and Georgia claims

Note: This article was revised on December 12, 2018, to advise providers that the public health emergency (PHE) declaration and Section 1135 waiver authority for Florida expires on January 5, 2019. Also, the PHE and Section 1135 waiver authority for Georgia expires on January 7, 2019. All other information is unchanged. This information was previously published in the *November 2018 Medicare B Connection*, pages 13-15.

Provider type affected

This MLN Matters® Special Edition Article is intended for providers and suppliers who submit claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries in the states of Florida and Georgia 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 10, 2018, President Trump declared a similar emergency for the State of Georgia 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. Also, on October 11, 2018, Secretary Azar declared that a public health emergency exists in the State of Georgia, retroactive to October 9, 2018, and authorized the same waivers and modifications for Georgia. The PHE and Section 1135 waiver authority for Florida expires on January 5, 2019. The PHE and Section 1135 waiver authority for Georgia expires on January 7, 2019.

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, retroactive to October 7, 2018. On October 11, 2018, the CMS Administrator authorized the same waivers for the state of Georgia, retroactive to October 9, 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 states of Florida and Georgia. 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/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 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 and for the State of Georgia from October 9, 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/Past-Emergencies/Hurricanes-and-tropical-storms.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 States of Florida and Georgia. 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 and Georgia.
 - 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 and October 9, 2018, for Georgia.

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

See **MICHAEL**, page 10

MICHAEL

from page 9

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 areas of **Florida and Georgia**. 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 3-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 States of Florida and Georgia. 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.

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,

See **MICHAEL**, page 11

MICHAEL

from page 10

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-webside-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 web page 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 |
|-------------------|--|
| December 12, 2018 | The article was revised to advise providers that the PHE declaration and Section 1135 waiver authority for Florida expires on January 5, 2019. Also, the PHE and Section 1135 waiver authority for Georgia expires on January 7, 2019. All other information is unchanged. |
| October 12, 2018 | The article was revised to add information regarding the emergency declared for the state of Georgia as a result of Hurricane Michael. |
| October 11, 2018 | Initial article released. |

MLN Matters® Number: SE18021 *Revised*
 Related CR Release Date: December 12, 2018
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Changes to Amount in Controversy (AIC) for Appeals in 2019

The amount that must remain in controversy for ALJ hearing requests filed on or before December 31, 2018 is \$160. **This amount will remain at \$160 for ALJ hearing requests filed on or after January 1, 2019.** The amount that must remain in controversy for reviews in Federal District Court requested on or before December 31, 2018 is \$1,600. **This amount will increase to \$1,630 for appeals to Federal District Court filed on or after January 1, 2019.**

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

Note: This article was revised on December 10, 2018, to update the language regarding when MACs can return an MBI through the MBI look up tool (page 1). All other information remains the same. This information was previously published in the *July 2018 Medicare B Connection*, pages 15-16.

Provider type affected

This Special Edition MLN Matters® Article is intended for physicians, providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs), including Durable Medical Equipment MACs (DME MACs) and Home Health and Hospice MACs, for services provided to Medicare beneficiaries.

Provider action needed

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

1. Ask your Medicare patients

Ask your Medicare patients for their new Medicare card when they come for care. If they haven't received a new card at the completion of their geographic mailing wave, give them the "Still Waiting for Your New Card?" handout (in [English](#) or [Spanish](#)) or refer them to 1-800-Medicare (1-800-633-4227).

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

You can look up MBIs for your Medicare patients when they don't or can't give them. [Sign up](#) for the Portal to use the tool. You can use this tool even after the end of the transition period – it doesn't end on December 31, 2019.

