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

In this issue

Update to Medicare Deductible, Coinsurance and Premium Rates for Calendar Year (CY) 2020

Provider type affected

This MLN Matters Article is for physicians, providers and suppliers submitting claims to Medicare Administrative Contractors (MACs), including Home Health and Hospice MACs and Durable Medical Equipment (DME MACs) for services provided to Medicare beneficiaries.

Provider action needed

CR 11542 instructs the MACs to update the claims processing system with the new Calendar Year (CY) 2020 Medicare rates. These updates relate to Chapter 3, sections 10.3, 20.2, and 20.6 of the Medicare General Information, Eligibility, and Entitlement Manual, which are attachments to the CR. Please make sure your billing staffs are aware of these changes.

Background

Beneficiaries who use covered Part A services may be subject to deductible and coinsurance requirements. Beneficiaries are responsible for an inpatient hospital deductible amount, which is deducted from the amount payable by the Medicare program to the hospital, for inpatient hospital services furnished in a spell of illness. When beneficiaries receive such services for more than 60 days during a spell of illness, they are responsible for a coinsurance amount equal to one-fourth (25 percent) of the inpatient hospital deductible per day for the 61st through 90th days in the hospital. A beneficiary has 60 lifetime reserve days of coverage, which they may elect to use after the 90th day in a spell of illness. The coinsurance amount for these days is equal to one-half of the inpatient hospital deductible. A beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible per day for the 21st through the 100th day of Skilled Nursing Facility (SNF) services furnished during a spell of illness.

See **UPDATE**, page 5

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.

UPDATE

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Most individuals aged 65 and older, and many disabled individuals under age 65, are insured for Health Insurance (HI) benefits without a premium payment. The Social Security Act (the Act) provides that certain aged and disabled persons who are not insured may voluntarily enroll, but are subject to the payment of a monthly premium. Since 1994, voluntary enrollees may qualify for a reduced premium if they have 30-39 quarters of covered employment. When voluntary enrollment takes place more than 12 months after a person's initial enrollment period, a 10-percent penalty is assessed for 2 years for every year they could have enrolled and failed to enroll in Part A.

Under Part B of the Supplementary Medical Insurance (SMI) program, all enrollees are subject to a monthly premium. Most SMI services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay), which are set by statute. When Part B enrollment takes place more than 12 months after a person's initial enrollment period, there is a permanent 10-percent increase in the premium for each year the beneficiary could have enrolled and failed to enroll.

The 2020 Part A and B deductible, coinsurance, and premium rates are as follows:

2020 Part A – Hospital Insurance (HI)

- **Part A Deductible**
  - o $1,408.00
- **Part A Coinsurance**
  - o $352.00 a day for 61st-90th days
  - o $704.00 a day for 91st-150th days (lifetime reserve days)
  - o $176.00 a day for 21st-100th days (SNF coinsurance)
- **Part A Base Premium (BP)**
  - $458.00 a month
- **Part A BP with 10-Percent Surcharge**
  - o $503.80 a month
- **Part A BP with 45-Percent Reduction**
  - o $252.00 a month (for those who have 30-39 quarters of coverage)
- **Part A BP with 45-Percent Reduction and 10-Percent Surcharge**
  - o $277.20 a month

2020 Part B – Supplementary Medical Insurance (SMI)

Part B Standard Premium
- o $144.60 a month
- **Part B Deductible**
  - o $198.00 a year
- **Pro Rata Data Amount**
  - o $140.46 - 1st month
  - o $57.54 - 2nd month
- **Coinsurance**
  - o 20 percent

Note: See Attachment A of CR11542 for "Income Parameters for Determining Part B Premium"

Additional information

The official instruction, CR 11542, issued to your MAC regarding this change is available at *https://www.cms.gov/files/document/r129gi*.

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

Document history

Date of change	Description
November 22, 2019	Initial article released.

