

C Medicare B CONNECTION

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A Newsletter for MAC Jurisdiction N Providers

October 2019



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Notify First Coast Service Options if you file bankruptcy

If you have filed a bankruptcy petition or are involved in a bankruptcy proceeding, First Coast requests that you notify us immediately so that we can properly coordinate with the Centers for Medicare & Medicaid Services (CMS) and the Department of Justice (DOJ) to resolve Medicare financial obligations. Even if there are no outstanding payments at the time of the bankruptcy filing, this notification ensures that we handle your situation properly.

Notify us of the bankruptcy by email at FCSO-BankruptcyNotification@fcso.com providing:

- Name the bankruptcy is filed under
- District where the bankruptcy was filed
- Docket number
- National Provider Identifier (NPI).

You must also serve CMS and the DOJ with notice of



bankruptcy under the applicable federal laws, rules and regulations. Hyperlink: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Bankruptcy/index.html>.



WHEN EXPERIENCE COUNTS & QUALITY MATTERS

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

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

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About the Medicare B Connection

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

Important notifications that require communication in between publications will be posted to the First Coast Medicare [provider education website](#). 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.

Take action to combat the flu

Now is the perfect time for providers to vaccinate Medicare beneficiaries, as it can take two weeks after vaccination to develop antibodies that protect against seasonal influenza. As a health care provider, you play an important role in setting an example by getting yourself vaccinated and recommending and promoting influenza vaccination.

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](#).

Reproducible copies of Form CMS-R-131 ABNs (in English and Spanish) and other BNI information may be found [here](#).

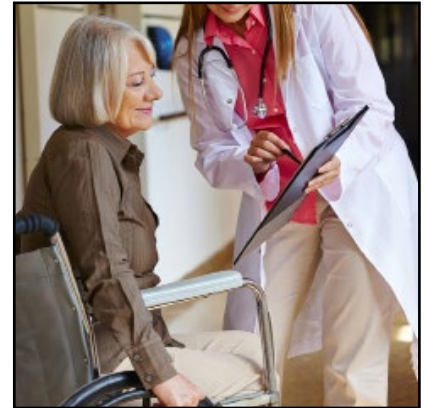
ABN modifiers

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.

Retired LCDs

Azacitidine (Vidaza®) -- retired Part A and Part B LCD

LCD ID number: L33266 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on data analysis review of the local coverage determination (LCD) for azacitidine (Vidaza®), 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 **October 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](#).

Bendamustine hydrochloride -- retired Part A and Part B LCD

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

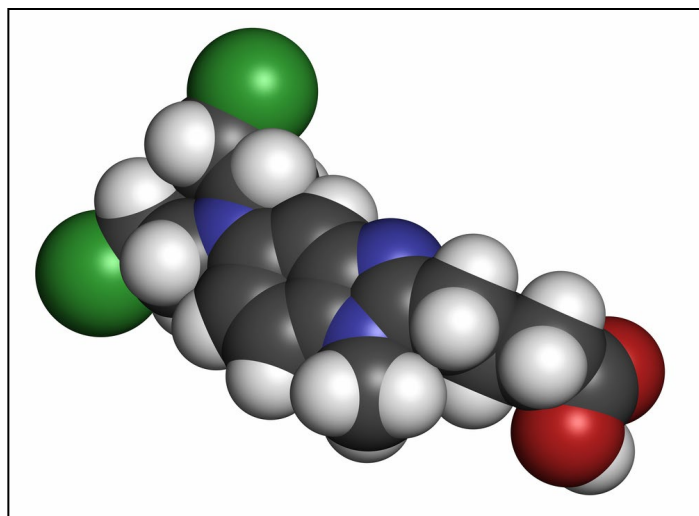
Based on data analysis review of the local coverage determination (LCD) for bendamustine hydrochloride, it was determined that it is no longer required. Therefore, the LCD, related billing and coding article (A56665) and related local coverage article (A56662) are also being retired.

Effective date

The retirement of this LCD, related billing and coding article and local coverage article is effective for services rendered on or after **October 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](#).

Gemcitabine (Gemzar®) -- retired Part A and Part B LCD

LCD ID number: L33726 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on data analysis review of the local coverage determination (LCD) for gemcitabine (Gemzar®), 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 **October 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](#).

Revisions to LCDs

Ophthalmological diagnostic services -- revision to the Part B LCD

LCD ID number: L33925 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 10901, the local coverage determination (LCD) for ophthalmological diagnostic services 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.

Also, the Social Security Act, Code of Federal Regulations, and the Internet Only Manual (IOM) reference sections were updated.

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](#).

Transcranial doppler studies -- revision to the Part B LCD

LCD ID number: L33977 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 10901, the local coverage determination (LCD) for transcranial doppler studies 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.