3. Check the remittance advice

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

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

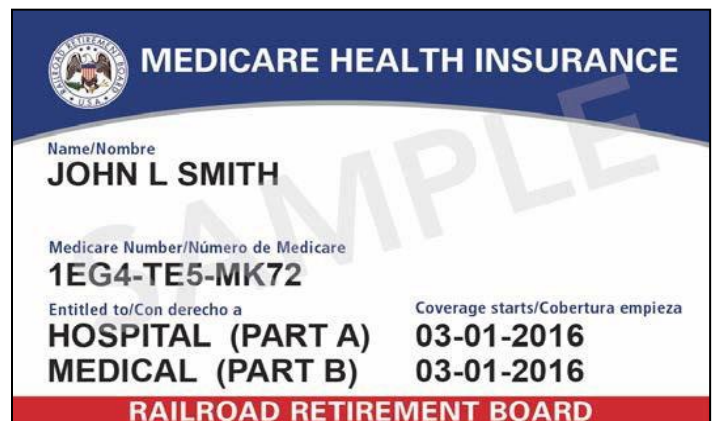
Background

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS to remove Social Security Numbers from all Medicare cards by April 2019. A new, randomly generated Medicare Beneficiary Identifier, or MBI, is replacing the SSN-based HICN. The new MBI is noticeably different than the HICN. **Just like with the HICN, the MBI hyphens on the card are for illustration purposes: don't include the hyphens or spaces on transactions.** The MBI uses numbers 0-9 and all uppercase letters except for S, L, O, I, B, and Z. We exclude these letters to avoid confusion when differentiating some letters and numbers (e.g., between "0" and "O").



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

RRB issued Medicare card



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

The beneficiary or their authorized representative can

See **MBI**, page 13

MBI

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

FFS claims submissions with:

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

FFS eligibility transactions when the:

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

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

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

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

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

The MBI does not change Medicare benefits. Medicare beneficiaries may start using their new Medicare cards and

MBIs as soon as they get them. Use MBIs as soon as your patients share them. The new cards are effective the date beneficiaries are eligible for Medicare.

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

Additional information

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

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

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

Document history

| Date of change | Description |
|-------------------|---|
| December 10, 2018 | The article was revised to update the language regarding when MACs can return an MBI through the MBI lookup tool (page 1). All other information remains the same. |
| July 11, 2018 | This article was revised to provide additional information regarding the format of the MBI not using letters S, L, O, I, B, and Z (page 2). |
| June 25, 2018 | This article was revised to provide additional information regarding the ways your staff can get MBIs (<i>Provider action needed</i> section). |
| June 21, 2018 | The article was revised to emphasize the need to submit the MBI without hyphens or spaces to avoid rejection of your claim. All other information remains the same. |
| May 25, 2018 | Initial article released. |

MLN Matters® Number: SE18006 *Revised*

Related CR Release Date: December 10, 2018

Related CR Transmittal Number: N/A

Related Change Request (CR) Number: N/A

Effective Date: N/A

Implementation N/A

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Ambulance inflation factor for calendar year 2019 and productivity adjustment

Provider type affected

This MLN Matters® Article is intended for ambulance providers and suppliers submitting claims to Medicare Administrative Contractors (MACs) for Medicare Part B ambulance services provided to Medicare beneficiaries.

Provider action needed

CR 11031 furnishes the Calendar Year (CY) 2019 Ambulance Inflation Factor (AIF) for determining the payment limit for ambulance services. The AIF for CY 2019 is 2.3 percent. Make sure that your billing staffs are aware of this change.

Background

Section 1834(l)(3)(B) of the Social Security Act provides the basis for an update to the payment limits for ambulance services that is equal to the percentage increase in the Consumer Price Index for all Urban Consumers (CPI-U) for the 12-month period ending with June of the previous year. On March 23, 2010, the Affordable Care Act (Pub. L. 111-148) was enacted. Following the enactment of Pub. L. 111-148, the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152 (enacted on March 30, 2010), amended certain provisions of Pub. L. 111-148. These public laws are collectively known as the Affordable Care Act (ACA). Section 3401 of the ACA amended Section 1834(l)(3) of the Act to apply a productivity adjustment to this update equal to the 10-year moving average of changes in economy-wide private nonfarm business multi-factor productivity (MPF) beginning January 1, 2011. The resulting update percentage is referred to as the AIF.

