MD AAHAM – Medicare Updates

March 15, 2024
1:00 p.m. ET

NOVITAS SOLUTIONS

Your Presenter

- Diane Hess
- Education Specialist

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Acronym List

Acronym	Definition
CAH	Critical Access Hospital
CMS	Center for Medicare & Medicaid Services
CPT	Current Procedural Terminology
CY	Calendar Year
DDE	Direct Data Entry
DSMT	Diabetes Self-Management Training
ERA	Electronic Remittance Advice
FISS	Fiscal Intermediary Shared System
HCPCS	Healthcare Common Procedure Coding System
IOP	Intensive Outpatient Therapy
MAC	Medicare Administrative Contractor
NPI	National Provider Identifier

Acronym List Two

Acronym	Definition
OPPS	Outpatient Prospective Payment System
OT	Occupational Therapy
PECOS	Provider Enrollment, Chain, and Ownership System
PFS	Physician Fee Schedule
PT	Physical Therapy
PTAN	Provider Transaction Access Number
SLP	Speech Language Pathology
TOB	Type of Bill

Agenda

1. Novitas Initiatives
2. Change Healthcare Cybersecurity Incident
3. Medicare Updates
4. CY 2024 Telehealth Updates
5. Part A Claim Errors

Novitas Initiatives

Sub header option

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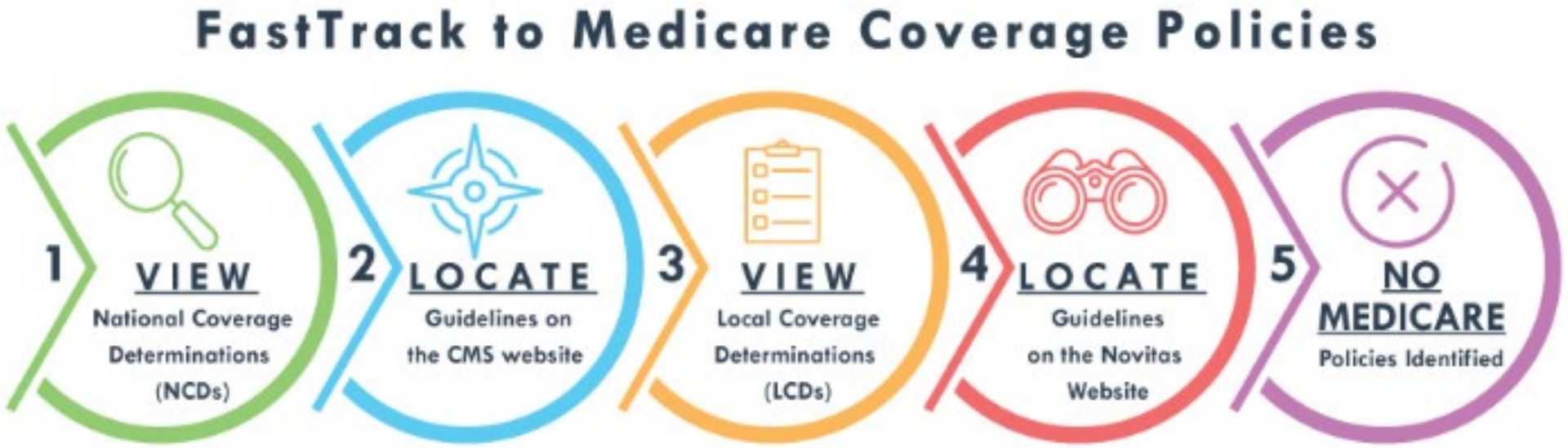
Journey to Local Coverage Determination (LCD) Coverage

- Medical Affairs is pleased to announce the publication of the "Journey to LCD Coverage" located on the LCD Center main page
- Each step provides understanding on how LCDs work for you

- Additional new publications include:
  - Strength of Evidence
  - LCD Development Process flowchart
  - Local and National Coverage Reference Guide

