Medicare B CONNECTION
medicare.fcso.com
FIRST COAST SERVICE OPTIONS, INC.
A Newsletter for MAC Jurisdiction N Providers
November 2020

In this issue

MLN Connects® – Special Edition – Tuesday, November 3, 2020

ESRD & Home Health Payment Rules

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- *Home Health Agencies: CY 2021 Payment and Policy Changes and Home Infusion Therapy Benefit*
- *CMS' New One-Stop Nursing Home Resource Center Assists Providers, Caregivers, Residents*

ESRD PPS: CY 2021 Payment Policies and Rates

On November 2, 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 enrolled in Original Medicare on or after January 1, 2021. 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.

The final CY 2021 ESRD PPS base rate is $253.13, which represents an increase of $13.80 to the current base rate of $239.33. This amount reflects the application of the updated wage index budget-neutrality adjustment factor (.999485), the addition to the base rate of $9.93 to include calcimimetics, and a productivity-adjusted market basket increase, as required by section 1881(b)(14)(F)(i)(I) of the Act (1.6 percent), equaling $253.13 (($239.33 x .999485) + $9.93 x 1.016 = $253.13).

CMS finalized the following:

- Update to the ESRD PPS wage index to adopt the 2018 Office of Management and Budget delineations with a transition period
- Changes to the eligibility criteria and determination process for the Transitional add-on Payment adjustment for New and Innovative Equipment and Supplies (TPNIES)
- Expansion of the TPNIES to include new and innovative capital-related assets that are home dialysis machines
- Change to the low-volume payment adjustment eligibility criteria and attestation requirement to account for the COVID-19 public health emergency

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Contents

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

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.

Fee news

2021 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. (**Note**: The dates listed for release of the participation enrollment/fee disclosure material are subject to publication of the annual final rule.)

The 2021 Medicare physician fee schedule (MPFS) payment rates will be posted to First Coast Service Options' Medicare Provider website after publication of the MPFS final rule in the *Federal Register*. This publication usually occurs in mid-November.

Find fees faster: Try First Coast's fee schedule lookup

Find the fee schedule information you need fast - with First Coast's fee schedule lookup, located at *https://medicare.fcso.com/Fee_lookup/fee_schedule.asp.* This exclusive online resource features an intuitive interface that allows you to search for fee information by procedure code. Plus, you can find any associated local coverage determinations (LCDs) with just the click of a button.

Local Coverage Determinations

The *LCDs/Medical Affairs* section of our website provides you with the latest *medical affairs news*, *active LCDs*, and *proposed LCDs*. You can also find information on *self-administered drug exclusions* and *clinical trials*.

First Coast has made it easy to locate active, proposed and retired LCDs on the *active LCD index*. The *LCD search tool* 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.

In addition to using the search tools, First Coast's LCDs are available using the Centers for Medicare & Medicaid Services (CMS) *Medicare coverage database (MCD)* .

Reasonable and necessary guidelines

In the absence of a Local Coverage Determination (LCD) (*JN*), *national coverage determination (NCD)*, or the Centers for Medicare & Medicaid Services Manual Instruction, reasonable and necessary guidelines still apply.

Section 1862(a) (1) (A) of the Social Security Act directs the following:

"No payment may be made under Part A or Part B for any expenses incurred for items or services not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."

Note: malformed is defined as (of a person or part of the body) abnormally formed; misshapen.

The Medicare administrative contractor will determine if an item or service is "reasonable and necessary" under §1862(a) (1) (A) of the Act if the service is:

- Safe and effective;
- Not experimental or investigational; and
- Appropriate, including the duration and frequency in terms of whether the service or item is:
    - Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the beneficiary's condition or to improve the function of a malformed body member;
    - Furnished in a setting appropriate to the beneficiary's medical needs and condition;
    - Ordered and furnished by qualified personnel; and
    - One that meets, but does not exceed, the beneficiary's medical need

For any service reported to Medicare, it is expected that the medical documentation clearly demonstrates that the service meets all of the above criteria. All documentation must be maintained in the patient's medical record and be available to the contractor upon request.