Also, the following unspecified ICD-10-CM diagnosis codes were removed as it is the provider's responsibility to code to the highest level of specificity: I60.00, I60.10, I60.30, I60.50, I60.7, I63.019, I63.039, I63.119, I63.139, I63.219, I63.239, I63.30, I63.319, I63.329, I63.339, I63.349, I63.40, I63.419, I63.429, I63.439, I63.449, I63.50, I63.519, I63.529, I63.539, I63.549, I65.09, I65.29, I66.09, I66.19, I66.29, I66.9.

In addition, based on a reconsideration request, the following ICD-10-CM codes were added to the "Group 1 Codes" "ICD-10 codes that are covered" section of the newly created billing and coding article: G45.2, G45.3,

G45.4, G45.8, G45.9, G46.0, G46.1, G46.2, G97.31, G97.32, G97.48, G97.49, G97.51, G97.52, I61.0, I61.1, I61.3, I61.4, I61.5, I61.6, I61.8, I63.09, I63.19, I63.29, I67.1, I67.2, I67.7, I67.81, I67.82, I67.841, I67.848, I67.89, I67.9, I72.6, I74.9, I76, S09.0XXA, S09.0XXD, S09.0XXS, S15.111A, S15.111D, S15.111S, S15.112A, S15.112D, S15.112S, S15.121A, S15.121D, S15.121S, S15.122A, S15.122D, S15.122S, S15.191A, S15.191D, S15.191S, S15.192A, S15.192D, S15.192S, Z09.

Effective date

The LCD 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 LCD revisions related to the removal of the unspecified ICD-10-CM diagnosis codes and a reconsideration request are effective for services rendered **on or after October 29, 2019**. LCDs are available through the CMS Medicare coverage database at <https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>.

A 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](#).

Iridotomy by laser surgery -- revision to the Part B LCD

LCD ID number: L33914 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 10901, the local coverage determination (LCD) for iridotomy by laser surgery 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.

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.

Laser trabeculoplasty -- revision to the Part B LCD

LCD ID number: L33917 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 10901, the local coverage determination (LCD) for laser trabeculoplasty 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.

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.

Laser treatment for psoriasis -- revision to the Part B LCD

LCD ID number: L33918 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 10901, the local coverage determination (LCD) for laser treatment for psoriasis 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.

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 Social Security Act and Internet Only Manual (IOM) reference sections were updated.

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](#).

In addition, the Social Security Act and Internet Only Manual (IOM) reference sections were updated.

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](#).

In addition, the Social Security Act and Internet Only Manual (IOM) reference sections were updated.

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](#).

Post-voiding residual ultrasound -- revision to the Part B LCD

LCD ID number: L33935 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 10901, the local coverage determination (LCD) for post-voiding residual ultrasound 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.

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 Social Security Act, Code of Federal Regulations, and Internet Only Manual (IOM) reference sections were updated.

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](#).

Reduction mammoplasty -- revision to the Part B LCD

LCD ID number: L33939 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 10901, the local coverage determination (LCD) for reduction mammoplasty 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, the Social Security Act and Internet Only Manuals (IOM) reference sections were updated and language from the Centers for Medicare & Medicaid

Services (CMS) IOM manual and Social Security Act regulations was removed and instead the applicable manual/regulation reference was listed.

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](#).

Sacroiliac joint injection -- revision to the Part B LCD

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

Based on change request (CR) 10901, the local coverage determination (LCD) for sacroiliac joint injection 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, the Social Security Act and Internet Only Manual (IOM) reference sections were updated.

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](#).

Somatosensory testing -- revision to the Part B LCD

LCD ID number: L33958 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 10901, the local coverage determination (LCD) for somatosensory testing 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, the Social Security Act, Code of Federal

Regulations, and Internet Only Manual (IOM) reference sections were updated.

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**.

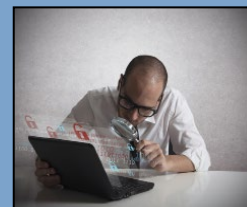
LCDs are available through the CMS Medicare coverage database at <https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>.

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.



BRCA1 and BRCA2 genetic testing -- revision to the Part A and Part B LCD

LCD ID number: L36499 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 10901, the local coverage determination (LCD) for BRCA1 and BRCA2 genetic testing 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.

In addition, based on CR 11406, CR 11412 and CR 11451 (October 2019 Quarterly Updates), Current Procedural Terminology (CPT®) codes 0129U, 0131U, 0132U, 0134U, 0135U, 0137U, and 0138U were added to the newly created billing and coding article.

Also, ICD-10-CM diagnosis code Z85.3 was added to "ICD-10-CM Codes that Support Medical Necessity" section of the newly created billing and coding article

Effective date

This LCD 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 LCD revision related to CR 11406, CR 11412 and CR 11451 is effective for services rendered on or after October 1, 2019.

The LCD revision related to ICD-10-CM diagnosis code Z85.3 is effective for services rendered **on or after November 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, please [click here](#).

Genetic testing for lynch syndrome -- revision to the Part A and Part B LCD

LCD ID number: L34912 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 10901, the local coverage determination (LCD) for genetic testing for lynch syndrome 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. 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.