Section 3401 of the ACA requires that specific Prospective Payment System (PPS) and Fee Schedule (FS) update factors be adjusted by changes in economy-wide productivity. The statute defines the productivity adjustment to be equal to the 10-year moving average of changes in annual economy-wide private nonfarm business MFP (as projected by the Secretary of Health and Human Services (the Secretary) for the 10-year period ending with the applicable fiscal year, cost reporting period, or other annual period).

The MFP for CY 2019 is 0.6 percent and the CPI-U for 2019 is 2.9 percent. According to the ACA, the CPI-U is reduced by the MFP, even if this reduction results in a negative AIF update. Therefore, the AIF for CY 2019 is 2.3 percent.



The Part B coinsurance and deductible requirements apply to payments under the ambulance fee schedule.

Additional information

The official instruction, CR 11031, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4172CP.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 |
|-------------------|---------------------------|
| November 30, 2018 | Initial article released. |

MLN Matters® Number: MM11031
 Related CR Release Date: November 30, 2018
 Related CR Transmittal Number: R4172CP
 Related Change Request (CR) Number: 11031
 Effective Date: January 1, 2019
 Implementation January 7, 2019

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Preventive Services

Quarterly influenza virus vaccine code update – January 2019

Note: This article was revised on December 14, 2018 to reflect the revised CR10871 issued on September 27. In the article, the CR release date, transmittal number, and the Web address for accessing CR10871 are revised. All other information remains the same. This information was previously published in the [September 2018 Medicare B Connection](#), pages 5-6.

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) 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.

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/R4141CP.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 |
|-------------------|--|
| December 14, 2018 | The article was revised to reflect the revised CR10871 issued on September 27. In the article, the CR release date, transmittal number, and the Web address for accessing CR10871 are revised. All other information remains the same. |
| 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 27, 2018
 Related CR Transmittal Number: R4141CP
 Related Change Request (CR) Number: 10871
 Effective Date: January 1, 2019
 Implementation January 7, 2019

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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

Multiple Part A and Part B local coverage determinations (LCDs) being retired

LCD ID numbers: L34376, L34377 (Florida, Puerto Rico/U.S. Virgin Islands)

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

L34376 - magnetic resonance imaging of the spine

L34377 - magnetic resonance imaging of upper extremity

Effective date

The retirement of these LCDs is effective for services

rendered **on or after December 13, 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](#).

Computed tomography of the abdomen and pelvis – retired Part A and Part B LCD

LCD ID number: L33284 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on data analysis review of the local coverage determination (LCD) for computed tomography of the abdomen and pelvis, it was determined that the LCD and associated “Coding Guideline” article are no longer required and therefore, are being retired.

Effective date

The retirement of this LCD and “Coding Guideline” article

is effective for services rendered **on or after December 4, 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](#).

Abatacept – retired Part A and Part B LCD

LCD ID number: L33257 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on data analysis review of the local coverage determination (LCD) for abatacept, 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 December 15, 2018**. LCDs are

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

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

Note: To review active, future and retired LCDs, please [click here](#).

B-scan – retired Part B Local Coverage Determination

LCD ID number: L33904 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on data analysis review of the local coverage determination (LCD) for b-scan, 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 December 15, 2018**. LCDs are

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

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

Note: To review active, future and retired LCDs, please [click here](#).

Magnetic resonance imaging of the orbit, face, and/or neck – retired Part A and Part B LCD

LCD ID number: L34375 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on data analysis review of the local coverage determination (LCD) and related “Coding Guidelines” for magnetic resonance imaging of the orbit, face, and/or neck, it was determined that they are no longer required and therefore, are being retired.

Effective date

This retirement of this LCD and related “Coding Guideline” is effective for services rendered **on or after December 11, 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](#).

Magnetic resonance imaging of the brain – retired Part A and Part B LCD

LCD ID number: L34374 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on data analysis review of the local coverage determination (LCD) and related “Coding Guidelines” for magnetic resonance imaging of the brain, it was determined that they are no longer required and therefore, are being retired.

Effective date

This retirement of this LCD and related “Coding Guidelines” is effective for services rendered **on or after**

December 13, 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](#).

