Medicare B CONNECTION

medicare.fcso.com

FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction N Providers

August 2019

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- OPPS and ASC Proposed Rule Listening Session — August 14

Physician Fee Schedule Proposed Rule: Understanding 3 Key Topics Listening Session — August 12

Monday, August 12 from 1-2:30 pm ET

Register for Medicare Learning Network events.

Proposed changes to the CY 2020 Physician Fee Schedule are aimed at reducing burden, recognizing clinicians for the time they spend taking care of patients, removing unnecessary measures, and making it easier for clinicians to be on the path towards value-based care. During this listening session, CMS experts briefly cover three provisions from the proposed rule and address your clarifying questions to help you formulate your written comments for formal submission:

- Increasing value of Evaluation and Management (E/M) payments
- Continuing to improve the Quality Payment Program by streamlining the program's requirement's in order to reduce clinician burden
- Creating the new Opioid Treatment Program benefit in response to the opioid epidemic

We encourage you to review the following materials prior to the call:

- *Proposed rule*
- *Press release*
- *Physician Fee Schedule proposed rule fact sheet*
- *Quality Payment Program proposed rule fact sheet*

Note: Feedback received during this listening session is not a substitute for your formal comments on the rule. See the *proposed rule* for information on submitting these comments by September 27.

See **SPECIAL EDITION**, page 16

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.

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.

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 webpage 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.

Retired LCDs

Fulvestrant (Faslodex®) -- retired Part A and Part B LCD

LCD ID number: L33998 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on data analysis review of the local coverage determination (LCD) for fulvestrant (Faslodex®), it was determined that it is no longer required and therefore, is being retired.

Effective date

The retirement of this LCD is effective for services rendered **on or after July 31, 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, please *click here*.

Monitored anesthesia care (MAC) for certain interventional pain management services -- retired Part A and Part B LCD

LCD ID number: L33595 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on data analysis review of the local coverage determination (LCD) for monitored anesthesia care (MAC) for certain interventional pain management services, it was determined that it is no longer required and therefore, is being retired.

Effective date

The retirement of this LCD is effective for services rendered **on or after July 27, 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, please *click here*.

Revisions to LCDs

Vitamin D; 25 hydroxy, includes fraction(s), if performed -- revision to the Part A and Part B LCD

LCD ID number: L33771 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 10901, the local coverage determination (LCD) for vitamin D; 25 hydroxy, includes fraction(s), if performed, was revised to remove all billing and coding information as well as 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. Also, 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, the Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual (IOM) language has been removed from the "Limitations" section of the LCD and instead, the IOM citation related to this language is referenced.

Effective date

This LCD revision is effective for claims processed **on or after January 8, 2019**, for services rendered **on or after October 3, 2018.**

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, 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) and related billing and coding article for diagnostic colonoscopy, 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.

Effective date

This LCD revision is effective for services rendered **on or after July 30, 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, please *click here*.

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

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

Based on change request (CR) 11295, the local coverage determination (LCD) for intravenous immune globulin was revised to add ICD-10-CM diagnosis codes D80.2, D80.3, D80.4, D80.6, D80.7, D81.5, D82.1, D82.4, D83.1 and G11.3 to the "ICD-10 Codes that Support Medical Necessity/Group 1 Codes:" section of the LCD.

Effective date

This LCD revision is effective for services rendered **on or after August 13, 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, please *click here*.

3D interpretation and reporting of imaging studies -- revision to the Part A and Part B LCD

LCD ID number: L33256 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 10901, the local coverage determination (LCD) for 3D interpretation and reporting of imaging studies, if performed was revised to remove all billing and coding information as well as 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. Also, 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, the Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual (IOM) language has been removed from the "Limitations" section of the LCD and instead, the IOM citation related to this language is referenced.

Effective date

This LCD revision is effective for claims processed **on or after January 8, 2019**, for services rendered **on or after October 3, 2018**. 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, please *click here*.

Urinary tumor markers for bladder cancer -- revision to the Part B LCD

LCD ID number: L33965 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 10901, the local coverage determination (LCD) for urinary tumor markers for bladder cancer 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.

