Medicare B CONNECTION
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FIRST COAST SERVICE OPTIONS, INC.
A Newsletter for MAC Jurisdiction N Providers
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Note: *This article was revised on January 24, 2019, to advise providers that the public health emergency (PHE) declaration and Section 1135 waiver authority for the United States Virgin Islands expired on December 9, 2018. All other information remains the same. This information was previously published in the September 2018 Medicare B Connection, pages 10-12.*

Provider type affected

This MLN Matters® Special Edition Article is intended for providers and suppliers who submit claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries in the United States Virgin Islands and the Commonwealth of Puerto Rico who were affected by Hurricane Maria.

Provider information available

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

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

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

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

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.

Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - April 2019 Update

Provider type affected

This MLN Matters Article is for physicians, providers and suppliers billing Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider action needed

This article informs you that the Centers for Medicare & Medicaid Services (CMS) has issued payment files to the MACs based upon the 2019 Medicare Physician Fee Schedule (MPFS) Final Rule. CR 11163 amends those payment files. Please be sure your billing staffs are aware of these changes.

Background

The 2019 Medicare Physician Fee Schedule (MPFS) Final Rule, published in the Federal Register on November 23, 2018, is effective for services furnished between January 1, 2019, and December 31, 2019.

Below is a summary of the changes for the April update to the 2019 Medicare Physician Fee Schedule Database (MPFSD). These changes are effective for dates of service on and after January 1, 2019. CMS has added new HCPCS codes (G2001-G2009 and G2013-G2015) to the 2019 MPFSDB and updated another code (G9987) as shown in the table below. CMS communicated instructions for these new codes (G2001-G2009 and G2013-G2015) through a separate CR (CR 10907). Please consult MLN Matters article MM10907 at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10907.pdf* for these instructions and other information.

Table: April Updates to the 2019 MPFSD

HCPCS	ACTION
G9987	Assistant Surgery, Co-Surgeon, & Team Surgeon indicator = 9
G2001	All MPFS indicators and RVUs = 99341
G2002	All MPFS indicators and RVUs = 99342
G2003	All MPFS indicators and RVUs = 99343
G2004	All MPFS indicators and RVUs = 99344
G2005	All MPFS indicators and RVUs = 99345
G2006	All MPFS indicators and RVUs = 99347
G2007	All MPFS indicators and RVUs = 99348
G2008	All MPFS indicators and RVUs = 99349
G2009	All MPFS indicators and RVUs = 99350
G2013	All MPFS indicators and RVUs = 99345
G2014	All MPFS indicators and RVUs = 99339
G2015	All MPFS indicators and RVUs = 99340

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

Additional information

The official instruction, CR 11163, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2019Downloads/R4234CP.pdf*.

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

Document history

Date of change	Description
February 8, 2019	Initial article released.

MLN Matters® Number: MM11163
Related CR Release Date: February 1, 2019
Related CR Transmittal Number: R4234CP
Related Change Request (CR) Number: 11163
Effective Date: January 1, 2019
Implementation Date: April 1, 2019

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General Coverage

New local coverage determinations process

***Note**: We revised the article on February 14, 2019, to reflect the revised CR 10901 issued on February 12, 2019, that includes changes to the updates in Chapter 13 of the Medicare Program Integrity Manual. The CR changed the effective date to October 3, 2018, we made that change in the article. CMS also revised the CR release date, transmittal number, and the web address of the CR. All other information remains the same. This information was previously published in the January 2019 Medicare B Connection, pages 9-11.*

Provider type affected

This MLN Matters Article is intended for physicians, providers, and suppliers billing Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider action needed

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

Background

Through feedback received in the proposed Calendar Year (CY) 2018 Physician Fee Schedule (PFS) Rule (82 FR 33950), and through meetings and correspondence; stakeholders, including providers and health care associations, have provided CMS with valuable insight regarding modernization of the LCD process.

Most stakeholders acknowledged that the local coverage process is an important means to provide decisions related to the items and services that benefit Medicare's beneficiaries and to ensure beneficiary access to life saving and medically necessary products and procedures. However, there is concern about the lack of local coverage process transparency, including notifying stakeholders of proposed revisions to, and drafting of, new LCDs.

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

In CR10901, the revisions to the Medicare Program Integrity Manual, Chapter 13, CMS is revising instructions to MACs, reflecting policy process changes in response to the new statutory (21st century Cures Act) requirements and to the stakeholder comments. These changes will help to increase transparency, clarity, consistency, reduce provider burden and enhance public relations while retaining the ability to be responsive to local clinical and

coverage policy concerns.

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

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

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

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

NEW LCD process

The key parts of the new LCD process are summarized as

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follows:

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

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

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

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

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

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

3. Clinical Guidelines, Consensus Documents and Consultation

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

4. Publication of the Proposed LCD

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

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

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

5. Contractor advisory committee (CAC)

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

MACs will establish one CAC per state or have the option of establishing one CAC per jurisdiction or multi-jurisdictional CAC with representation from each state. If a MAC chooses to have one CAC per jurisdiction or multi-jurisdictional CAC, the MAC must endeavor to ensure that each state has a full committee and the opportunity to discuss the quality of the evidence used to make a determination.

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

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6. Open Meeting

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

7. Publication of the Final Determination

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

8. Response to Public Comments

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

9. Notice period

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

Full details of this new process are contained in the updated manual which is an attachment to CR10901.

LCD reconsideration process

The LCD reconsideration process is a mechanism by which a beneficiary or stakeholder (including a medical professional society or physician) in the MAC's jurisdiction can request a revision to an LCD. The LCD reconsideration process differs from an initial request for an LCD in that it is available only for final effective LCDs. The whole LCD or any provision of the LCD may be reconsidered. In addition, MACs have the discretion to revise or retire their LCDs at any time on their own initiative. This process is summarized as follows:

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

Other important changes

Other key changes to the manual include the following:

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

Additional information

The official instruction, CR10901, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2019Downloads/R863PI.pdf*. The complete manual revision is included in CR10901.

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

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

Document history

Date of change	Description
February 14, 2019	CMS revised the article to reflect the revised CR 10901 issued on February 12, 2019, that includes changes to the updates in Chapter 13 of the Medicare Program Integrity Manual. The CR changed the effective date to October 3, 2018, and we made that change in the article. CMS also revised the CR release date, transmittal number, and the web address of the CR.
February 1, 2019	The article was revised to reflect the revised CR 10901 issued on January 30, 2019, to include the updates in Chapter 13 of the "Medicare Program Integrity Manual", which were erroneously not updated in the most recent on-line manual change. The effective date in the article was also corrected. We also revised the CR release date, transmittal number, and the web address of the CR.
January 11, 2019	We revised the article to reflect the revised CR 10901 issued on January 11. In the article, we added language to show that MACs have the discretion to host multi-jurisdictional CACs. Also, we revised the CR release date, transmittal number, and the web address of the CR. All other information remains the same.
October 3, 2018	Initial article released.

MLN Matters® Number: MM10901 *Revised*
Related CR Release Date: February 12, 2019
Related CR Transmittal Number: R863PI
Related Change Request (CR) Number: 10901
Effective Date: October 3, 2018
Implementation Date: January 8, 2019

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Guidance on Coding and Billing Date of Service on Professional Claims

***Note**: This article was revised on February 1, 2019, to correct a statement in the Home Health Certification and Recertification Section to read, "the physician completes and signs the plan of care." All other information is unchanged.*

Provider type affected

This MLN Matters Article is intended for physicians, non-physician practitioners, and others submitting claims on a CMS-1500 form or the X12 837 Professional Claim to Medicare Administrative Contractors (MACs) for reimbursement for Medicare Part B services.