In addition, based on CR 11406, CR 11412 and CR 11451 (October 2019 Quarterly Updates), Current Procedural Terminology (CPT®) code 0130U was added to the newly created billing and coding article "CPT®/HCPCS Codes/ Group 1 Paragraph" section.

Effective date

This LCD 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 LCD revision related to CR 11406, CR 11412 and CR 11451 is effective for services rendered on or after October 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, please [click here](#).

Molecular pathology procedures -- revision to the Part A and Part B LCD

LCD ID number: L34519 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 10901, the local coverage determination (LCD) for molecular pathology procedures 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. 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 "Coverage Guidance" section of the LCD and instead, the IOM citation related to this language is referenced. In addition, based on CR 11406, CR 11412 and CR 11451 (October 2019

Quarterly Updates), Current Procedural Terminology (CPT®) codes 0111U, 0129U, and 0130U were added to the newly created billing and coding article.

Effective date

This LCD 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 LCD revision related to CR 11406, CR 11412 and CR 11451 is effective for services rendered on or after October 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, please [click here](#).

Ophthalmoscopy -- revision to the Part A and Part B LCD

LCD ID number: L34017 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 10901, the local coverage determination (LCD) for ophthalmoscopy 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.

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 Social Security Act, Code of

Federal Regulations, and the Internet Only Manual (IOM) reference sections were updated.

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](#).

Sinus x-ray(s) -- revision to the Part A and Part B LCD

LCD ID number: L33600 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 10901, the local coverage determination (LCD) for sinus x-ray(s) 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. 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 Social Security Act, Code of Federal Regulations, and Internet

Only Manual (IOM) reference sections were updated.

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](#).

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

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

Based on change request (CR) 10901, the local coverage determination (LCD) for polysomnography and sleep testing 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.

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 Centers for Medicare & Medicaid Services (CMS) Internet Only Manual (IOM) language has been removed from the LCD and instead, the IOM citation related to this language is referenced in the "CMS National Coverage Policy" section of the LCD.

In addition, the Social Security Act, Code of Federal Regulations, and IOM reference sections were updated.

Effective date

This LCD revision is effective for claims processed on

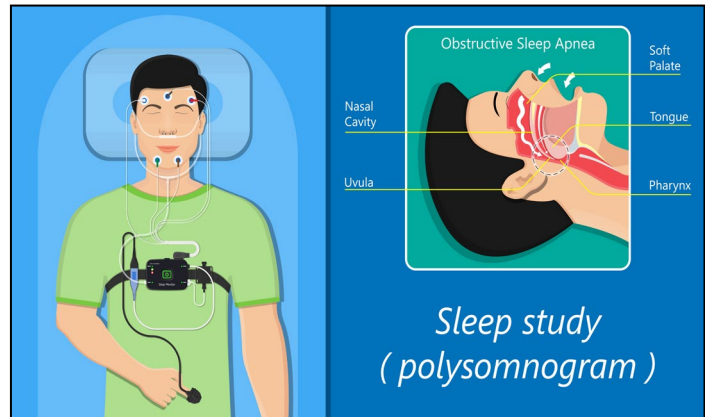
Psychiatric diagnostic evaluation and psychotherapy services -- revision to the Part A and Part B LCD

LCD ID number: L33252 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 10901, the local coverage determination (LCD) for psychiatric diagnostic evaluation and psychotherapy services 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.

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 Social Security Act, Code of Federal Regulations, and Internet Only Manual (IOM) reference sections were updated.



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](#).

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](#).

Erythropoiesis stimulating agents -- revision to the Part A and Part B LCD

LCD ID number: L36276 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on an internal correspondence inquiry, the local coverage determination (LCD) for erythropoiesis stimulating agents (ESA) was revised to update language related to the enrollment and compliance with the ESA APPRISE oncology program in the "Limitations" section of the LCD. Also, the "Sources of Information" section of the LCD was updated to include a published source from an internal correspondence inquiry.

In addition, based on change request (CR) 10901, the LCD 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. Furthermore, the Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual (IOM) language has been removed from the LCD and billing and coding article, and instead the IOM citations related to this language is referenced throughout the LCD and billing and coding article. Similarly, the Food and Drug Administration (FDA) language has been removed from the LCD and billing and coding article, and instead the FDA citation related to this language is referenced to the FDA approved product labels. Moreover, the LCD was revised to update the "CMS National Coverage Policy" section of the LCD to add additional CMS IOM citations and Social Security Act (Title XVIII) Standard References.

Additionally, Healthcare Common Procedure Coding System (HCPCS) codes J0882, J0887 and Q5105 were removed from the "Group 2 Codes" in the "CPT®/HCPCS Codes" section of the billing and coding article.

Also, the "ICD-10-CM Codes that are covered" section of the billing and coding article was updated for the following groups.

For Group 1 codes and Group 6 codes, ICD-10-CM diagnosis codes N18.1, N18.2, and N18.9 were removed.

