Medicare B CONNECTION
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FIRST COAST SERVICE OPTIONS, INC.
A Newsletter for MAC Jurisdiction N Providers
June 2019

In this issue

MLN Connects® -- Special Edition for June 6, 2019

CMS Seeks Public Input on Patients over Paperwork Initiative to Further Reduce Administrative, Regulatory Burden to Lower Healthcare Costs

On June 6, CMS issued a Request for Information (RFI) seeking new ideas from the public on how to continue the progress of the Patients over Paperwork initiative. Since launching in fall 2017, Patients over Paperwork has streamlined regulations to significantly cut the "red tape" that weighs down our healthcare system and takes clinicians away from their primary mission—caring for patients. As of January 2019, we estimate that through regulatory reform alone, the healthcare system will save an estimated 40 million hours and $5.7 billion through 2021. These estimated savings come from both final and proposed rules.

This RFI provides an opportunity to share new ideas not conveyed during the first Patients over Paperwork RFI in 2017 and continue the national conversation on improving healthcare delivery. We are especially seeking innovative ideas that broaden perspectives on potential solutions to relieve burden and ways to improve:

- Reporting and documentation requirements
- Coding and documentation requirements for Medicare or Medicaid payment
- Prior authorization procedures
- Policies and requirements for rural providers, clinicians, and beneficiaries
- Policies and requirements for dually enrolled (i.e., Medicare and Medicaid) beneficiaries
- Beneficiary enrollment and eligibility determination
- CMS processes for issuing regulations and policies

Key Burden Reduction Milestones to Date:

We gathered feedback on burdensome requirements from medical and patient communities through other RFIs, listening sessions, and on-site meetings with frontline clinicians, healthcare staff, and patients and are working every day to reduce regulatory burden while safeguarding patient safety, quality, and program integrity. Achievements so far:

- Simplified Documentation and Coding
- Improved Quality and Operational Efficiency
- Meaningful Measures
- Changing CMS Culture

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Contents

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

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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.

CMS clarifies proper use of modifier 59

***Note**: We revised this article on May 17, 2019, to reflect that CPT Code 11100 was deleted on January 1, 2019. In Example 1, CPT Code 11100 is replaced with CPT Code 11102. All other information is unchanged. This information was previously published in the January 2018 Medicare B Connection, pages 5-9*.

Provider types affected

This MLN Matters® Special Edition Article is intended for physicians and providers submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider action needed

This special edition article is being provided by the Centers for Medicare & Medicaid Services (CMS) to clarify the proper use of Modifier 59. The article only clarifies existing policy. Make sure that your billing staffs are aware of the proper use of Modifier 59.

Background

The Medicare National Correct Coding Initiative (NCCI) includes Procedure-to-Procedure (PTP) edits that define when HCPCS)/ Current Procedural Terminology (CPT) codes should not be reported together either in all situations or in most situations.

For PTP edits that have a Correct Coding Modifier Indicator (CCMI) of "0," the codes should never be reported together by the same provider for the same beneficiary on the same date of service. If they are reported on the same date of service, the column one code is eligible for payment and the column two code is denied.

For PTP edits that have a CCMI of "1," the codes may be reported together only in defined circumstances which are identified on the claim by the use of specific NCCI-associated modifiers. (Refer to the *National Correct Coding Initiative Policy Manual for Medicare Services*, Chapter 1, for general information about the NCCI program, PTP edits, CCMIs, and NCCI-associated modifiers. This manual is available in the download section at *http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html*).

One function of NCCI PTP edits is to prevent payment for codes that report overlapping services except in those instances where the services are "separate and distinct." Modifier 59 is an important NCCI-associated modifier that is often used incorrectly.

The *CPT Manual* defines modifier 59 as follows:

"**Distinct Procedural Service:** Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25."

Modifier 59 and other NCCI-associated modifiers **should NOT be used** to bypass a PTP edit unless the proper criteria for use of the modifier are met. Documentation in the medical record must satisfy the criteria required by any NCCI-associated modifier that is used.

1. **Modifier 59 is used appropriately for different anatomic sites during the same encounter only when procedures which are not ordinarily performed or encountered on the same day are performed on different organs, or different anatomic regions, or in limited situations on different, non-contiguous lesions in different anatomic regions of the same organ**.

   One of the common uses of modifier 59 is for surgical procedures, non-surgical therapeutic procedures, or diagnostic procedures that are performed at different anatomic sites, are not ordinarily performed or encountered on the same day, and that cannot be described by one of the more specific anatomic NCCI-associated modifiers –that is, RT, LT, E1-E4, FA, F1-F9, TA, T1-T9, LC, LD, RC, LM, or RI. (See examples 1, 2, and 3.) From an NCCI perspective, the definition of different anatomic sites includes different organs or, in certain instances, different lesions in the same organ. However, NCCI edits are typically created to prevent the inappropriate billing of lesions and sites that should not be considered to be separate and distinct. Modifier 59 should only be used to identify clearly independent services that represent significant departures from the usual situations described by the NCCI edit. The treatment of contiguous structures in the same organ or anatomic region **does not** constitute treatment of different anatomic sites. For example:

   - Treatment of the nail, nail bed, and adjacent soft tissue distal to and including the skin overlying the distal interphalangeal joint on the same toe or finger constitutes treatment of a single anatomic site. (See example 4.)
   - Treatment of posterior segment structures in the eye constitutes treatment of a single anatomic site. (See example 5.)
   - Arthroscopic treatment of structures in adjoining areas of the same shoulder constitutes treatment of a single anatomic site. (See example 6.)