MLN Matters® Number: MM11542
Related CR Release Date: November 22, 2019
Related CR Transmittal Number: R129GI
Related Change Request (CR) Number: 11542
Effective Date: January 1, 2020
Implementation Date: January 6, 2020

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.*

2020 Annual Update of Per-Beneficiary Threshold Amounts

Provider type affected

This MLN Matters Article is intended for physicians, therapists, and other providers submitting claims to Medicare Administrative Contractors (MACs), including Home Health & Hospice MACs, for outpatient therapy services provided to Medicare beneficiaries.

Provider action needed

CR 11532 updates the annual per-beneficiary incurred expenses amounts now called the KX modifier thresholds and related policy for CY 2020. These amounts were previously associated with the financial limitation amounts that were more commonly referred to as "therapy caps" before the Bipartisan Budget Act of 2018 was signed into law repealing the application of the caps.

For CY 2020, the KX modifier threshold amounts are: (a) $2,080 for Physical Therapy (PT) and Speech-Language Pathology (SLP) services combined, and (b) $2,080 for Occupational Therapy (OT) services. Make sure your billing staffs are aware of these updates.

Background

Section 50202 of the Bipartisan Budget Act of 2018, P.L. 115-123 (BBA of 2018) amended Section 1833(g) of the Social Security Act (the Act) to repeal the application of the therapy caps while also retaining and adding limitations to ensure appropriate therapy.

A provision of Section 50202 of the BBA of 2018 adds Section 1833(g)(7)(A) of the Act to preserve the former therapy cap amounts as thresholds above which claims must include the KX modifier to confirm that services are medically necessary as justified by appropriate documentation in the medical record. These amounts are now known as the KX modifier thresholds; and, there is one amount for PT and SLP services combined and a separate amount for OT services. Medicare will deny your claims for therapy services above these amounts without the KX modifier.

These per-beneficiary amounts under Section 1833(g) of the Act (as amended by 1997 BBA are updated each year by the Medicare Economic Index (MEI). For CY 2020, the KX modifier threshold amounts are: (a) $2,080 for PT and SLP services combined, and (b) $2,080 for OT services.

Another provision of Section 50202 of the BBA of 2018 adds Section 1833(g)(7)(B) of the Act to maintain the targeted medical review process (first established through Section 202 of the Medicare Access and CHIP Reauthorization Act of 2015) but at a lower threshold amount of $3,000. This threshold amount is now termed the Medical Record (MR) threshold amount – one MR threshold amount for PT and SLP services combined and another for OT services – remains at $3,000 until CY 2028 at which time it will be updated by the MEI.

Additional information

The official instruction, CR 11532, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2019Downloads/R4419CP.pdf*.

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

Document history

Date of change	Description
November 12, 2019	Initial article released.

MLN Matters® Number: MM11532
Related CR Release Date: October 25, 2019
Related CR Transmittal Number: R4419CP
Related Change Request (CR) Number: 11532
Effective Date: January 1, 2020
Implementation Date: January 6, 2020

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.

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.

Additional Information

National noncovered services -- revision to the Part A and Part B Billing and Coding Article

Article ID number: A57742 (Florida, Puerto Rico/U.S. Virgin Islands)

Based on the 2020 Healthcare Common Procedure Coding System (HCPCS) Update, the national noncovered services billing and coding article was revised to add Current Procedural Terminology (CPT®) codes 0567T and 0568T to the "Article Text:" section under "Part B Only". In addition, CPT® code 58565 was added under the "Part A and Part B:" section of this billing and coding article (not related to the 2020 HCPCS Update).

Effective date

This Billing and Coding Article revision is effective for services rendered **on or after January 1, 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*.

2020 HCPCS Part A/B, Part A and Part B billing and coding article changes

First Coast Service Options Inc. has revised local coverage determination (LCD) billing and coding articles impacted by the 2020 Healthcare Common Procedure Coding System (HCPCS) annual update. Procedure codes have been added, revised, replaced and deleted. The following is a list of the impacted LCD billing and coding articles.