Provider action needed

STOP – Impact to you:

Physicians and non-physician practitioners need to identify the correct date of service for the services they provide to a Medicare patient.

CAUTION – What you need to know:

This MLN Matters Article is intended for physicians, providers, and suppliers billing MACs for services provided to Medicare beneficiaries.

GO – What you need to do:

Providers need to determine the Medicare rules and regulations concerning the date of service and submit claims appropriately. Be sure your billing and coding staffs are aware of this information.

Background

The information below will not provide all the billing instructions for the individual services. The article does not present any new or revised Medicare policy. Instead, the article reiterates current Medicare policy. This information concentrates on the date(s) of service to submit when billing for these services. If you are providing these services, please take advantage of the information available on the CMS website in addition to your MACs. The Medicare Benefit Policy Manual, Chapter 15, Section 20 shows that expenses are considered to have been incurred on the date the beneficiary received the item or service, regardless of when it was paid for or ordered. You may review this manual section at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf*.

Radiology Services

Typically, radiology services have two separate components: a professional and technical component. These services will have a PC/TC indicator of "1" on the Medicare Physician Fee Schedule (MPFS) Relative Value File. The technical component is billed on the date the patient had the test performed. When billing a global service, the provider can submit the professional component with a date of service reflecting when the review and interpretation is completed or can submit the date of service as the date the technical component was performed. This will allow ease of processing for both Medicare and the supplemental payers. If the provider did not perform a global service and instead performed only one component, the date of service for the technical component would the date the patient received the service and the date of service for the professional component would be the date the review and interpretation is completed.

The Medicare Physician Fee Schedule Relative Value File is available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html*.

Surgical and Anatomical Pathology

Surgical and anatomical pathology services may have two components: a professional and a technical component. These services will have a PC/TC indicator of "1" on the MPFS Relative Value File. The technical component is billed on the date the specimen was collected. This would be the surgery date. When billing a global service, the provider can submit the professional component with a date of service reflecting when the review and interpretation is completed or can submit the date of service as the date the technical component was performed. This will allow ease of processing for both Medicare and the supplemental payers. If the provider did not perform a global service and instead performed only one component, the date of service for the technical component would the date the patient received the service and the date of service for the professional component would be the date the review and interpretation is completed.

When the collection spans two calendar dates, use the date the specimen collection ended. There are exceptions for stored specimens as follows:

Stored specimens

In the case of a test/service performed on a stored specimen, if a specimen was stored for less than or equal to 30 calendar days from the date it was collected, the DOS of the test/service must be the date the test/service was performed only if:

- The test/service is ordered by the patient's physician at least 14 days following the date of the patient's discharge from the hospital
- The specimen was collected while the patient was undergoing a hospital surgical procedure
- It would be medically inappropriate to have collected the sample other than during the hospital procedure for which the patient was admitted
- The results of the test/service do not guide treatment provided during the hospital stay; and

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- The test/service was reasonable and medically necessary for treatment of an illness.

If the specimen was stored for more than 30 calendar days before testing, the specimen is considered to have been archived and the DOS of the test/service must be the date the specimen was obtained from storage.

For more information, see the Medicare Claims Processing Manual, Chapter 16, Section 40.8, which is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c16.pdf*.

Care Plan Oversight (CPO)

CPO is physician supervision of a patient receiving complex and/or multidisciplinary care as part of Medicare covered services provided by a participating home health agency or Medicare approved hospice. Providers must provide physician supervision of a patient involving 30 or more minutes of the physician's time per month to report CPO services. The claim for CPO must not include any other services and is only billed after the end of the month in which CPO was provided. The date of service submitted on the claim can be the last date of the month or the date in which at least 30 minutes of time is completed.

For more information, see the Medicare Claims Processing Manual, Chapter 12, Section 180.1.A, at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf* And the Medicare Benefit Policy Manual, Chapter 15, Section 30.G at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf*.

Home Health Certification and Recertification

The date of service for the Certification is the date the physician completes and signs the plan of care. The date of the Recertification is the date the physician completes the review.

For more information, see the Medicare Claims Processing Manual, Chapter 12, Section 180.1.B, at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf*.

Physician End-Stage Renal Disease (ESRD) Services

A physician may provide monthly or daily oversight of a patient on dialysis with ESRD. The date of service for a patient beginning dialysis is the date of their first dialysis through the last date of the calendar month. For continuing patients, the date of service is the first through the last date of the calendar month. For transient patients or less than a full month service, these can be billed on a per diem basis. The date of service is the date of responsibility for the patient by the billing physician. This would also include when a patient's dies during the calendar month. When submitting a date of service span for the monthly capitation procedure codes, the day/units should be coded as "1".

For more information, see the Medicare Claims Processing Manual, Chapter 8, Section 140, at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c08.pdf*.

Transitional Care Management (TCM)

TCM services are 30-day services provided when a patient is discharged from an appropriate facility and requires moderate or high-complexity medical decision making. The date of service is the date the practitioner completes the required face-to-face visit. Keep in mind, there are additional services to be provided during the 30-day period.

TCM Guidance including Questions and Answers and Fact Sheets are available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Care-Management.html*.

Clinical Laboratory Services

Generally, the date of service for clinical laboratory services is the date the specimen was collected. If the specimen is collected over a period that spans two calendar dates, the date of service is the date the collection ended. There are three exceptions to the general date of service rule for clinical laboratory tests:

1. Date of service for tests/services performed on stored specimens

In the case of a test/service performed on a stored specimen, if the specimen was stored less than or equal to 30 calendar days from the date it was collected, the date of service of the test/service must be the date the test/service was performed only if:

- The test/service was ordered by the patient's physician at least 14 days following the date of the patient's discharge from the hospital;
- The specimen was collected while the patient was undergoing a hospital surgical procedure;
- It would be medically inappropriate to have collected the sample other than during the hospital procedure for which the patient was admitted;
- The results of the test/service do not guide treatment provided during the hospital stay; and
- The test/service was reasonable and necessary for the treatment of an illness.

If the specimen was stored for more than 30 calendar days before testing, the specimen is considered to

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have been archived and the date of service of the test/service must be the date the specimen was obtained from storage.

2. Date of service for chemotherapy sensitivity tests/services performed on live tissue
    - In the case of a chemotherapy sensitivity test/service performed on live tissue, the date of service of the test/service must be the date the test/service was performed only if:
    - The decision as to the specific chemotherapy agent to test is made at least 14 days after discharge;
    - The specimen was collected while the patient was undergoing a hospital surgical procedure;
    - It would be medically inappropriate to have collected the sample other than during the hospital procedure for which the patient was admitted;
    - The results of the test/service do not guide treatment provided during the hospital stay; and
    - The test/service was reasonable and medically necessary for treatment of an illness.
3. Date of service for advanced diagnostic laboratory tests (ADLTs) and molecular pathology tests

In the case of a molecular pathology test or a test designated by CMS as an ADLT under paragraph (1) of the definition of advanced diagnostic laboratory test in 42 CFR 414.502, the date of service must be the date the test was performed only if:

- The test was performed following a hospital outpatient's discharge from the hospital outpatient department;
- The specimen was collected from a hospital outpatient during an encounter;
- It was medically appropriate to collect the sample from the hospital outpatient during the hospital outpatient encounter;
- The results of the test do not guide treatment provided during the hospital outpatient encounter; and
- The test was reasonable and necessary for the treatment of an illness.

ADLTs and molecular pathology tests subject to the third exception to the general laboratory date of service rule are available on the Medicare Clinical Laboratory Fee Schedule web page under the Laboratory Date of Service Policy tab at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html*.

