Medicare B CONNECTION
medicare.fcso.com
FIRST COAST SERVICE OPTIONS, INC.
A Newsletter for MAC Jurisdiction N Providers
November 2019

In this issue

MLN Connects® – Special Edition for November 4, 2019

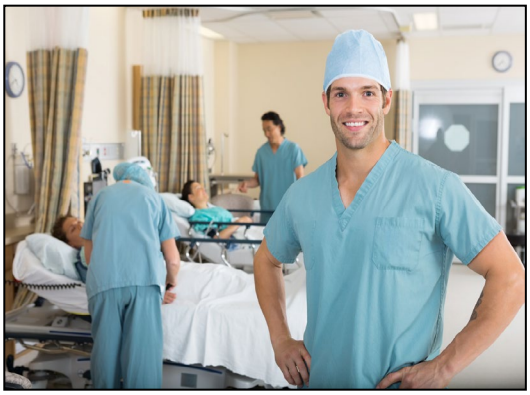
Physician Fee Schedule and OPPS/ASC Final Rules Call — November 6

Wednesday, November 6 from 2:15 to 3:45 pm ET

Register for Medicare Learning Network events.

During this call, learn about the provisions in two CMS CY 2020 final rules:

- Physician Fee Schedule and Quality Payment Program: *Final Rule*, *Press Release*, *Physician Fee Schedule Fact Sheet*, and *Quality Payment Program Fact Sheet*
- Medicare Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) payment systems: *Final Rule* and *Fact Sheet*



Changes to the 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. Topics include:

- Payment and supervision policy updates
- Merit-based Incentive Payment System Value Pathways: Streamlining the Quality Payment Program to reduce clinician burden
- Creating the new Opioid Treatment Program benefit in response to the opioid epidemic

In addition, updates and policy changes under the Medicare OPPS and ASC payment systems lay the foundation for a patient-driven health care system.

A question and answer session follows the presentation. We encourage you to review the final rules prior to the call.

Target Audience: Medicare Part B fee-for-service clinicians; office managers and administrators; state and national associations that represent health care providers; all hospitals operating in the United States; and other stakeholders.

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*. 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*.

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.

Appeals

Changes to amount in controversy (AIC) for appeals in 2020

The amount that must remain in controversy for Administrative Law Judge (ALJ) hearing requests (third-level appeal) filed on or before December 31, 2019, is $160. This amount will increase to $170 for ALJ hearing requests filed on or after January 1, 2020.

The amount that must remain in controversy for reviews in Federal District Court (fifth-level appeal) requested on or before December 31, 2019, is $1,630. This amount will increase to $1,670 for appeals to Federal District Court filed on or after January 1, 2020.

Fee News

2020 Medicare physician fee schedule payment rates and participation program

The annual physician and supplier participation period begins January 1 of each year, and runs through December 31. The annual participation enrollment is scheduled to begin mid-November of each year.

The 2020 Medicare physician fee schedule (MPFS) payment rates have been posted to First Coast Service Options' Medicare Provider website as publication of the MPFS final rule has been put in display in the Federal Register.

Source: Publication 100-04, Chapter 1, Section 30.3.12.1 (B2)

Processing Issue

Ambulance claims denied by common working file (CWF) skilled nursing facility (SNF) consolidated billing (CB) edit 7275

Issue

CWF SNF CB edit 7275 is denying Part B ambulance claims inappropriately. This is occurring when the beneficiary is in a covered Part A SNF stay but requires a Part B covered transport for emergency services and when the transport claim is billed with Healthcare Common Procedure Coding System (HCPCS) code A0427, A0429, or A0433.

Resolution

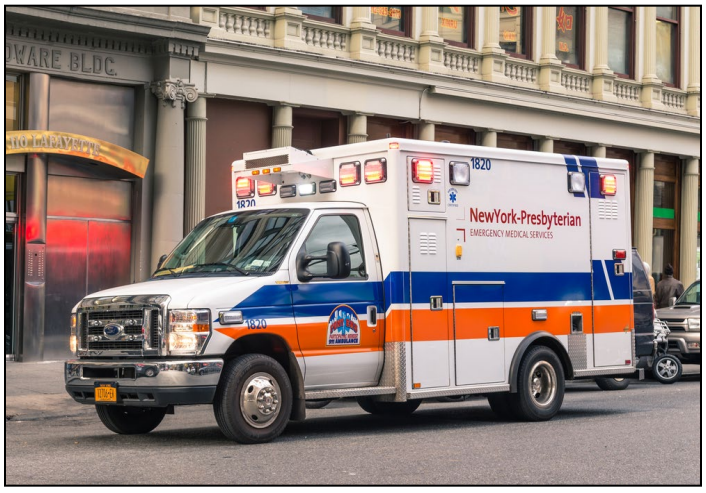
Medicare administrative contractors (MACs) will manually bypass the CWF SNF CB 7275 for incoming ambulance transportation claims containing HCPCS code A0427, A0429, or A0433 billed with or without A0425.

Status/date resolved

Open.

Provider action

None; however, MACs will reprocess claims brought to their attention that were denied in error.