Medicare news

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.

2021 ICD-10-CM coding changes

The billing and coding articles were revised with the 2021 updates to the ICD-10-CM diagnosis coding structure effective for services rendered **on or after October 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 a LCD (when present) may be found at the bottom of the LCD 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*.

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LCDs

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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 Affairs at:

First Coast Service Options

Medical Affairs

2020 Technology Parkway

Suite 100

Mechanicsburg, PA 17050-9419

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: December 16
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.

MLN Connects®

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 22, 2020

Medicare Coverage for Opioid Use Disorder Treatment

MLN Connects® for Thursday, October 22, 2020

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News

- Opioid Use Disorder Treatment: Medicare Coverage
- Clinical Diagnostic Laboratory Tests Advisory Panel: Request for Nominations
- Medicare Diabetes Prevention Program: Become a Medicare-Enrolled Supplier

Events

- CMS-CDC Fundamentals of COVID-19 Prevention for Nursing Home Management Call — October 22
- Medicare Part A Cost Report: New Bulk e-Filing Feature Webcast — October 29

MLN Matters Articles

- Ambulance Inflation Factor (AIF) for Calendar Year (CY) 2021 and Productivity Adjustment
- Medicare Fee-for-Service (FFS) Response to the Public Health Emergency on the Coronavirus (COVID-19) — Revised
- New Waived Tests — Revised

Multimedia

- Nursing Home COVID-19 Preparedness for Fall & Winter Web-Based Training

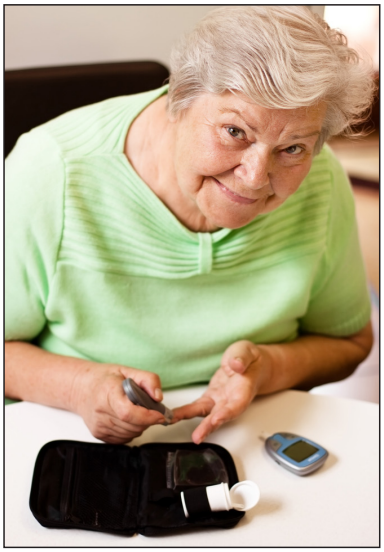
Information for Medicare Patients

- Diabetes Management Resources

MLN Connects® – Special Edition – Tuesday, October 27, 2020

New CMS Proposals Streamline Medicare Coverage, Payment, and Coding for Innovative New Technologies and Provide Beneficiaries with Diabetes Access to More Therapy Choices

Durable Medical Equipment (DME) proposed rule would reduce administrative burden for new innovative technologies



On October 27, under the leadership of President Trump, CMS proposed new changes to Medicare Durable Medical Equipment, Prosthetics, Orthotic Devices, and Supplies (DMEPOS) coverage and payment policies. This rule would provide more choices for beneficiaries with diabetes, while streamlining the process for innovators in getting their technologies approved for coverage, payment, and coding by Medicare.

The proposed rule would expand the interpretation regarding when external infusion pumps are appropriate for use in the home and can be covered as DME under Medicare Part B, increasing access to drug infusion therapy services in the home. The proposed rule also drastically reduces administrative burdens – such as complicated government coverage, payment, and coding processes – that block innovators from getting their products to Medicare beneficiaries in a timely manner. This action aligns with President Trump's Executive Order on Protecting and Improving Medicare for Our Nation's Seniors.

"With the policies outlined in this proposed rule, innovators have a much more predictable path to understanding the kinds of products that Medicare will pay for," said CMS Administrator Seema Verma. "For manufacturers, bringing a new product to market will mean they can get a Medicare payment amount and billing code right off the bat, resulting in quicker access for

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Medicare beneficiaries to the latest technological advances and the most, cutting-edge devices available. It's clearly a win-win for patients and innovators alike."