FastTrack to Medicare Coverage Policies Tool

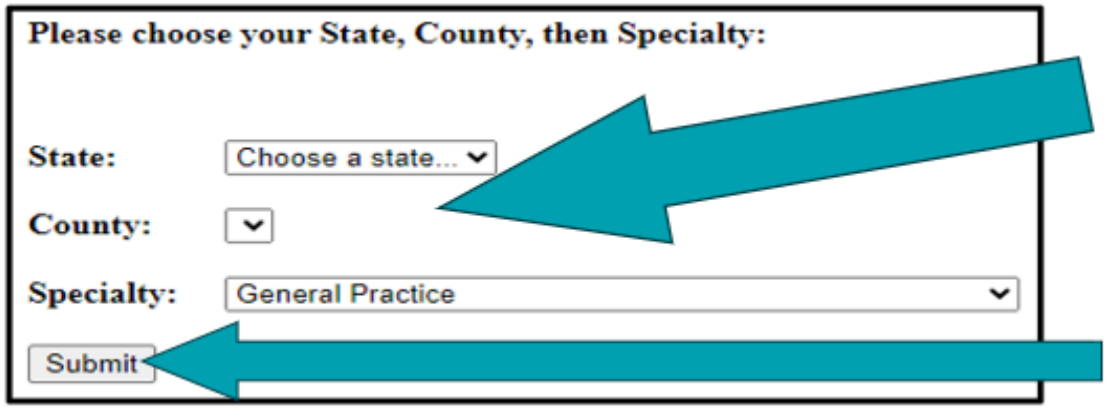
- The tool provides easy steps to follow and useful links to resources to help find your Medicare coverage answers
- Reference:
  - FastTrack to Medicare Coverage Tool



2024 Medicare Participating Physicians/Suppliers Directory (MEDPARD)

- 2024 MEDPARD is now available (JL)

Click "Find a Physician"



Use the arrow/pull-down menus to select a specific state, county and specialty

Click "Submit" and the supplier choices will display, in alphabetical order, in a popup window

Learning Center

- Join us for our engaging live educational events!
- The events below are in the spotlight for March
- Visit our Learning Center calendar of events for a complete listing of events
- Don't miss out – Register today!

Date	Title	Medicare A or B
03/18/2024-03/21/2024	StayConnected New Provider Workshop series	A/B
03/25/2024	Behavioral Health Services	B
03/26/2024	Evaluation and Management: Observation and Inpatient Hospital Services	B
03/26/2024	Medicare Compliance: Getting to Know Your Medicare Review Contractors	A/B
03/27/2024	Evaluation and Management: Interactive Scoresheet for Inpatient Hospital Services	B
03/27/2024	Self-Service Tools and You: Navigating the Part A Novitas Website	A
03/27/2024	Evaluation and Management: Interactive Scoresheet for Inpatient Hospital Services	B
03/28/2024	Medicare Coverage for Dental Services	A/B
03/28/2024	Rural Emergency Hospital Guidelines	A
03/28/2024	Evaluation and Management: Critical Care Services	B

Social Media!