Current processing issues

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

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* 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 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* helps you find the coverage information you need quickly and easily. Just enter a procedure code, keyword, or the LCD's "L number," click the corresponding button, and the application will automatically display links to any LCDs applicable to the parameters you specified. Best of all, depending upon the speed of your internet connection, the LCD search process can be completed in less than 10 seconds.

Advance beneficiary notice

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

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

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

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

Your Feedback Matters

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

New LCDs

Endovenous stenting – new Part A and Part B LCD

LCD ID number: L38231 (Florida/Puerto Rico/ U.S. Virgin Islands)

This new local coverage determination (LCD) addresses "Coverage Indications, Limitations, and/or Medical Necessity," "Place of Service," and "Provider Qualifications" requirements for endovenous stenting. The central focus is on the indications for placement of endovenous stents in severely symptomatic obstructions. Also, the related Billing and Coding article (A56644) addresses coding guidelines in support of the reasonable and necessary services as outlined in the LCD.

Effective date

This new LCD is effective for services rendered **on or after December 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 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*.

Gastrointestinal pathogen (GIP) panels utilizing multiplex nucleic acid amplification techniques (NAATs) – new Part A and Part B LCD

LCD ID number: L38227 (Florida/Puerto Rico/ U.S. Virgin Islands)

This new local coverage determination (LCD) addresses "Coverage Indications, Limitations, and/or Medical Necessity," and "Provider Qualifications" requirements for gastrointestinal pathogen (GIP) panels utilizing multiplex nucleic acid amplification techniques (NAATs) panels, for the evaluation of Medicare beneficiaries with acute or persistent diarrhea, paralytic ileus or persistent diarrhea with an immunocompromising medical condition. Also, the related Billing and Coding article (A56638) addresses coding guidelines in support of the reasonable and necessary services as outlined in the LCD.

Effective date

This new LCD is effective for services rendered **on or after December 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 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*.

Micro-invasive glaucoma surgery (MIGS) – new Part A and Part B LCD

LCD ID number: L38233 (Florida/Puerto Rico/ U.S. Virgin Islands)

This new local coverage determination (LCD) addresses "Coverage Indications, Limitations, and/or Medical Necessity," and "Provider Qualifications" requirements for micro-invasive glaucoma surgery (MIGS) and corresponding available U.S. Food and Drug Administration (FDA) approved glaucoma drainage devices, for the treatment of Medicare beneficiaries with mild or moderate open-angle glaucoma. Also, the related Billing and Coding article (A56647) addresses coding guidelines in support of the reasonable and necessary services as outlined in the LCD.

Effective date

This new LCD is effective for services rendered **on or after December 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 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.

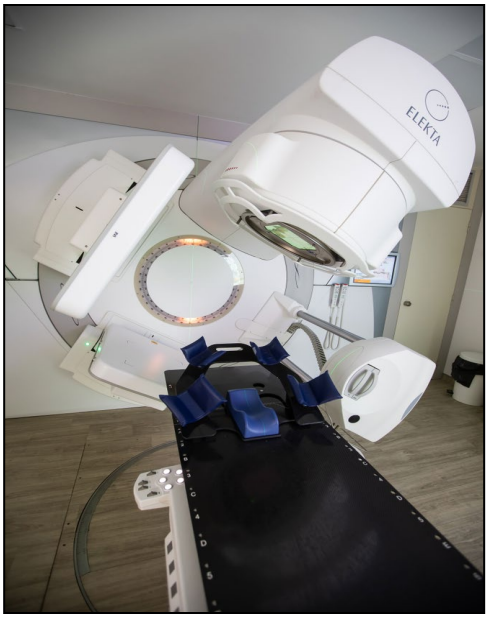
Note: To review active, future and retired LCDs, please *click here*.

Revisions to LCDs

Proton beam radiotherapy – revision to the Part B LCD

LCD ID number: L33937 (Florida/Puerto Rico/ U.S. Virgin Islands)

