



Announcement

About Medicare Participation for Calendar Year 2017

We wish to emphasize the importance and advantages of being a Medicare participating (PAR) provider, and we are pleased that the favorable trend of participation continued into 2016 with a participation rate of 97.2 percent. As you plan for 2017 and become familiar with the coming changes, we hope that you will continue to be a PAR provider or, if you are non-participating (Non-PAR), will consider becoming a PAR provider.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) Quality Payment Program, which replaces the flawed Sustainable Growth Rate (SGR), will equip clinicians with the tools and flexibility to provide high-quality, patient-centered care. With clinicians as partners, the Administration is building a system that delivers better care, one in which clinicians work together and have a full understanding of patients' needs, Medicare pays for what works and spends taxpayer money more wisely, and patients are in the center of their care, resulting in a healthier country. The Quality Payment Program policy will reform Medicare payments for more than 600,000 clinicians across the country, and is a major step in improving care across the entire health care delivery system. To be successful in the long run, the Quality Payment Program must account for diversity in care delivery, giving clinicians options that work for them and their patients. Additional information about the Quality Payment Program can be found below in this announcement.

WHY BECOME A PARTICIPATING MEDICARE PROVIDER

All physicians, practitioners and suppliers – regardless of their Medicare participation status – must make their calendar year (CY) 2017 Medicare participation decision by December 31, 2016. Providers who want to maintain their current PAR status or Non-PAR status do not need to take any action during the upcoming annual participation enrollment period. To sign a participation agreement is to agree to accept assignment for all covered services that you provide to Medicare patients in CY 2017. The overwhelming majority of physicians, practitioners and suppliers have chosen to participate in Medicare. During CY 2016, 97.2 percent of all physicians and practitioners are billing under Medicare participation agreements.

If you participate and bill for services paid under the Medicare physician fee schedule (MPFS), your Medicare fee schedule amounts are 5 percent higher than if you do not participate. Your Medicare

Administrative Contractor (MAC) publishes an electronic directory of providers that choose to participate.

WHAT TO DO

If you choose to be a PAR physician in CY 2017:

- Do nothing if you are currently participating, or
- If you are not currently a Medicare participant, complete the available [blank agreement](#) and mail it (or a copy) to each MAC to which you submit Part B claims. (On the form show the name(s) and identification number(s) under which you bill.)

If you decide not to participate in CY 2017:

- Do nothing if you are currently not participating, or
- If you are currently a participant, write to each MAC to which you submit claims, advising of the termination of your participation in the participating physician program effective January 1, 2017. This written notice must be postmarked prior to January 1, 2017.

We hope you will decide to be a Medicare participant in CY 2017. Please call 1-866-454-9007 if you have any questions or need further information on participation.

The Medicare Learning Network® (MLN) offers many products on how providers and suppliers can enroll in the Medicare Program. The products include specific information for physicians and other Part B suppliers; ordering/referring providers; institutional providers; and Durable Medical Equipment, Prosthetics, Orthotics and Supplies suppliers as well as information on the electronic Medicare enrollment system, Provider Enrollment, Chain and Ownership System (PECOS). Refer to “[Medicare Provider-Supplier Enrollment National Educational Products](#)” for a list of all MLN provider-supplier products.

How Medicare is Getting Better for Doctors and Beneficiaries

Starting in 2017, Medicare will implement an important set of changes to improve how Medicare pays for primary care, care coordination, and mental health care. Clinicians will be compensated for spending more time with their patients, serving their patients’ needs outside of the office visit, and better coordinating care. These changes will deliver improved health outcomes that matter to the patient. With these changes, Medicare continues to move toward a health care system that encourages teams of clinicians to work together and collaborate in order to provide more personalized care for their patients. For more information about these new codes and other changes for 2017 see [here](#).

In addition, Medicare is laying the groundwork to expand access to the Medicare Diabetes Prevention Program (MDPP) model starting in 2018. The model has shown clear short-term benefits to the health of beneficiaries and the Medicare program from these commonsense improvements. For the long term, we know that fewer people with diabetes also saves patients and Medicare money because they use fewer expensive prescription drugs and have fewer hospital visits. And most importantly, by

preventing diabetes, patients and families across the country can avoid suffering from a debilitating disease. That's why we are expanding the model to make it available to all eligible Medicare beneficiaries.