Part A/B Combined LCD Billing and Coding Articles

L33615/A57635 Biofeedback

L36209/A57076 Cardiology – non-emergent outpatient testing: exercise stress test, stress echo, MPI SPECT, and cardiac PET

L34043/A57675 Dysphagia/Swallowing Diagnosis and Therapy

L36276/A57628 Erythropoiesis Stimulating Agents

L34519/A57451 Molecular Pathology Procedures

L33777/A57743 Noncovered Services

L34017/A57470 Ophthalmoscopy

L33707/A57127 Pulmonary Diagnostic Services

L34521/A57667 Special EEG Tests

L33413/A57156 Therapy and Rehabilitation Services

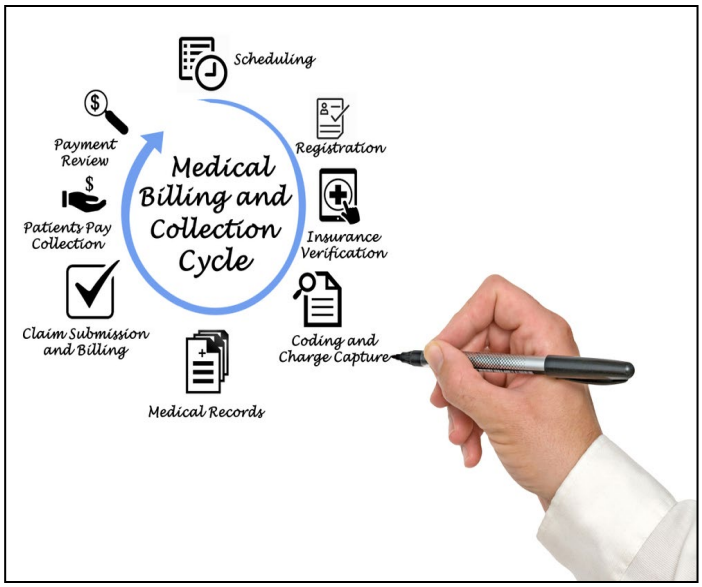
Part B only LCD Billing and Coding Articles

L33815/A57082 Diagnostic Nasal Endoscopy

L33834/A57754 Health and Behavior Assessment/ Intervention

L33910/A57807 Independent Diagnostic Testing Facility (IDTF)

L33933/A57788 Peripheral Nerve Blocks



Effective date

These LCD billing and coding article revisions are effective for services rendered **on or after January 1, 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*.

Noncovered services -- revision to the Part A and Part B Billing and Coding Article

Article ID number: A57743 (Florida, Puerto Rico/U.S. Virgin Islands)

Based on development of a new local coverage determination (LCD) for micro-invasive glaucoma surgery (MIGS), the noncovered services billing and coding article was revised to remove Current Procedural Terminology (CPT®) codes 0253T and 0450T from the "CPT®/HCPCS Codes/Group 1 Codes:" section and place them in the related billing and coding article for the new MIGS LCD under the "Group 3 Codes:" (CPT codes that are considered not medically and reasonable and necessary [non-covered]) section.

Effective date

This Billing and Coding Article revision 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 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*.

Bone mineral density studies -- revision to the Part A and Part B Billing and Coding Article

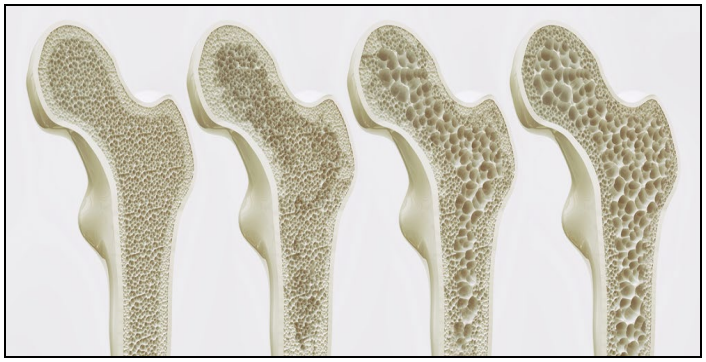
Article ID number: A56484 (Florida, Puerto Rico/U.S. Virgin Islands)