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



Also, based on review of the newly created billing and coding article, the following ICD-10-CM diagnosis code was added to the "ICD-10 Codes that Support Medical Necessity/Group 1 Codes" section: D43.3. The following ICD-10-CM diagnosis codes were removed from the "ICD-10 Codes that Support Medical Necessity/ Group 1 Codes" section: C40.00, C40.01, C40.02, C40.10, C40.11, C40.12, C40.20, C40.21, C40.22, C40.30, C40.31, C40.32, C40.80, C40.81, C40.82, C40.90, C40.91, C40.92, C41.9, C47.0, C47.10, C47.11, C47.12, C47.20, C47.21, C47.22, C47.3, C47.4, C47.5, C47.6, C47.8, C47.9, C49.0, C49.10, C49.11, C49.12, C49.20, C49.21, C49.22, C49.3, C49.4, C49.5, C49.6, C49.8, C49.9, C64.1, C64.2, C64.9, C69.00, C69.01, C69.02, C69.10, C69.11, C69.12, C69.20, C69.30, C69.40, C69.50, C69.51, C69.52, C69.60, C69.80, C69.90, C69.91, C69.92, C70.9, C71.9, C72.20, C72.30, C72.40, C72.50, C72.9, D32.9, D33.2, D42.9, and D43.2. The following ICD-10-CM diagnosis codes were added to the "ICD-10 Codes that Support Medical Necessity/ Group 2 Codes" section: C02.0, C02.1, C02.2, C02.4, C02.8, C14.8, C15.5, C16.0, C16.1, C16.2, C16.3, C16.4, C16.8, C26.1, C40.01, C40.02, C40.11, C40.12, C40.21, C40.22, C40.31, C40.32, C40.81, C40.82, C47.0, C47.11, C47.12, C47.21, C47.22, C47.3, C47.4, C47.5, C49.0, C49.11, C49.12, C49.21, C49.22, C49.3, C49.4, C49.5, C49.8, C50.022, C50.122, C50.222, C50.322, C50.422, C50.522, C50.622, C50.812, C50.822, C54.0, C54.1, C54.2, C54.3, C54.8, C57.01, C57.02, C57.11, C57.12, C57.21, C57.22, C57.3, C57.7, C57.8, C74.01, C74.02, C74.11, C74.12, C7A.026, C7A.090, C7B.02, C79.49, C79.71, and C79.72. The following ICD-10-CM diagnosis codes were removed from the "ICD-10 Codes that Support Medical Necessity/Group 2 Codes" section: C04.9, C05.9, C06.80, C06.9, C10.9, C11.9, C13.9, C14.0, C21.0, C25.9, C31.9, C32.9, C34.00, C34.10, C34.30, C34.80, C34.90, C34.91, C34.92, 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, C50.011, C50.019, C50.111, C50.119, C50.211, C50.219, C50.311, C50.319, C50.411, C50.419, C50.511, C50.519, C50.611, C50.619, C56.9, C67.9, C76.1, C76.2 and C78.00.

In addition, the following ICD-10-CM diagnosis codes under the "ICD-10 Codes that Support Medical Necessity/ Group 2 Codes" section of the billing and coding article now require a dual diagnosis: ICD-10-CM diagnosis code C44.01, C44.02, C44.09, C44.1121, C44.1122, C44.1191, C44.1192, C44.1221, C44.1222, C44.1291, C44.1292, C44.1321, C44.1322, C44.1391, C44.1392, C44.1921, C44.1922, C44.1991, C44.1992, C44.212, C44.219, C44.222, C44.229, C44.292, C44.299, C44.311, C44.319, C44.321, C44.329, C44.391, C44.399, C44.41, C44.42, C44.49, C44.510, C44.511, C44.519, C44.520, C44.521, C44.529, C44.590, C44.591, C44.599, C44.612, C44.619, C44.622, C44.629, C44.692, C44.699, C44.712, C44.719, C44.722, C44.729, C44.792, C44.799, C44.81, C44.82 and C44.89 must be billed with ICD-10-CM diagnosis code C79.49.

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 revision related to the addition/deletion of ICD-10-CM diagnosis codes and dual diagnosis requirement is effective for services rendered **on or after December 16, 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*.

Noncovered services – revision to the Part A and Part B LCD

LCD ID number: L33777 (Florida/Puerto Rico/ U.S. Virgin Islands)

Based on Change Request (CR) 10901, the local coverage determination (LCD) for noncovered services 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 local coverage billing and coding article (A57743). Also, the current related Coding Guidelines Local Coverage Article (A54675) is being retired and the information within this article is being included in a separate newly created national noncovered services billing and coding article (A57742). In addition, the Social Security Act and Internet Only Manual (IOM) reference sections were updated.

Based on review of the newly created local coverage billing and coding article, Current Procedural Terminology (CPT®) code 64999 (Blood Brain Barrier Disruption [BBBD]) was removed as it is included in a newly created national noncovered services article. In addition, CPT® code 97799 (Vertebral Axial Decompression/Intervertebral Differential Dynamics) was removed from the newly created local coverage billing and coding article. Also, based on review of the newly created national noncovered services billing and coding article, the following CPT®/ HCPCS codes were removed: A9155 (Artificial saliva), E1399 (Pelvic floor stimulator), J3490-GY (Rebetron), V2799 (Investigational IOLs in FDA Core Study or Modified Core Study), 15775, 15776, 22526, 22527, 95199-GY (Repository antigen), and 99199 (Indirect calorimetry used to assess nutritional status as a respiratory therapy). Furthermore, modifier GY was added to Healthcare Common Procdure Coding System (HCPCS) code G0283.

Also, based on review of the newly created National Noncovered Services Billing and Coding Article, CPT codes 56805 and 57335 were removed.

Effective date

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

The revisions related to the newly created local and national noncovered services articles are effective for services rendered **on or after November 27, 2019**.

The revision related to CPT® codes 56805 and 57335 is effective for services rendered **on or after May 30, 2014**.

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*.

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

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

Based on change request (CR) 10901, the treatment of varicose veins of the lower extremity 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. In addition, the Social Security Act and Internet Only Manual (IOM) reference sections were updated.

Also, based on review of the newly created billing and coding article, the following ICD-10-CM diagnosis codes that did not support medically reasonable and necessary coverage as outlined in the LCD were deleted from "ICD-10 Codes that Support Medical Necessity/Group 1 Codes": I80.11, I80.12, I80.13, I80.221, I80.222, I80.223, I80.231, I80.232, I80.233, I80.291, I80.292, I80.293, and I80.3.