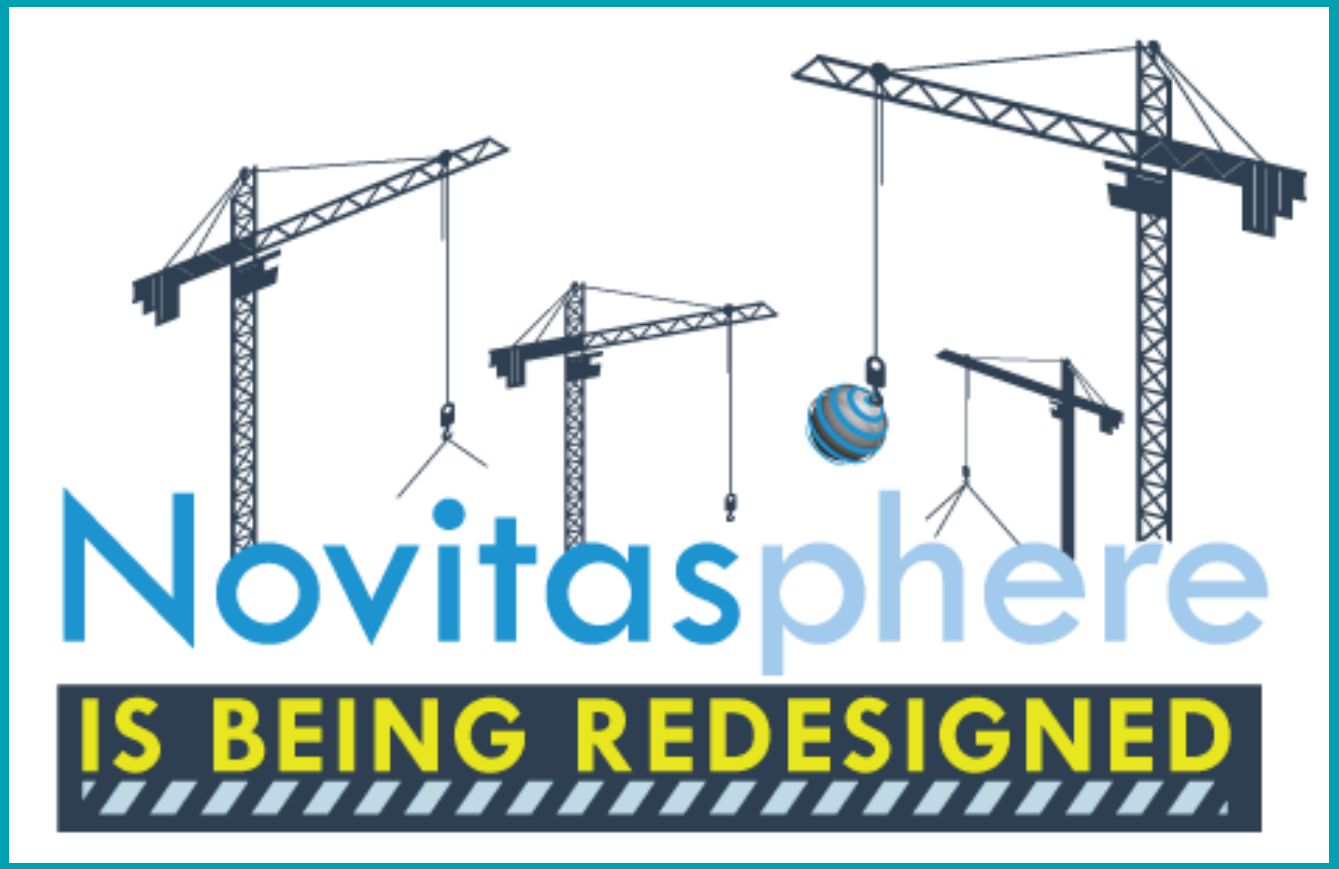
- Novitas Solutions is active in the world of social media. We cannot wait to show you how we care about what we do, who we serve and each other. Stay tuned for important business information, our community engagement initiatives and a peek into the dynamic culture of our company!
- Don’t miss out on important updates
- Follow us now on LinkedIn and YouTube channel

Are You Enrolled in Novitasphere?

- Novitasphere is a secure internet portal that provides easy and quick access to access to many time-saving features.
- Some features available include patient eligibility, claim status, medical review records and electronic claim file submission
- Available to JH and JL Part A and Part B providers, billing services and clearinghouses for FREE
- Live Chat feature
- Dedicated Help Desk- 1-855-880-8424
- Novitasphere Home page

Novitasphere – REDESIGNED!

- **COMING in 2024 -** Novitasphere is being redesigned to a more modern look and feel!
- The redesigned Novitasphere will include the same current features and several feature enhancements.