For Group 2 codes and Group 4 codes the following ICD-10-CM diagnosis codes were removed: C00.2, C00.5, C00.9, C02.9, C03.9, C04.9, C05.9, C06.9, C08.9, C10.9, C11.9, C13.9, C14.0, C15.9, C16.9, C17.9, C18.9, C21.0, C24.9, C25.9, C26.0, C26.9, C31.9, C32.9, C34.00, C34.10, C34.30, C34.80, C34.90, C39.0, C39.9, C40.00, C40.10, C40.20, C40.30, C40.80, C40.90, C43.10, C43.20, C43.30, C43.60, C43.70, C43.9, C4A.10, C4A.20, C4A.30, C4A.60, C4A.70, C4A.9, C44.00, C44.101, C44.1021,

C44.1022, C44.1091, C44.1092, C44.111, C44.121, C44.131, C44.191, C44.201, C44.202, C44.209, C44.211, C44.221, C44.291, C44.300, C44.301, C44.309, C44.310, C44.320, C44.390, C44.40, C44.500, C44.501, C44.509, C44.601, C44.602, C44.609, C44.611, C44.621, C44.691, C44.701, C44.702, C44.709, C44.711, C44.721, C44.791, C44.80, C44.90, C44.91, C44.92, C44.99, C45.9, C46.50, C46.9, C47.10, C47.20, C47.6, C47.9, C48.2, C49.10, C49.20, C49.6, C49.9, C49.A0, C50.019, C50.029, C50.119, C50.129, C50.219, C50.229, C50.319, C50.329, C50.419, C50.429, C50.519, C50.529, C50.619, C50.629, C50.819, C50.829, C50.919, C50.929, C51.9, C53.9, C54.9, C55, C56.9, C57.00, C57.10, C57.20, C57.9, C60.9, C62.00, C62.10, C62.90, C62.91, C62.92, C63.00, C63.10, C63.9, C64.9, C65.9, C66.9, C67.9, C68.9, C69.00, C69.10, C69.20, C69.30, C69.40, C69.50, C69.60, C69.80, C69.90, C69.91, C69.92, C70.9, C71.9, C72.20, C72.30, C72.40, C72.50, C72.9, C74.00, C74.10, C74.90, C74.91, C74.92, C75.9, C7A.00, C7A.019, C7A.029, C7A.094, C7A.095, C7A.096, C7B.00, C76.40, C76.50, C77.9, C78.00, C78.30, C78.80, C79.00, C79.10, C79.40, C79.60, C79.70, C79.9, C80.1, C81.00, C81.10, C81.20, C81.30, C81.40, C81.70, C81.90, C82.00, C82.10, C82.20, C82.30, C82.40, C82.50, C82.60, C82.80, C82.90, C83.00, C83.10, C83.30, C83.50, C83.70, C83.80, C83.90, C84.00, C84.10, C84.40, C84.60, C84.70, C84.A0, C84.Z0, C84.90, C85.10, C85.20, C85.80, C85.90, C88.9, C90.01, C90.11, C90.21, C90.31, C91.01, C91.11, C91.31, C91.41, C91.51, C91.61, C91.A1, C91.Z1, C91.91, D00.00, D01.40, D01.9, D02.20, D02.4, D03.10, D03.20, D03.30, D03.60, D03.70, D03.9, D04.10, D04.20, D04.30, D04.60, D04.70, D04.9, D05.00, D05.10, D05.80, D05.90, D06.9, D07.30, D07.60, D09.10, D09.20, D09.9, D37.9, D38.6, D39.10, D39.9, D40.10, D40.9, D41.00, D41.10, D41.20, D41.9, D42.9, D43.9, D44.10, D44.9, D45, D48.60, D48.9, D49.519, D49.9, and Q85.00.

For Group 3 codes the following ICD-10-CM diagnosis code were added: B97.35, M05.611, M05.612, M05.621, M05.622, M05.631, M05.632, M05.641, M05.642, M05.651, M01.652, M05.661, M05.662, M05.671, M05.672, and M05.69 and the following ICD-10-CM diagnosis codes were removed: M05.40, M05.419, M05.429, M05.439, M05.449, M05.459, M05.469, M05.479, M05.50, M05.519, M05.529, M05.539, M05.549, M05.559, M05.569, M05.579, M05.70, M05.719, M05.729, M05.739, M05.749, M05.759, M05.769, M05.779, M05.80, M05.819, M05.829, M05.839, M05.849, M05.859, M05.869, M05.879, M05.9, M06.00, M06.019, M06.029, M06.039, M06.049, M06.059, M06.069, M06.079, M06.20, M06.219, M06.229, M06.239, M06.249, M06.259, M06.269, M06.279, M06.30, M06.319, M06.329, M06.339, M06.349, M06.359, M06.369, M06.379, M06.80, M06.819, M06.829, M06.839, M06.849, M06.859, M06.869, M06.879, M06.9, N18.1, N18.2, and N18.9.

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ERYTHROPOIESIS

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Effective date

The revision related to the internal correspondence inquiry is effective for claims processed **on or after October 29, 2019**, for services rendered **on or after April 13, 2017**.