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 the removal of ICD-10-CM diagnosis codes is effective for services rendered **on or after November 27, 2019.**

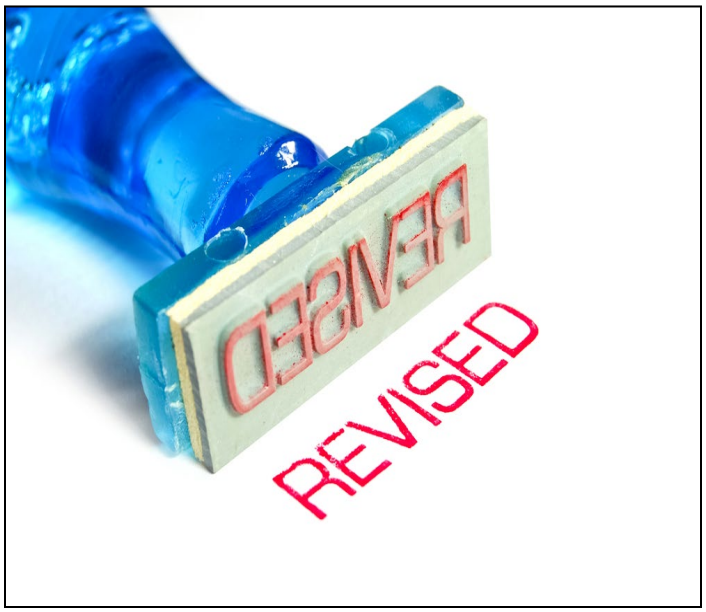
LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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*.

Multiple LCD revisions – Part A and Part B

Based on change request (CR) 10901, the following local coverage determinations (LCDs) were 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, those that had ICD-10-CM diagnosis code ranges were broken out and listed individually. In addition, the Social Security Act, Code of Federal Regulations, and/or the Internet Only Manual (IOM) reference sections were updated. Also, language contained in LCDs from the Centers for Medicare & Medicaid Services (CMS) IOM and/or regulations was removed and instead the applicable manual/regulation reference was listed. Furthermore, brand names included in LCDs were removed and the indications and dosing information was replaced with the Food and Drug Administration (FDA) label reference.



Part A/B Combined LCDs

- L36237 Amniotic Membrane- Sutureless Placement on the Ocular Surface
- L36377 Application of Skin Substitute Grafts for Treatment of DFU and VLU of Lower Extremities
- L33609 Autonomic Function Tests
- L33615 Biofeedback
- L33271 Biventricular Pacing/ Cardiac Resynchronization Therapy
- L33274 Botulinum Toxins
- L33267 B-Type Natriuretic Peptide (BNP)
- L36617 Chiropractic Services
- L33283 Computed Tomographic Colonography
- L35698 CYP2C19, CYP2D6, CYP2C9, and VKORC1 Genetic Testing
- L37561 Cystatin C Measurement
- L36232 Diagnostic Evaluation and Medical Management of Moderate-Severe Dry Eye Disease (DED)
- L33674 Duplex Scanning
- L34043 Dysphagia/Swallowing Diagnosis and Therapy
- L37398 Electroretinography (ERG)
- L37697 Emergency and Non-Emergency Ground Ambulance Services
- L36230 Evaluation and Management Services in a Nursing Facility
- L33661 Flow Cytometry
- L33997 Fluorescein Angiography
- L34002 G-CSF Filgrastim
- L33586 Gene Expression Profiling Panel for use in the Management of Breast Cancer Treatment
- L36238 Humanitarian Use Device (HUD) and Humanitarian Device Exemption (HDE) process
- L36504 Hyperbaric Oxygen (HBO) Therapy
- L33704 Infliximab
- L34006 Interspinous Process Decompression
- L34007 Intravenous Immune Globulin
- L33382 Lumbar Spinal Fusion for Instability and Degenerative Disc Conditions
- L33685 Luteinizing Hormone-Releasing Hormone (LHRH) Analogs
- L34372 Magnetic Resonance Angiography (MRA)
- L33618 Major Joint Replacement (Hip and Knee)
- L33594 Manipulation Under Anesthesia (MUA)
- L33689 Mohs Micrographic Surgery (MMS)
- L34518 Molecular Pathology Procedures for Human Leukocyte Antigen (HLA) Typing
- L33296 Noncovered Procedures - Endoscopic Treatment of Gastroesophageal Reflux Disease (GERD)
- L37798 Noncovered Service - 4Kscore Test
- L33695 Non-invasive Extracranial Arterial Studies
- L33747 Pegfilgrastim
- L33406 Posterior Tibial Nerve Stimulation (PTNS)

See **REVISIONS**, page 11

4Kscore test algorithm – revision to the Part A and Part B LCD

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

Based on re-analysis of data and supporting literature, the local coverage determination (LCD) and billing and coding article for 4Kscore test algorithm were revised to provide limited coverage for Current Procedural Terminology (CPT®) code 81539. The "Covered Indications," "Limitations," "Summary of Evidence," "Analysis of Evidence," and "Bibliography" sections in the LCD and the billing and coding article have been updated to include language which supports the limited coverage outlined in the LCD.