Change Healthcare Cybersecurity Incident

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Change Healthcare/Optum Payment Disruption (CHOPD) Accelerated and Advance Payment Request

- Providers and suppliers experiencing disruption in Medicare claims processing may request:
  - Accelerated payments to Medicare Part A providers
  - Advance payments to Medicare Part B suppliers
- Use the Request for Change Healthcare/Optum Payment Disruption (CHOPD) Accelerated Payments to Part A Providers and Advance Payments to Part B Suppliers template:
  - Must be initiated and signed by provider's authorized official
  - Providers part of a health system may attach a list of PTANs/NPIs with the request
  - Submit completed request templated to the Accelerated and Advance Payment mailbox:
    - AAP@novitas-solutions.com
  - Requests processed in the order they are received
  - If request includes all required information
    - Payment will be made on or after five calendar days from the date request is submitted
- Review the CMS CHOPD Accelerated Payments to Part A Providers and Advance Payments to Part B Suppliers Fact Sheet for eligibility requirements, required acknowledgement of terms and payment amounts
- Reference:
  - Request for Change Healthcare/Optum Payment Disruption Accelerated and Advance Payment

Claim Submission Options for Impacted Providers of the Change Healthcare Cybersecurity Incident

- Providers impacted by the Change Healthcare cybersecurity incident:
  - Check with them first for further instructions
- Options for claim submission:
  - Novitasphere:
    - Claim Submission/ERA feature to submit ANSI 837 electronic claims:
      - Separate software used to create file such as PC-ACE or software from an approved vendor
  - Select a different third-party biller:
  - Convert to a direct billing vender
  - Part A Direct Data Entry (DDE):
    - Part A providers only
    - For more information, visit the FISS Access webpage
  - Paper claims:
    - Paper claim processing requires a minimum 29-day payment floor
    - No automated editing for claim errors:
      - Claim returned to make corrections and resubmit
    - If currently required to submit electronic claim:
      - Administrative Simplification Compliance Act (ASCA) Waiver Request form may be completed indicating on the form that the waiver request is being made due to the Change Healthcare cybersecurity incident
- Reference:
  - Claim submission options for impacted providers of the Change Healthcare cybersecurity incident
  - Claim submission webpage
  - Approved vendor list
  - EDI enrollment forms and instructions

Submit Claims and Retrieve Remittance using Novitasphere

- Claims Submission/ERA feature:
  - Provides a direct connection to the Novitas system to transfer electronic claim files
  - A separate software is needed to create the electronic claim file:
    - PC-ACE software program
    - Approved vendors
- Two ways to obtain remittance information:
  - View Remittance under Retrieve Documents feature:
    - Provides a readable remittance like a standard paper remittance (SPR)
  - Claims Submission/ERA feature:
    - Provides an electronic remittance file that would need interpreted by a separate software
    - Could be used for auto-posting to accounts
- Need to enroll:
  - Novitasphere Enrollment eGuide:
    - Walks you through the steps needed to gain access
  - To enroll for the PC-ACE software, simply select Yes from the PC-ACE dropdown on the Novitasphere enrollment form
- Reference:
  - Submit claims and retrieve remittance using Novitasphere