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 removal of HCPCS codes J0882, J0887, and Q5105 is effective for claims processed **on or after October 29, 2019**. The addition and removal of ICD-10 CM diagnosis codes is effective

for services rendered **on or after October 29, 2019**.

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

A 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](#).

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

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

Based on change request (CR) 10901, the local coverage determination (LCD) for allergy testing 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, the Social Security Act, Code of Federal Regulations, and Internet Only Manual (IOM) reference sections were updated.

Also, after review of the information that was moved from the LCD to the billing and coding article, the following revisions were made: Current Procedural Terminology (CPT®) codes 86343, 95831, 95832, 95833, and 95834 were removed as they are already included in First Coast Service Options noncovered services LCD and do not apply to this LCD and CPT codes 83516, 84600, 86140, 86628, 88341, 88342, 88344, and 88346 were removed as they do not apply to this LCD. In addition, ICD-10-

CM codes T63.001A-T63.414S, T63.431A-T63.434S, T63.481A-T63.94XS were removed from the "ICD-10-CM Codes that Support Medical Necessity/Group 1 Codes and Group 2 Codes" sections of the billing and coding article as they do not apply to this LCD. Furthermore, CPT codes 86001, 86332, 86485, and 95065 were added to the "ICD-10-CM Codes that Do Not Support Medical Necessity/Group 1 Paragraph" section of the billing and coding article as the allergy testing limitations apply to these CPT codes.

Effective date

The LCD 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 billing and coding article revision is effective for services rendered **on or after November 19, 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](#).

Syphilis test -- revision to the Part A and Part B LCD

LCD ID number: L33754 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 10901, the local coverage determination (LCD) for syphilis test 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. 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 Social Security Act, Code of Federal Regulations, and Internet Only Manual (IOM)

reference sections were updated.

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](#).

Surgical decompression for peripheral polyneuropathy -- revision to the Part A and Part B LCD

LCD ID number: L34025 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 10901, the local coverage determination (LCD) for surgical decompression for peripheral polyneuropathy 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 DO NOT 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, the Social Security Act and Internet Only Manual (IOM) reference sections were updated.

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](#).

Bisphosphonates (intravenous [IV]) and monoclonal antibodies in the treatment of osteoporosis and their other indications -- revision to the Part A and Part B LCD

LCD ID number: L33270 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 10901, the local coverage determination (LCD) bisphosphonates (intravenous [IV]) and monoclonal antibodies in the treatment of osteoporosis and their other indications 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 Centers for Medicare & Medicaid (CMS) IOM language has been removed from the LCD and instead, the IOM citation related to this language is referenced in the “CMS National Coverage Policy,” “Covered Indications,” and “Limitations” sections of the LCD. In addition, the Social Security Act and IOM reference sections were updated.

Also, after review of the information that was moved from the LCD to the billing and coding article the language/”Z” ICD-10-CM diagnosis codes in the “ICD-10-CM Codes that Support Medical Necessity” section of the billing and coding article related to the triple diagnosis requirement for treatment of bone loss in women/men at high risk for fracture has been removed.

Effective date

The LCD 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 billing and coding article revision is effective for services rendered **on or after October 15, 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](#).

Additional Information

Frequency of hemodialysis -- revision to Part A and Part B billing and coding Article

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

The Local Coverage Article A56666 Billing and Coding: Frequency of Hemodialysis for the local coverage determination (LCD) for frequency of hemodialysis was revised and published October 3, 2019. This version was created in collaboration with the All Medicare Administrative Contactor (MAC) End-Stage Renal Disease (ESRD) workgroup. Some of the verbiage in the article text has been revised for clarification. There will not be a lapse in coverage and there has been no change to the coverage content of the LCD.

Effective date

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

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

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

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

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

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

The following drugs have been added to the Medicare administrative contractor (MAC) Jurisdiction N (JN) self-administered drug (SAD) list: Actemra® (tocilizumab) subcutaneous (J3262), Aimovig® (erenumab-aooe) (C9399/J3490/J3590), Ajovy™ (fremanezumab-vfrm) (J3031), Benlysta® (belimumab) subcutaneous (J0490), Cyltezo™ (adalimumab-adbm) (C9399/J3490/J3590), Emgality® (galcanezumab-gnlm) (C9399/J3490/J3590), Kevzara® (sarilumab) (C9399/J3490/J3590), LANTUS SoloStar® (insulin glargine injection) (C9399/J3490/J3590), Ozempic® (semaglutide) (C9399/J3490/J3590), Takhzyro® (lanadelumab-flyo) (J0593) and Tymlos™ (abaloparatide) (C9399/J3490/J3590).

In addition, a "Route of Administration Modifier" section

has been added for drugs that have multiple routes of administration. The JB modifier must be billed when the subcutaneous form of the drug is administered. Drugs that require the JB modifier have been listed with an asterisk in the coding table. The following drugs require the JB modifier when the subcutaneous form of the drug is administered: Actemra® (J3262), Benlysta® (J0490), Orenzia® (J0129), and Sandostatin® (J2354).