Due to administrative constraints, the process for making Medicare benefit classifications, pricing determinations, and creating billing codes for DMEPOS used to routinely take up to 18 months to complete. Last year, CMS changed this process through sub-regulatory guidance to reduce that timeframe to six months in many cases, and is now proposing to establish a streamlined process for coding, coverage, and payment in regulation. Under this accelerated process, benefit classification and pricing decisions could happen on the same day the billing codes used for payment of new items take effect, which would facilitate seamless coverage and payment for new DMEPOS and services. If finalized, this proposed rule would allow innovators to bring their products to Medicare beneficiaries quicker giving them more choices and increased access to the latest, cutting-edge devices.

If finalized, this proposed rule will also expand Medicare coverage and payment for Continuous Glucose Monitors (CGMs) that provide critical information on blood glucose levels to help patients with diabetes manage their disease. Currently, CMS only covers therapeutic CGMs or those approved by the FDA for use in making diabetes treatment decisions, such as changing one's diet or insulin dosage based solely on the readings of the CGM.

CMS is proposing to classify all CGMs (not just limited to therapeutic CGMs) as DME and establish payment amounts for these items and related supplies and accessories. CGMs that are not approved for use in making diabetes treatment decisions can be used to alert beneficiaries about potentially dangerous glucose levels while they sleep and that they should further test their glucose levels using a blood glucose monitor. With one in every three Medicare beneficiaries having diabetes, this proposal would give Medicare beneficiaries and their physicians a wider range of technology and devices to choose from in managing diabetes. This proposal will improve access to these medical technologies and empower patients to make the best health care decisions for themselves.

In addition, the proposed rule would expand classification of external infusion pumps under the DME benefit making home infusion of more drugs possible for beneficiaries. An external infusion pump is a medical device used to deliver fluids such as nutrients or medications into a patient's body in a controlled manner. The proposal would expand classification of external infusion pumps as DME in cases where assistance from a skilled home infusion therapy supplier is necessary for safe infusion in the home, allowing beneficiaries more choices to get therapies at home instead of traveling to a health care facility.

Lastly, in the proposed rule, CMS proposes to continue to pay higher amounts to suppliers for DMEPOS items and services furnished in rural and non-contiguous areas to encourage suppliers to provide access and choices for beneficiaries living in those areas. CMS is making this proposal based on previous stakeholder feedback that indicate unique challenges and higher costs for providing for DMEPOS items for beneficiaries in rural and remote areas.

For More Information:

- *Proposed Rule*
- *Fact Sheet*

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 ***here***.

MLN Connects® – Special Edition – Wednesday, October 28, 2020

Trump Administration Acts to Ensure Coverage of Life-Saving COVID-19 Vaccines & Therapeutics

Under President Trump's leadership, CMS is taking steps to ensure all Americans, including the nation's seniors, have access to the coronavirus disease 2019 (COVID-19) vaccine at no cost when it becomes available. On October 28, the agency released a comprehensive plan with proactive measures to remove regulatory barriers and ensure consistent coverage and payment for the administration of an eventual vaccine for millions of Americans. CMS released a set of toolkits for providers, states and insurers to help the health care system prepare to swiftly administer the vaccine once it is available. These resources are designed to increase the number of providers that can administer the vaccine, ensure adequate reimbursement for administering the vaccine in Medicare, while making it clear to private insurers and Medicaid programs their responsibility to cover the vaccine at no charge to beneficiaries. In addition, CMS is taking action to increase reimbursement for any new COVID-19 treatments that are approved or authorized by the FDA.

"Under President Trump's leadership, we have developed a comprehensive plan to support the swift and successful distribution of a safe and effective vaccine for COVID-19," said CMS Administrator Seema Verma. "As Operation Warp Speed nears its goal of delivering the vaccine in record time, CMS is acting now to remove bureaucratic barriers while ensuring that states, providers and health plans have the information and direction they need to ensure broad vaccine access and coverage for all Americans."