In the Diabetes Prevention Program Model, Medicare beneficiaries at high risk for developing diabetes are provided strategies to increase their physical activity, control their weight and decrease their risk of type 2 diabetes. These interventions have been shown to lead to a 5 percent reduction in weight and will save Medicare an estimated \$2,650 for each person enrolled over a 15-month period, more than enough to cover the cost of the program.

New Data Reporting Requirement for the Clinical Laboratory Fee Schedule

On June 23, 2016, CMS released the "Medicare Clinical Diagnostic Laboratory Tests Payment System" [final rule](#), requiring laboratories performing clinical diagnostic laboratory tests to report the amounts paid by private payors for tests on the Clinical Laboratory Fee Schedule (CLFS). For the system's first year, laboratories, including physician offices laboratories, are required to collect HCPCS laboratory codes, associated private payor rates, and volume data from the period of January 1, 2016 through June 30, 2016 and report it to CMS by March 31, 2017, if they:

- Have more than \$12,500 in Medicare revenues from laboratory services on the CLFS during the data collection period and
- Receive more than 50 percent of their Medicare revenues from laboratory and physician services during the data collection period.

CMS will use this data to set CLFS payment rates effective January 1, 2018. For more information, visit the CLFS [PAMA Regulations](#) webpage.

New Payment and Care Delivery Model Tests at the CMS Innovation Center:

Physicians can directly participate in health care transformation through the efforts of the CMS Innovation Center which is charged with identifying, testing, and evaluating innovative payment and service delivery models that show promise of providing better access to quality care at lower costs for beneficiaries of Medicare, Medicaid and the Children's Health Insurance Program (CHIP). The CMS Innovation Center offers opportunities for innovators working in the field to share ideas, contribute to the discussion of improvements in health care, and participate in model tests.

As of September 30, 2015 more than 61,000 providers in all 50 states, the District of Columbia, and Puerto Rico are currently participating in over 25 Innovation Center payment and service delivery model tests, serving an estimated 4.7 million beneficiaries of Medicare, Medicaid, and CHIP. Participants include states, organizations, and a broad array of health care professionals, as well as other stakeholders in the health care community. Millions of other Americans are benefiting from CMS Innovation Center quality improvement initiatives and the engagement of other payers in model tests.

The broad engagement of providers across the country in alternative payment and service delivery models is leading to improvement. Medicare per capita spending growth rates have reached historic lows, and hospital readmission rates have declined meaningfully. All alternative payment models and payment reforms that seek to deliver better care at lower cost share a common pathway for success. Providers, payers, and others in the health care system must make fundamental changes in their day-to-day operations that improve quality and reduce the cost of health care.

This work aligns with the goals the Department of Health and Human Services (HHS) set in January of 2015 of tying 30 percent of traditional, or fee-for-service (FFS), Medicare payments to quality or value through alternative payment models, such as Accountable Care Organizations (ACOs) or bundled payment by the end of 2016, and tying 50 percent of payments to these models by the end of 2018. In March of 2016, President Obama announced that HHS had met its 30 percent target 11 months ahead of schedule. HHS also set a goal of tying 85 percent of all traditional Medicare payments to quality or value by 2016 and 90 percent by 2018 through programs such as physician value-based payment modifier (VM).

We encourage providers to join the [Health Care Payment Learning and Action Network](#) that brings together private payers, providers, employers, state partners, consumer groups, individual consumers, and many others to accelerate the transition to alternative payment models. If you would like to join the Network, please complete the [online form](#).

We also encourage you to visit the [CMS Innovation Center website](#) for further information and for announcements of new opportunities including large scale transformation of clinical practices to accomplish our aims of better care and better health at lower costs.

Medicare Shared Savings Program:

Currently, over 400 ACOs participate in the Medicare Shared Savings Program (Shared Savings Program). When an ACO succeeds in both delivering high-quality care and lowering growth in Medicare spending on patients its providers serve, it may share in the savings it achieves for the Medicare program. In performance year 2015, we shared more than \$645 million in savings with 119 ACOs. ACOs that reported quality in both 2014 and 2015 improved on 84 percent of the quality measures that were reported in both years. The average quality performance improved by over 15 percent between 2014 and 2015 for four measures: screening for risk of future falls, depression screening and follow-up, blood pressure screening and follow-up, and providing pneumonia vaccinations. Over 91 percent of ACOs in a second or third performance year during 2015 increased their overall quality performance score through Quality Improvement Reward points in at least one of four quality measure domains.