Additional information is available in the Medicare Claims Processing Manual, Chapter 16, Section 40.8, at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c16.pdf*.

Home Prothrombin Time (PT/INR) Monitoring

There are several procedure codes applicable to this service. The G0248 describes the initial demonstration use of home INR monitoring and instructions for reporting. The date of service is the date the demonstration and instructions for reporting are given in a face-to-face setting with the patient. G0249 describes the provision of test materials and equipment for home INR monitoring. The date of service is the date the test materials and equipment are given to the patient. G0250 describes the physician review, interpretation, and patient management of home INR testing. This service is payable only once every 4 weeks. The date of service is the date of the fourth test interpretation. For 2018, there is also code 93793 describing the physician interpretation and instructions. The appropriate date of service is the date of the review.

For more information, see the Medicare Claims Processing Manual, Chapter 32, Section 60.5, at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c32.pdf*.

Cardiovascular Monitoring Services

There are many different procedure codes that represent the cardiovascular monitoring services. These can be identified as professional components, technical components, or a combination of the two. Some of these monitoring services may take place at a single point in time, others may take place over 24 or 48 hours, or over a 30-day period. The determination of the date of service is based on the description of the procedure code and the time listed. When the service includes a physician review and/or interpretation and report, the date of service is the date the physician completes that activity. If the service is a technical service, the date of service is the date the monitoring concludes based on the description of the service. For example, if the description of the procedure code includes 30 days of monitoring and a physician interpretation and report, then the date of service will be no earlier than the 30th day of monitoring and will be the date the physician completed the professional component of the service.

For more information, see the Medicare National Coverage Determination Manual, Chapter 1, Section 20.8.1.1, at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_part1.pdf*.

Psychiatric Testing and Evaluations

In some cases, for various reasons, psychiatric evaluations (90791/90792) and/or psychological and neuropsychological tests (96101/96146) are completed in multiple sessions that occur on different days. In these situations, the date of service that should be reported on the claim is the date of service on which the service (based on CPT code description) concluded.

Documentation should reflect that the service began on one day and concluded on another day (the date of service reported on the claim). If documentation is requested,

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medical records for both days should be submitted.

Psychiatric Testing when provided over multiple days based on the patient being able to provide information, is billed based on the time involved as described by CPT and the last date of the test. For more information, see the Medicare Benefit Policy Manual, Chapter 15, Section 80.2, at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf*.

Surgical Services

Medicare's payment for most surgical services is made using the global surgery rules. All services considered to be part of the global package including follow-up visits, are considered to have occurred on the same day as the surgical service and are not submitted separately. Surgeons who perform the surgery and then transfer post-operative care to another practitioner will submit their claims using the date of the surgery as the date of service along with Modifier 54. If the surgeon keeps responsibility for the patient for some of the post-operative care, he/she would submit the date of the surgery, the surgery procedure code with Modifier 55, and the last date of responsibility indicated in Item 19 or the electronic equivalent. The practitioner receiving the transfer of care will submit his/her post-operative services using the surgical procedure code with Modifier 55 with the date of the surgery as his/her date of service. If the practitioner receives the patient on a date other than the discharge date from an inpatient stay, Item 19 or the electronic equivalent will include the date care began. For more information, see the Medicare Claims Processing Manual, Chapter 12, Section 40 *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf*.

Maternity Benefits

All expenses incurred for surgical and obstetrical care including preoperative/prenatal examinations, testing, and post-operative/postnatal services are part of the maternity package and may be billed under the appropriate surgical code on the date of delivery or termination. Charges the practitioner may impose that are not related to the delivery are incurred on the date furnished.

For more information, see the Medicare Benefit Policy Manual, Chapter 15, Section 20.1, at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf*.

Services Which Transpire Over to Another Calendar Date

This category could include multiple types of services. The service would be started on one day and concluded the following day. The service cannot be submitted to Medicare until completed. Unless otherwise notated, the billing entity can use either the date the service began or the following day when the service concluded.

Note: This document was developed through the A/B Medicare Administrative Contractor (MAC) Provider Outreach & Education (POE) Collaboration Team. This joint effort ensures consistent communication and education throughout the nation on a variety of topics and will assist the provider and physician community with information necessary to submit claims appropriately and receive proper payment in a timely manner.

Additional information

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

Document history

Date of change	Description
February 1, 2019	This article was revised to correct a statement in the Home Health Certification and Recertification Section to read, "the physician completes and signs the plan of care."
January 24, 2019	CMS reissued the article to clarify information.
October 2, 2017	CMS rescinded the article.
September 19, 2017	Initial article released.

MLN Matters® Number: SE17023 *Revised*
Article Release Date: February 1, 2019
Related CR Transmittal Number: N/A
Related Change Request (CR) Number: N/A
Effective Date: N/A
Implementation Date: N/A

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authority for the United States Virgin Islands expired on December 9, 2018.

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

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

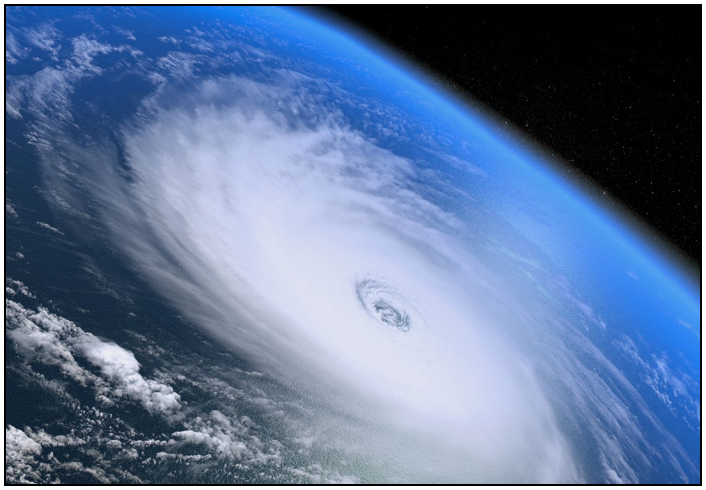
The most current waiver information can be found at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Past-Emergencies/Hurricanes-and-tropical-storms.html*. See the *Background* section of this article for more details.

Background

Section 1135 and Section 1812(f) Waivers

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

1. Change Request (CR) 6451 (Transmittal 1784, Publication 100-04) issued on July 31, 2009, applies to items and services furnished to Medicare beneficiaries within the United States Virgin Islands from September 16, 2017, and the Commonwealth of Puerto Rico from September 17, 2017, for the duration of the emergency. In accordance with 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 can be found at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Past-Emergencies/Hurricanes-and-tropical-storms.html*. Medicare FFS Questions & Answers (Q&As) posted on that webpage and also referenced below are applicable for items and services furnished to Medicare beneficiaries within the United States Virgin Islands and the Commonwealth of Puerto Rico. These Q&As are displayed in two files:
   - One file addresses policies and procedures that are applicable without any Section 1135 or other formal waiver. These policies are always applicable in any kind of emergency or disaster, including the current emergency in the United States Virgin Islands and the Commonwealth of Puerto Rico.
   - Another file addresses policies and procedures that are applicable only with approved Section 1135 waivers or, when applicable, approved Section 1812(f) waivers. These Q&As are applicable for approved Section 1135 blanket waivers and approved individual 1135 waivers requested by providers and are effective September 16, 2017, for the United States Virgin Islands and September 17, 2017, for the Commonwealth of Puerto Rico.