To ensure broad access to a vaccine for America's seniors, CMS released an Interim Final Rule with Comment Period (IFC) that establishes that any vaccine that receives Food and Drug Administration (FDA) authorization, either through an Emergency Use Authorization (EUA) or licensed under a Biologics License Application (BLA), will be covered under Medicare as a preventive vaccine at no cost to beneficiaries. The IFC also implements provisions of the CARES Act that ensure swift coverage of a COVID-19 vaccine by most private health insurance plans without cost sharing from both in and out-of-network providers during the course of the public health emergency (PHE).

In anticipation of the availability of new COVID-19 treatments, the IFC also establishes additional Medicare hospital payment to support Medicare patients' access to these potentially life-saving COVID-19 therapies. In Medicare, hospitals are generally reimbursed a fixed payment amount for the services they provide during an inpatient stay, even if their costs exceed that amount. Under current rules, hospitals may qualify for additional "outlier payments," but only when their costs for a particular patient exceed a certain threshold. Under this IFC, hospitals would qualify for additional payments

when they treat patients with innovative new products approved or authorized to treat COVID-19 to mitigate any losses they may experience from making these therapies available, even if they do not reach the current outlier threshold. The IFC also makes changes to reimbursement for outpatient hospital services to ensure payment for certain innovative treatments for COVID-19 that occur outside of bundled arrangements and are paid separately. In addition, CMS released information to prepare hospitals to bill for the outpatient administration of a monoclonal antibody product in the event one is approved under an emergency use authorization (EUA).

This rule also allows states to employ a broad range of strategies - based on local needs - to appropriately manage their Medicaid program costs. The guidance and flexibility provided to states in the IFC will help them maintain Medicaid beneficiary enrollment while receiving the temporary increase in federal funding in the Families First Coronavirus Response Act (FFCRA).

CMS is also taking continued steps to ensure that price transparency extends to COVID-19 testing during the PHE. Provisions in the IFC require that any provider who performs a COVID-19 diagnostic test post their cash prices online. Providers that are non-compliant may face civil monetary penalties.

In addition to these provisions, the IFC:

- Provides an extension of Performance Year 5 for the Comprehensive Care for Joint Replacement (CJR) model; and
- Creates flexibilities in the public notice requirements and post-award public participation requirements for a State Innovation Waiver under Section 1332 of the Patient Protection and Affordable Care Act during the COVID-19 PHE.

Along with these regulatory changes, CMS is issuing three toolkits aimed at state Medicaid agencies, providers who will administer the vaccine, and health insurance plans. Together, these toolkits will help ensure the health care system is prepared to successfully administer a safe and effective vaccine by addressing issues related to access, billing and payment, and coverage.

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Increasing Access to Vaccines for Medicare & Medicaid Beneficiaries

The toolkits issued today give health care providers not currently enrolled in Medicare the information needed to administer and bill vaccines to Medicare patients. CMS is working to increase the number of providers that will administer a COVID-19 vaccine to Medicare beneficiaries when it becomes available, to make it as convenient as possible for America's seniors. New providers are now able to enroll as a "Medicare mass immunizers" through an expedited 24-hour process. The ability to easily enroll as a mass immunizer is important for some pharmacies, schools, and other entities that may be non-traditional providers or otherwise not eligible for Medicare enrollment. To further increase the number of providers who can administer the COVID -19 vaccine, CMS will continue to share approved Medicare provider information with states to assist with Medicaid provider enrollment efforts. CMS is also making it easier for newly enrolled Medicare providers to also enroll in state Medicaid programs to support state administration of vaccines for Medicaid recipients.