Medicare Updates

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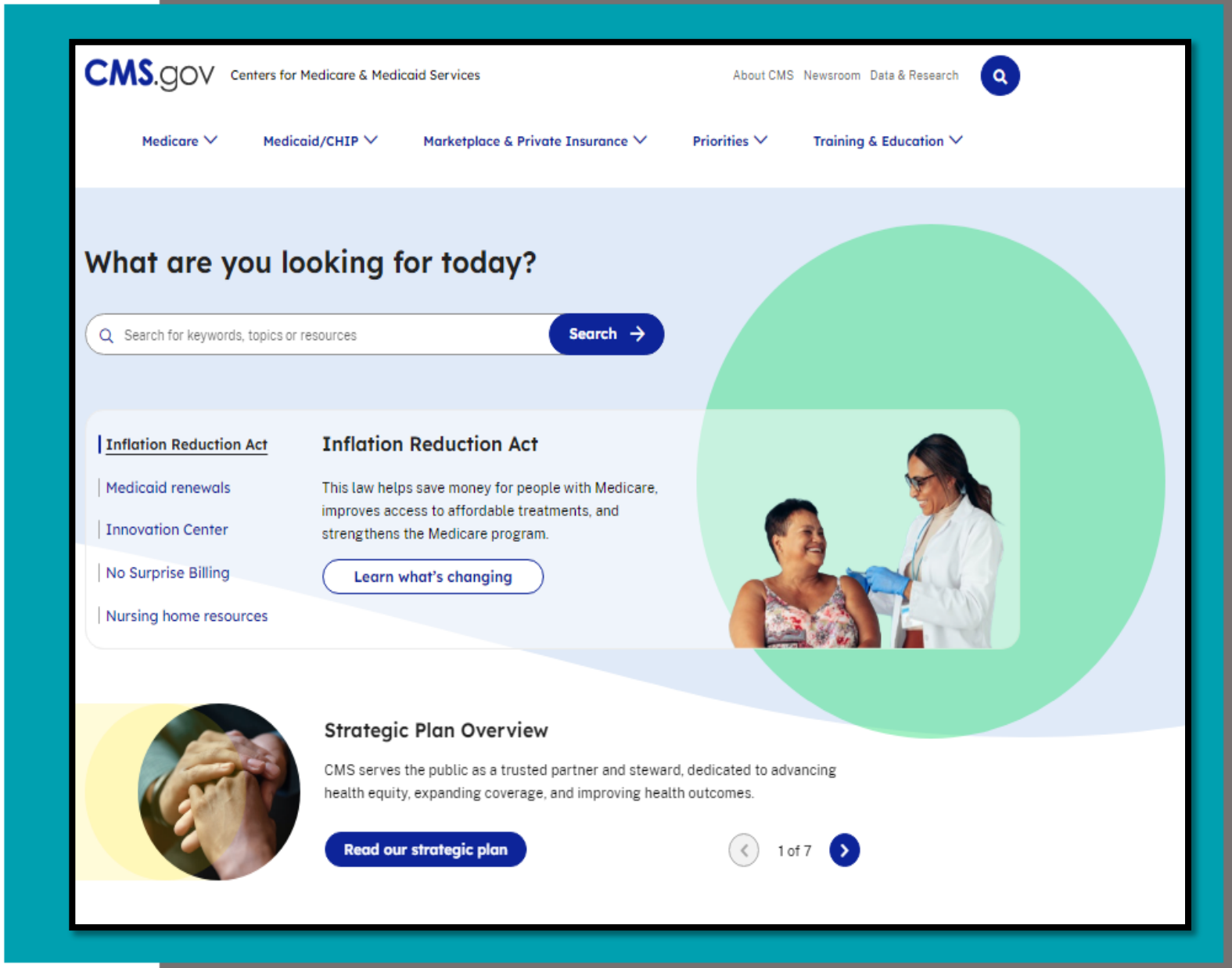
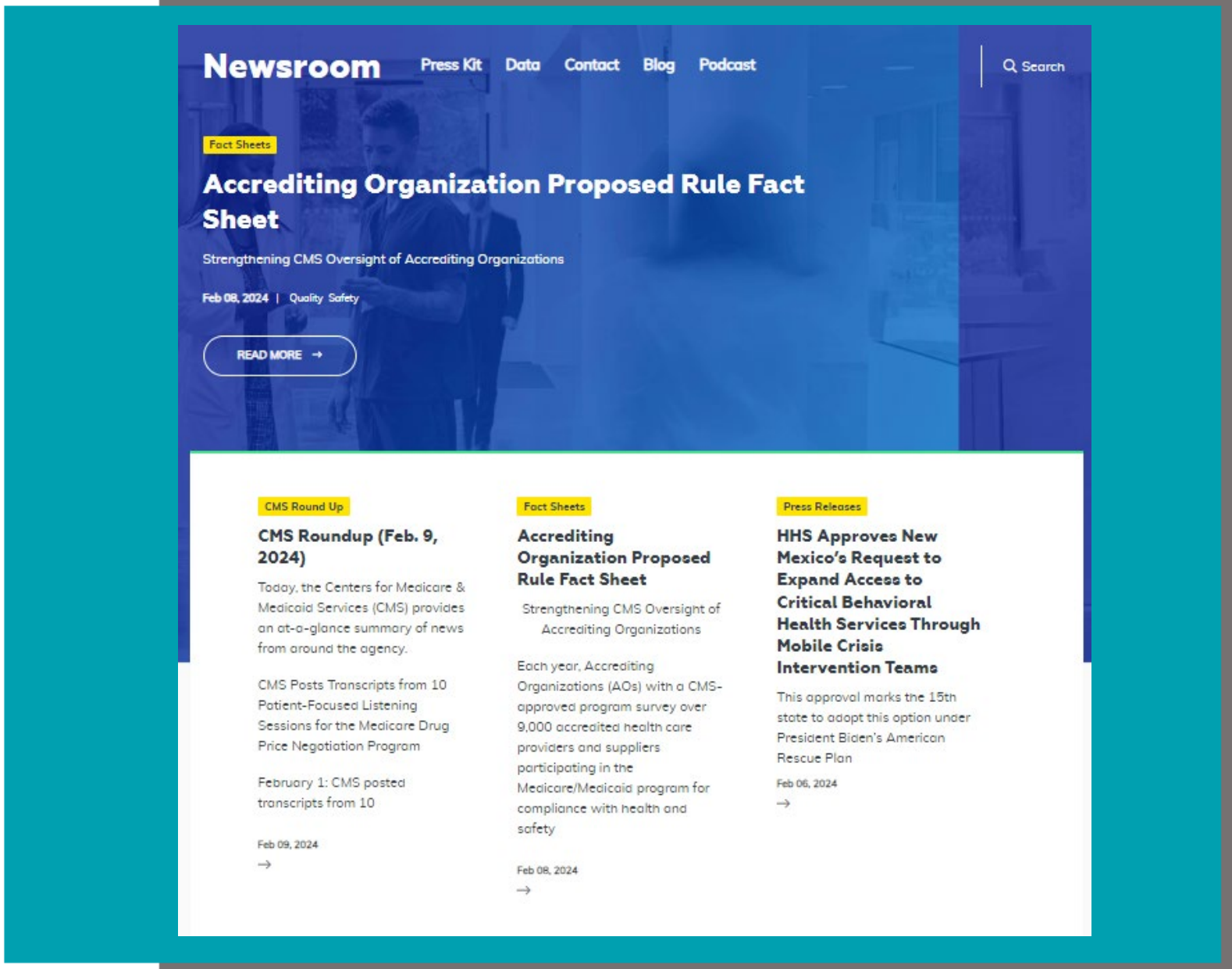
CMS Website