Also, the "ICD-10 Codes that Support Medical Necessity/ Group 1 Codes" section of the billing and coding article was revised to include ICD-10-CM diagnosis code R97.20.

Effective date

This LCD and billing and coding article revision is effective for services rendered **on or after January 6, 2020.**

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

from page 10

- L36775 Prostatic Urethral Lift (PUL)
- L34520 Psychological and Neuropsychological Tests
- L33751 Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI)
- L34021 Sedimentation Rate, Erythrocyte
- L34022 Serum Phosphorus
- L34521 Special EEG Tests
- L36234 Special Histochemical Stains & Immunohistochemical Stains
- L36035 Spinal Cord Stimulation for Chronic Pain
- L34522 Transcranial Magnetic Stimulation for Major Depressive Disorder
- L34976 Vertebroplasty, Vertebral Augmentation; Percutaneous
- L33766 Visual Field Examination
- L37166 Wound Care

Part A only LCD

- L33975 Psychiatric Inpatient Hospitalization

Part B only LCDs

- L37800 Allergen Immunotherapy
- L33810 Computerized Corneal Topography
- L33813 Destruction of Malignant Skin Lesions
- L33814 Destruction of Paravertebral Facet Joint Nerve(s)
- L33903 Diagnostic Laryngoscopy
- L33818 Excision of Malignant Skin Lesions
- L33834 Health and Behavior Assessment/ Intervention
- L33907 Hepatic (Liver) Function Panel
- L33908 High Sensitivity C-Reactive Protein (hsCRP)
- L33909 Incision and Drainage of Abscess of Skin, Subcutaneous and Accessory Structures
- L33911 Indocyanine-Green Angiography
- L33922 Nail Debridement
- L33924 Omalizumab
- L33927 Optical Coherence Biometry
- L33929 Osteopathic Manipulative Treatment
- L33930 Paravertebral Facet Joint Blocks
- L33933 Peripheral Nerve Blocks
- L33833 Surgical Treatment of Nails
- L33961 Therapy Services billed by Physicians/ Nonphysician Practitioners
- L33967 Vitamin B12 Injections

Effective date

These LCD revisions are 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*.

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

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

Based on change request (CR) 10901, the local coverage determination (LCD) for independent diagnostic testing facility (IDTF) 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, the Social Security Act, Code of Federal Regulations, and Internet Only Manual (IOM) reference sections were updated. Also, the Centers for Medicare & Medicaid Services (CMS) IOM language has been removed from the LCD and instead, the IOM citation related to this language is referenced.

Furthermore, based on review of the newly created billing and coding article Current Procedural Terminology (CPT®) code 74283 is being removed as it is not appropriate for an IDTF to perform a therapeutic service.

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 revision related to the removal of CPT® code

74283 is effective for claims processed **on or after November 25, 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*.

Find out first: Subscribe to First Coast *eNews*

Subscribe to First Coast Service Options *eNews*, to learn the latest Medicare news and critical program changes affecting the provider community. Join as many lists as you wish, in English or Spanish, and customize your subscription to fit your specific needs, line of business, specialty, or topics of interest. So, *subscribe to eNews, and stay informed.*

Retired LCDs

Multiple Part A and Part B LCDs being retired

LCD ID numbers: L33273/L33275/L33278/ L33722/L33723/L33727/L33729/L33730/ L33752/ L33978/L33989/L33272/L33748 (Florida/Puerto Rico/U.S. Virgin Islands)

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

- L33273 Bortezomib (Velcade®)
- L33275 Carboplatin (Paraplatin®, Paraplatin-AQ®)
- L33278 Cetuximab (Erbitux®)
- L33722 Doxorubicin, Liposomal (Doxil/Lipodox)
- L33723 Etoposide (Etopophos®, Toposar®, Vepesid®, VP-16)
- L33727 Irinotecan
- L33729 Oxaliplatin (Eloxatin®)
- L33730 Pacilitaxel (Taxol®)
- L33752 Topotecan (Hycamtin®)
- L33978 Pemetrexed
- L33989 Docetaxel (Taxotere®)
- L33272 Bone and/or Joint Imaging
- L33748 Romiplostim (Nplate®)

Effective date

The retirement of these LCDs is effective for services rendered **on or after November 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*.

Multiple Part B LCDs being retired

LCD ID numbers: L33808 and L33934 (Florida/ Puerto Rico/U.S. Virgin Islands)

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

- L33808 Cataract Extraction
- L33934 Physician Certification and Recertification of Home Health Services

Effective date

The retirement of these LCDs 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*.

Upcoming provider outreach and educational events

Medicare quarterly updates (B)

Date: Wednesday, December 11
Time: 11 a.m. - 12:30 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.