Coverage

As a condition of receiving free COVID-19 vaccines from the federal government, providers will be prohibited from charging consumers for administration of the vaccine. To ensure broad and consistent coverage across programs and payers, the toolkits have specific information for several programs, including:

Medicare: Beneficiaries with Medicare pay nothing for COVID-19 vaccines and their copayment/coinsurance and deductible are waived.

Medicare Advantage (MA): For calendar years 2020 and 2021, Medicare will pay directly for the COVID-19 vaccine and its administration for beneficiaries enrolled in MA plans. MA plans would not be responsible for reimbursing providers to administer the vaccine during this time. Medicare Advantage beneficiaries also pay nothing for COVID-19 vaccines and their copayment/coinsurance and deductible are waived.

Medicaid: State Medicaid and CHIP agencies must provide vaccine administration with no cost sharing for most beneficiaries during the public health emergency. Following the public health emergency, depending on the population, states may have to evaluate cost sharing policies and may have to submit state plan amendments if updates are needed.

Private Plans: CMS, along with the Departments of Labor and the Treasury, is requiring that most private health plans and issuers cover a recommended COVID-19 vaccine and its administration, both in-network and out-of-network, with no cost sharing. The rule also provides that out-of-network rates cannot be unreasonably low, and references CMS's reimbursement rates as a potential guideline for insurance companies.

Uninsured: For individuals who are uninsured, providers will be able to be reimbursed for administering the COVID-19 vaccine to individuals without insurance through the Provider Relief Fund, administered by the Health Resources and Services Administration (HRSA).

Billing and Payment

The toolkits also address issues related to billing and payment. After the FDA either approves or authorizes a vaccine for COVID-19, CMS will identify the specific vaccine codes, by dose if necessary, and specific vaccine administration codes for each dose for Medicare payment. CMS and the American Medical Association (AMA) are working collaboratively on finalizing a new approach to report use of COVID-19 vaccines, which include separate vaccine-specific codes. Providers and insurance companies will be able to use these to bill for and track vaccinations for the different vaccines that are provided to their enrollees.

Medicare Payment

CMS also released new Medicare payment rates for COVID-19 vaccine administration. The Medicare payment rates will be $28.39 to administer single-dose vaccines. For a COVID-19 vaccine requiring a series of two or more doses, the initial dose(s) administration payment rate will be $16.94, and $28.39 for the administration of the final dose in the series. These rates will be geographically adjusted and recognize the costs involved in administering the vaccine, including the additional resources involved with required public health reporting, conducting important outreach and patient education, and spending additional time with patients answering any questions they may have about the vaccine. Medicare beneficiaries, those in Original Medicare or enrolled in Medicare Advantage, will be able to get the vaccine at no cost.

CMS is encouraging state policymakers and other private insurance agencies to utilize the information on the Medicare reimbursement strategy to develop their vaccine administration payment plan in the Medicaid program, CHIP, the Basic Health Program (BHP), and private plans. Using the Medicare strategy as a model would allow states to match federal efforts in successfully administering the full vaccine to the most vulnerable populations.

The IFC (*CMS-9912-IFC*) is scheduled to display at the Federal Register as soon as possible with an immediate effective date and a 30-day comment period.

For More Information:

- *Fact Sheet*
- *COVID-19 vaccine resources* for provider, health plans and State Medicaid programs
- *FAQs* on billing for therapeutics

MLN Connects® for Thursday, October 29, 2020

Quality Payment Program APMs: Update Billing Information to Get Paid

MLN Connects® for Thursday, October 29, 2020

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News

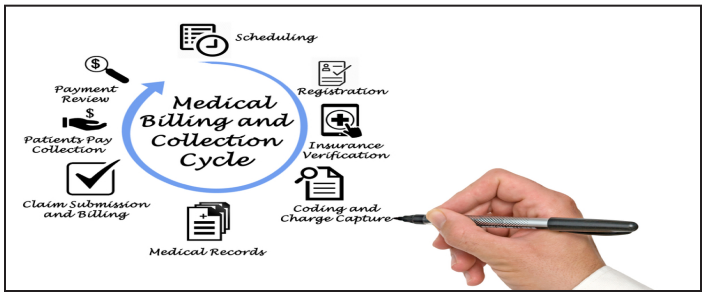
- Quality Payment Program APMs: Update Billing information by November 13