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2. Modifier 59 is used appropriately when the procedures are performed in different encounters on the same day.

Another common use of modifier 59 is for surgical procedures, non-surgical therapeutic procedures, or diagnostic procedures that are performed during different patient encounters on the same day and that cannot be described by one of the more specific NCCI-associated modifiers – i.e., 24, 25, 27, 57, 58, 78, 79, or 91. (See example 7) As noted in the CPT definition, modifier 59 should only be used if no other modifier more appropriately describes the relationship of the two procedure codes.

3. Modifier 59 is used inappropriately if the basis for its use is that the narrative description of the two codes is different.

One of the common misuses of modifier 59 is related to the portion of the definition of modifier 59 allowing its use to describe a "different procedure or surgery." The code descriptors of the two codes of a code pair edit usually represent different procedures, even though they may be overlapping. The edit indicates that the two procedures should not be reported together if performed at the same anatomic site and same patient encounter as those procedures would not be considered to be "separate and distinct." The provider should not use modifier 59 for such an edit based on the two codes being "different procedures." (See example 8.) However, if the two procedures are performed at separate anatomic sites or at separate patient encounters on the same date of service, modifier 59 may be appended to indicate that they are different procedures on that date of service. Additionally, there may be limited circumstances sometimes identified in the *National Correct Coding Initiative Policy Manual for Medicare Services* (available in the downloads section at *https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html*) when the two codes of an edit pair may be reported together with modifier 59 when performed at the same patient encounter or at the same anatomic site.

4. Other specific appropriate uses of modifier 59

There are three other limited situations in which two services may be reported as separate and distinct because they are separated in time and describe non-overlapping services even though they may occur during the same encounter, i.e.:

A. Modifier 59 is used appropriately for two services described by timed des provided during the same encounter only when they are performed sequentially. There is an appropriate use for modifier 59 that is applicable only for codes for which the unit of service is a measure of time (e.g., per 15 minutes, per hour). If two timed services are provided in time periods that are separate and distinct and not interspersed with each other (i.e., one service is completed before the subsequent service begins), modifier 59 may be used to identify the services. (See example 9.)

B. Modifier 59 is used appropriately for a diagnostic procedure which precedes a therapeutic procedure only when the diagnostic procedure is the basis for performing the therapeutic procedure. When a diagnostic procedure precedes a surgical procedure or non-surgical therapeutic procedure and is the basis on which the decision to perform the surgical procedure is made, that diagnostic test may be considered to be a separate and distinct procedure as long as (a) it occurs before the therapeutic procedure and is not interspersed with services that are required for the therapeutic intervention; (b) it clearly provides the information needed to decide whether to proceed with the therapeutic procedure; and (c) it does not constitute a service that would have otherwise been required during the therapeutic intervention. (See example 10.) If the diagnostic procedure is an inherent component of the surgical procedure, it should not be reported separately.

C. Modifier 59 is used appropriately for a diagnostic procedure which occurs subsequent to a completed therapeutic procedure only when the diagnostic procedure is not a common, expected, or necessary follow-up to the therapeutic procedure. When a diagnostic procedure follows the surgical procedure or non-surgical therapeutic procedure, that diagnostic procedure may be considered to be a separate and distinct procedure as long as (a) it occurs after the completion of the therapeutic procedure and is not interspersed with or otherwise commingled with services that are only required for the therapeutic intervention, and (b) it does not constitute a service that would have otherwise been required during the therapeutic intervention. If the post-procedure diagnostic procedure is an inherent component or otherwise included (or not separately payable) post-procedure service of the surgical procedure or non-surgical therapeutic procedure, it should not be reported separately.

Use of Modifier 59 does not require a different diagnosis for each HCPCS/CPT coded procedure. Conversely, different diagnoses are not adequate criteria for use of modifier 59. The HCPCS/CPT codes remain bundled unless the procedures are performed at different anatomic sites or separate patient encounters or meet one of the other three scenarios described above.

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Modifiers XE, XS, XP, and XU are effective January 1, 2015. These modifiers were developed to provide greater reporting specificity in situations where modifier 59 was previously reported and may be utilized in lieu of modifier 59 whenever possible. (Modifier 59 should only be utilized if no other more specific modifier is appropriate.)