Based on change request (CR) 11392 (ICD-10 and Other Coding Revisions to National Coverage Determinations [NCDs] - January 2020 Update), the billing and coding article was revised to remove ICD-10-CM diagnosis codes M85.9, M89.9, M94.9, and Q55.4 for Current Procedural Terminology (CPT®) codes 77080, 77085, and 0508T and ICD-10-CM diagnosis codes M85.9 and Q55.4 for CPT®/HCPCS codes 0554T, 0555T, 0556T, 0557T, 0558T, 76977, 77078, 77081, and G0130.

Effective date

This Billing and Coding Article revision is effective for services rendered **on or after January 1, 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*.

Keep updated...

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

Upcoming provider outreach and educational events

Medicare quarterly updates (Part B)

Date: March 18
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® – Special Edition for November 19, 2019

New Medicare Card: Get Paid January 1, 2020 – Use MBIs Now

Do not wait. Update your patients' records and use Medicare Beneficiary identifiers (MBIs) now, before you are busy with other patient insurance changes in January.

We encourage people with Medicare to carry their cards with them since we removed the Social Security Number-based number; if your patients do not bring their Medicare cards with them:

- Give them the Get Your New Medicare Card flyer in *English* (or *Spanish*)
- Use your Medicare Administrative Contractor's look-up tool. *Sign up* for the Portal to use the tool
- Check the remittance advice. Until December 2019, we return the MBI on the remittance advice for every claim with a valid and active Health Insurance Claim Number (HICN)

Starting January 1, you must use MBIs to bill Medicare regardless of the date of service:

- We will reject claims submitted with HICNs with a few *exceptions*
- We will reject all eligibility transactions submitted with HICNs

See the *MLN Matters Article* for answers to your questions on using MBIs.

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, November 21, 2019

MLN Connects® for Thursday, November 21, 2019

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News

- Promoting Interoperability Programs: Updated list of eCQMs
- MIPS Improvement Activities Technical Expert Panel: Nominations due November 29
- DMEPOS Competitive Bidding Surveys: Comment by December 20
- Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier
- Modernizing CMS: Organizational Changes Announced

Compliance

- Improper Payment for Intensity-Modulated Radiation Therapy Planning Services

Claims, Pricers & Codes

- Medicare Diabetes Prevention Program: Valid Claims

Events

- Hospital Price Transparency Final Rule Call — December 3
- Hospice Quality Reporting Program Forum Webinar — December 4
- Ground Ambulance Organizations: Data Collection System Call — December 5

MLN Matters® Articles

- 2020 Annual Update to the Therapy Code List
- 2020 Annual Update of Per-Beneficiary Threshold Amounts
- Home Health Prospective Payment System (HH PPS) Rate Update for Calendar Year (CY) 2020
- Home Health (HH) Patient-Driven Groupings Model (PDGM) - Revised and Additional Manual Instructions
- Medicare Physician Fee Schedule Database (MPFSDB) Update to Status Indicators
- Positron Emission Tomography (PET) Scan - Allow Tracer Codes Q9982 and Q9983 in the Fiscal Intermediary Shared System (FISS)
- Update to Rural Health Clinic (RHC) All Inclusive Rate (AIR) Payment Limit for Calendar Year (CY) 2020

Publications

- Medical Privacy of Protected Health Information — Revised
- Remittance Advice Resources and FAQs — Revised

Multimedia

- Part A Cost Report Webcast: Audio Recording and Transcript
- Improving Health Care Quality for LGBTQ People Web-Based Training Course — Updated

MLN Connects® – Special Edition for November 26, 2019

New Medicare Card: Claim Reject Codes After January 1

Get paid. Use Medicare Beneficiary Identifiers (MBIs) now.