Effective date

This LCD revision is effective for claims processed **on or after January 8, 2019**, for services rendered **on or after October 3, 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 review of the local coverage determination (LCD) and related billing and coding article for E&M home and domiciliary visits, 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.

Effective date

The LCD revision is effective for services rendered **on or after July 23, 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*.

Sacral neuromodulation -- revision to the Part B LCD

LCD ID number: L36296 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on review of the local coverage determination (LCD) and related billing and coding article for sacral neuromodulation, typographical and formatting errors were identified and corrected.

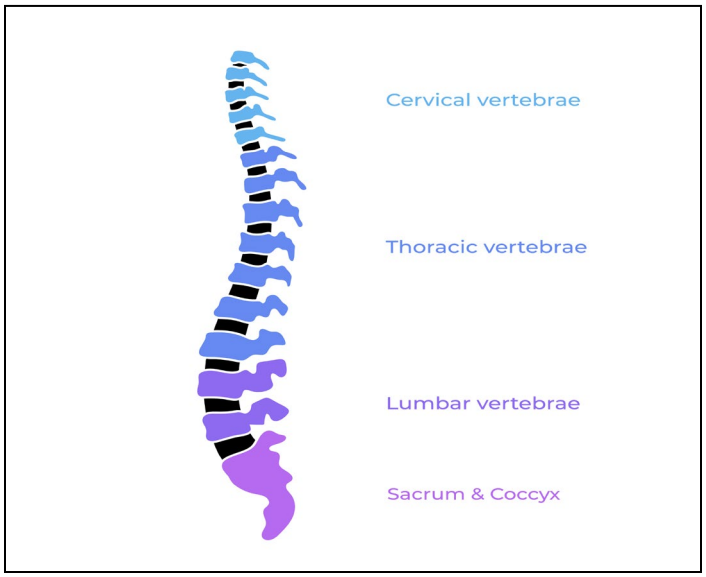
Also, the "Bibliography" section of the LCD was updated to be consistent with American Medical Association (AMA) formatting.

Effective date

This LCD revision is effective for services rendered **on or after August 6, 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, please *click here*.

YAG laser capsulotomy -- revision to the Part B LCD

LCD ID number: L33968 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 10901, the local coverage determination (LCD) for YAG laser capsulotomy was revised to remove all billing and coding information as well as 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. In addition, 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.

Effective date

This LCD revision is effective for claims processed **on or after January 8, 2019**, for services rendered **on or after October 3, 2018.** 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, please *click here*.

Where do I find...

Looking for something specific and don't know where to find it? Find out how to perform routine tasks or locate information that visitors frequently visit our site to accomplish or find. Check out the "Where do I find" page.

Upcoming provider outreach and educational events

Advantages of having a SPOT internet Portal account (A/B)

Date: September 30
Time: 10 - 11:30 a.m. ET
Type of Event: Webcast

https://medicare.fcso.com/Events/0441240.asp

View our complete calendar of events

https://medicare.fcso.com/Events/139814.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 *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.).

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 Thursday, July 25, 2019

MLN Connects® for Thursday, July 25, 2019

View this edition as a PDF

News

- New Medicare Card: Questions about Using the MBI?
- 2020 QRDA III Implementation Guide, Schematron, and Sample Files
- Antipsychotic Drug Use in Nursing Homes: Trend Update
- Clinical Diagnostic Laboratories: Resources about the Private Payor Rate-Based CLFS
- Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier
- World Hepatitis Day: Medicare Coverage for Viral Hepatitis

Compliance

- Importance of Proper Documentation: Provider Minute Video

Events

- Enrollment: Multi–Factor Authentication for I&A System Webcast — July 30
- Diagnosing and Treating Dementia: Current Best Practices Webinar — July 30
- Quality Payment Program Performance Information on Physician Compare Webinar — July 30/Aug 1
- Disability-Competent Care Conversation on Access Webinar — July 31
- IRF Appeals Settlement Initiative Call — August 13
- Home Health Patient-Driven Groupings Model: Operational Issues Call — August 21

MLN Matters® Articles

- Importance of Proper Documentation: Provider Minute Video

Publications

- Medicare DMEPOS Improper Inpatient Payments
- Medicare Part D Vaccines — Revised
- Provider Compliance Tips for Enteral Nutrition Pumps — Revised