Computed tomography scans of the head or brain – retired Part A and Part B LCD

LCD ID number: L33721 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on data analysis review of the local coverage determination (LCD) and related “Coding Guidelines” article for computed tomography scans of the head or brain, it was determined that they are no longer required and therefore, are being retired.

Effective date

The retirement of this LCD and related “Coding Guidelines”

article is effective for services rendered **on or after December 13, 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](#).

Computed tomography of the thorax – retired Part A and Part B LCD

LCD ID number: L33285 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on data analysis review of the local coverage determination (LCD) for computed tomography of the thorax, it was determined that the LCD and associated “Coding Guidelines” article are no longer required and, therefore, are being retired.

Effective date

This retirement of this LCD and “Coding Guidelines” article

is effective for services rendered **on or after December 13, 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](#).

Magnetic resonance imaging of any joint of the lower extremities – retired Part B LCD

LCD ID number: L34373 (Florida/Puerto Rico/ U.S. Virgin Islands)

Based on data analysis review of the local coverage determination (LCD) for magnetic resonance imaging (MRI) of any joint of the lower extremities, 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 December 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](#).

Revisions to LCDs

Intravenous immune globulin – revision to the Part A and Part B LCD

LCD ID number: L34007 (Florida/Puerto Rico/ U.S. Virgin Islands)

Based on reconsideration requests, the local coverage determination (LCD) for intravenous immune globulin was revised to update the “Sources of information” section of the LCD with multiple published sources. The content of the LCD has not been changed in response to these reconsideration requests.

Effective date

This LCD revision is effective for services rendered **on or after November 13, 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](#).

Psychological and neuropsychological tests – revision to the Part A and Part B LCD

LCD ID number: L34520 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on a reconsideration request, the local coverage determination (LCD) for psychological and neuropsychological tests was revised to add ICD-10-CM diagnosis codes B20 and G35 to the “ICD-10 Codes that Support Medical Necessity” section of the LCD for Current Procedural Terminology (CPT®)/Healthcare Common Procedure Coding System (HCPCS) codes 96101, 96102, 96103, 96118, 96119, 96120, and G0451. In addition, the “Sources of Information” section of the LCD was updated.

Effective date

This LCD revision is effective for services rendered **on or after November 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](#).

Carboplatin (Paraplatin®, Paraplatin-AQ®) – revision to the Part A and Part B LCD

LCD ID number: L33275 (Florida/Puerto Rico/ U.S. Virgin Islands)

Based on a reconsideration request of the carboplatin (Paraplatin®, Paraplatin AQ®) local coverage determination (LCD), the “ICD-10 Codes that Support Medical Necessity” section of the LCD was updated to include ICD-10-CM diagnosis code C45.1 (Mesothelioma of the peritoneum). Also, the “Coverage Indications, Limitations, and/or Medical Necessity” section of the LCD was updated to include “Malignant neoplasm of the peritoneum (mesothelioma)” and the “Sources of Information” section of the LCD was updated to add multiple published sources.

Effective date

This revision to the LCD is effective for services rendered **on or after December 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](#).

Bortezomib (Velcade) – revision to the Part A and Part B LCD

LCD ID number: L33273 (Florida/Puerto Rico/ U.S. Virgin Islands)

Based on an annual review, the local coverage determination (LCD) for bortezomib (Velcade) was revised to update language in the “Coverage Indications, Limitations, and/or Medical Necessity” and the “Route of Administration” sections of the LCD to add subcutaneous injection. The Food and Drug Administration (FDA) approved the subcutaneous route of administration as an alternative to the existing intravenous route of administration for the treatment of patients with multiple myeloma and mantle cell lymphoma. Also, the “Sources of Information” section of the LCD was updated.

Effective date

This LCD revision is effective for claims processed **on or after January 1, 2019**, for services rendered **on or after January 23, 2012**. LCDs are available through the CMS Medicare coverage database at <https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>.

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

Note: To review active, future and retired LCDs, please [click here](#).

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

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

Based on change request (CR) 10784, the local coverage determination (LCD) for therapy and rehabilitation services was revised to remove the “Functional Reporting” section of the LCD under “Documentation Requirements”.