Although NCCI will eventually require use of these modifiers rather than modifier 59 with certain edits, providers may begin using them for claims with dates of service on or after January 1, 2015. The modifiers are defined as follows:

- XE – "Separate encounter, A service that is distinct because it occurred during a separate encounter" This modifier should only be used to describe separate encounters on the same date of service
- XS – "Separate Structure, A service that is distinct because it was performed on a separate organ/structure"
- XP – "Separate Practitioner, A service that is distinct because it was performed by a different practitioner"
- XU – "Unusual Non-Overlapping Service, The use of a service that is distinct because it does not overlap usual components of the main service"

Examples of Modifier 59 Usage

Following are some examples developed to help guide physicians and providers on the proper use of Modifier 59 (**Please remember that Medicare policy is that Modifier 59 is used appropriately for different anatomic sites during the same encounter only when procedures which are not ordinarily performed or encountered on the same day are performed on different organs, or different anatomic regions, or in limited situations on different, non-contiguous lesions in different anatomic regions of the same organ.)**:

Example 1: Column 1 Code / Column 2 Code - 17000/11102

- CPT Code 17000 – Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); first lesion
- CPT Code - 11102 Tangential biopsy of skin (e.g., shave, scoop, saucerize, curette); single lesion

Modifier 59 may be reported with code 11102 if the procedures are performed at different anatomic sites on the same side of the body and a specific anatomic modifier is not applicable. If the procedures are performed on different sides of the body, modifiers RT and LT or another pair of anatomic modifiers should be used, not modifier 59.

Modifier 59 is used appropriately for different anatomic sites during the same encounter only when procedures which are not ordinarily performed or encountered on the same day are performed on different organs, or different anatomic regions, or in limited situations on different, non-contiguous lesions in different anatomic regions of the same organ.

Example 2: Column 1 Code/Column 2 Code 47370/76942

- CPT Code 47370 – Laparoscopy, surgical, ablation of one or more liver tumor(s); radiofrequency
- CPT Code 76942 – Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation

CPT code 76942 should not be reported and Modifier 59 should not be used if the ultrasonic guidance is for needle placement for the laparoscopic liver tumor ablation procedure. Code 76942 may be reported with modifier 59 if the ultrasonic guidance for needle placement is unrelated to the laparoscopic liver tumor ablation procedure.

Example 3: Column 1 Code/Column 2 Code 93453/76000

- CPT Code 93453 – Combined right and left heart catheterization including intraprocedural injections(s) for left ventriculography, imaging supervision and interpretation, when performed
- CPT Code 76000 – Fluoroscopy (separate procedure), up to one hour physician time, other than 71023 or 71034 (eg, cardiac fluoroscopy)

CPT code 76000 should not be reported and Modifier 59 should not be used for fluoroscopy that is used in conjunction with a cardiac catheterization procedure. Modifier 59 may be reported with code 76000 if the fluoroscopy is performed for a procedure unrelated to the cardiac catheterization procedure.

Example 4: Column 1 Code / Column 2 Code - 11055/11720

- CPT Code 11055 - Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); single lesion
- CPT Code 11720 – Debridement of nail(s) by any method(s); one to five

CPT codes 11720 and 11055 should not be reported together for services performed on skin distal to and including the skin overlying the distal interphalangeal joint of the same toe. Modifier 59 should not be used if a nail is debrided on the same toe on which a hyperkeratotic lesion of the skin on or distal to the distal interphalangeal joint is pared. Modifier 59 may be reported with code 11720 if one to five nails are debrided and a hyperkeratotic lesion is pared on a toe other than one with a debrided toenail or the hyperkeratotic lesion is proximal to the skin overlying the distal interphalangeal joint of a toe on which a nail is debrided.

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Example 5: Column 1 Code / Column 2 code - 67210/67220

- CPT Code 67210 – Destruction of localized lesion of retina (eg, macular edema, tumors), 1 or more sessions; photocoagulation
- CPT Code 67220 – Destruction of localized lesion of choroid (eg, choroidal neovascularization); photocoagulation (eg, laser), 1 or more sessions

CPT code 67220 should not be reported and Modifier 59 should not be used if both procedures are performed during the same operative session because the retina and choroid are contiguous structures of the same organ.

Example 6: Column 1 Code / Column 2 Code - 29827/29820

- CPT Code 29827 – Arthroscopy, shoulder, surgical; with rotator cuff repair
- CPT Code 29820 – Arthroscopy, shoulder, surgical; synovectomy, partial

CPT code 29820 should not be reported and Modifier 59 should not be used if both procedures are performed on the same shoulder during the same operative session because the shoulder joint is a single anatomic structure. If the procedures are performed on different shoulders, modifiers RT and LT should be used, not Modifier 59.