When a Shared Savings Program ACO successfully reports required quality measures through the Physician Quality Reporting System (PQRS) Group Practice Reporting Option (GPRO) web interface, eligible professionals (EPs), (i.e. physicians and other practitioners) that bill under the Tax Identification Number (TIN) of an ACO participant will be deemed eligible to avoid the PQRS payment adjustment, will have their Clinical Quality Measure (CQM) reporting requirements satisfied for the Medicare Electronic Health Record (EHR) Incentive Program if they extract the data necessary for the ACO to satisfy the quality reporting requirements from certified EHR technology *and* the EPs

meet all other requirements of the Medicare EHR Incentive Program; and will avoid the automatic downward adjustment under the Value-Based Payment Modifier (Value Modifier) and may be eligible for upward adjustments under the Value Modifier based on the ACO's quality performance. For more information on how to access Quality and Resource Use Reports (QRURs), please refer to the QRUR section of this letter.

We encourage you to consider joining or forming an ACO under the Shared Savings Program. We also encourage physicians and other practitioners to collaborate with ACOs in your area so that together they can achieve the goals of the Shared Savings Program including successful reporting and performance on quality measures.

Please visit the [Shared Savings Program webpage](#) for more information about the program including how to apply, join or learn about ACOs in your area.

Moving From a Patchwork of Quality Programs

On December 31, 2018, three CMS quality programs: the Physician Quality Reporting System, the Medicare EHR Incentive Program and the Value-Based Payment Modifier program will end. The Quality Payment Program, which is a part of the bipartisan MACRA legislation, will transition the way clinicians are paid- from a system where payments are based on volume to payments based on quality- with the ultimate goal in mind of better care, smarter spending, and healthier beneficiaries.

To wrap-up reporting for the existing programs, clinicians should be aware of the following 2017 updates:

- There is still time to successfully report quality measures for 2016 to avoid the 2018 negative 2% PQRS payment adjustment. The 2016 reporting period ends December 31, 2016 with submission beginning January 1, 2017.
- All 2016 quality data reported under PQRS, including Qualified Clinical Data Registries (QCDR) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) for PQRS data, are available for public reporting on Physician Compare in late 2017. Learn more about public reporting by visiting the [Physician Compare Initiative page](#) or contacting the Physician Compare support team at PhysicianCompare@Westat.com.

Introducing the Quality Payment Program:

In April 2015, an overwhelmingly bipartisan Congress passed MACRA. MACRA ended the SGR and its potential payment cliffs, and created a new, streamlined Medicare payment system that supports and rewards quality care for clinicians. CMS named this new payment system the **Quality Payment Program** and created a [website](#) to help clinicians learn about this new program.

Who's in the Quality Payment Program?

You're a part of the Quality Payment Program if you bill Medicare more than \$30,000 a year **and** provide care for more than 100 Medicare patients a year. In addition, you must be a physician,

physician assistant, nurse practitioner, clinical nurse specialist, or a certified registered nurse anesthetist to be in the program. If it is your first year participating in Medicare, then you're not in the Quality Payment Program. CMS will be providing additional support to help you determine your eligibility soon.

When does the Quality Payment Program start?

The first performance year of the Quality Payment Program begins in 2017 and it will affect payments starting in 2019. The Quality Payment Program replaces PQRS, the EHR Incentive Program (also known as Medicare Meaningful Use), and the Value-based Payment Modifier. You will no longer need to submit information for PQRS and the Medicare EHR Incentive Program after 2016. Beginning January 1, 2017, clinicians may participate in the Quality Payment Program through one of two tracks:

- **Advanced Alternative Payment Models (APMs)**, which are care organizations or approaches that let practices earn more for taking on some risk related to their patients' outcomes. You may earn a 5% incentive payment by going further in improving patient care and taking on risk through an Advanced APM. To qualify for the 5% incentive payment, you must receive at least 25% of Medicare covered professional services or see at least 20% of your Medicare patients through an Advanced APM in 2017. Examples of Advanced APMs include Medicare Shared Savings Program Track 2 and 3. A full list of Advanced APMs is available [here](#).
- **The Merit-based Incentive Payment System (MIPS)**, which gives you the opportunity to be paid more for better care and investments that support patients. In the first year, you may earn as much as a 4% payment adjustment for participating in MIPS by submitting evidence-based and practice-specific quality data. If you do not submit any information to MIPS and do not qualify for the 5% incentive payment through an Advanced APM, then you will receive a 4% negative payment adjustment in 2019. You must submit 2017 information by March 31, 2018 to earn the positive payment adjustment. Learn more about MIPS and the information available to submit [here](#).