If you do not use MBIs on claims (with a few *exceptions*) after January 1, you will get:

- Electronic claims reject codes: Claims Status Category Code of A7 (acknowledgment rejected for invalid information), a Claims Status Code of 164 (entity's contract/member number), and an Entity Code of IL (subscriber)
- Paper claims notices: Claim Adjustment Reason Code (CARC) 16 "Claim/service lacks information or has submission/billing error(s)" and Remittance Advice Remark Code (RARC) N382 "Missing/incomplete/ invalid patient identifier"

We encourage people with Medicare to carry their cards with them since we removed the Social Security Number-based number; if your patients do not bring their Medicare cards with them:

- Give them the Get Your New Medicare Card flyer in *English* (or *Spanish*)
- Use your Medicare Administrative Contractor's look-up tool. *Sign up* for the Portal to use the tool
- Check the remittance advice. Until December 2019, we return the MBI on the remittance advice for every claim with a valid and active Health Insurance Claim Number (HICN)

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

MLN Connects® for Wednesday, November 27, 2019

MLN Connects® for Thursday, November 27, 2019

View this edition as a PDF

News

- FY 2019 Medicare FFS Improper Payment Rate Lowest Since 2010
- Patients Over Paperwork Newsletter
- Celebration of National Rural Health Day
- November is Home Care and Hospice Month
- World AIDS Day is December 1

Compliance

- Ambulance Fee Schedule and Medicare Transports

Events

- Hospital Price Transparency Final Rule Call — December 3
- Ground Ambulance Organizations: Data Collection System Call — December 5

MLN Matters® Articles

- Home Health Agencies (HHAs) Urged to Establish Access to the Internet Quality Improvement and Evaluation System (iQIES) By December 23, 2019
- Claim Status Category and Claim Status Codes Update
- Implementation of Changes in the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) and Payment for Dialysis Furnished for Acute Kidney Injury (AKI) in ESRD Facilities for Calendar Year (CY) 2020
- Implement Operating Rules - Phase III Electronic Remittance Advice (ERA) Electronic Funds Transfer (EFT): Committee on Operating Rules for Information Exchange (CORE) 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) Rule - Update from Council for Affordable Quality Healthcare (CAQH) CORE
- Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update
- Update to Medicare Deductible, Coinsurance and Premium Rates for Calendar Year (CY) 2020
- Updating Fiscal Intermediary Shared System (FISS) Editing for Practice Locations to Bypass Mobile Facility and/or Portable Units and Services Rendered in the Patient's Home
- Changes to the Laboratory National Coverage Determination (NCD) Edit Software for January 2020 — Revised

Publications

- Quality Payment Program: MIPS and APM Resources
- ACOs: Beneficiary Engagement Toolkit and Case Studies

Multimedia

- Physician Fee Schedule and Hospital OPPS/ASC Call: Audio Recording and Transcript

MLN Connects® – Special Edition for December 3, 2019

MBI Transition Ends This Month: Will You Be Paid on January 1?

The 21 month transition period will end on December 31; use Medicare Beneficiary identifiers (MBIs) now.

- You are currently submitting 86% of claims with MBIs
- Get MBIs from your patients and through the MAC portals (*sign up*) now and after the transition period. You can also find the MBI on the remittance advice
- Protect your patients from identity theft - use MBIs

Starting January 1, if you do not use the MBI (regardless of the date of service) for Medicare transactions

- We will reject claims submitted with HICNs with a few *exceptions*
- We will reject all eligibility transactions

See the *MLN Matters Article* for more information on getting and using MBIs.