Example 7: Column 1 Code / Column 2 Code - 93015/93040

- CPT Code 93015 – Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report
- CPT Code 93040 – Rhythm ECG, one to three leads; with interpretation and report

Modifier 59 may be reported if the rhythm ECG is performed at a different encounter than the cardiovascular stress test. If a rhythm ECG is performed during the cardiovascular stress test encounter, CPT code 93040 should not be reported and Modifier 59 should not be used. **Modifier 59 is used appropriately when the procedures are performed in different encounters on the same day.**

Example 8: Column 1 Code/Column 2 code - 34833/34820

- CPT code 34833 - Open iliac artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by abdominal or retroperitoneal incision, unilateral (List separately in addition to code for primary procedure)
- CPT code 34820 - Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral (List separately in addition to code for primary procedure)

CPT code 34833 is followed by a *CPT Manual* instruction that states: "(Do not report 34833 in conjunction with 33364, 33953, 33954, 33959, 33962, 33969, 33984, 34820 when performed on the same side)." Although the CPT code descriptors for 34833 and 34820 describe different procedures, they should not be reported together for the same side. Modifier 59 should not be appended to either code to report the two procedures for the same side of the body. If the two procedures were performed on different sides of the body, they may be reported with modifiers LT and RT as appropriate. **However, modifier 59 is used inappropriately if the basis for its use is that the narrative description of the two codes is different.**

Example 9: Column 1 Code / Column 2 Code - 97140/97530

- CPT Code 97140 – Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes
- CPT Code 97530 – Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes

Modifier 59 may be reported if the two procedures are performed in distinctly different 15 minute time blocks. For example, one service may be performed during the initial 15 minutes of therapy and the other service performed

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during the second 15 minutes of therapy. Alternatively, the therapy time blocks may be split. For example, manual therapy might be performed for 10 minutes, followed by 15 minutes of therapeutic activities, followed by another 5 minutes of manual therapy. CPT code 97530 should not be reported and modifier 59 should not be used if the two procedures are performed during the same time block. **Modifier 59 is used appropriately when two timed procedures are performed in different blocks of time on the same day.**

Example 10: Column 1 Code / Column 2 Code - 37220/75710

- CPT Code 37220 – Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty
- CPT Code 75710 – Angiography, extremity, unilateral, radiological supervision and interpretation

Modifier 59 may be reported with CPT code 75710 if a diagnostic angiography has not been previously performed and the decision to perform the revascularization is based on the result of the diagnostic angiography. The *CPT Manual* defines additional circumstances under which diagnostic angiography may be reported with an interventional vascular procedure on the same artery. **Modifier 59 is used appropriately for a diagnostic procedure which precedes a therapeutic procedure only when the diagnostic procedure is the basis for performing the therapeutic procedure.**

Additional information

The CMS webpage on the National Correct Coding Initiative Edits is available at *http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html* on the CMS website. There is a modifier 59 article on this website also. The CPT Manual includes the definition of Modifier 59, as well as CPT codes used with Modifier 59. The manual is available at *http://www.ama-assn.org/ama* on the American Medical Association (AMA) website.

You may want to review MLN Matters® article *MM8863* that alerts providers that CMS is establishing four new HCPCS Modifiers to define subsets of Modifier 59, Distinct Procedural Services.

Document history

Date of change	Description
May 17, 2019	We revised this article to reflect that CPT Code 11100 was deleted on January 1, 2019. In Example 1, CPT Code 11100 is replaced with CPT Code 11102.
January 3, 2018	We updated the article to conform with latest Modifier 59 article on the NCCI website with the latest Modifier 59 article. The key update was the addition of information regarding the XE, XS, XP, and XU modifiers.
May 27, 2015	This article was revised to provide a reference to MLN Matters Article *SE1503* that advises physicians, providers and suppliers submitting bills to Medicare that additional guidance and education on the appropriate use of the new X modifiers will be introduced in a gradual, controlled fashion by CMS and that providers may continue to use Modifier -59 after January 1, 2015, in any instance in which it was correctly used before January 1, 2015. All other information is unchanged.
June 2, 2014	Initial article released.

MLN Matters® Number: SE1418 *Revised*
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Related Change Request (CR) Number: N/A
Effective Date: N/A
Implementation N/A

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

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

Effective and notice dates

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

Electronic notification

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

More information

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

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

Looking for LCDs?

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

Advance beneficiary notice

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

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

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

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

Take the time to 'chat' with the website team

You now have the opportunity to save your valuable time by asking your website-related questions online – with First Coast's new Live Chat service.

New LCD

Anorectal manometry and electromyography (EMG) of the urinary and anal sphincters – new Part A and Part B LCD

LCD ID number: L37943 (Florida/Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for anorectal manometry and electromyography (EMG) of the urinary and anal sphincters was developed to address coverage criteria, coding requirements, documentation requirements, and utilization parameters for anorectal manometry and electromyography. The LCD also addresses providers eligible to perform this service. Furthermore, in creating this new LCD, the current LCD for anorectal manometry and EMG of the urinary and anal sphincters (L33263) will be retired when the new LCD and related billing and coding article become effective.