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

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

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

Blanket waivers issued by CMS

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

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Skilled nursing facilities

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

Home health agencies

- 42 CFR 484.20(c)(1): This waiver provides relief to Home Health Agencies on the timeframes related to OASIS Transmission. (Blanket waiver for all impacted agencies)

Critical access hospitals

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

Housing acute care patients in excluded distinct part units

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

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

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

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

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

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

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

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

Appeal administrative relief for areas affected by Hurricane Maria

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

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file an appeal, please contact your Medicare Administrative Contractor.

Replacement prescription fills

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

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

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

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

Requesting an 1135 waiver

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

Additional information

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

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

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

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

Document history

Date of change	Description
January 24, 2019	This article was revised to advise providers that the PHE declaration and Section 1135 waiver authority for the United States Virgin Islands expired on December 9, 2018. All other information remains the same.
September 13, 2018	The article was revised September 13, 2018, to advise providers that the PHE declaration and Section 1135 waiver authority for the U.S. Virgin Islands were renewed again September 11, 2018. All other information is unchanged.
July 25, 2018	This article was revised to advise providers that the PHE declaration and Section 1135 waiver authority for the U.S. Virgin Islands were renewed again June 13, 2018. The PHE and Section 1135 waiver authority for Puerto Rico expired June 13, 2018. The article was updated October 2, 2017, to include the section 'Applicability of reporting requirements for inpatient psychiatric facilities, skilled nursing facilities, home health agencies, hospices, inpatient rehabilitation facilities, ambulatory surgical centers, and renal dialysis facilities affected by Hurricane Maria.' All other information remains the same.
October 2, 2017	The article was updated October 2, 2017, to include the section 'Applicability of reporting requirements for inpatient psychiatric facilities, skilled nursing facilities, home health agencies, hospices, inpatient rehabilitation facilities, ambulatory surgical centers, and renal dialysis facilities affected by Hurricane Maria.' All other information remains the same.
September 21, 2017	Initial article released.

MLN Matters® Number: SE17028 *Revised*
Related CR Release Date: January 24, 2019
Related CR Transmittal Number: N/A
Related Change Request (CR) Number: N/A
Effective Date: N/A
Implementation N/A

Processing Issues

Physician anesthesia claims for SNF patients

Issue

Some anesthesia claims for 2018 dates of service were incorrectly denied for Part B skilled nursing facility consolidated billing: HCPCS codes 00731, 00732, 00811, 00812, and 00813.

Resolution

Claims for these services will automatically be reprocessed by Medicare administrative contractors beginning January 28.

Status/date resolved

Open.

Provider action

None.

Current processing issues

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

MIPS: Error in 2019 payment adjustment

Issue

Recently, the Centers for Medicare & Medicaid Services (CMS) discovered an error in the implementation of the 2019 Merit-based Incentive Payment System (MIPS) payment adjustment; it incorrectly applies payments for Medicare Part B drugs and other non-physician services billed by physicians.

Resolution

Adjustments to impacted claims will occur in the near future. If a claim was overpaid based on this error, you will get a notification for recoupment from your Medicare administrative contractor. If a claim was underpaid, it will be adjusted.

Status/date resolved

Open.

Provider action

None.

Current processing issues

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

Inappropriate denials for extracranial Doppler imaging

Issue

Due to an incorrect system edit, some claims for extracranial Doppler imaging (CPT® codes 93800 and 93882) were denied inappropriately.

Resolution

Medicare administrative contractors (MACs) will perform mass adjustments to allow payment of the denied claims where appropriate.

Status/date resolved

Open.

Provider action

None.

Current processing issues

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

Provider Enrollment

Physicians and non-physician practitioners: New Medicare enrollment application

CMS received approval for a new Medicare enrollment application for physicians and non-physician practitioners (*CMS-855I* dated 12/2018). Many changes are minor; the major ones reduce provider burden:

- Eliminated reporting for advanced diagnostic imaging, Clinical Laboratory Improvement Amendments number, and the Food and Drug Administration radiology certification number
- Expanded instructions for individual and group affiliations to simplify reporting
- Made it optional to list a contact person
- Added electronic storage information for those who no longer keep paper records
- Created a more logical data flow

You may begin using the new application immediately. Through April 30, Medicare administrative contractors will accept applications dated 7/2011, but after that, you have to use the new version.

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.

Your Feedback Matters

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

New LCDs

Noncovered service- 4kscore test algorithm – new Part A and Part B LCD

LCD ID number: L37798 (Florida/Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for noncovered service – 4kscore test algorithm was developed to communicate the non-coverage for the 4Kscore assay (Current Procedural Terminology [CPT®] code 81539).

Effective date

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

Frequency of hemodialysis – new Part A and Part B LCD

LCD ID number: L37564 (Florida/Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for frequency of hemodialysis and the "Coding and Billing Article" were displayed on the Centers for Medicare & Medicaid Services (CMS) Medicare Coverage Database (MCD) on January 10, 2019 for a 45-day notice period, with an original effective date of February 25, 2019. The LCD original effective date has been changed to March 1, 2019 and it will be displayed on the MCD on February 21, 2019. The original effective date was the only change made to this LCD. Furthermore, in creating this new LCD, the current LCD for frequency of hemodialysis services (L33970) and the companion "Coding Guidelines" will be retired when this new LCD and "Coding and Billing Article" becomes effective.

Effective date

This new LCD and related "Coding and Billing Article" is effective for services rendered **on or after March 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*.

Revisions to LCDs

Destruction of paravertebral facet joint nerve(s) – revision to the Part B LCD

LCD ID number: L33814 (Florida/Puerto Rico/ U.S. Virgin Islands)

Based on review of the local coverage determination (LCD) for destruction of paravertebral facet joint nerve(s), grammatical and formatting errors were corrected throughout the LCD. Also, the "Indications" section of the LCD was revised to assure consistency with the Centers for Medicare & Medicaid Services (CMS) source. In addition, based on change request (CR) 10901, the "Indications" section of the LCD was revised to update the section number for Pub. 100-08, Chapter 13 from Section 5.1 to Section 13.5.4 and the "CMS National Coverage Policy" section of the LCD was updated to add this CMS source.

Effective date

The LCD revision related to grammatical and formatting errors is effective for claims processed **on or after January 22, 2019**.

The LCD revision related to the CMS sources is effective for services rendered **on or after January 22, 2019.**

The LCD revision related to CR 10901 is effective for claims processed **on or after January 8, 2019**, for services rendered **on or after September 26, 2018**. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

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

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

Based on a review of the local coverage determination (LCD) for E & M home and domiciliary visits, grammatical and formatting errors were corrected. Also, based on change request (CR) 10901 the "Centers for Medicare & Medicaid Services (CMS) National Coverage Policy" and "Background and Provisions of Coverage:" sections of the LCD were revised to update the section number for Pub. 100-08, Chapter 13 from Section 5.1 to Section 13.5.4. In addition, based on the Federal Register, November 23, 2018, (83 FR 59630) final rule, the "Documentation Requirements" section of the LCD was revised to remove the first paragraph related to the requirement that the medical record document the medical necessity of furnishing the visit in the home rather than in the office.

Effective date

The LCD revision related to grammatical and formatting errors is effective for claims processed **on or after January 22, 2019**.

The LCD revision related to CR 10901 is effective for claims processed **on or after January 8, 2019**, for services rendered **on or after September 26, 2018**.

The LCD revision related to documentation requirements for home visits 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*.

Vitamin B12 injections – revision to the Part B LCD

LCD ID number: L33967 (Florida/Puerto Rico/ U.S. Virgin Islands)

Based on a review of the local coverage determination (LCD) for vitamin B12 injections, the registered trademark was added to the drug name "Alimta®" and outdated Centers for Medicare & Medicaid Services (CMS) sources were removed from the LCD.