Effective date

This revision to the LCD is effective for services rendered **on or after January 1, 2019**. 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](#).

Sacroiliac joint injection – revision to the Part B LCD

LCD ID number: L33957 (Florida/Puerto Rico/ U.S. Virgin Islands)

Based on an annual review, the local coverage determination (LCD) for sacroiliac joint injection was revised to change ICD-10-CM diagnosis code range M48.8X1 – M48.8X9 to ICD-10-CM diagnosis code range M48.8X5-M48.8X9 (deleting ICD-10-CM diagnosis codes M48.8X1, M48.8X2, M48.8X3, and M48.8X4) in the “ICD-10 Codes that Support Medical Necessity” section of the LCD.

Effective date

This LCD revision is effective for claims processed **on or after December 19, 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

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

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

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

Effective for services rendered **on or after January 1, 2019**, Haegarda® (c1 esterase inhibitor subcutaneous

[human]) (Healthcare Common Procedure Coding System [HCPCS] codes J3490/J3590) has been removed and Haegarda® (c1 esterase inhibitor [human]) (HCPCS codes J0599) has been added to the Medicare administrative contractor (MAC) Jurisdiction N (JN) self-administered drug (SAD) list.

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

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

Note: To review active, future and retired LCDs, please [click here](#).

2019 HCPCS Part A/B, Part A and Part B local coverage determination changes

First Coast Service Options Inc. has revised local coverage determinations (LCDs) impacted by the 2019 Healthcare Common Procedure Coding System (HCPCS) annual update. Procedure codes have been added, revised, replaced and deleted. The following is a list of the impacted LCDs.

Part A/B Combined LCDs

- L33273 Bortezomib (Velcade®)
- L36499 BRCA1 and BRCA2 Genetic Testing
- L36393 Controlled Substance Monitoring and Drugs of Abuse Testing
- L35698 CYP2C19, CYP2D6, CYP2C9, and VKORC1 Genetic Testing
- L37398 Electroretinography (ERG)
- L36230 Evaluation and Management Services in a Nursing Facility
- L33684 Hemophilia Clotting Factors
- L33704 Infliximab (Remicade™)
- L33689 Mohs Micrographic Surgery (MMS)
- L34519 Molecular Pathology Procedures
- L33777 Noncovered Services
- L33747 Pegfilgrastim (Neulasta®)

- L34520 Psychological and Neuropsychological Tests
- L33746 Rituximab (Rituxan®)
- L36035 Spinal Cord Stimulation for Chronic Pain
- L33413 Therapy and Rehabilitation Services
- L33767 Viscosupplementation Therapy for Knee

Part A only LCD

- L33972 - Psychiatric Partial Hospitalization Program

Part B only LCD

- L33910 Independent Diagnostic Testing Facility (IDTF) (Coding Guideline Only).

Effective date

These LCD revisions are effective for services rendered **on or after January 1, 2019**. 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](#).

Keep updated...

Use the tools and useful information found on [medicare.fcso.com](https://www.medicare.fcso.com) to stay updated on changes associated with the Medicare program.



Upcoming provider outreach and educational events

Topic: Local coverage determinations: Learn what we're doing to increase transparency in the process

Date: Tuesday, January 8
Time: 11:30 a.m.-12:30 p.m.
Type of Event: Webcast

<https://medicare.fcso.com/Events/0420976.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.



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 November 21, 2018

MLN Connects[®] for November 21, 2018

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News & Announcements

- SNF PPS: New Patient Driven Payment Model Webpage
- Open Payments: Review Program Year 2017 Data through December 31
- Hospice Item Set Manual: New Version
- Hospice Comprehensive Assessment Quality Measure Fact Sheet
- Provider Enrollment Application Fee Amount for CY 2019
- National Rural Health Day, Improving Rural Health
- Recommend Influenza Vaccination: Each Office Visit is an Opportunity

Provider Compliance

- Improper Payment for Intensity-Modulated Radiation Therapy Planning Services — Reminder

Upcoming Events

- SNF PPS: New Patient Driven Payment Model Call — December 11
- National Provider Enrollment Conference — March 12