Effective date

This new LCD is effective for services rendered **on or after August 12, 2019.**

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

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

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

Revisions to LCDs

Epidural -- revisions to the Part B LCD

LCD ID number: L33906 (Florida/Puerto Rico/U.S. Virgin Islands)

Based on change request (CR) 10901, the local coverage determination (LCD) for epidural was revised to remove all billing and coding and all language not related to reasonable and necessary provisions ("Bill Type Codes," "Revenue Codes," "CPT®/HCPCS codes," "ICD-10 Codes that Support Medical Necessity," "Documentation Requirements," and "Utilization Guidelines," sections of the LCD) and place them into a newly created billing and coding article. During the process of moving the ICD-10-CM diagnosis codes to the billing and coding article, the ICD-10-CM diagnosis code ranges were broken out and listed individually.

In addition, based on a review of the LCD, the "ICD-10 Codes that are covered" section of the newly created billing and coding article for Group 1 codes was updated. The following ICD-10-CM diagnoses codes were added as they were omitted in error: C76.1, C76.2, C76.3, C76.40, C76.41, C76.42, C76.50, C76.51, C76.52, C76.8, C77.0, C77.1, C77.2, C77.3, C77.4, C77.5, C77.8, C77.9, C78.00, C78.01, C78.02, C78.1, C78.2, C78.30, C78.39, C78.4, C78.5, C78.6, C78.7, C78.80, C78.89, C79.00, C79.01, C79.02, C79.10, C79.11, C79.19, C79.2, C79.31, C79.32, C79.40, C79.49, C79.51, C79.52, C79.60, C79.61, C79.62, C79.70, C79.71, C79.72, C79.81, C79.82, C79.89, C79.9, C80.0, C80.1, D37.02, D37.030, D37.031, D37.032, D37.039, D37.04, D37.05, D37.09, D37.1, D37.2, D37.3, D37.4, D37.5, D37.6, D37.8, D37.9, D38.0, D38.1, D38.2, D38.3, D38.4, D38.5, D38.6, D39.0, D39.10, D39.11, D39.12, D39.2, D39.8, D39.9, D40.0, D40.10, D40.11, D40.12, D40.8, D40.9, D41.00, D41.01, D41.02, D41.10, D41.11, D41.12, D41.20, D41.21, D41.22, D41.3, D41.4, D41.8, D41.9, D42.0, D42.1, D42.9, D43.0, D43.1, D43.2, D43.3, D43.4, D43.8, D43.9, D44.0, D44.10, D44.11, D44.12, D44.2, D44.3, D44.4, D44.5, D44.6, D44.7, D44.9, D45, D46.0, D46.1, D46.20, and D46.21.

Effective date

The revision related to CR 10901 is effective for claims processed **on or after January 8, 2019**, for services rendered **on or after October 3, 2018.**

The revision related to the addition of diagnoses omitted in error is effective for claims processed **on or after June 18, 2019**, for services rendered **on or after October 1, 2015**.

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

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

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

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 review of the local coverage determination (LCD) and related billing and coding article for bone mineral density studies, typographical and formatting errors were identified and corrected. Also, the "Bibliography" section of the LCD was updated to be consistent with American Medical Association (AMA) formatting. In addition, national coverage determination (NCD) and internet-only manual (IOM) language was removed from the billing and coding article and instead the NCD IOM citation related to this language is referenced in the LCD.

Effective date

The LCD revision is effective for services rendered **on or after June 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 billing and coding article for an LCD (when present) may be found by selecting "Related Local Coverage Documents" in the "Section Navigation" drop-down menu at the top of the LCD page.

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

Hemophilia clotting factors -- revision to the Part A and Part B LCD

LCD ID number: L33684 (Florida/Puerto Rico/U.S. Virgin Islands)

Based on change requests (CRs) 11293, 11296, 11298, 11318, and 11328, the billing and coding article for hemophilia clotting factors (A56482) was updated to remove Healthcare Common Procedure Coding System (HCPCS) codes C9141 and J7199 and replace them with HCPCS code J7208 (Injection, factor viii, [antihemophilic factor, recombinant], pegylated-aucl, [Jivi], 1 i.u). In addition, based on review of the the local coverage determination (LCD) and related billing and coding article for hemophilia clotting factors, typographical and formatting errors were corrected.

Effective date

These revisions are effective for services rendered **on or after July 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 billing and coding article for an LCD (when present) may be found by selecting "Related Local Coverage Documents" in the "Section Navigation" drop-down menu at the top of the LCD page.

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

Screening and diagnostic mammography -- revision to the Part A and Part B LCD

LCD ID number: L36342 (Florida/Puerto Rico/U.S. Virgin Islands)

Based on change request (CR) 11132, the local coverage determination (LCD) for screening and diagnostic mammography was revised to delete revenue codes 0400 and 0524 and add revenue codes 096x, 097x, 098x and 0520.