Compliance

- Hospice Aide Services: Enhancing RN Supervision

MLN Matters Articles

- Change to the Payment of Allogeneic Stem Cell Acquisition Services — Revised



Publications

- Medicare Quarterly Provider Compliance Newsletter

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For More Information:

- *Final rule*
- *Press release*
- Full text of *fact sheet*

Home Health Agencies: CY 2021 Payment and Policy Changes and Home Infusion Therapy Benefit

On October 29, CMS issued a final rule that finalizes routine updates to the home health payment rates for Calendar Year (CY) 2021 in accordance with existing statutory and regulatory requirements. This rule also finalizes the regulatory changes related to the use of telecommunications technology in providing care under the Medicare home health benefit.

CMS estimates that Medicare payments to Home Health Agencies (HHAs) in CY 2021 will increase in the aggregate by 1.9 percent, or $390 million, based on the finalized policies. This increase reflects the effects of the 2.0 percent home health payment update percentage ($410 million increase) and a 0.1 percent decrease in payments due to reductions in the rural add-on percentages mandated by the Bipartisan Budget Act of 2018 for CY 2021 ($20 million decrease). This rule also updates the home health wage index including the adoption of revised Office of Management and Budget statistical area delineations and limiting any decreases in a geographic area's wage index value to no more than 5 percent in CY 2021.

This final rule also:

- Finalizes Medicare enrollment policies for qualified home infusion therapy suppliers
- Updates the home infusion therapy services payment rates for CY 2021
- Finalizes a policy excluding home infusion therapy services from home health services as required by law
- Finalizes policies under the Home Health Value Based Purchasing Model published in the interim final rule with comment period, as required by law

For More Information:

- *Final rule*
- *Home Health Prospective Payment System* website
- *HHA Center* webpage
- *Home Health Patient-Driven Groupings Model* webpage
- *Home Infusion Therapy Services* website
- Full text of *Fact Sheet*

CMS' New One-Stop Nursing Home Resource Center Assists Providers, Caregivers, Residents

On October 30, CMS launched a new online platform - *the Nursing Home Resource Center* - to serve as a centralized hub bringing together the latest information, guidance, and data on nursing homes that is important to facilities, frontline providers, residents, and their families, especially as the fight against COVID-19 continues.

The Resource Center consolidates all nursing home information, guidance, and resources into a user-friendly, one-stop-shop that is easily navigable so providers and caregivers can spend less time searching for critical answers and more time caring for residents. Moreover, the new platform contains features specific to residents and their families, ensuring they have the information needed to make empowered decisions about their health care.

With the new page, people can efficiently navigate all facility inspection reports and data – including COVID-19 pandemic and Public Health Emergency (PHE) information. This tool will remain active through and beyond the COVID-19 PHE.

Full text of *News Alert.*

MLN Connects® for Thursday, November 5, 2020

COVID-19 Vaccine: Find Out How to Prepare

MLN Connects® for Thursday, November 5, 2020

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News

- COVID-19 Vaccine: Find Out How to Prepare
- Hospital Price Transparency: Requirements Effective January 1
- SNF Quality Reporting Program: October Refresh
- Flu Shots: Each Visit is an Opportunity

Compliance

- Inhalant Drugs: Bill Correctly

Events

- CMS-CDC Fundamentals of COVID-19 Prevention for Nursing Home Management Call — November 5

MLN Matters Articles

- Special Provisions for Radiology Additional Documentation Requests
- Update to Chapter 10 of Publication (Pub.) 100-08 - Enrollment Policies for Home Infusion Therapy (HIT) Suppliers
- October Quarterly Update for 2020 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule — Revised
- Penalty for Delayed Request for Anticipated Payment (RAP) Submission -- Implementation — Revised
- Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) – October 2020 Update — Revised