Multimedia

- Hospital Listening Session: Audio Recording and Transcript
- Hospice Quality Reporting Program Web-Based Courses

MLN Connects® -- Special Edition for July 29, 2019

CMS Provider Education Message:

- PFS: Proposed Policy, Payment, and Quality Provisions Changes for CY 2020
- Medicare OPPS and ASC Payment System CY 2020 Proposed Rule
- ESRD and DMEPOS CY 2020 Proposed Rule

PFS: Proposed Policy, Payment, and Quality Provisions Changes for CY 2020

On July 29, CMS issued a proposed rule that includes proposals to update payment policies, payment rates, and quality provisions for services furnished under the Medicare Physician Fee Schedule (PFS) on or after January 1, 2020. This proposed rule is one of several proposed rules that reflect a broader Administration-wide strategy to create a health care system that results in better accessibility, quality, affordability, empowerment, and innovation. It also includes proposals to streamline the Quality Payment Program with the goal of reducing clinician burden. This includes a new, simple way for clinicians to participate in our pay-for-performance program, the Merit-based Incentive Payment System (MIPS), called the MIPS Value Pathways.

The proposed rule also includes:

- CY 2020 PFS rate setting and conversion factor
- Medicare telehealth services
- Payment for evaluation and management services
- Physician supervision requirements for physician assistants
- Review and verification of medical record documentation
- Care management services
- Comment solicitation on opportunities for bundled payments
- Medicare coverage for opioid use disorder treatment services furnished by opioid treatment programs
- Bundled payments for substance use disorders
- Therapy services
- Ambulance services
- Ground ambulance data collection system
- Open Payments Program
- Medicare Shared Savings Program
- Stark advisory opinion process.

For additional information:

- *Proposed Rule*: Public comments due by September 27
- *Press Release*
- *PFS Proposed Rule Fact Sheet*
- *Quality Payment Program Proposed Rule fact Sheet*

See the full text of this excerpted *Fact Sheet* (Issued July 29).

Medicare OPPS and ASC Payment System CY 2020 Proposed Rule

On July 29, CMS proposed policies that follow directives in President Trump's Executive Order, entitled "Improving Price and Quality Transparency in American Health Care to Put Patients First," that lay the foundation for a patient-driven health care system by making prices for items and services provided by all hospitals in the United States more transparent for patients so that they can be more informed about what they might pay for hospital items and services.

The proposed changes also encourage site-neutral payment between certain Medicare sites of services. Finally, the proposed rule proposes updates and policy changes under the Medicare Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System. The proposed polices in the CY 2020 OPPS/ASC Payment System proposed rule would further advance the agency's commitment to increasing price transparency, (including proposals for requirements that would apply to each hospital operating in the United States), strengthening Medicare, rethinking rural health, unleashing innovation, reducing provider burden, and strengthening program integrity so that hospitals and ambulatory surgical centers can operate with better flexibility and patients have what they need to become active health care consumers.

In accordance with Medicare law, CMS is proposing to update OPPS payment rates by 2.7 percent. This update is based on the projected hospital market basket increase of 3.2 percent minus a 0.5 percentage point adjustment for Multi-Factor Productivity (MFP).

In the CY 2019 OPPS/ASC final rule with comment period, we finalized our proposal to apply the hospital market basket update to ASC payment system rates for an interim period of 5 years (CY 2019 through CY 2023). CMS is not proposing any changes to its policy to use the hospital market basket update for ASC payment rates for CY 2020-2023. Using the hospital market basket, CMS proposes to update ASC rates for CY 2020 by 2.7 percent for ASCs meeting relevant quality reporting requirements. This change is based on the projected hospital market basket increase of 3.2 percent minus a 0.5 percentage point adjustment for MFP.

This change will also help to promote site neutrality between hospitals and ASCs and encourage the migration of services from the hospital setting to the lower cost ASC setting.