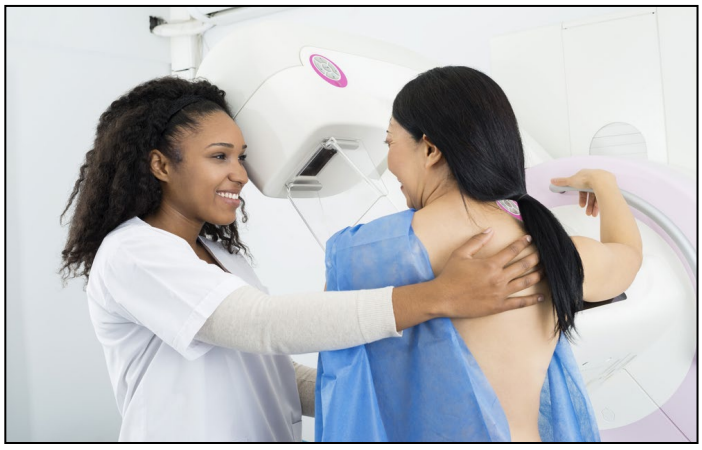
Also, bill type code 071x was added.

Effective date

This LCD revision is effective for services rendered **on or after July 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 billing and coding article for an LCD (when present) may be found by selecting "Related Local Coverage Documents" in the "Section Navigation" drop-down menu at the top of the LCD page.

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

Bendamustine hydrochloride (Treanda®, Bendeka™) -- revision to the Part A and Part B LCD

LCD ID number: L33268 (Florida/Puerto Rico/U.S. Virgin Islands)

Based on change request (CR) 10901, the local coverage determination (LCD) for bendamustine hydrochloride (Treanda®, Bendeka™) was revised to remove all billing and coding and all language not related to reasonable and necessary provisions ("Bill Type Codes," "Revenue Codes," "CPT®/HCPCS Codes," "ICD-10 Codes that Support Medical Necessity," "Documentation Requirements" and "Utilization Guidelines" sections of the LCD) and place them into a newly created billing and coding article.

During the process of moving the ICD-10-CM diagnosis codes to the billing and coding article, the ICD-10-CM diagnosis code ranges were broken out and listed individually. Also, the Food and Drug Administration (FDA) language has been removed from the LCD and instead the FDA citation related to this language is referenced to the FDA approved product labels.

Also, based on CRs 11293, 11296, 11298, 11318, and 11328, the LCD was revised to add Healthcare Common Procedure Coding System (HCPCS) code J9036 (Injection, bendamustine hydrochloride, [Belrapzo/bendamustine], 1 mg).

In addition, "Treanda®" and "Bendeka™" was removed from the title and the "Coverage Indications, Limitations, and/or Medical Necessity" section of the LCD and the "Sources of Information" section of the LCD has been updated.

Effective date

The LCD revision related to CR 10901 is for claims processed **on or after January 8, 2019,** for services rendered **on or after October 3, 2018.** The LCD revision related to CRs 11293, 11296, 11298, 11318, and 11328 is effective for services rendered **on or after July 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 billing and coding article for an LCD (when present) may be found by selecting "Related Local Coverage Documents" in the "Section Navigation" drop-down menu at the top of the LCD page.

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

Keep updated...

Use the tools and useful information found on *medicare.fcso.com* to stay updated on changes associated with the Medicare program.

Frequency of hemodialysis -- revision to 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 was revised and published June 27, 2019, consistent with change request (CR)10901, to remove language from the Centers for Medicare and Medicaid Services (CMS) Internet-Only Manuals (IOM) and/or regulations, list applicable manual/regulation reference, and to remove all Current Procedural Terminology (CPT®) codes and ICD-10-CM diagnosis codes.

IOM references have been updated and all codes have been placed in the companion Local Coverage Article A56666 Billing and Coding: Frequency of Hemodialysis.

There will not be a lapse in coverage and there has been no change to the coverage content of this LCD.

Effective date

This LCD revision is effective for services rendered **on or after July 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, *click here*.

Trastuzumab (Herceptin®) - revisions to the Part A and Part B LCD

LCD ID number: L34026 (Florida/Puerto Rico/U.S. Virgin Islands)

Based on change request (CR) 10901, the local coverage determination (LCD) for trastuzumab was revised to remove all billing and coding and all language not related to reasonable and necessary provisions (“Bill Type Codes,” “Revenue Codes,” “CPT®/HCPCS codes,” “ICD-10 Codes that Support Medical Necessity,” “Documentation Requirements,” and “Utilization Guidelines,” sections of the LCD) and place them into a newly created billing and coding article. During the process of moving the ICD-10-CM diagnosis codes to the billing and coding article, the ICD-10-CM diagnosis code ranges were broken out and listed individually. Also, the Food and Drug Administration (FDA) language has been removed from the LCD and instead the FDA citation related to this language is referenced to the FDA approved product labels.