Effective date

The LCD revision is effective for services rendered **on or after January 22, 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*.

Nail debridement – revision to the Part B LCD

LCD ID number: L33922 (Florida/Puerto Rico/ U.S. Virgin Islands)

Based on review of the local coverage determination (LCD) for nail debridement, grammatical and formatting errors were corrected throughout the LCD. In addition, the "Coverage Indications, Limitations, and/or Medical Necessity" and "Documentation Requirements" sections of the LCD were revised to assure consistency with the Centers for Medicare & Medicaid Services (CMS) sources.

Effective date

The LCD revision related to grammatical and formatting errors is effective for claims processed **on or after January 22, 2019**.

The LCD revision related to the CMS sources is effective for services rendered **on or after January 22, 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*.

Independent diagnostic testing facility (IDTF) – revision to the Part B LCD

LCD ID number: L33910 (Florida/Puerto Rico/ U.S. Virgin Islands)

Based on review of the local coverage determination (LCD) for independent diagnostic testing facility (IDTF), grammatical and formatting errors were corrected throughout the LCD. Also, it was determined that some of the italicized language in the "Coverage Indications, Limitations, and/or Medical Necessity" and "Documentation Requirements" sections of the LCD do not represent direct quotations from some of the Centers for Medicare & Medicaid Services (CMS) sources listed in the LCD; therefore, this LCD is being revised to assure consistency with the CMS sources. In addition, based on change request (CR) 10901, the "CMS National Coverage Policy" and "Coverage Indications, Limitations, and/or Medical Necessity" sections of the LCD were revised to update the section number for Pub. 100-08, Chapter 13 from Section 13.5.1 to Section 13.5.4.

Effective date

The LCD revision related to grammatical and formatting errors is effective for claims processed **on or after January 22, 2019**.

The LCD revision related to the CMS sources is effective for services rendered **on or after January 22, 2019.**

The LCD revision related to CR 10901 is effective for claims processed **on or after January 8, 2019**, for services rendered **on or after September 26, 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*.

Vestibular function tests – revision to the Part B LCD

LCD ID number: L33966 (Florida/Puerto Rico/ U.S. Virgin Islands)

Based on review of the local coverage determination (LCD) for vestibular function tests, grammatical errors were corrected. In addition, the "Centers for Medicare & Medicaid Services (CMS) National Coverage Policy" section of the LCD was revised to update the outdated section number for Pub. 100-02, Chapter 15, from Section 50.4.1 to Sections 80; 80.3-80.3.1. In addition, based on change request (CR) 10901, the "CMS National Coverage Policy" and "Training and Expertise" sections of the LCD were revised to update the section number for Pub. 100-08, Chapter 13, from Section 5.1 to Section 13.5.4.

Effective date

The LCD revision related to grammatical errors and Pub. 100-02 is effective for claims processed **on or after January 22, 2019**.

The LCD revision related to CR 10901 is effective for claims processed **on or after January 8, 2019**, for services rendered **on or after September 26, 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*.

Omalizumab (Xolair®) – revision to the Part B LCD

LCD ID number: L33924 (Florida/Puerto Rico/ U.S. Virgin Islands)

Based on a review of the local coverage determination (LCD) for omalizumab (Xolair®), grammatical errors were corrected. In addition, based on change request (CR) 10901, the "Centers for Medicare & Medicaid Services (CMS) National Coverage Policy" and "Utilization Guidelines" sections of the LCD were revised to update the section number for Pub. 100-08, Chapter 13, from Section 5.1.C to Section 13.5.4.

Effective date

The LCD revision related to grammatical errors is effective for claims processed **on or after January 22, 2019**.

The LCD revision related to CR 10901 is effective for claims processed **on or after January 8, 2019**, for services rendered **on or after September 26, 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 angiography – revision to the Part A and Part B LCD

LCD ID number: L34372 (Florida/Puerto Rico/ U.S. Virgin Islands)

Based on a review of the local coverage determination (LCD) for magnetic resonance angiography, grammatical errors were corrected throughout the LCD. Also, it was determined that some of the italicized language in the "Coverage Indications, Limitations, and/or Medical Necessity" section of the LCD does not represent direct quotations from some of the Centers for Medicare & Medicaid Services (CMS) sources listed in the LCD; therefore, this LCD is being revised to assure consistency with the CMS sources.

Effective date

The LCD revision related to grammatical errors is effective for claims processed **on or after January 22, 2019**.

The LCD revision related to the CMS sources is effective for services rendered **on or after January 22, 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*.

Polysomnography and sleep testing – revision to the Part A and Part B LCD

LCD ID number: L33405 (Florida/Puerto Rico/ U.S. Virgin Islands)

Based on review of the local coverage determination (LCD) for polysomnography and sleep testing, the "Sources of Information" section of the LCD was updated to add multiple published sources. The content of the LCD has not been changed due to these additions.

Effective date

This LCD revision is effective for claims processed **on or after January 22, 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*.

Diagnostic colonoscopy – revision to the Part A and Part B LCD

LCD ID number: L33671 (Florida/Puerto Rico/ U.S. Virgin Islands)

Based on review of the local coverage determination (LCD) for diagnostic colonoscopy, grammatical errors were corrected. In addition, the "Sources of Information" section of the LCD was revised to update the sources.

Effective date

The LCD revision related to grammatical errors is effective for claims processed **on or after January 29, 2019**.

The LCD revision related to sources is effective for services rendered **on or after January 29, 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*.

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

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

Based on an external correspondence, the local coverage determination (LCD) for duplex scan of lower extremity arteries was revised to add ICD-10-CM diagnosis code ranges S91.001A – S91.001S and S91.002A – S91.002S to the "ICD-10 Codes that Support Medical Necessity" section of the LCD.

In addition, based on change request (CR) 10901, the "TRAINING REQUIREMENTS" and "Centers for Medicare & Medicaid Services (CMS) National Coverage Policy" sections of the LCD were revised to update the section number for Pub. 100-08, Chapter 13 from Section 13.5.1 to Section 13.5.4. Also, the "TRAINING REQUIREMENTS" section of the LCD was revised to update the language to be consistent with this CMS source.

Effective date

The LCD revision related to the addition of diagnoses is effective for claims processed **on or after January 29, 2019**, for services rendered **on or after October 1, 2015.**

The LCD revision related to CR 10901 is effective for claims processed **on or after January 8, 2019**, for services rendered **on or after September 26, 2018**. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

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

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

Based on a review of the local coverage determination (LCD) for treatment of varicose veins of the lower extremity, grammatical errors were corrected. In addition, based on change request (CR) 10901, the "Centers for Medicare & Medicaid Services (CMS) National Coverage Policy" and "Training and Qualifications" sections of the LCD were revised to update the section number for Pub. 100-08, Chapter 13 from Section 5.1 to Section 13.5.4.

Effective date

The LCD revision related to grammatical errors is effective for claims processed **on or after January 22, 2019**.

The LCD revision related to CR 10901 is effective for claims processed **on or after January 8, 2019**, for services rendered **on or after September 26, 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*.

Wireless capsule endoscopy – revision to the Part A and Part B LCD

LCD ID number: L33774 (Florida/Puerto Rico/ U.S. Virgin Islands)

Based on a review of the local coverage determination (LCD) for wireless capsule endoscopy, grammatical errors were corrected. In addition, based on change request (CR) 10901, the "Centers for Medicare & Medicaid Services (CMS) National Coverage Policy" section of the LCD was revised to update the section number for Pub. 100-08, Chapter 13 from Section 5.1 to Section 13.5.4.

Effective date

The LCD revision related to grammatical errors is effective for claims processed **on or after January 22, 2019**.