Publications

- Medicare Wellness Visits

Multimedia

- SNF Quality Reporting Program: Confusion Assessment Method Video Tutorial
- SNF Quality Reporting Program: Brief Interview for Mental Status Video Tutorial

MLN Connects® – Special Edition – Tuesday, November 10, 2020

CMS Takes Steps to Ensure Medicare Beneficiaries Have Wide Access to COVID-19 Antibody Treatment

Coverage Available at No Cost to Beneficiaries Across Variety of Settings in Health Care System

CMS announced that starting November 10, Medicare beneficiaries can receive coverage of monoclonal antibodies to treat COVID-19 with no cost-sharing during the Public Health Emergency (PHE). CMS' coverage of monoclonal antibody infusions applies to bamlanivimab, which received an Emergency Use Authorization (EUA) from the FDA on November 9.

"Today, CMS is announcing a historic, first-of-its kind policy that drastically expands access to COVID-19 monoclonal antibodies to beneficiaries without cost sharing," said CMS Administrator Seema Verma. "Our timely approach means beneficiaries can receive these potentially life-saving therapies in a range of settings – such as in a doctor's office, nursing home, infusion centers, as long as safety precautions can be met. This aggressive action and innovative approach will undoubtedly save lives."

CMS anticipates that this monoclonal antibody product will initially be given to health care providers at no charge. Medicare will not pay for the monoclonal antibody products that providers receive for free but this action provides for reimbursement for the infusion of the product. When health care providers begin to purchase monoclonal antibody products, Medicare anticipates setting the payment rate in the same way it set the payment rates for COVID-19 vaccines, such as based on 95% of the average wholesale price for COVID-19 vaccines in many provider settings. CMS will issue billing and coding instructions for health care providers in the coming days.

CMS anticipates the announcement will allow for a broad range of providers and suppliers, including freestanding and hospital-based infusion centers, home health agencies, nursing homes, and entities with whom nursing homes contract, to administer this treatment in accordance with the EUA, and bill Medicare to administer these infusions.

Under section 6008 of the Families First Coronavirus Response Act (FFCRA), state and territorial Medicaid programs may receive a temporary 6.2 percentage point increase in the Federal Medical Assistance Percentage (FMAP), through the end of the quarter in which the COVID-19 PHE ends. A condition for receipt of this enhanced federal match is that a state or territory must cover COVID-19 testing services and treatments, including vaccines and their administration, specialized equipment, and therapies for Medicaid enrollees without cost sharing. This means that this monoclonal antibody infusion is expected to be covered when furnished to Medicaid beneficiaries, in accordance with the EUA, during this period, with limited exceptions.

View the *Monoclonal Antibody COVID-19 Infusion Program Instruction.*

MLN Connects® for Thursday, November 12, 2020

COVID-19: Non-Physician Practitioner Billing for Audio Services

MLN Connects® for Thursday, November 12, 2020

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News

- Critical Care: Comparative Billing Report in November
- Raising Awareness of Diabetes in November

Compliance

- SNF 3-Day Rule Billing

Claims, Pricers & Codes

- COVID-19: Non-Physician Practitioner Billing for CPT Codes 98966-98968

MLN Matters Articles

- Home Health Prospective Payment System (HH PPS) Rate Update for Calendar Year (CY) 2021
- 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) 2021
- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs)--April 2021
- Manual Updates Related to the Hospice Election Statement and the Implementation of the Election Statement Addendum
- Updates to Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM) Claims