The proposed rule also includes:

- Proposed definition of 'hospital,' 'standard charges,' and 'items and services'

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SPECIAL EDITION

from page 12

- Proposed requirements for making public all standard charges for all items and services
- Proposed requirements for making public consumer-friendly standard charges for a limited set of 'shoppable services'
- Proposals for monitoring and enforcement
- Method to control for unnecessary increases in utilization of outpatient services
- Changes to the Inpatient Only list
- ASC covered procedures list
- High-cost/low-cost threshold for packaged skin substitutes
- Device pass-through applications
- Addressing wage index disparities
- Changes in the level of supervision of outpatient therapeutic services in hospitals and critical access hospitals
- Hospital Outpatient Quality Reporting Program
- Ambulatory Surgical Center Quality Reporting Program
- CY 2020 OPPS payment methodology for 340B purchased drugs
- Partial Hospitalization Program rate setting and update to per diem rates
- Revision to the organ procurement organization conditions for certification
- Potential changes to the organ procurement organization and transplant center regulations: Request for Information

For more information:

- *Proposed Rule*: Public comments due by September 27
- *Press Release*

See the full text of this excerpted *CMS Fact Sheet* (issued July 29).

ESRD and DMEPOS CY 2020 Proposed Rule

On July 29, CMS issued a proposed rule that proposes to update payment policies and rates under the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) for renal dialysis services furnished to beneficiaries on or after January 1, 2020. This rule also:

- Proposes updates to the Acute Kidney Injury (AKI) dialysis payment rate for renal dialysis services furnished by ESRD facilities to individuals with AKI
- Proposes changes to the ESRD Quality Incentive Program
- Includes requests for information on data collection resulting from the ESRD PPS technical expert panel, on possible updates and improvements to the ESRD PPS wage index, and on new rules for the competitive bidding of diabetic testing strips.

In addition, this rule proposes a methodology for calculating fee schedule payment amounts for new Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) items and services and making adjustments to the fee schedule amounts established using supplier or commercial prices if such prices decrease within five years of establishing the initial fee schedule amounts. This rule would also:

- Make amendments to revise existing policies related to the competitive bidding program for DMEPOS
- Streamline the requirements for ordering DMEPOS items, and create one Master List of DMEPOS items that could potentially be subject to face-to-face encounter and written order prior to delivery and/or prior authorization requirements

The proposed CY 2020 ESRD PPS base rate is $240.27, an increase of $5.00 to the current base rate of $235.27. This proposed amount reflects a reduced market basket increase as required by section 1881(b)(14)(F)(i)(I) of the Act (1.7 percent) and application of the wage index budget-neutrality adjustment factor (1.004180).

The proposed rule also includes:

- Annual update to the wage index
- Update to the outlier policy
- Eligibility criteria for the Transitional Drug Add-on Payment Adjustment (TDAPA)
- Basis of Payment for the TDAPA for calcimimetics
- Average sales price conditional policy for the application of the TDAPA:
- New and innovative renal dialysis equipment and supplies
- Discontinuing the application of the erythropoiesis-stimulating agent monitoring policy
- Impact analysis

For More Information:

- *Proposed Rule* Public comments due by September 27
- *Press Release*

See the full text of this excerpted *CMS Fact Sheet* (issued July 29)

MLN Connects® for Thursday, August 1, 2019

MLN Connects® for Thursday, August 1, 2019

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News

- SNF: FY 2020 Payment and Policy Changes
- IPF: FY 2020 Payment and Quality Reporting Updates
- Protect Your Patients' Identities: Use the MBI Now
- CMS Advances MyHealthEData with New Pilot to Support Clinicians
- Reducing Administrative Burden: Comment by August 12
- Medicare Coverage for Treatment Services Furnished by Opioid Treatment Programs
- Open Payments Program Expansion
- Improve Accessibility of Care for People with Disabilities: New Resources
- Part A Providers: Formal Telephone Discussion Demonstration
- July – September Quarterly Provider Update
- Disaster Preparedness Resources
- Vaccines Are Not Just for Kids

Compliance

- DMEPOS: Bill Correctly for Items Provided During Inpatient Stays

Events

- Emergency Triage, Treat, and Transport Model Application Tutorial Webinar — August 8
- Physician Fee Schedule Proposed Rule: Understanding 3 Key Topics Listening Session — August 12
- IRF Appeals Settlement Initiative Call — August 13
- OPPS and ASC Proposed Rule Listening Session — August 14
- ESRD Quality Incentive Program: CY 2020 ESRD PPS Proposed Rule Call — August 20
- Home Health Patient-Driven Groupings Model: Operational Issues Call — August 21
- Understanding Your SNF VBP Program Performance Score Report Call — August 27