The LCD revision related to CR 10901 is effective for claims processed **on or after January 8, 2019**, for services rendered **on or after September 26, 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*.

Viscosupplementation therapy for the knee – revision to the Part A and Part B LCD

LCD ID number: L33767 (Florida/Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 10901, the local coverage determination (LCD) for viscosupplementation therapy for the knee was revised. The "CMS National Coverage Policy" section of the LCD was revised to update the section number for Pub. 100-08, Chapter 13 from Section 5.1 to Section 13.5.4.

Effective date

This LCD revision is effective for claims processed **on or after January 8, 2019**, for services rendered **on or after September 26, 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*.

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

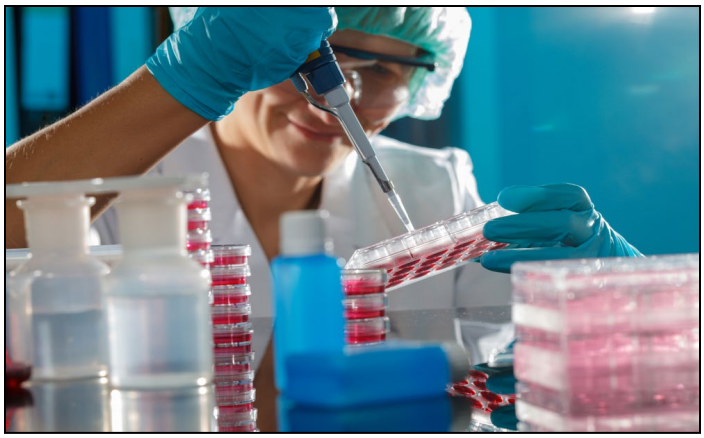
LCD ID number: L35698 (Florida/Puerto Rico/ U.S. Virgin Islands)

Based on review of the local coverage determination (LCD) for CYP2C19, CYP2D6, CYP2C9, and VKORC1 genetic testing, formatting errors were corrected throughout the LCD. In addition, it was determined that some of the italicized language in the "Coverage Indications, Limitations, and/or Medical Necessity" section of the LCD do not represent direct quotations from some of the Centers for Medicare & Medicaid Services (CMS) sources listed in the LCD; therefore, this LCD is being revised to assure consistency with the CMS sources.

Effective date

The LCD revision related to formatting errors is effective for claims processed **on or after January 22, 2019**.

The LCD revision related to the CMS sources is effective for services rendered **on or after January 22, 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*.

Special histochemical stains & immunohistochemical stains – revision to the Part A and Part B LCD

LCD ID number: L36234 (Florida/Puerto Rico/ U.S. Virgin Islands)

Based on a review of the local coverage determination (LCD) for special histochemical stains & immunohistochemical stains, grammatical errors were corrected. In addition, the "Coverage Indications, Limitations, and/or Medical Necessity" section of the LCD was revised under subtitle "Special Stains and/or IHC for Prostate Pathology" to change "=3+4=7" to "≥3+4=7" and "=4+3=7" to "≥4+3=7".

Effective date

This LCD revision is effective for claims processed **on or after January 22, 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*.

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

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

Based on a review of the local coverage determination (LCD) for scanning computerized ophthalmic diagnostic imaging (SCODI), grammatical errors were corrected. Also, based on change request (CR) 10901, the "Coverage Indications, Limitations, and/or Medical Necessity" section of the LCD was revised to update the section number for Pub. 100-08, Chapter 13, from Section 13.5.1 to Section 13.5.4. In addition, "Pub. 100-08, Chapter 13, Section 13.5.4" was added to the "Centers for Medicare & Medicaid Services (CMS) National Coverage Policy" section of the LCD.

Effective date

The LCD revision related to grammatical errors is effective for claims processed **on or after January 29, 2019**.

The LCD revision related to CR 10901 is effective for claims processed **on or after January 8, 2019**, for services rendered **on or after September 26, 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*.

Transcranial magnetic stimulation for major depressive disorder – revision to the Part A and Part B LCD

LCD ID number: L34522 (Florida/Puerto Rico/ U.S. Virgin Islands)

Based on a review of the local coverage determination (LCD) for transcranial magnetic stimulation for major depressive disorder, grammatical errors were corrected and the "Sources of Information" section of the LCD was revised to alphabetize the references. In addition, based on change request (CR) 10901, the "Coverage Indications, Limitations, and/or Medical Necessity" section of the LCD was revised to update the section number for Pub. 100-08, Chapter 13, from Section 13.5.1 to Section 13.5.4. Also, "Pub. 100-08, Chapter 13, Section 13.5.4" was added to the "Centers for Medicare & Medicaid Services (CMS) National Coverage Policy" section of the LCD.

Effective date

The LCD revisions related to grammatical errors and the references in the "Sources of Information" section of the LCD are effective for claims processed **on or after January 22, 2019**.

The LCD revision related to CR 10901 is effective for claims processed **on or after January 8, 2019**, for services rendered **on or after September 26, 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*.

Electroretinography – revision to the Part A and Part B LCD

LCD ID number: L37398 (Florida/Puerto Rico/ U.S. Virgin Islands)

Based on a review of the local coverage determination (LCD) for electroretinography, grammatical errors were corrected. In addition, based on change request (CR) 10901, the "Centers for Medicare & Medicaid Services (CMS) National Coverage Policy" and "Coverage Indications, Limitations, and/or Medical Necessity" sections of the LCD were revised to update the section number for Pub. 100-08, Chapter 13, from Section 13.5.1 to Section 13.5.4.

Effective date

The LCD revision related to grammatical errors is effective for claims processed **on or after January 29, 2019**.

The LCD revision related to CR 10901 is effective for claims processed **on or after January 8, 2019**, for services rendered **on or after September 26, 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*.

Spinal cord stimulation for chronic pain – revision to the Part A and Part B LCD

LCD ID number: L36035 (Florida/Puerto Rico/ U.S. Virgin Islands)

Based on review of the local coverage determination (LCD) and related "Coding Guidelines" article for spinal cord stimulation for chronic pain, grammatical errors were identified and corrected. Also, in the second bullet under the "Limitations" section of the LCD, "item A" was replaced with "Implanted Peripheral Nerve Stimulators" to be consistent with National Coverage Determination (NCD) 160.7 language. In addition, based on change request (CR) 10901, the "Training and Qualifications" section of the LCD was revised to update the section number for Pub. 100-08, Chapter 13, from Section 5.1 to Section 13.5.4. Also, "Pub. 100-08, Chapter 13, Section 13.5.4" was added to the "Centers for Medicare and Medicaid Services (CMS) National Coverage Policy" section of the LCD.

Effective date

The LCD and "Coding Guideline" article revision related to grammatical errors and NCD 160.7 language is effective for claims processed **on or after January 22, 2019.**

The LCD revision related to CR 10901 is effective for claims processed **on or after January 8, 2019**, for services rendered **on or after September 26, 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*.

Colorectal cancer screening – revision to the Part A and Part B LCD

LCD ID number: L36355 (Florida/Puerto Rico/ U.S. Virgin Islands)

Based on a review of the local coverage determination (LCD) for colorectal cancer screening, grammatical and formatting errors were corrected throughout the LCD. Also, it was determined that some of the italicized language in the "Coverage Indications, Limitations, and/or Medical Necessity" section of the LCD does not represent direct quotations from some of the Centers for Medicare & Medicaid Services (CMS) sources listed in the LCD; therefore, this LCD is being revised to assure consistency with the CMS sources.

Effective date

The LCD revision related to grammatical and formatting errors is effective for claims processed **on or after January 22, 2019**.