Also, "subcutaneous" has been added to the descriptor for Sandostatin® (J2354) and HAEGARDA® (J0599) and any typographical errors that were identified have been corrected.

Furthermore, the unlisted Healthcare Common Procedure Coding System (HCPCS) codes (C9399, J3490, and J3590) have been removed and replaced with HCPCS code J0129 for Orenzia®.

Effective date

This article revision is effective for **services rendered on or after December 2, 2019**.

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

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

Upcoming provider outreach and educational events

Medicare secondary payer: MSP billing options (B)

Date: November 13

Time: 11:30 a.m.-1:00 p.m. ET

Type of Event: Webcast

[View our complete calendar of events](#)

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](#) 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.



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, September 26, 2019

MLN Connects[®] for Thursday, September 26, 2019

[View this edition as a PDF](#)

News

- New Medicare Card: More Questions about Using the MBI?
- Quality Payment Program: Submit Comments on 2020 Proposed Rule by September 27
- SNF PPS Patient Driven Payment Model: Get Ready for Implementation on October 1
- 2019 QRDA I Implementation Guide and Sample File for Hospital Quality Reporting: Updated
- Post-Acute Care and Hospice Utilization and Payment Public Use Files
- Clinical Diagnostic Laboratories: Resources about the Private Payor Rate-Based CLFS
- Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier
- Hospice Quality Reporting Program Quarterly Updates
- National Cholesterol Education Month and World Heart Day

Compliance

- DME Proof of Delivery Documentation Requirements

Claims, Pricers & Codes

- Medicare Diabetes Prevention Program: Valid Claims

Events

- IRF/LTCH: Reporting Health Care Personnel Influenza Vaccination Data Webinars — October 1, 3, or 9

MLN Matters[®] Articles

- Quarterly Update for the Temporary Gap Period of the Durable Medical Equipment, Prosthetics, Orthotics,

and Supplies (DMEPOS) Competitive Bidding Program (CBP) - January 2020

- October 2019 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files — Revised
- Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes – October 2019 Update — Revised

Publications

- Quality Payment Program: Resources for Clinicians New to the Program in 2019
- Medicare Enrollment for Physicians and Other Part B Suppliers — Reminder
- Medicare Preventive Services Poster — Reminder
- Safeguard Your Identity and Privacy Using PECOS — Reminder

Multimedia

- Quality Payment Program: All-Payer Combination Option in 2019 Web-Based Training Course
- Quality Payment Program Merit-based Incentive Payment System (MIPS): Promoting Interoperability Performance Category in 2019 Web-Based Training Course
- Dementia Care Call: Audio Recording and Transcript
- Quality Payment Program for Advanced APMs in 2019 Web-Based Training Course — Revised
- Quality Payment Program Merit-based Incentive Payment System (MIPS): Participation in 2019 Web-Based Training Course — Revised
- Transitioning to an Advanced APM: 2019 Update Web-Based Training Course — Revised

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MLN Connects® – Special Edition for September 26, 2019

Omnibus Burden Reduction (Conditions of Participation) Final Rule

On September 26, CMS took action at President Trump's direction to "cut the red tape," by reducing unnecessary burden for American's health care providers allowing them to focus on their priority – patients.

The Omnibus Burden Reduction (Conditions of Participation) Final Rule removes Medicare regulations identified as unnecessary, obsolete, or excessively burdensome on hospitals and other health care providers to reduce inefficiencies and moves the nation closer to a health care system that delivers value, high quality care and better outcomes for patients at the lowest possible cost.

This rule advances the Patients over Paperwork initiative by saving providers an estimated 4.4 million hours of time previously spent on paperwork with an overall total projected savings to providers of \$800 million annually.

This rule finalizes the provisions of three proposed rules

- Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction ("Omnibus Burden reduction"), published September 20, 2018
- Hospital and Critical Access Hospital (CAH) Changes to Promote Innovation, Flexibility, and Improvement in Patient Care, published June 16, 2016
- Fire Safety Requirements for Certain Dialysis Facilities, published November 4, 2016

For more information:

- [Final Rule](#)
- [Press Release](#)

See the full text of this excerpted [CMS Fact Sheet](#) (issued September 26).

Discharge Planning Rule Supports Interoperability and Patient Preferences

On September 26, CMS issued a final rule that empowers patients preparing to move from acute care into Post-Acute Care (PAC), a process called discharge planning. The rule puts patients in the driver's seat of their care transitions and improves quality by requiring hospitals to provide patients access to information about PAC provider choices, including performance on important quality measures and resource-use measures, including:

- Number of pressure ulcers
- Proportion of falls that lead to injury
- Number of readmissions back to the hospital

The rule also:

- Advances CMS's interoperability efforts by requiring the seamless exchange of patient information between health care settings, and ensuring that a patient's health care information follows them after discharge from a hospital or PAC provider.
- Revises the discharge planning requirements that hospitals (including long-term care hospitals, Critical Access Hospitals (CAHs) psychiatric hospitals, children's hospitals, and cancer hospitals), inpatient rehabilitation facilities, and home health agencies must meet to participate in Medicare and Medicaid programs. It requires the discharge planning process to focus on a patient's goals and treatment preferences. Hospitals are mandated to ensure each patient's right to access their medical records in an electronic format.
- Implements requirements from the Improving Medicare Post-Acute Care Transformation Act of 2014 (*IMPACT Act*) that includes how facilities will account for and document a patient's goals of care and treatment preferences.