MLN Connects® for Wednesday, December 5, 2019

MLN Connects® for Thursday, December 5, 2019

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News

- Direct Contracting Risk-Sharing Options: Submit Letter of Intent by December 10
- DMEPOS Competitive Bidding Surveys: Comment by December 20
- Quality Payment Program: Technical Expert Panel Nominations due December 20
- Quality Payment Program: MIPS Exception Applications due December 31
- Clinical Laboratory Fee Schedule: CY 2020 Final Payment Determinations
- Quality Payment Program: 2019 APM Incentive Payment Details
- PEPPERs for Short-term Acute Care Hospitals
- eCQM Reporting: Updated 2020 QRDA III Implementation Guide
- National Influenza Vaccination Week
- National Handwashing Awareness Week

Compliance

- Cardiac Device Credits: Medicare Billing

Claims, Pricers & Codes

- Average Sales Price Files: January 2020
- Home Health RAPs: Hold Starting January 1, 2020

Events

- Hospital Price Transparency Special Open Door Forum — December 10
- Medicare Promoting Interoperability Program 2020 Webinar — January 16

MLN Matters® Articles

- Overview of the Patient-Driven Groupings Model
- Payments and Payment Adjustments under the Patient-Driven Groupings Model
- Update to the Federally Qualified Health Center (FQHC) Prospective Payment System (PPS) for Calendar Year (CY) 2020 - Recurring File Update

Publications

- Disproportionate Share Hospital — Revised
- Federally Qualified Health Center — Revised
- Medicare Learning Network (MLN) Learning Management System (LMS) FAQs — Revised

Multimedia

- Clinical Labs Call: Audio Recording and Transcript

MLN Connects® – Special Edition for December 10, 2019

Most HICN Claims Reject – Regardless of Date of Service

Use Medicare Beneficiary Identifiers (MBIs) now to avoid claim and eligibility transaction rejects. Starting January 1, 2020, regardless of the date of service on the Medicare transaction, most Social Security Number – based Health Insurance Claim Number (HICN) Medicare transactions will reject with a few *exceptions*.

If you do not use MBIs on claims after January 1, you will get:

- Electronic claims reject codes: Claims Status Category Code of A7 (acknowledgment rejected for invalid information), a Claims Status Code of 164 (entity's contract/member number), and an Entity Code of IL (subscriber)
- Paper claims notices: Claim Adjustment Reason Code (CARC) 16 "Claim/service lacks information or has submission/billing error(s)" and Remittance Advice Remark Code (RARC) N382 "Missing/incomplete/invalid patient identifier"

Thank you for transitioning to MBIs during the 21 month transition period, protecting your patients from identity theft.

- You are currently submitting 87% of claims with MBIs
- If your patient doesn't have their new card, give them the Get Your New Medicare Card flyer in *English* or *Spanish*
- Get MBIs through the MAC portals (*sign up*) now and after the transition period. You can also find the MBI on the remittance advice.

See the *MLN Matters Article* (PDF) for more information on getting and using MBIs.

MLN Connects® for Thursday, December 12, 2019

MLN Connects® for Thursday, December 12, 2019

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News

- Open Payments: Review and Dispute Data by December 31
- LTCH Provider Preview Reports: Review Your Data by January 9
- IRF Provider Preview Reports: Review Your Data by January 9
- Quality Payment Program: Check Your Final 2019 MIPS Eligibility Status
- Quality Payment Program: MIPS Low-Volume Threshold Criteria for 2019
- Home Health Agencies: OASIS Considerations for PDGM Transition

Compliance

- Bill Correctly for Device Replacement Procedures

Claims, Pricers & Codes

- Payment for Outpatient Clinic Visit Services at Excepted Off-Campus Provider-Based Departments

Events

- ESRD Quality Incentive Program: CY 2020 ESRD PPS Final Rule Call — January 14

MLN Matters® Articles

- Medicare Part B Home Infusion Therapy Services with the Use of Durable Medical Equipment
- CY 2020 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule
- Summary of Policies in the Calendar Year (CY) 2020 Medicare Physician Fee Schedule (MPFS) Final Rule, Telehealth Originating Site Facility Fee Payment Amount and Telehealth Services List, CT Modifier Reduction List, and Preventive Services List
- Update to Medicare Claims Processing Manual, Chapters 1, 23 and 35
- Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging – Educational and Operations Testing Period - Claims Processing Requirements — Revised
- Home Health Prospective Payment System (HH PPS) Rate Update for Calendar Year (CY) 2020 — Revised
- Looking for an MLN Matters Article?