If you belong to a practice with 15 or fewer clinicians, then you will soon be eligible to receive free, on-the-ground help from a local organization. We're listening and want your input on how to improve the Quality Payment Program. Email us at gpp@cms.hhs.gov or call [1-866-288-8292](tel:1-866-288-8292) weekdays from 8 AM to 8 PM ET. Together, we're moving towards a modern Medicare that supports better patient care through smarter spending for a healthier America.

Availability of the 2015 Annual and Supplemental Quality and Resource Use Reports (QRURs):

We encourage all groups and solo practitioners nationwide to access their 2015 Annual QRUR which were made available in September 2016, to learn about their 2017 Value Modifier payment adjustment and performance on quality and cost measures. These QRURs are also available for groups and solo practitioners that participated in the Shared Savings Program, the Pioneer ACO Model, or the Comprehensive Primary Care initiative in 2015. The 2015 Annual QRURs show how groups and solo practitioners, as identified by their Medicare-enrolled TIN, performed in 2015 on the quality and cost measures used to calculate the 2017 Value Modifier. For physicians in TINs who are subject to the 2017 Value Modifier, the QRUR shows how the Value Modifier will apply to physician payments

under the MPFS for physicians who bill under the TIN in 2017. Detailed information about the Annual QRURs is available on the [2015 QRUR and 2017 Value Modifier website](#).

In October 2016, CMS made available the 2015 Supplemental QRURs. These QRURs are confidential feedback reports provided to group practices with cost information on the management of their Medicare (FFS) patients based on 23 episodes of care (“episodes”) that include 9 major acute condition episode types and 14 major procedural episode types. The Supplemental QRURs are for informational purposes only and complement the per capita cost and quality information provided in the Annual QRURs. Information contained in the Supplemental QRURs is not used in the Value Modifier Program and does not impact payment. Detailed information about the Supplemental QRURs is available on the [Supplemental QRUR website](#).

The Annual and Supplemental QRURs are available [here](#) and can be accessed by an authorized representative of the TIN using an Enterprise Identity Management (EIDM) account with the correct role. Please see the [How to Obtain a QRUR](#) website for instructions on how to set up an EIDM account and access your TIN’s QRURs.

Medicare and Medicaid EHR Incentive Programs:

In 2016, EPs will use EHR technology certified to the 2014 Edition or if available may use EHR technology certified to the 2015 edition or a combination of both to meet the objectives and measures of meaningful use as modified in a recent final rule¹, which includes alternate exclusions for EPs scheduled to be in Stage 1. We are proposing EPs will have a 90-day EHR reporting period within CY 2016 and attest between January 3 through February 28, 2017. For more information about the EHR Incentive Programs, including the 2016 definition of meaningful use, visit the [EHR Incentive Programs website](#).

In order to align programs and reduce the burden on physicians and other eligible professionals, physicians may submit CQM data for both the Medicare EHR Incentive Program and the PQRS program electronically.

Physicians who fail to demonstrate meaningful use for the applicable EHR reporting period may be subject to a payment adjustment to their Medicare claims. In 2017, the result will be payment of 97% of the MPFS amount. Physicians must successfully demonstrate meaningful use every year to avoid the Medicare payment adjustments. Successful demonstration of meaningful use for an EHR reporting period in 2016 will enable physicians to avoid the payment adjustment in 2018. Physicians also have the option of filing a significant hardship exception application by July 1, 2017. Don’t wait until the last minute to meet meaningful use or file a hardship exception!

For more information on CMS Quality Programs:

[PQRS webpage](#)

¹ Medicare and Medicaid Programs; Electronic Health Record Incentive Program—Stage 3 and Modifications to Meaningful Use in 2015 Through 2017; Final Rule, 80 Fed. Reg. 62,762 (Oct. 16, 2015).