- CMS website has been redesigned



CMS Newsroom

- CMS Newsroom issues press releases and fact sheets.



CMS Transmittals

- CMS issues transmittals to communicate new or changed policies or procedures

2024 Transmittals

Displaying 1 - 10 of 53

Show entries: 10 per page

Filter On

Apply

Transmittal #	Issue Date	Subject	Implementation Date	CR #	Provider Education	Provider Education Release Date	Provider Education Revision Date
R12456FM	2024-06-30	New Physician Specialty Code for Epileptologists	2024-01-10	13425			
R5SPMP	2024-02-09	Revisions to the Manual for the State Payment of Medicare Premiums		N/A			
R12238FM	2024-02-08	**Manual Update for New Medicare Provider Specialty Codes (E1 and E2) and Payment...**	2024-10-02	13346			
R12506OTN	2024-02-08	**User Enhancement Change Request (UECR): New Multi-Carrier System (MCS) Inquiry...**	2024-04-01	13344			
R12498CP	2024-02-08	Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy...	2024-07-01	13517			

Comprehensive Error Rate Testing (CERT) Program

- Purpose:
  - CMS implemented the Comprehensive Error Rate Testing (CERT) program to measure improper payments in the Medicare Fee-for-Service (FFS) program
- CERT Process:
  - The CERT Program selects a random sample of approximately 50,000 claims during each reporting period
  - CMS calculates a national improper payment rate and contractor-and-service-specific improper payment rates
  - An independent medical contractor reviews the sample to determine if paid properly under Medicare coverage, coding, and billing rules
- CERT Findings:
  - 2023 Medicare Fee-for-Service Supplemental Improper Payment Data
- Novitas CERT Page