The LCD revision related to the CMS sources is effective for services rendered **on or after January 22, 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*.

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

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

Based on a review of the local coverage determination (LCD) for bone mineral density studies, grammatical errors were identified and corrected. In addition, the "Sources of Information" section of the LCD was updated to add an additional reference.

Effective date

This LCD revision is effective for claims processed **on or after February 5, 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*.

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

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

Based on a review of the local coverage determination (LCD) for cardiology – non-emergent outpatient testing: exercise stress test, stress echo, MPI SPECT, and cardiac PET, grammatical errors were corrected. Also, based on change request (CR) 10901, the "Limitations" section of the LCD was revised to update the section number for Pub. 100-08, Chapter 13, from Section 13.5.1 to Section 13.5.4. In addition, "Pub. 100-08, Chapter 13, Section 13.5.4" was added to the "Centers for Medicare & Medicaid Services (CMS) National Coverage Policy" section of the LCD.

Effective date

The LCD revision related to grammatical errors is effective for claims processed **on or after January 31, 2019.**

The LCD revision related to CR 10901 is effective for claims processed **on or after January 8, 2019**, for services rendered **on or after September 26, 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*.

Allergy testing – revision to the Part A and Part B LCD

LCD ID number: L33261 (Florida/Puerto Rico/ U.S. Virgin Islands)

Based on a review of the local coverage determination (LCD) for allergy testing, Current Procedural Terminology (CPT®) code 86005 was removed from the "ICD-10 Codes that DO NOT Support Medical Necessity" section of the LCD as this service is a non-specific screening test that does not identify a specific antigen, and is not covered. In addition, the "Coding Guideline" attachment was revised to delete CPT® code 95075 and replace it with CPT codes 95076 and 95079. Also, the asterisked statement was updated to be consistent with NCD 110.12 language.

Effective date

The LCD revision related to CPT® code 86005 is effective for claims processed **on or after February 7, 2019.**

The "Coding Guideline" attachment revision related to CPT code 95075 is effective for claims processed **on or after February 7, 2019**, for services rendered **on or after January 1, 2013**. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Upcoming provider outreach and educational events

Ask-the-contractor teleconference (ACT): Medicare basics part 1 - The Medicare program and eligibility

Date: Wednesday, March 27
Time: 2:00 p.m.-3:30 p.m.
Type of Event: Webcast

https://medicare.fcso.com/Events/0424994.asp

Note: Unless otherwise indicated, designated times for educational events are stated as ET, and the focus is to Florida, Puerto Rico, and the U.S. Virgin Islands.

Two easy ways to register

Online – Visit our provider training website at *https://gm1.geolearning.com/geonext/fcso/opensite.geo*, log on to your account and select the course you wish to register. Class materials are available under "My Courses" no later than one day before the event**.**

First-time User? Set up an account by completing *Request User Account Form* online. Providers who do not have yet a national provider identifier may enter "99999" in the NPI field. You will receive logon information within 72 hours of your request.

Fax – Providers without internet access may request a fax registration form through our Registration Hotline at 1-904-791-8103. Class materials will be faxed to you the day of the event.

Please Note:

- Pre-registration is required for all teleconferences, webcasts and in-person educational seminars.
- Dates and times are subject to change prior to opening of event registration.

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Provider Address: _____

City, State, ZIP Code: _____

Keep checking our website, *https://medicare.fcso.com/*, for details and newly scheduled educational events (teleconferences, webcasts, etc.) or call the First Coast Provider Education Registration Hotline at 1-904-791-8103 to learn more about the about our newest training opportunities for providers.

Never miss a training opportunity

If you or your colleagues were unable to attend one of our past Medicare educational webcasts, you still have the opportunity to learn about the topics covered during the training session. Visit the First Coast Medicare training website, download the recording of the event, and listen to the webcast when you have the time.

Take advantage of 24-hour access to free online training

In addition to live training events, we also offer you the advantage of self-paced, free online courses that will allow you and your staff to train when and where it is most convenient for you. In addition, our comprehensive course catalog allows you to find the Medicare training that fits your specific needs, and several of our online courses offer CEUs. Learn more on the First Coast Medicare training website and explore our catalog of online courses.

CMS MLN Connects®

The Centers for Medicare & Medicaid Services (CMS) *MLN Connects®* is an official *Medicare Learning Network®* (*MLN*) – branded product that contains a week's worth of news for Medicare fee-for-service (FFS) providers. CMS sends these messages weekly to national health industry provider associations, who then disseminates the *MLN Connects®* to its membership as appropriate.

MLN Connects® for January 24, 2019

MLN Connects® for Thursday, January 24, 2019

View this edition as a PDF

News & Announcements

- New Medicare Card: Web Updates
- CDC Opioids Training Modules
- Open Payments Data Update
- Medicare Shared Savings Program and Quality Payment Program Interactions Guide
- Continue Seasonal Influenza Vaccination through January and Beyond

Provider Compliance

- Reporting Changes in Ownership — Reminder

Upcoming Events

- New Electronic System for Provider Reimbursement Review Board Appeals Call — February 5
- Home Health Patient-Driven Groupings Model Call — February 12
- New Part D Opioid Overutilization Policies Call — February 14

Medicare Learning Network Publications & Multimedia

- Proof of Delivery Documentation Requirements MLN Matters Article — New
- New System for PRRB Appeals MLN Matters Article — New
- Appropriate Use Criteria for Advanced Diagnostic Imaging Fact Sheet — New
- Canes and Crutches: Provider Compliance Tips Fact Sheet — New
- Tracheostomy Supplies: Provider Compliance Tips Fact Sheet — New
- Ventilators: Provider Compliance Tips Fact Sheet — New
- Commodes, Bed Pans, and Urinals: Provider Compliance Tips Fact Sheet — New
- Comprehensive Outpatient Rehabilitation Facilities: Provider Compliance Tips Fact Sheet—New
- New MBI: Get It, Use It MLN Matters Article — Revised
- CLFS and Laboratory Services: CY 2019 Update MLN Matters Article — Revised
- ASC Payment System: January 2019 Update MLN Matters Article — Revised
- DMEPOS Update MLN Matters Article — Revised
- ESRD PPS: Payment for Dialysis Furnished for AKI: CY 2019 MLN Matters Article — Revised
- Influenza Virus Vaccine Code Update: January 2019 MLN Matters Article — Revised
- Next Generation ACO Model 2019 Benefit Enhancement MLN Matters Article — Revised
- ICD-10-CM, ICD-10-PCS, CPT, and HCPCS Code Sets Educational Tool — Reminder

Medicare Learning Network®

The *Medicare Learning Network®* (*MLN*) is the home for education, information, and resources for the health care professional community. The *MLN* provides access to CMS Program information you need, when you need it, so you can focus more on providing care to your patients. Find out what the *MLN* has to offer you and your staff at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html*.