Medicare Learning Network Publications & Multimedia

- FISS: Implementation of the MoIDX MLN Matters

Article — New

- CWF Provider Queries NPI and Submitter ID MLN Matters Article — New
- ESRD PPS: CY 2019 Payment for Dialysis Furnished for AKI MLN Matters Article — New
- Home Health Rural Add-on Payments MLN Matters Article — New
- RHC AIR Payment Limit: CY 2019 Update MLN Matters Article — New
- HH PPS Rate: CY 2019 Update MLN Matters Article — New
- IVIG Demonstration: 2019 Payment Update MLN Matters Article — New
- RARC, CARC, MREP and PC Print Update MLN Matters Article — New
- Uniform Use of CARC, RARC, and CAGC Rule Update MLN Matters Article — New
- HCPCS Code Updates for Home Health Consolidated Billing Enforcement MLN Matters Article — New
- Physician Compare Webcast: Audio Recording and Transcript — New
- New Waived Tests MLN Matters Article — Revised

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MLN Connects[®] – Special Edition for November 27, 2018

Public Comments on New Product Categories for DMEPOS Competitive Bidding

CMS is extending the public comment period on new product categories to be phased-in for the next round of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program.

Comments will now be accepted through December 17, 2018. See the [Public Comments on New Product Categories](#) webpage for more information.

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MLN Connects® for November 29, 2018

MLN Connects® for November 29, 2018

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News & Announcements

- CMS Takes Action to Lower Prescription Drug Costs by Modernizing Medicare
- Nursing Homes: Efforts to Improve Patient Safety, Quality of Care
- New Online Tool Displays Cost Differences for Certain Surgical Procedures
- Improved eCQI Resource Center Website
- Hospital-Based Incident Command Systems: Real Experiences and Practical Applications
- World AIDS Day is December 1

Provider Compliance

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

MLN Connects® for December 6, 2018

MLN Connects® for Thursday, December 6, 2018

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News & Announcements

- CMS Strengthens Nursing Home Oversight and Safety to Ensure Adequate Staffing
- Hospital Value-Based Purchasing Program Results for FY 2019
- Physician Compare Preview Period Open through December 31
- QRURs and PQRS Feedback Reports: Access Ends December 31
- Quality Payment Program: Check Your Final 2018 MIPS Eligibility Status
- Quality Payment Program: MIPS Resources
- Nursing Home Staff Competency Assessment Toolkit
- PEPPERs for Short-term Acute Care Hospitals
- eCQM Resources for the 2019 Performance Period
- Updated QRDA I Conformance Statement Resource for Hospital Submissions
- National Influenza Vaccination Week: December 2 through 8
- National Handwashing Awareness Week: December 2 through 8

Provider Compliance

- Cardiac Device Credits: Medicare Billing — Reminder

Claims, Pricers & Codes

- DME: Denial of Serial Claims

Upcoming Events

- IPPS Final Rule: Changes to the Medicare Promoting Interoperability Program Webinar — December 5
- Palliative Care for Dually Eligible Older Adults Webinar — December 5
- SNF PPS: New Patient Driven Payment Model Call — December 11

Medicare Learning Network Publications & Multimedia

- FQHC PPS Recurring File: CY 2019 Update MLN Matters Article — New
- Home Health Call: Audio Recording and Transcript — New
- Medicare Basics: Commonly Used Acronyms Educational Tool — Revised

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Upcoming Events

- SNF PPS: New Patient Driven Payment Model Call — December 11
- Hospice Public Reporting Webinar — December 13