Publications

- Opioid Treatment Programs (OTPs) Medicare Billing & Payment
- Hospice Comprehensive Assessment Measure

Multimedia

- Hospital Price Transparency Call: Audio Recording and Transcript

MLN Connects® – Special Edition for December 17, 2019

New Medicare Card Transition Ends in 2 Weeks: Use MBIs Now to Get Paid January 1

The 21-month Medicare Beneficiary identifier (MBI) transition period ends in two weeks. Update your patients' records and use MBIs now. Starting January 1, you must use MBIs to bill Medicare 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

Need the MBI?

We encourage people with Medicare to carry their cards with them since we removed the Social Security Number-based number; if your patients do not bring their Medicare cards with them:

- Give them the Get Your New Medicare Card flyer in *English* (PDF) or *Spanish* (PDF).
- Use your Medicare Administrative Contractor's look-up tool. *Sign up* (PDF) for the Portal to use the tool
- Check the remittance advice. Until December 31, we return the MBI on the remittance advice for every claim with a valid and active HICN

MBI on a Patient's Card Doesn't Work?

Medicare beneficiaries, their authorized representatives, or CMS can ask to change MBIs; for example, if the number is compromised. It is possible your patient will seek care before getting a new card with the new MBI.

If you get an eligibility transaction error code (AAA 72) of "invalid member ID," your patient's MBI may have changed.

See **SPECIAL EDITION**, page 16

MLN Connects® for Thursday, December 19, 2019

MLN Connects® for Thursday, December 19, 2019

View this edition as a PDF

News

- DMEPOS: Changes to Conditions of Payment Reduce Burden
- DMEPOS Competitive Bidding Surveys: Comment by December 20
- Mohs Microsurgery: Comparative Billing Report in December
- Hospice Provider Preview Reports: Review Your Data by January 15
- Hospice Providers: Volunteer for Alpha Testing of HOPE Assessment Instrument
- LTCH Compare Refresh
- IRF Compare Refresh
- 2020 Eligible Clinician Electronic Clinical Quality Measure Flows
- Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier

Compliance

- Provider Minute Video: The Importance of Proper Documentation

Claims, Pricers & Codes

- Payment for Outpatient Clinic Visit Services at Excepted Off-Campus Provider-Based Departments: Updated

Events

- Mohs Microsurgery: Comparative Billing Report Webinar — January 7
- ESRD Quality Incentive Program: CY 2020 ESRD PPS Final Rule Call — January 14
- Listening Sessions on MAC Opportunities to Enhance Provider Experience — January 15, 22, or 29

MLN Matters® Articles

- Calendar Year (CY) 2020 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment
- Changes to the Laboratory National Coverage Determination (NCD) Edit Software for April 2020
- Update Inpatient Prospective Payment System (IPPS) Pricer and Related Claims Reprocessing
- 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 — Revised
- Medicare Part B Home Infusion Therapy Services with the Use of Durable Medical Equipment — Revised
- Looking for an MLN Matters Article?

Publications

- Hospital Quality Reporting: QRDA I Conformance Statement Resource

Multimedia

- Ambulance Services Call: Audio Recording and Transcript

SPECIAL EDITION

from page 15

- Do a historic eligibility search to get the termination date of the old MBI
- Get the new MBI from your Medicare Administrative Contractor's secure look-up tool. *Sign up* (PDF) for the Portal to use the tool

See the *MLN Matters Article* (PDF) for answers to your questions on using MBIs.

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
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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
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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

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Centers for Medicare & Medicaid Services

E-learning Center
First Coast University

Beneficiaries

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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

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877-847-4992

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888-845-8614
877-660-1759 (TTY)
FAX: 904-361-0737

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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

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P.O. Box 45036
Jacksonville, FL 32232-5036

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Jacksonville, FL 32231-4071

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

Medicare Education and Outreach
FAX: 904-361-0407
elearning@fcso.com

Fraud and abuse
Fraud and abuse complaints
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Jacksonville, FL 32232-5087

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

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

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