Hospitals and CAHs are already conducting most of the revised discharge planning requirements, with the exception of the discharge planning requirements of the IMPACT Act.

MLN Connects® – Special Edition for September 30, 2019

New HCPCS Code J0642 for levoleucovorin Injection

For dates of service on or after October 1, use HCPCS code J0642 for levoleucovorin injection products marketed under the brand name of Khapzory.

MLN Connects® for Thursday, October 3, 2019

MLN Connects® for Thursday, October 3, 2019

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News

- New Medicare Card: Do You Refer Patients?
- Opioid Treatment Programs: Get Ready to Participate in the New Benefit
- Home Health Preview Reports for January 2020 Refresh
- LTCH Provider Preview Reports: Review Your Data by October 11
- IRF Provider Preview Reports: Review Your Data by October 11
- Hospice Provider Preview Reports: Review Your Data by October 11
- CLFS CY 2020 Preliminary Payment Determinations: Comment by October 27
- MIPS: Virtual Group Election Period Open Through December 31
- LTCH Compare Refresh
- IRF Compare Refresh
- Qualified Medicare Beneficiary Billing Requirements
- Ostomies are Life-Savers
- Looking for Educational Materials?

Compliance

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

MLN Matters® Articles

- Changes to the Laboratory National Coverage Determination (NCD) Edit Software for January 2020
- January 2020 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files
- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs) - January 2020 Update — Revised

Publications

- Quality Payment Program: 2019 APM Incentive Payment Fact Sheet
- Billing Information for Rural Providers and Suppliers — Revised

Multimedia

- Reducing Opioid Misuse Listening Session: Audio Recording and Transcript
- SNF PPS: Patient Driven Payment Model Videos

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MLN Connects® – Special Edition for October 9, 2019

Modernizing and Clarifying the Physician Self-Referral Regulations Proposed Rule

On October 9, CMS issued a proposed rule to modernize and clarify the regulations that interpret the Medicare physician self-referral law (often called the “Stark Law”), which has not been significantly updated since it was enacted in 1989.

The proposed rule supports the CMS “Patients over Paperwork” initiative by reducing unnecessary regulatory burden on physicians and other health care providers while reinforcing the Stark Law’s goal of protecting patients from unnecessary services and being steered to less convenient, lower quality, or more expensive services because of a physician’s financial self-interest.

Through the Patients over Paperwork initiative, the proposed rule opens additional avenues for physicians and other health care providers to coordinate the care of the patients they serve – allowing providers across different health care settings to work together to ensure patients receive the highest quality of care.

For more information:

- [Proposed Rule](#) Public comments due by December 31
- [Press Release](#)

See the full text of this excerpted [CMS Fact Sheet](#) (issued October 9).

MLN Connects® for Thursday, October 10, 2019

MLN Connects® for Thursday, October 10, 2019

[View this edition as a PDF](#) 

News

- New Medicare Card: 80% of Claims Submitted with MBI
- Nursing Homes: Enhancing Transparency about Abuse and Neglect
- Quality Payment Program: MIPS Dates and Deadlines
- October is National Breast Cancer Awareness Month

Compliance

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

Claims, Pricers & Codes

- FY 2020 IPPS and LTCH PPS Claims Hold

Events

- Submitting Your Medicare Part A Cost Report Electronically Webcast — November 5

MLN Matters® Articles

- Ambulance Inflation Factor for Calendar Year (CY) 2020 and Productivity Adjustment
- Provider Enrollment Rebuttal Process
- Implementation of the Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM) — Revised

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

Publications

- Medicare Preventive Services — Revised
- Medicare Enrollment for Providers Who Solely Order or Certify — Reminder
- Medicare Fraud & Abuse Poster — Reminder
- Medicare Fraud & Abuse: Prevent, Detect, Report — Reminder
- Medicare Overpayments — Reminder
- PECOS for DMEPOS Suppliers — Reminder
- PECOS for Physicians and NPPs — Reminder
- PECOS for Provider and Supplier Organizations — Reminder

Multimedia

- Opioid Treatment Program Listening Session: Audio Recording and Transcript

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Medicare Learning Network®

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

MLN Connects® for Thursday, October 17, 2019

MLN Connects® for Thursday, October 17, 2019

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News

- New Medicare Card: MBI Transition Ends in Less Than 10 Weeks
- Guide for Appropriate Tapering or Discontinuation of Long-Term Opioid Use
- ICD-10 Coordination and Maintenance: Deadline for Comments November 8
- CMS Health Equity Award: Submit Nomination by November 15
- Quality Payment Program: Participation Status Tool Includes Second Snapshot of Data
- Atherectomy: Comparative Billing Report in October
- Protect Your Patients from Influenza this Season