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, October 24, 2019

MLN Connects® for Thursday, October 24, 2019

View this edition as a PDF

News

- New Medicare Card: Claim Reject Codes After January 1
- Take Medicare Fraud, Waste and Abuse Fighting Further, Through Innovation
- Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier

Compliance

- Proper Coding for Specimen Validity Testing Billed in Combination with Urine Drug Testing

Claims, Pricers & Codes

- ICD-10 Vaping Coding Guidance

Events

- Submitting Your Medicare Part A Cost Report Electronically Webcast — November 5
- Clinical Diagnostic Laboratory Test Payment System: Data Reporting Call — November 14

MLN Matters® Articles

- Updating Calendar Year (CY) 2020 Medicare Diabetes Prevention Program (MDPP) Payment Rates

Multimedia

- CDC Opioids Training Module for Nurses
- Quality Payment Program: APMs Web-Based Training

The Medicare Learning Network®, MLN Connects®, and MLN Matters® are registered trademarks of the U.S. Department of Health and Human Services (HHS).

MLN Connects® for Thursday, October 31, 2019

MLN Connects® for Thursday, October 31, 2019

View this edition as a PDF

News

- Protect Your Patients' Identities: Use the MBI Now
- Hospital Value-Based Purchasing Program Results for FY 2020
- IRF/LTCH/SNF Quality Reporting Program Submission Deadline: November 15
- Nursing Home Compare Refresh
- Influenza Vaccination: Protect Your Patients this Season

Compliance

- DMEPOS: Bill Correctly for Items Provided During Inpatient Stays

Claims, Pricers & Codes

- Liver Transplant Claims: Possible Overpayment

Events

- Submitting Your Medicare Part A Cost Report Electronically Webcast — November 5
- Clinical Diagnostic Laboratory Test Payment System: Data Reporting Call — November 14
- Success with the Hospice Quality Reporting Program Webinar — November 14

MLN Matters® Articles

- Billing Instructions for Beneficiaries Enrolled in Medicare Advantage (MA) Plans for Services Covered by Decision Memo CAG-00451N
- Overview of the Repetitive, Scheduled Non-emergent Ambulance Prior Authorization Model — Revised
- What New Home Health Agencies (HHAs) Need to Know About Being Placed in a Provisional Period of Enhanced Oversight — Revised

Multimedia

- Medicare Fraud & Abuse: Prevent, Detect, and Report Web-Based Training Course
- Quality Payment Program: MIPS 2019 Web-Based Training Courses

The Medicare Learning Network®, MLN Connects®, and MLN Matters® are registered trademarks of the U.S. Department of Health and Human Services (HHS).

MLN Connects® – Special Edition for October 31, 2019

Final Payment Rules for HH, ESRD, and DMEPOS

- **HHAs: CY 2020 Payment and Policy Changes and CY 2021 Home Infusion Therapy Benefit**
- **ESRD and DMEPOS CY 2020 Final Rule**

HHAs: CY 2020 Payment and Policy Changes and CY 2021 Home Infusion Therapy Benefit

CMS issued a final rule with comment period that finalizes routine updates to the home health payment rates for CY 2020, in accordance with existing statutory and regulatory requirements. This rule with comment period includes:

- Modification to the payment regulations pertaining to the content of the home health plan of care
- Allows therapist assistants to furnish maintenance therapy
- Finalizes policies related to the split percentage payment approach under the Home Health Prospective Payment System (HH PPS)
- Final policies related to the implementation of the permanent home infusion therapy benefit in CY 2021, including payment categories, amounts, and required and optional adjustments, and solicits comments on options to enhance future efforts to improve policies related to coverage of eligible drugs for home infusion therapy
- Implementation of the Patient-Driven Groupings Model (PDGM), an alternate case-mix adjustment methodology with a 30-day unit of payment, mandated by the Bipartisan Budget Act of 2018 (BBA of 2018)

CMS projects that aggregate Medicare payments to Home Health Agencies (HHAs) in CY 2020 will increase by 1.3 percent, or $250 million. This increase reflects the effects of the 1.5 percent home health payment update percentage ($290 million increase), mandated by the BBA of 2018; and a 0.2 percent aggregate decrease (-$40 million) in payments to HHAs due to the changes in the rural add-on percentages, also mandated by the BBA of 2018. The rate updates also include a budget-neutral adjustment to the CY 2020 30-day payment amount to offset anticipated provider behavior changes upon implementation of the PDGM; the use of updated wage index data for the home health wage index; and updates to the fixed-dollar loss ratio to determine outlier payments. Given the scale of the PDGM payment system changes for CY 2020, it may take HHAs more time before they fully implement the behavior assumed by CMS; therefore, we applied the three previously outlined behavior change assumptions to half of the 30-day periods in our analytic file, resulting in a smaller adjustment to the 30-day payment amount needed to maintain budget neutrality, as required by law. CMS is finalizing a CY 2020 30-day payment amount (for those HHAs that report the required quality data) of $1,864.03.

The final rule also includes:

- Enhance and modernize program integrity while reducing regulatory burden
- Paraprofessional roles – Improving access to care
- Home Health Quality Reporting Program
- Home Health Value-Based Purchasing (HHVBP) Model

For More Information:

- *Final Rule*
- *Press Release*
- *HH PPS* website
- *HHA Center* website
- *PDGM* webpage
- *Home Infusion Therapy Services* website
- *Home Health Quality Reporting Requirements* webpage
- *HHVBP Model* webpage

See the full text of this excerpted *CMS Fact Sheet* (Issued October 31).