In addition, based on the Centers for Medicare & Medicaid Services (CMS) change requests (CRs) 11293, 11296, 11298, 11318, and 11328, the “CPT®/HCPCS Codes” section of the newly created billing and coding article was updated to change the descriptor for Healthcare Common Procedure Coding System (HCPCS) code J9355 and add new HCPCS codes J9356, Q5112, Q5113 and Q5114 to the “Group 1 Paragraph:” section of the billing and coding article. Also, the LCD title was changed to “Trastuzumab – Trastuzumab Biologics” (Herceptin was removed from the title).

Effective date

The revision related to CR 10901 is effective for claims processed **on or after January 8, 2019**, for services rendered **on or after October 3, 2018.**

The revision related to CRs 11293, 11296, 11298, 11318, and 11328 is effective for services rendered **on or after July 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 billing and coding article for an LCD (when present) may be found by selecting “Related Local Coverage Documents” in the “Section Navigation” drop-down menu at the top of the LCD page.

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

Upcoming provider outreach and educational events

Understanding the Basics of Medicare Secondary Payer (A/B)

Date: Tuesday, July 16
Time: 11:30 a.m. - 1:00 p.m. ET
Type of Event: Webcast

https://medicare.fcso.com/Events/0435640.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 *First Coast University*, 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 the *Create 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 May 23, 2019

MLN Connects® for Thursday, May 23, 2019

View this edition as a PDF

News

- No Shortcuts to Safer Opioids Prescribing: CDC Commentary
- CMS Takes Action to Lower Prescription Drug Prices and Increase Transparency
- SNF Provider Preview Reports: Review Your Data by May 30
- Draft 2020 QRDA Category III Implementation Guide: Submit Comments by June 5
- Medicare Shared Savings Program: Do You Plan to Apply to be an ACO?
- Promoting Interoperability Program: 2015 Edition CEHRT Required
- April – June Quarterly Provider Update
- Break Free from Osteoporosis

Compliance

- Provider Minute Video: The Importance of Proper Documentation

Claims, Pricers & Codes

- Medicare Diabetes Prevention Program: Valid Claims

Events

- DMEPOS Competitive Bidding: Round 2021 Webcast Series — Updated Schedule
- Post-Acute Care QRPs: Reporting Requirements and Resources Call — June 5
- Emergency Department Services: Comparative Billing Report Webinar — June 11
- Hospice Quality Reporting Program: Review and Correct Report Webinar — June 11

MLN Matters® Articles

- Claim Status Category and Claim Status Codes Update
- Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes – July 2019 Update
- Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update
- Reporting the HCPCS Level II Modifiers of the Patient Relationship Categories and Codes
- Proper Use of Modifier 59 — Revised

Publications

- Provider Compliance Tips for Positive Airway Pressure (PAP) Devices and Accessories Including Continuous Positive Airway Pressure (CPAP) — Revised
- Medicare Basics: Commonly Used Acronyms — Reminder

MLN Connects® for May 30, 2019

MLN Connects® for Thursday, May 30, 2019

View this edition as a PDF

News

- New Medicare Card Flyer for Your Patients
- Programs of All-Inclusive Care for the Elderly Final Rule
- Hospice Compare Refresh
- SNF PPS Patient Driven Payment Model: Get Ready for Implementation on October 1

Compliance

- Chiropractic Services: Comply with Medicare Billing Requirements

Claims, Pricers & Codes

- HETS Includes Medicare Diabetes Prevention Program Information

Events

- DMEPOS Competitive Bidding: Round 2021 Webcast Series — Updated Schedule
- Prior Authorization of Pressure Reducing Support Surfaces Special Open Door Forum — June 4
- Post-Acute Care QRPs: Reporting Requirements and Resources Call — June 5
- Delivering Dementia Capable Care within Health Plans: Why & How? Webinar — June 19
- Practices for Supporting Dually Eligible Older Adults with Complex Pain Needs Webinar — June 27

MLN Matters® Articles

- Additional Processing Instructions to Update the Standard Paper Remit (SPR)
- Home Health (HH) Patient-Driven Groupings Model (PDGM) – Additional Manual Instructions — Revised

Publications

- Outpatient Rehabilitation Therapy Services: Complying with Documentation Requirements

MLN Connects® for June 6, 2019

MLN Connects® for Thursday, June 6, 2019

View this edition as a PDF

News

- Medicare Shared Savings Program: Submit Notice of Intent to Apply Beginning June 11
- Promoting Interoperability Program: Submit Comments on Proposed Changes by June 24
- Promoting Interoperability Program: Submit a Measure Proposal by June 28
- Hospice Provider Preview Reports: Review Your Data by July 1
- PEPPERs for Short-term Acute Care Hospitals

Compliance

- Bill Correctly for Device Replacement Procedures

Claims, Pricers & Codes

- ICD-10-PCS Procedure Codes: FY 2020
- Average Sales Price Files: July 2019

Events

- DMEPOS Competitive Bidding: Round 2021 Webcast Series
- Developing a Hospice Assessment Tool Special Open Door Forum — June 12
- Ligature Risk in Hospitals Listening Session — June 20
- Hospital Co-location Listening Session — June 27