Compliance

- Cardiac Device Credits: Medicare Billing

Events

- Submitting Your Medicare Part A Cost Report Electronically Webcast — November 5
- Atherectomy: Comparative Billing Report Webinar — November 6
- Provider Compliance Focus Group Meeting — November 12

MLN Matters® Articles

- Add Dates of Service (DOS) for Pneumococcal Pneumonia Vaccination (PPV) Health Care Procedure Code System (HCPCS) Codes (90670, 90732), and Remove Next Eligible Dates for PPV HCPCS

- Fiscal Year (FY) 2020 Inpatient Prospective Payment System (IPPS) and Long Term Care Hospital (LTCH) PPS Changes
- Home Health Orders for Nurse Practitioners under the Maryland Total Cost of Care (TCOC) Model
- Implementation of the Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM) — Revised
- October 2019 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files — Revised
- October 2019 Update of the Ambulatory Surgical Center (ASC) Payment System — Revised
- October 2019 Update of the Hospital Outpatient Prospective Payment System (OPPS) — Revised

Publications

- Quality Payment Program: MIPS and APM Resources
- Roster Billing for Mass Immunizers — Revised
- Acute Care Inpatient Hospital Prospective Payment System — Reminder
- Hospice Payment System — Reminder
- Hospital Outpatient Prospective Payment System — Reminder
- Inpatient Psychiatric Facility Prospective Payment System — Reminder
- Inpatient Rehabilitation Facility Prospective Payment System — Reminder
- Long-Term Care Hospital Prospective Payment System — Reminder
- Telehealth Services — Reminder

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Phone numbers

Provider Contact 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
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
EDOC-CS-FLINQB@fcsso.com
[Online form](#)

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
medical.policy@fcsso.com

Medicare secondary payer

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

Electronic data interchange (EDI)

Medicare EDI
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
elarning@fcsso.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
Find your [other contractors](#) (e.g. DME, HHA, etc)

[Centers for Medicare & Medicaid Services](#)

E-learning Center
[First Coast University](#)

Beneficiaries

Centers for Medicare & Medicaid Services
medicare.gov

Phone numbers

Provider Contact 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

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Provider enrollment

888-845-8614

877-660-1759 (TTY)

FAX: 904-361-0737

The SPOT help desk

855-416-4199

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 EDOC-CS-FLINQB@fcsso.com

EDOC-CS-FLINQB@fcsso.com

[Online form](#)

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

medical.policy@fcsso.com

Medicare secondary payer

Medicare Part B Secondary Payer Dept.

P.O. Box 44078

Jacksonville, FL 32231-4078

Electronic data interchange (EDI)

Medicare EDI, 4C

P.O. Box 44071

Jacksonville, FL 32231-4071

Overpayments

Medicare Part B Debt Recovery

P.O. Box 45013

Jacksonville, FL 32232-5013

Medicare Education and Outreach

FAX: 904-361-0407

elearning@fcsso.com

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

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[Centers for Medicare & Medicaid Services](#)

E-learning Center

[First Coast University](#)

Beneficiaries

Centers for Medicare & Medicaid Services

medicare.gov

Phone numbers

Provider Contact Center

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

Electronic data interchange (EDI)

888-875-9779

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
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 45036
Jacksonville, FL 32232-5036

EDOC-CS-PRINQB@fcso.com

[Online form](#)

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
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 45040
Jacksonville, FL 32231-5040

Medicare Education and Outreach

FAX: 904-361-0407
elarning@fcso.com

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

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

[Centers for Medicare & Medicaid Services](#)

E-learning Center
[First Coast University](#)

Beneficiaries

Centers for Medicare & Medicaid Services
medicare.gov

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Note: Payment for fee schedules cannot be combined with payment for other items; separate payments are required for purchases of items from different accounts.

Item	Acct Number	Cost per item	Quantity	Total cost
Part B subscription – The Medicare Part B jurisdiction N publications, are available free of charge online in <i>English</i> or <i>Spanish</i> . Nonprovider entities or providers who need additional copies may purchase an annual subscription. This subscription includes all issues published from October 2019 through September 2020.	40300260	\$33		
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 in <i>English</i> or <i>Spanish</i> . Additional copies are available for purchase. The fee schedules contain payment rates for all localities. These items do not include the payment rates for injectable drugs, clinical lab services, mammography screening, or DMEPOS items. Note: Requests for hard copy paper disclosures will be completed as soon as CMS provides the direction to do so. Revisions to fees may occur; these revisions will be published in future editions of the Medicare Part B publication.	40300270	\$12		
Language preference: English [] Español []				
<i>Please write legibly</i>			Subtotal	\$
			Tax (<i>add % for your area</i>)	\$
			Total	\$

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