MLN Matters® Articles

- Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging – Educational and Operations Testing Period – Claims Processing Requirements
- New Waived Tests
- Documentation of Medical Necessity of the Home Visit; and Physician Management Associated with Superficial Radiation Treatment — Revised

Publications

- Skilled Nursing Facility 3-Day Rule Billing
- Provider Compliance Tips for Glucose Monitors and Diabetic Accessories/Supplies — Revised

Multimedia

- Quality Payment Program Merit-based Incentive Payment System (MIPS): Cost Performance Category in 2019 Web-Based Training Course — Revised
- Quality Payment Program 2019 Overview Web-Based Training Course — Revised
- Quality Payment Program Merit-based Incentive Payment System (MIPS): Quality Performance Category in 2019 Web-Based Training Course — Revised
- Quality Payment Program Merit-based Incentive Payment System (MIPS): Improvement Activities in 2019 Web-Based Training Course — Revised

MLN Connects® -- Special Edition for August 2, 2019

- IPPS/LTCH: FY 2020 PPS Final Rule
- IRF: FY 2020 Payment and Policy Changes
- Hospice: FY 2020 Hospice Payment Rate Final Rule

IPPS/LTCH: FY 2020 PPS Final Rule

On August 2, CMS finalized policy changes to spur competition and innovation that will help deliver improved care and outcomes at a better value to patients. The final rule updates Medicare payment policies for hospitals under the Inpatient Prospective Payment System (IPPS) and the Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) for FY 2020 and advances two key CMS priorities—"Rethinking Rural Health" and "Unleashing Innovation" by making historic changes to how Medicare pays hospitals. This final rule:

- Increases the wage index for certain low-wage index hospitals, including many rural hospitals
- Increases Medicare add-on payments for high cost eligible new technologies from 50-65%
- Clarifies policies on "substantial clinical improvement" to qualify for new technology add on payments
- Provides an alternative pathway where Breakthrough Devices are no longer required to demonstrate evidence of "substantial clinical improvement" to qualify for new technology add-on payments
- Provides an alternative pathway where Qualified Infectious Disease Products are no longer required to meet the "substantial clinical improvement" criteria for technology add-on payments, which are increased from 50 to 75%

For more information:

- *Final Rule*
- *Fact Sheet*

See the full text of this excerpted *CMS Press Release* (Issued August 2).

IRF: FY 2020 Payment and Policy Changes

On July 31, CMS issued a *final rule* that updates Medicare payment policies and rates for facilities under the Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) and the IRF Quality Reporting Program for FY 2020. We are continuing our efforts towards the eventual transition to a unified post-acute care system through updates to the data used for IRF payments, including revising the Case-Mix Groups (CMGs), updating the CMG relative weights and average length of stay values, and using concurrent inpatient prospective payment system wage index data for the IRF PPS to align wage index data across settings of care.

For FY 2020, CMS is finalizing updates to the IRF PPS payment rates using the most recent data to reflect an estimated 2.5 percent increase factor (reflecting an IRF-specific market basket increase factor of 2.9 percent, reduced by a 0.4 percentage point multifactor productivity adjustment). CMS projects that IRF payments will increase by 2.5 percent (or $210 million) for FY 2020, relative to payments in FY 2019.

This rule finalizes:

- Rebase and revise the IRF market basket
- Clarification of "rehabilitation physician"
- Two new quality measures

See the full text of this excerpted *CMS Fact Sheet* (issued July 31).

Hospice: FY 2020 Hospice Payment Rate Final Rule

On July 31, CMS issued a final rule that demonstrates continued commitment to strengthening Medicare by better aligning the hospice payment rates with the costs of providing care and increasing transparency so patients can make more informed choices. For FY 2020, hospice payment rates are updated by 2.6 percent ($520 million increase in their payments). The final hospice cap amount for the FY 2020 cap year will be $29,964.78, which is equal to the FY 2019 cap amount ($29,205.44) updated by the final FY 2020 hospice payment update percentage of 2.6 percent. The aggregate cap limits the overall payments per patient made to a hospice annually.