[Medicare EHR Incentive Program webpage](#)

[Value-Based Payment Modifier webpage](#)

Social Security Number Removal Initiative (SSNRI):

The [MACRA](#), requires CMS to remove Social Security Numbers (SSNs) from all Medicare cards by April 2019. A new Medicare Beneficiary Identifier (MBI) will replace the SSN-based Health Insurance Claim Number (HICN) on the new Medicare cards for Medicare transactions, such as claims, eligibility status, and claim status. Look at your practice management systems and business processes and determine what changes you need to make to use the new MBI. You'll need to make those changes and test them by April 2018, before we send out new Medicare cards. If you use vendors to bill Medicare, you should contact them to find out about their MBI practice management system changes. Visit our [SSNRI webpage](#) for more information.

Information Related to Medicare Prescription Drug (Part D) Coverage:

Prescriber Enrollment in Medicare

Physicians and EPs who write prescriptions for Part D drugs should be enrolled in Medicare in an approved status or have a valid record of opting out of Medicare. Any physicians and EPs not in compliance with these requirements should enroll now. The current enforcement date of the prescriber enrollment requirement is February 1, 2017. While CMS is committed to the implementation of the prescriber enrollment requirements, CMS also recognizes the need to minimize the impact on the beneficiary population and ensure beneficiaries have access to the care they need. To strike this balance, CMS will implement a multifaceted, phased approach which will align full enforcement of the Part D prescriber enrollment requirements with other ongoing CMS initiatives. Full enforcement of the Part D prescriber enrollment requirement is January 1, 2019.

Providers may enroll by completing an Internet-based PECOS application or they may complete and submit a CMS-855O application (allows the physician to enroll in Medicare to order and certify services and items, and to prescribe Part D drugs; however, this option does not confer billing privileges). Providers who wish to opt-out of Medicare may submit an opt-out affidavit to their MAC.

If you are unsure if you are compliant with this requirement, please review the prescriber enrollment file located [here](#). The file identifies those providers who are currently in compliance with the prescriber enrollment requirements.

As part of the enrollment process, provider credentials and eligibility are verified.

- If you haven't enrolled, please do so and encourage your colleagues who are not enrolled in Medicare to enroll now. The options available for enrolling or opting out of Medicare are

identified above. Please visit the [prescriber enrollment website](#) to obtain additional information.

- Interns, residents, and fellows who are prescribers of Part D drugs may enroll in Medicare to prescribe if the state licenses these prescribers. Licensure can include a provisional license or similarly- regulated credential. Otherwise, un-licensed interns, residents, and fellows must specify the teaching physician as the authorized prescriber on the prescription. Licensed residents have the option to either enroll or use the teaching physician on claims.
- Pharmacists need not enroll or opt out for their prescriptions to be covered under Part D. More information is available by visiting [Part D Prescriber Enrollment website](#).

NPPES Taxonomy

Please check your data in the National Plan and Provider Enumeration System (NPPES) and confirm that it still correctly reflects you as a health care provider. There is increased focus on the National Provider Identifier (NPI) as a health care provider identifier for program integrity purposes. Incorrect taxonomy data in NPPES may lead to unnecessary inquiries about your credentials as it may appear to Medicare oversight authorities that you may not be lawfully prescribing Part D drugs. Comprehensive information about how the NPI rule pertains to prescribers may be obtained [here](#).

Prescription Drug Abuse

Prescription drug abuse is the nation’s fastest growing drug problem. Additional prescriber awareness and engagement are crucial to addressing this problem. CMS has implemented an approach to help Medicare prescription drug plans identify and manage the most egregious cases of opioid overutilization, which often involves multiple prescribers and pharmacies who are not aware of each other. If you are contacted by a prescription drug plan about the opioid use of one of your patients, please take the time to provide your feedback and expertise to help assure the safe use of these products.

Prescriber Identifiers in Research

You should be aware that CMS now allows researchers to request the release of unencrypted prescriber identifiers contained in Medicare Part D data. This change in policy now gives researchers the ability to conduct important research that involves identified prescribers, which will increase the positive contributions researchers make to the evaluation and function of the Part D program. This access supports CMS’s growing role as a value-based purchaser of health care, and is only granted pursuant to CMS’s policies and procedures for release of such data to researchers.

Serving Qualified Medicare Beneficiaries (QMBs):

Many Medicare beneficiaries with limited incomes and resources are also covered by their state’s QMB program. This means that the state Medicaid agency is responsible for these beneficiaries’ Medicare cost sharing. We encourage all Medicare physicians and other practitioners to serve individuals eligible for the QMB program.