2024 Medicare Deductible, Coinsurance, and Premium rates

Who

- All Medicare beneficiaries

When

- Effective: January 1, 2024
- Implementation January 3, 2024

What

- Medicare Part A and Part B deductible and coinsurance rates

- Key Points:
  - 2024 Part A – Hospital Insurance:
    - Deductible: $1632.00
    - Coinsurance:
      - $408.00 a day for 61st-90th day
      - $816.00 a day for 91st-150th day (lifetime reserve days)
      - $204.00 a day for 21st-100th day (Skilled Nursing Facility coinsurance)
  - 2024 Part B –Medical Insurance:
    - Deductible: $240.00 a year
    - Coinsurance: 20 percent
- Reference:
  - Medicare Learning Network (MLN) Matters Article: MM13365 "Medicare Deductible, Coinsurance, & Premium Rates: CY 2024 Update"
  - Deductible/Co-Insurance/Therapy Threshold

2024 Annual Update of Per-Beneficiary Threshold Amounts

Who

- Physical Therapy (PT) and Speech-Language Pathology (SLP)

When

- Effective date: January 1, 2024
- Implementation date: January 2, 2024

What

- Update the annual per-beneficiary incurred expenses amounts now called the KX modifier thresholds and related policy for calendar year 2024

- Key information:
  - For CY 2024, the KX modifier threshold amounts are:
    - $2,330 for Physical Therapy (PT) and Speech-Language Pathology (SLP) services combined
    - $2,330 for Occupational Therapy (OT) services
  - The Medical Record (MR) threshold amount:
    - PT and SLP services combined remains at $3,000
    - OT services remains at $3,000
    - These threshold amounts will remain in place until CY 2028 at which time will be updated by the Medicare Economic Index (MEI)
- Reference:
  - Change Request (CR): CR13371 "2024 Annual Update of Per-Beneficiary Threshold Amounts"

Pulmonary Rehabilitation, Cardiac Rehabilitation, & Intensive Cardiac Rehabilitation Expansion of Supervising Practitioners

Who

- Physicians, suppliers and other providers submitting claims to Medicare

What

- Updates to pulmonary, cardiac and intensive cardiac rehabilitation services

When

- Effective Date: January 1, 2024
- Implementation Date: February 12, 2024

- Key information:
  - In CY2024 PFS Final Rule, revisions to the Pulmonary Rehabilitation (PR), Cardiac Rehabilitation (CR), Intensive Cardiac Rehibition (ICR) expanded the types of practitioners that may supervise
  - Allowing physician assistants, nurse practitioners, and clinical nurse specialists to supervise cardiac, intensive cardiac and pulmonary rehabilitation programs
- Reference:
  - Medicare Learning Network Matters (MLN) article: MM13513 – Pulmonary Rehabilitation, Cardiac Rehabilitation, & Intensive Cardiac Rehabilitation Expansion of Supervising Practitioners

New Benefit Category for Marriage and Family Therapists (MFTs) and Mental Health Counselors (MHCs)

Who

- Marriage and Family therapists (MFTs) and Mental Health Counselors (MHCs)

What

- New benefit category

When

- Effective Date: January 1, 2024
- Implementation Date: February 12, 2024

- Key information:
  - MFT and MHC services are defined as services for the diagnosis and treatment of mental illnesses (other than services furnished to an inpatient of a hospital)
  - MTF and MHC services are covered when furnished in a rural health clinic and federally qualified health center
  - All MFT and MHC billing Medicare will be required to enroll with Medicare:
    - Specialty codes E1 and E2
- References:
  - CMS Change Request (CR) 13346
  - CMS Change Request (CR) 13469
  - Mental Health Counselor (MHC) (JH) (JL)
  - Mental Health Services (JH) (JL)

Billing Requirements for Intensive Outpatient Program (IOP) Services

Who

- Hospital outpatient departments
- Critical access hospitals (CAHs)
- Community mental health centers (CMHCs)
- Other providers billing MACs for IOP services they provide to Medicare patients