MLN Connects® for January 31, 2019

MLN Connects® for Thursday, January 31, 2019

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News & Announcements

- New App Displays What Original Medicare Covers
- Physicians and Non-Physician Practitioners: New Medicare Enrollment Application
- QPP Videos: Create an Account in HARP
- QPP Videos: MIPS Data Submission
- eCQM Resources
- Hospice Quality Reporting Program: FY 2021 Data Collection Began January 1
- Hospice Training: Updates to Public Reporting in FY 2019
- Prevent Legionnaires' Disease: Water Management Program Training

Provider Compliance

- Cochlear Devices Replaced Without Cost: Bill Correctly — Reminder

Claims, Pricers & Codes

- Physician Anesthesia Claims for SNF Patients

Upcoming Events

- New Electronic System for Provider Reimbursement Review Board Appeals Call — February 5
- New Medicare Card Open Door Forum — February 6
- Home Health Patient-Driven Groupings Model Call — February 12
- New Part D Opioid Overutilization Policies Call — February 14
- MIPS Data Submission Office Hours Sessions — February 26 and March 19

Medicare Learning Network Publications & Multimedia

- RHCs/FQHCs: Communication Technology Based Services and Payment MLN Matters Article — New
- Quality Payment Program in 2018: Transitioning to an Advanced APM Web-Based Training — New
- Hospital Based Hospice Provider Compliance Tips Fact Sheet — New
- Lab Tests: Urinalysis Provider Compliance Tips Fact Sheet — New
- Lab Tests: Routine Venipuncture Provider Compliance Tips Fact Sheet — New
- Lenses Provider Compliance Tips Fact Sheet — New
- Parenteral Nutrition Provider Compliance Tips Fact Sheet — New
- Patient Lifts Provider Compliance Tips Fact Sheet — New
- Polysomnography Provider Compliance Tips Fact Sheet — New
- Pressure Reducing Support Surfaces Provider Compliance Tips Fact Sheet — New
- TENS Provider Compliance Tips Fact Sheet — New
- ESRD Call: Audio Recording and Transcript — New
- Clinical Labs Call: Audio Recording and Transcript — New
- Typhoon Yutu and Medicare Disaster Related Commonwealth of the Northern Mariana Islands Claims MLN Matters Article — Revised
- DMEPOS Fee Schedule: CY 2019 Update MLN Matters Article — Revised
- Hospital OPPS: January 2019 Update MLN Matters Article — Revised
- Diabetic Shoes Provider Compliance Tips Fact Sheet — Revised
- Coding and Billing Date of Service on Professional Claims MLN Matters Article — Reissued
- TKA Removal from IPO List and 2-Midnight Rule MLN Matters Article — Reissued

MLN Connects® for February 7, 2019

MLN Connects® for Thursday, February 7, 2019

View this edition as a PDF

News & Announcements

- New Medicare Card: Are You Using the MBI?
- Open Payments Registration
- Promoting Interoperability Programs: IPPS Final Rule Fact Sheet
- Promoting Interoperability Programs: Hospitals Submit Attestation Data by February 28
- SNF Provider Preview Reports: Review Your Data by March 4
- Nursing Home Compare Refresh
- QRDA III Implementation Guide Addendum
- DMEPOS: Strategies to Support Access for Dually Eligible Individuals
- February is American Heart Month

Provider Compliance

- DME Proof of Delivery Documentation Requirements

Claims, Pricers & Codes

- MIPS: Error in 2019 Payment Adjustment
- DMEPOS 2019 Fee Schedule File Revision for HCPCS Code L3761

See **MLN**, page 31

MLN Connects® for February 14, 2019

MLN Connects® for Thursday, February 14, 2019

View this edition as a PDF

News & Announcements

- New Medicare Card: 0 not O
- Home Health Compare Refresh
- MIPS: Check Your Preliminary 2019 Eligibility
- Comparative Billing Report on Family Practitioner Office Visits in February
- 2019 CMS Health Equity Award Winners
- Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier
- Influenza Activity Continues: Are Your Patients Protected?

Provider Compliance

- Medicare Hospital Claims: Avoid Coding Errors — Reminder

Upcoming Events

- Comparative Billing Report: Family Practitioner Office Visits Webinar — February 28
- Dementia Care & Psychotropic Medication Tracking Tool Call — March 12
- Open Payments: Transparency and You Call — March 13

Medicare Learning Network Publications & Multimedia

- Home Health PDGM MLN Matters Article — New
- ICD-10 and Other Coding Revisions to NCDs MLN Matters Article — New
- Implementation of the SNF PDPM MLN Matters Article — New
- Implementation to Exchange the List of eMDR for Registered Providers MLN Matters Article — New
- Independent Laboratory Billing of Tests for ESRD Beneficiaries MLN Matters Article — New
- Medicare Physician Fee Schedule Database: April 2019 Update MLN Matters Article — New
- Processing Instructions to Update the SPR MLN Matters Article — New
- Supervised Exercise Therapy for Symptomatic PAD MLN Matters Article — New
- Update to ICR Programs MLN Matters Article — New
- CWF Provider Queries NPI Verification MLN Matters Article — Revised
- Medicare FFS Response to the 2018 California Wildfires MLN Matters Article — Revised
- Advance Beneficiary Notice of Noncoverage Interactive Tutorial — Revised
- CLIA Program and Medicare Laboratory Services Fact Sheet— Revised
- Long-Term Care Hospital Prospective Payment System — Revised
- Medicare Advance Written Notices of Noncoverage Booklet — Revised
- Medicare Parts A & B Appeals Process Booklet — Revised

MLN

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Upcoming Events

- Home Health Patient-Driven Groupings Model Call — February 12
- Falls Prevention for Older Adults Webinar — February 13
- New Part D Opioid Overutilization Policies Call — February 14
- Quality Payment Program: Overview of APMs for Year 3 Webinar — February 21

Medicare Learning Network Publications & Multimedia

- Functional Reporting Requirements and Therapy Provisions Update MLN Matters Article — New
- Organ Acquisition Charges Not Included in IPPS Payment MLN Matters Article — New
- RA Messaging: 20-Hour Weekly Minimum for PHP Services MLN Matters Article — New
- VA Inpatient Claims Exempt from POA Reporting MLN Matters Article — New
- ASP Medicare Part B Drug Pricing Files: April 2019 MLN Matters Article — New
- Coding and Billing Date of Service on Professional Claims MLN Matters Article — Revised
- CWF Provider Queries NPI and Submitter ID Verification MLN Matters Article — Revised
- LCDs MLN Matters Article — Revised
- Inpatient Psychiatric Facility Prospective Payment System Booklet — Revised
- Skilled Nursing Facility Prospective Payment System Booklet — Revised
- Medicare Enrollment for Providers Who Solely Order, Certify, or Prescribe Booklet — Reminder

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

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877-847-4992

Provider enrollment

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

The SPOT help desk

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

Addresses

Claims

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

Redeterminations

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

Redetermination of overpayments

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

Reconsiderations

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

General inquiries

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

Provider enrollment

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

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

Medical policy

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

Medicare secondary payer

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

Electronic data interchange (EDI)

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

Overpayments

Medicare Part B Debt Recovery
P.O. Box 45013
Jacksonville, FL 32232-5013

Medicare Education and Outreach

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

Fraud and abuse

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

Freedom of Information Act requests

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

Special courier service

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

Websites

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https://www.cms.gov

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

Beneficiaries

Centers for Medicare & Medicaid Services

https://www.medicare.gov

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)

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877-847-4992

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

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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

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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

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2020 Technology Parkway Suite 100
Mechanicsburg, PA 17055-1849

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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

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

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Fraud and abuse complaints
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Jacksonville, FL 32232-5092,

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

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2019 fee schedule – The Medicare Part B Physician and Nonphysician Practitioner Fee Schedules, effective for services rendered January 1 through December 31, 2019, are available free of charge online at *https://medicare.fcso.com/Data_files/* (English) or *https://medicareespanol.fcso.com/Fichero_de_datos/* (Español). Additional copies are available for purchase. The fee schedules contain payment rates for all localities. These items do not include the payment rates for injectable drugs, clinical lab services, mammography screening, or DMEPOS items. **Note:** Requests for hard copy paper disclosures will be completed as soon as CMS provides the direction to do so. Revisions to fees may occur; these revisions will be published in future editions of the Medicare Part B publication.	40300270	$12		
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