We also remind all Medicare physicians and other practitioners that they may not bill their QMB patients for Medicare cost sharing, including deductibles, coinsurance, and copayments. These rules apply to all QMB patients, including those enrolled in a Medicare Advantage (Part C) plan. Under federal law, Medicare payment plus any Medicaid payment are considered payment in full for services rendered to a beneficiary participating in the QMB program. Physicians and other practitioners may want to refresh their understanding of how their state handles QMB cost sharing claims. In most states, claims submitted to Medicare are crossed over automatically to the state Medicaid agency. States may require providers to register with their State payment system in order to receive cost sharing payments. Providers can also query their state's Medicaid eligibility verification system to identify QMBs.

Providers should make sure their billing software and administrative staff exempt QMB individuals from Medicare cost-sharing billing and related collection efforts. If they become aware of improper billing of QMBs, providers should refund any erroneous charges and recall any past or existing bills (including referrals to collection agencies) as appropriate. More information on billing procedures for QMBs is available [here](#).

Revalidation:

CMS has met the requirements established in section 6401(a) of the Affordable Care Act (ACA) and has mailed revalidation letters to all 1.6 million providers and suppliers by the March 23, 2015 deadline. CMS is resuming regular revalidation cycles every 3 years for Durable Medical Equipment (DME) suppliers and every 5 years for all other providers and suppliers.

CMS has implemented several revalidation processing improvements to include establishing due dates by which a provider or supplier must revalidate. Revalidation due dates will fall on the last day of the month (i.e.: June 30, 2016, July 31, 2016, August 30, 2016) and are posted to <https://data.cms.gov/revalidation>. Providers and suppliers are expected to submit their revalidation application by this date. Generally, this due date will remain with you throughout subsequent revalidation cycles.

In addition to the posted lists, providers and suppliers will still receive email or mailed revalidation notices from their MACs when they are due to revalidate. Providers can revalidate their enrollment information using the [Internet-based PECOS](#) or the [CMS-855 paper application](#). CMS encourages all practitioners to respond timely to revalidation requests received by their MAC. Failure to submit a complete revalidation application, including all supporting documents, may result in deactivation of your Medicare billing privileges.

For more information on the revalidation process please refer to the [Revalidations website](#) and this [MLN Matters Special Edition Article](#).

The Medicare Learning Network® (MLN):

The MLN offers free educational materials for health care professionals on CMS programs, policies, and initiatives. Visit the [MLN homepage](#) for information on:

Publications & Multimedia

- [MLN Publications](#) offer current information on many topics such as billing, policy initiatives, and program updates.
- [MLN Matters® Articles](#) explain national Medicare policy in an easy-to-understand format and focus on coverage, billing, and payment rules for specific provider types.
- [Multimedia](#) offers videos, podcasts, and graphics that help explain the Medicare Program. Videos are also available on the YouTube [MLN playlist](#).

Events & Training

- [National Provider Calls & Events](#) are conference calls and webcast presentations explaining new policies and changes to the Medicare Program and typically include Question & Answer sessions for participants.
- [Web-Based Training Courses](#) offer self-paced training on many topics such as coding, fraud and abuse, Medicare payment policy, and provider compliance. CMS provides continuing education credit for most courses.

Newsletter

- [MLN Connects® Provider eNews](#) is a weekly email newsletter for health care professionals containing CMS program and policy news, announcements, upcoming events, claim, pricer, and code information, and MLN updates.

Continuing Education (CE) Credit

We offer many ways to earn continuing education credit. Visit the [Earn credit](#) page for more details.

CMS is accredited to provide continuing education credit by the [International Association for Continuing Education and Training \(IACET\)](#) and the [Accreditation Council for Continuing Medical Education \(ACCME\)](#). [Click here to see CMS' Accreditation Statements](#). In addition, many professional associations offer continuing education credit to complete training activities designed for health care professionals including physicians, nurses, billers, coders, and other clinicians. You can find a broad range of courses that focus on Medicare updates, meeting professional development goals, and state license renewal requirements.

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2017 Payment Rates

When available, 2017 payment rates for First Coast Service Options, Inc. will be at: http://medicare.fcso.com/Fee_news/. First Coast may be contacted at 1-800-454-9007 (Florida, U.S. Virgin Islands) or 1-877-715-1921 (Puerto Rico). Additional information will be posted to <http://medicare.fcso.com/> as it becomes available.