Publications

- Provider Compliance Tips — Revised

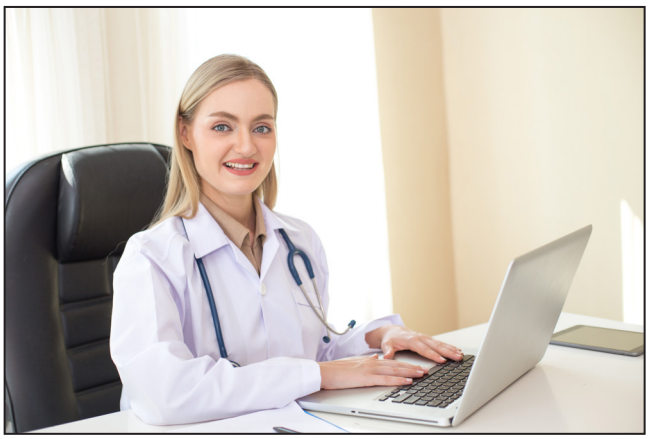
Information for Medicare Patients

- 2021 Medicare Part B Premiums Remain Steady

MLN Connects® – Special Edition – Friday, November 13, 2020

COVID-19 vaccine codes and PC-ACE software update

In anticipation of the availability of a vaccine(s), for the novel coronavirus (SARS-CoV-2) in response to the coronavirus disease 2019 (COVID-19), the *American Medical Association (AMA)*, working with the Centers for Medicare & Medicaid Services (CMS), created new codes for the vaccine and the administration of the vaccine. To prepare for the vaccine administration claims, the PC-ACE software is also updated and ready for providers to download.



If you intend to administer the COVID-19 vaccines when they become available, or the new monoclonal antibody bamlanivimab, especially if you intend to roster bill these codes, please download and install the new release of *PC-ACE*. This release includes the coding structure, currently comprised of both a *HCPCS Level I CPT* code structure issued by the American Medical Association (AMA) and a HCPCS Level II code structure issued by CMS. Together, these codes support the administration of the COVID-19 vaccines and the monoclonal antibody infusions, as they become available; this structure includes the codes for bamlanivimab. This code structure was developed to facilitate efficient claims processing for any COVID-19 vaccines and monoclonal antibody infusions that receive FDA EUA or approval. CMS and the AMA are working collaboratively regarding which codes to submit for COVID-19 vaccines and administration. Most of these codes are not currently effective and not all codes will be used. We will issue specific code descriptors in the future. Effective dates for the codes for Medicare purposes will coincide with the date of the FDA EUA or approval.

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866-454-9007
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Fax number (for general inquiries)
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Interactive voice response (IVR) system
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877-660-1759 (TTY)
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The SPOT help desk
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FCSOSPOTHelp@FCSO.com

Addresses

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First Coast Service Options
Part B Claims and Claims ADR FL P.O. Box 2009
Mechanicsburg, PA 17055-0709

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Overpayment Redetermination, Review Request
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Mechanicsburg, PA 17055-1850

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Mechanicsburg, PA 17055-1850
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Medical Affairs
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Suite 100
Mechanicsburg, PA 17050-9419
medicalaffairs@guidewellsource.com

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JN Part B Florida Debt Recovery and Check Mail
P.O. Box 3092
Mechanicsburg, PA 17055-1810

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Websites

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Centers for Medicare & Medicaid Services

E-learning Center
First Coast University

Beneficiaries
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Part B Claims VI
P.O. Box 2004
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JN Redeterminations Part A/B
P.O. Box 3412
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Overpayment Redetermination, Review Request
P.O. Box 3412
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Mechanicsburg PA 17050

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First Coast Service Options
Medical Affairs
2020 Technology Parkway
Suite 100
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medicalaffairs@guidewellsource.com

Medicare secondary payer

First Coast Service Options Inc.
Part B Claims VI
P.O. Box 2004
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Attention: JN EDI
PO Box 3703
Mechanicsburg, PA 17055-1861

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First Coast Service Options
JN Part B Puerto Rico and Virgin
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Medicare Education and Outreach

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JN Part A and B Complaint Processing Unit P.O. Box 3419
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