This rule finalizes:

- Rebasing to more accurately align Medicare payments with the costs of providing care
- Modifications to the election statement beginning in FY 2021, increasing coverage transparency for beneficiaries under a hospice election
- Hospice Quality Reporting Program updates, including developing a hospice assessment tool for real-time patient assessments

For More Information:

- *Final Rule*
- *Hospice Center*
- *Hospice Quality Reporting* webpage

See the full text of this excerpted *CMS Fact Sheet* (issued July 31)

SPECIAL EDITION

from page 1

Target Audience: Medicare Part B fee-for-service clinicians; office managers and administrators; state and national associations that represent health care providers; and other stakeholders.

OPPS and ASC Proposed Rule Listening Session — August 14

Register for Medicare Learning Network events.

CMS proposed updates and policy changes under the Medicare Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) payment systems, including price and quality transparency that lay the foundation for a patient-driven health care system. During this listening session, CMS experts briefly cover provisions from the proposed rule and address your clarifying questions to help you formulate your written comments for formal submission. Topics include:

- Price transparency: Requirements for all United States hospitals to make their standard charges public
- Increasing choices and encouraging site neutrality, including payments for clinic visits

We encourage you to review the *proposed rule*, *press release*, and *fact sheet* prior to the call. Note: Feedback received during this listening session is not a substitute for your formal comments on the rule. See the *proposed rule* for information on submitting these comments by September 27.

Target Audience: All hospitals operating in the United States and other stakeholders.

MLN Connects® for Thursday, August 8, 2019

MLN Connects® for Thursday, August 8, 2019

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News

- New Medicare Card: Will Your Claims Reject?
- Securing Access to Life-Saving Antimicrobial Drugs for American Seniors
- IRF/LTCH/SNF Quality Reporting Programs: Submission Deadline August 15
- Hospice Patient Assessment Instrument Focus Groups: Respond by August 26
- Emergency Triage, Treat, and Transport Model: Apply by September 19
- SNF PPS Patient Driven Payment Model: Get Ready for Implementation on October 1
- 2019 QRDA III Implementation Guide: Updated Addendum
- Quality Payment Program: Reporting Patient Relationship Categories

Compliance

- Skilled Nursing Facility 3-Day Rule Billing

Events

- Physician Fee Schedule Proposed Rule: Understanding 3 Key Topics Listening Session — August 12
- IRF Appeals Settlement Initiative Call — August 13
- OPPS and ASC Proposed Rule Listening Session — August 14
- ESRD Quality Incentive Program: CY 2020 ESRD PPS Proposed Rule Call — August 20
- Home Health Patient-Driven Groupings Model: Operational Issues Call — August 21
- Radiation Oncology Model Listening Session — August 22
- Understanding Your SNF VBP Program Performance Score Report Call — August 27

MLN Matters® Articles

- Inpatient Rehabilitation Facility (IRF) Annual Update: Prospective Payment System (PPS) Pricer Changes for FY 2020
- Instructions for Use of Informational Remittance Advice Remark Code Alert on Laboratory Service Remittance Advices
- Medicare Shared Savings Program (Shared Savings Program) Skilled Nursing Facility (SNF) Affiliates' Requirement to Include Demonstration Code 77 on SNF 3-Day Rule Waiver Claims
- Modification to the National Coordination of Benefits Agreement (COBA) Crossover Process
- October Quarterly Update to 2019 Annual Update of HCPCS Codes Used for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Enforcement
- Oxygen Policy Update
- Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment

Multimedia

- CMS: Beyond the Policy Podcast: Nursing Home Strategy Part 1 – Strengthening Oversight
- CLFS Public Meetings: Videos

MLN Connects® for Thursday, August 15, 2019

MLN Connects® for Thursday, August 15, 2019

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News

- New Medicare Card: Transition Period Ends in Less Than 5 Months
- CAR T-Cell Cancer Therapy Available to Medicare Beneficiaries Nationwide
- DMEPOS Competitive Bidding: Round 2021 Deadlines
- MACRA Patient Relationship Categories and Codes: Learn More