Medicare Learning Network Publications & Multimedia

- New Medicare Webpage on Patient Driven Payment Model MLN Matters Article — New
- Ambulance Inflation Factor for CY 2019 and Productivity Adjustment MLN Matters Article — New
- ICD-10 and Other Coding Revisions to NCDs MLN Matters Article — New
- Implementation of Bundled Payment for Multi-Component DME MLN Matters Article — New
- NCD 20.4 Implantable Cardiac Defibrillators MLN Matters Article — New
- New Telehealth Modifier for Individuals with Stroke MLN Matters Article — New
- New Waived Tests MLN Matters Article — New
- NCCI Procedure-to-Procedure Edits, Version 25.0: Quarterly Update MLN Matters Article — New
- IRF PPS Call: Audio Recording and Transcript — New
- Physician Fee Schedule Call: Audio Recording and Transcript — New
- NGACO Model Post Discharge Home Visit HCPCS MLN Matters Article — Revised
- HIPAA Basics for Providers: Privacy, Security, and Breach Notification Rules Fact Sheet — Revised

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MLN Connects® for December 13, 2018

MLN Connects® for Thursday, December 13, 2018

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News & Announcements

- New Medicare Card: MAC Look-Up Tool Updated
- 2019 Medicare Part D Opioid Policies: Training Materials
- Open Payments: Review Program Year 2017 Data through December 31
- LTCH Provider Preview Reports: Review Your Data by January 2
- IRF Provider Preview Reports: Review Your Data by January 2
- Hospice Provider Preview Reports: Review Your Data by January 9
- Hospice Compare Quarterly Refresh
- Quality Payment Program: Webinar Library
- Quality Payment Program: Updated List of APMs
- 2018 QRDA Category I Implementation Guide Addendum
- QRDA I File: Sample Hybrid Hospital-Wide Readmission Measure

MLN Connects® for December 20, 2018

MLN Connects® for December 20, 2018

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News & Announcements

- Opioids Training Modules
- Open Payments: Review Program Year 2017 Data through December 31
- QRURs and PQRS Feedback Reports: Access Ends December 31
- LTCH Provider Preview Reports: Review Your Data by January 2
- IRF Provider Preview Reports: Review Your Data by January 2
- Hybrid Hospital-Wide Readmission Measure: Voluntary Reporting Extended to January 4
- LTCH Compare Refresh
- IRF Compare Refresh
- Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier
- CY 2018 eCQM Data Receiving System Edits Document

Provider Compliance

- Billing for Stem Cell Transplants — Reminder

Upcoming Events

- ESRD Quality Incentive Program: CY 2019 ESRD

Provider Compliance

- Bill Correctly for Device Replacement Procedures — Reminder

Claims, Pricers & Codes

- HETS Includes Medicare Diabetes Prevention Program Information

Upcoming Events

- Medicare Diabetes Prevention Program Enrollment Tutorial Webinar — January 9

Medicare Learning Network Publications & Multimedia

- Per-Beneficiary Therapy Amounts: Annual Update MLN Matters Article — New
- CY 2019 MPFS Final Rule: Summary of Policies MLN Matters Article — New
- Quality Payment Program: MIPS Participation in 2018 Web-Based Training Course — New
- NCD 20.4 Implantable Defibrillators MLN Matters Article — Revised
- MLN Catalog: December 2018 – Revised

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PPS Final Rule Call — January 15

- Clinical Diagnostic Laboratories to Collect and Report Private Payor Rates Call — January 22

Medicare Learning Network Publications & Multimedia

- DMEPOS Fee Schedule: CY 2019 Update MLN Matters Article — New
- Inpatient Psychiatric Facility Benefit Policy Manual Update MLN Matters Article — New
- Next Generation Sequencing NCD MLN Matters Article — New
- Physician Supervision of Diagnostic Procedures, Telehealth Services MLN Matters Article — New
- RHC and FQHC Medicare Benefit Policy Manual Update MLN Matters Article — New
- Hurricane Florence and Medicare Disaster Related North Carolina, South Carolina, and the Commonwealth of Virginia Claims MLN Matters Article — Updated
- Hurricane Michael and Medicare Disaster Related Florida and Georgia Claims MLN Matters Article — Updated

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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@fcsso.com>>
Online form: <https://medicare.fcsso.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@fcsso.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

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Centers for Medicare & Medicaid Services

<https://www.cms.gov>

E-learning Center

<https://gm1.geolearning.com/geonext/fcsso/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
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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>

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| <p>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.</p> <p>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.</p> | 40300270 | \$12 | | |
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