ESRD and DMEPOS CY 2020 Final Rule

On October 31, CMS issued a final rule that updates 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 updates the Acute Kidney Injury (AKI) dialysis payment rate for renal dialysis services furnished by ESRD facilities to individuals with AKI and finalizes changes to the ESRD Quality Incentive Program.

In addition, this rule includes:

- 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
- Revises existing policies related to the competitive bidding program for DMEPOS
- Streamlines the requirements for ordering DMEPOS items and creates 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
- Summaries of responses to requests for information on data collection resulting from the ESRD PPS technical expert panel, possible updates and improvements to the ESRD PPS wage index, and new rules for the competitive bidding of diabetic testing strips

CMS projects that the updates for CY 2020 will increase

See **SPECIAL**, page 18

MLN Connects® – Special Edition for November 1, 2019

Physician Fee Schedule, Hospital OPPS, and ASC Final Rules

- **Physician Fee Schedule: Finalized Policy, Payment, and Quality Provisions for CY 2020**
- **Medicare Hospital OPPS and ASC Payment System Final Rule for CY 2020**

Physician Fee Schedule: Finalized Policy, Payment, and Quality Provisions for CY 2020

On November 1, CMS issued a final rule that includes updates to payment policies, payment rates, and quality provisions for services furnished under the Medicare Physician Fee Schedule (PFS) effective on or after January 1, 2020.

Payment Provisions:

- Rate setting and conversion factor
- Medicare telehealth services
- Evaluation and management services
- Physician supervision requirements for physician assistants
- Review and verification of medical record documentation
- Care management services
- Medicare coverage for opioid use disorder treatment services furnished by opioid treatment programs
- Bundled payments under the PFS for opioid use disorders
- Therapy services

Other Provisions:

- Quality Payment Program
- Ambulance services
- Ground ambulance data collection system
- Open Payments Program
- Medicare Shared Savings Program

For More Information

- *Final Rule*
- *Press Release*
- *Press Release* – Treatment for Opioid Use Disorder
- *Quality Payment Program Fact Sheet*
- *Register* for November 6 Call

See the full text of this excerpted *CMS Fact Sheet* (Issued November 1).

Medicare Hospital OPPS and ASC Payment System Final Rule for CY 2020

On November 1, CMS finalized policies that aim to increase choices, encourage medical innovation, empower patients, and eliminate waste, fraud, and abuse to protect seniors and taxpayers. The changes build on existing efforts to increase patient choice by making Medicare payment available for more services in different sites of services and adopting policy changes under the Medicare Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System.

In accordance with Medicare law, CMS is updating OPPS payment rates for hospitals that meet applicable quality reporting requirements by 2.6 percent. This update is based on the projected hospital market basket increase of 3.0 percent minus a 0.4 percentage point adjustment for Multi-Factor Productivity (MFP).

Using the hospital market basket, CMS is finalizing an update to the ASC rates for CY 2020 equal to 2.6 percent. The update applies to ASCs meeting relevant quality reporting requirements. This change is based on the projected hospital market basket increase of 3.0 percent minus a 0.4 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 final rule with comment period includes:

- Increasing choices and encouraging site neutrality
- Method to control for unnecessary increases in utilization of outpatient services
- Changes to the inpatient only list
- ASC covered procedures list
- Payment for procedures involving skin substitutes
- Rethinking rural health
- Changes in the level of supervision of outpatient therapeutic services in hospitals and critical access hospitals
- Addressing wage index disparities
- Unleashing innovation
- Device pass-through applications
- Protecting taxpayer dollars
- Meaningful Measures/Patients Over Paperwork
- Hospital Outpatient Quality Reporting Program
- Ambulatory Surgical Center Quality Reporting Program
- OPPS payment methodology for 340B purchased drugs
- Partial Hospitalization Program (PHP) rate setting
- Update to PHP per diem rates
- Revision to the organ procurement organization conditions for certification

For More Information:

- *Final Rule*
- *Register* for November 6 Call

See the full text of this excerpted *CMS Fact Sheet* (Issued November 1).

MLN Connects® for Thursday, November 7, 2019

MLN Connects® for Thursday, November 7, 2019

View this edition as a PDF

News

- New Medicare Card: HICN Claims Reject January 1, 2020
- IRF/LTCH/SNF Quality Reporting Program: Submission Deadline Extended to November 18
- MIPS Heart Failure Measure: Call for Public Comment Closes November 27
- CAHs: Hardship Exception Application Deadline December 2
- DMEPOS Competitive Bidding Surveys: Comment by December 20
- MIPS: Virtual Group Election Period Open Through December 31
- Medicare Ground Ambulance Data Collection System: Starts January 1, 2020
- Home Health Agency: Final OASIS D-1 Data Submission Specifications
- MACRA Patient Relationship Categories and Codes: Learn More
- Recommend Influenza Vaccination: Each Office Visit is an Opportunity

Compliance

- Bill Correctly for Medicare Telehealth Services

Claims, Pricers & Codes

- Skilled Nursing Facility Claims Hold

Events

- Clinical Diagnostic Laboratory Test Payment System: Data Reporting Call — November 14
- Ground Ambulance Organizations: Data Collection System Call — December 5