Compliance

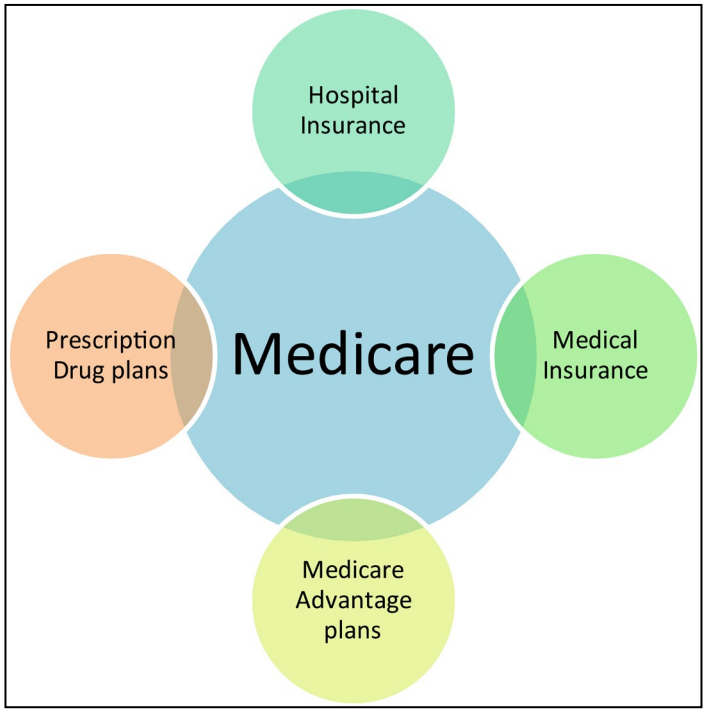
- Inpatient Rehabilitation Facility Services: Follow Medicare Billing Requirements

Events

- ESRD Quality Incentive Program: CY 2020 ESRD PPS Proposed Rule Call -- August 20
- IPPS/LTCH PPS FY 2020 Final Rule Special Open Door Forum -- August 20
- Home Health Patient-Driven Groupings Model: Operational Issues Call -- August 21
- Self-Direction for Dually Eligible Individuals Utilizing LTSS Webinar -- August 21
- Radiation Oncology Model Listening Session -- August 22
- Understanding Your SNF VBP Program Performance Score Report Call -- August 27
- Dementia Care: Supporting Comfort and Resident Preferences Call -- September 107

MLN Matters® Articles

- Bypassing Payment Window Edits for Donor Post-Kidney Transplant Complication Services
- Display PARHM Claim Payment Amounts



- Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Updates for Fiscal Year (FY) 2020
- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs) -- January 2020 Update

Publications

- Chronic Care Management Services -- Revised
- ICD-10-CM, ICD-10-PCS, CPT, and HCPCS Code Sets -- Revised

Multimedia

- I&A Enrollment Webcast: Audio Recording and Transcript
- SNF PPS: Patient Driven Payment Model Videos

Phone numbers

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

Electronic data interchange (EDI)
888-670-0940

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)
FAX: 904-361-0737

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
FAX: 904-361-0407
Email: elearning@fcso.com

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 2078
Jacksonville, FL 32231-2078

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

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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

Provider Contact Center

866-454-9007
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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

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CMS-855 Applications
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Medical policy

Medical Policy and Procedure
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Jacksonville, FL 32231-0048
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Medicare secondary payer

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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
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Jacksonville, FL 32232-5013

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Email: elearning@fcso.com

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Jacksonville, FL 32232-5087

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https://www.cms.gov

E-learning Center
First Coast University

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Puerto Rico Contact Information

Phone numbers

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1-888-216-8261 (speech and hearing impaired)

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888-875-9779

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877-847-4992

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877-660-1759 (TTY)
FAX: 904-361-0737

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Medicare Part B Claims
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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 45036
Jacksonville, FL 32232-5036

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Online form: *https://medicare.fcso.com/Feedback/161670.asp*

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Jacksonville, FL 32231-4078

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

Overpayments
Medicare Part B Debt Recovery
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Jacksonville, FL 32231-5040

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FAX: 904-361-0407
Email: elearning@fcso.com

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