MLN Matters® Articles

- Chimeric Antigen Receptor (CAR) T-Cell Therapy Revenue Code and HCPCS Setup Revisions
- Documentation of Medical Necessity of the Home Visit; and Physician Management Associated with Superficial Radiation Treatment
- July 2019 Integrated Outpatient Code Editor (I/OCE) Specifications Version 20.2
- July 2019 Update of the Hospital Outpatient Prospective Payment System (OPPS)
- Update to 46.2, 46.3, 46.4, and 46.5 in Publication (Pub.) 100-08

Publications

- Quality Payment Program: 2019 Measure Development Plan Annual Report

Multimedia

- CMS: Beyond the Policy Podcast: Innovation Center

MLN Connects® for June 13, 2019

MLN Connects® for Thursday, June 13, 2019

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News

- DMEPOS Competitive Bidding - Round 2021: Register Now
- Medicare Shared Savings Program: Submit Notice of Intent to Apply by June 28
- LTCH Provider Preview Reports: Review Your Data by July 10
- IRF Provider Preview Reports: Review Your Data by July 10
- When It Comes To Our Health – Every Second Counts: Comment on RFI by August 12
- LTCH Compare Refresh
- IRF Compare Refresh
- Men's Health Week Ends on Father's Day

Compliance

- Outpatient Rehabilitation Therapy Services: Comply with Medicare Billing Requirements

Events

- DMEPOS Competitive Bidding: Round 2021 Webcast Series
- Ligature Risk in Hospitals Listening Session — June 20
- Hospital Co-location Listening Session — June 27

Publications

- Quality Payment Program: 2019 Resources
- Provider Compliance Tips for Urological Supplies — Revised

Multimedia

- Medicare Billing: Form CMS-1450 and the 837 Institutional Web-Based Training Course — Reminder

MLN Connects® for June 20, 2019

New Medicare Card: 75% of Claims Submitted with MBI

MLN Connects® for Thursday, June 20, 2019

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News

- New Medicare Card: 75% of Claims Submitted with MBI
- IRF: Voluntary Appeals Settlement Options
- CMS Proposes to Update e-Prescribing Standards
- Medicare Shared Savings Program: Submit Notice of Intent to Apply by June 28
- Dermatology: Comparative Billing Report on Modifier 25 in June
- Hospice Provider Preview Reports: Review Your Data by July 1

Events

- DMEPOS Competitive Bidding: Round 2021 Webcast Series
- Hospital Co-location Listening Session — June 27
- Dermatology: Comparative Billing Report on Modifier 25 Webinar — July 10

MLN Matters® Articles

- Implement Operating Rules - Phase III Electronic Remittance Advice (ERA) Electronic Funds Transfer (EFT): Committee on Operating Rules for Information Exchange (CORE) 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC), and Claim Adjustment Group Code (CAGC) Rule - Update from Council for Affordable Quality Healthcare (CAQH) CORE

MLN SPECIAL EDITION

from page 1

For More Information:

- *RFI on Reducing Administrative Burden to Put Patients over Paperwork*
- *Patients over Paperwork* webpage

Read the full text of this excerpted *CMS Press Release* (issued June 6). Submit comments by August 12.

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
First Coast University

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

Phone numbers

Customer service

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

Education event registration hotline

904-791-8103 (NOT toll-free)

Electronic data interchange (EDI)

888-670-0940

Electronic funds transfers (EFT) (CMS-588)

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

Fax number (for general inquiries)

904-361-0696

Interactive voice response (IVR) system

877-847-4992

Provider enrollment

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

The SPOT help desk

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

Addresses

Claims

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

Redeterminations

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

Redetermination of overpayments

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

Reconsiderations

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

General inquiries

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

Provider enrollment

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

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

Medical policy

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

Medicare secondary payer

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

Electronic data interchange (EDI)

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

Overpayments

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

Medicare Education and Outreach

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

Fraud and abuse

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

Freedom of Information Act requests

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

Special courier service

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

Websites

Provider

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

https://medicare.fcso.com

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

Centers for Medicare & Medicaid Services

https://www.cms.gov

E-learning Center
First Coast University

Beneficiaries

Centers for Medicare & Medicaid Services

https://www.medicare.gov

Phone numbers

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

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

Electronic data interchange (EDI)
888-875-9779

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

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

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

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

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

Addresses

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

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

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

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

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

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

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

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

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

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

Electronic data interchange (EDI)
Medicare EDI, 4C
P.O. Box 44071
Jacksonville, FL 32231-4071

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

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

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

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

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

Websites

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

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

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

E-learning Center
First Coast University

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

Order form for Medicare Part B materials

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

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Item	Acct Number	Cost per item	Quantity	Total cost
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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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Medicare Publications
P.O. Box 406443
Atlanta, GA 30384-6443

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