MLN Matters® Articles

- Addition of Medical Severity Diagnosis Related Groups (MS-DRG) Subject to Inpatient Prospective Payment System (IPPS) Replaced Devices Offered Without Cost or With a Credit Policy
- Health Professional Shortage Area (HPSA) Bonus Payments for All Mental Health Specialties
- Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Edits, Version 26.0, Effective January 1, 2020
- April 2019 Update of the Hospital Outpatient Prospective Payment System (OPPS) — Revised
- Implementation to Exchange the List of Electronic Medical Documentation Requests (eMDR) for Registered Providers via the Electronic Submission of Medical Documentation (esMD) System — Revised

Publications

- Opioid Treatment Programs (OTPs) Medicare Enrollment
- Medicare Part B Immunization Billing: Seasonal Influenza Virus, Pneumococcal, and Hepatitis B — Revised

Multimedia

- Medicare Telehealth Services Video

SPECIAL

from page 16

the total payments to all ESRD facilities by 1.6 percent compared with CY 2019. For hospital-based ESRD facilities, CMS projects an increase in total payments of 2.1 percent, while for freestanding facilities, the projected increase in total payments is 1.6 percent.

The final rule also includes:

- 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 erythropoiesis-stimulating agent monitoring policy
- Requests for Information

For More Information:

- *Final Rule*
- *Press Release*

See the full text of this excerpted *CMS Fact Sheet* (Issued October 31).

The Medicare Learning Network®, MLN Connects®, and MLN Matters® are registered trademarks of the U.S. Department of Health and Human Services (HHS).

MLN Connects® – Special Edition for November 12, 2019

HICN Claims Reject

We are 50 days out from the end of the Medicare Beneficiary Identifier (MBI) transition period. Use the MBI on Medicare claims and other transactions now. Starting January 1, regardless of the date of service:

- We will reject claims submitted with Health Insurance Claim Numbers (HICNs) with a few *exceptions*
- We will reject all eligibility transactions submitted with HICNs

See the *MLN Matters Article* to learn how to get and use MBIs.

MLN Connects® for Thursday, November 14, 2019

MLN Connects® for Thursday, November 14, 2019

View this edition as a PDF

News

- New Medicare Card: If an MBI Changes
- Medicare Shared Savings Program: Application Deadlines for January 1, 2021, Start Date
- Drug Units in Excess of MUE: Comparative Billing Report in November
- Person-Centered Planning: Comment on Performance Measurement by December 2
- Emergency Preparedness Resources
- Raising Awareness of Diabetes in November
- Recognizing Lung Cancer Awareness Month and the Great American Smokeout

Compliance

- Skilled Nursing Facility 3-Day Rule Billing

Claims, Pricers & Codes

- MACRA Patient Relationship Categories and Codes: Reporting HCPCS Level II Modifiers

Events

- Kidney Care Choices Model Webinars — November 15 and 22
- 2020 Quality Payment Program Final Rule Webinar — November 19
- Drug Units in Excess of MUE: Comparative Billing Report Webinar — December 4
- Ground Ambulance Organizations: Data Collection System Call — December 5

MLN Matters® Articles

- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs) — April 2020 Update
- Updates to CR 11152 Implementation of the Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM)
- Display PARHM Claim Payment Amounts — Revised
- October 2019 Update of the Hospital Outpatient Prospective Payment System (OPPS) — Revised
- Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes - October 2019 Update — Revised

The Medicare Learning Network®, MLN Connects®, and MLN Matters® are registered trademarks of the U.S. Department of Health and Human Services (HHS).

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.

MLN Connects® – Special Edition for November 15, 2019

Hospital Price Transparency Requirements

CY 2020 Hospital Outpatient Prospective Payment System Policy Changes

On November 15, CMS finalized policies 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 policies in the final rule will further advance the agency's commitment to increasing price transparency. It includes requirements that would apply to each hospital operating in the United States. In response to comments, CMS is extending the effective date to January 1, 2021 to ensure hospital compliance with these regulations.

The final rule includes:

- Definitions of "hospital," "standard charges," and "items and services"
- Requirements for making public all standard charges for all items and services in a machine-readable format
- Requirements for displaying shoppable services in a consumer-friendly manner
- Monitoring and enforcement

For More Information:

- *View the final rule (CMS-1717-F2)*: This HHS-approved document has been submitted to the Office of the Federal Register (OFR) for publication and has not yet been placed on public display or published in the Federal Register. The document may vary slightly from the published document if minor editorial changes have been made during the OFR review process. The document published in the *Federal Register* is the official HHS-approved document.
- *Press Release*
- *Registration opening soon* for December 3 Call

See the full text of this excerpted *CMS Fact Sheet* (Issued November 15).

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 *CMS.gov*.

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
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@fcso.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@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
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

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

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 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@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, 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@fcso.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

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
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
elearning@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

Order form for Medicare Part B materials

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

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 *English* or *Spanish*. 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 *English* or *Spanish*. 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** [ ]				
Please write legibly			Subtotal	$
			Tax (***add % for your area***)	$
			Total	$

Mail this form with payment to:
First Coast Service Options Inc.
Medicare Publications
P.O. Box 406443
Atlanta, GA 30384-6443

Contact Name: _____

Provider/Office Name: _____

Phone: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

(Checks made to "purchase orders" not accepted; all orders must be prepaid)