When

- Effective Date: January 1, 2024
- Implementation Date: January 2, 2024

What

- New condition code 92 identifies claims for IOP services

- Key information:
  - Effective January 1, 2024, Medicare covers and pays for IOP services for individuals with mental health needs when furnished by hospital outpatient departments, and Community Mental Health Centers (CMHCs)
  - IOP provides treatment at a level more intense than outpatient day treatment or psychosocial rehabilitation, but less intense than a partial hospitalization program (PHP)
  - Hospitals (including CAHs) and CMHCs must use condition code 92 on all claims for IOP services
  - Payment for IOP services you bill with condition code 92 based on:
    - OPPS for OPPS hospitals submitting claims on type of bill (TOB) 013x
    - OPPS for CMHCs using TOB 076X
    - 101% of reasonable cost for CAHs using TOB 085x
    - Current payment methods for non-OPPS hospitals using TOB 013x
- References:
  - Medicare Learning Network (MLN) Matters Article: MM13222 "New Condition Code 92: Billing Requirements for Intensive Outpatient Program Services"
  - Intensive outpatient program (IOP) billing requirements for institutional services

IOP Coverage Requirements

- Patients receiving IOP services must be all of these:
  - Under the care of a physician who certifies the need for IOP services
  - Need a minimum of 9 hours of services per week, as shown by their plan of care
  - Requires a comprehensive, structured, multimodal treatment requiring medical supervision and coordination, provided under an individualized plan of care, because of a mental disorder, including substance use disorder, which severely interferes with multiple areas of daily life, including social, vocational, and educational functioning
  - Be able to cognitively and emotionally participate in the active treatment process and tolerate the intensity of an IOP program
- Change Request (CR) 13222 included revisions to the Medicare Claims Processing Manual, Pub. 100-04, Chapter 4 to add section 261 for IOP which includes:
  - Condition code 92
  - Revenue codes
  - HCPCS codes
  - Service units reporting
  - Claim examples
- Related CR 13496 makes changes to the Medicare Benefit Policy Manual, Pub. 100-02, Chapter 6 adding section 70.4 Intensive Outpatient Services which includes:
  - Program criteria
  - Patient eligibility
  - Covered services
  - Reasonable and necessary services
  - Reasons for denials
  - Documentation and physician supervision requirements

Behavior Health Initiatives (BHI)

- Behavioral health services :
  - Medicare covers behavioral, mental and psychiatric health services that may improve outcomes for Medicare patients:
    - Behavioral Health Integration (BHI) Services
    - Psychotherapy for Crisis
    - Opioid Use Disorder (OUD) Screening & Treatment
- Please share these valuable resources and references with your providers and patients
- References:
  - CR13389 - Requirements for a Provider Direct Mailing and Education & Outreach for Behavioral Health Initiatives
  - MLN Connects: 2023-11-02
- Webinar:
  - March 25, 2024, at 10:00 a.m.
  - Visit the JL Education Events calendar to register

Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - April 2024 Update

Who

- Physicians, hospitals, suppliers and other providers billing Medicare Administrative Contractors (MACs) for Medicare services

When

- Effective date: January 1, 2024
- Implementation date: April 1, 2024

What

- April 2024 updates to the MPFS

- Key information:
  - New codes have been added to the MPFSDB
  - One new G code is effective
  - Procedure status changes and revised short descriptors
- References:
  - Change Request (CR): CR13529 "Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - April 2024 Update"
  - Physician Fee Schedule

Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging: CY 2024 Update

Who

- Physicians, providers, suppliers, and other Medicare providers billing MACs for advanced diagnostic imaging services they provide to Medicare patients

When

- Effective Date: January 1, 2024
- Implementation Date: January 3, 2025

What

- Effective January 1, 2024, CMS has paused efforts to implement the AUC Program for reevaluation and rescinded the AUC Program regulations

- Key information:
  - CY 2024 PFS final rule finalized a pause to the AUC Program for reevaluation and rescinded the current AUC Program regulations
  - Effective January 1, 2024, providers and suppliers should no longer include AUC consultation information on Medicare FFS claims
  - Claims containing AUC-related codes with DOS in 2023 and 2024 will continue to process:
    - Includes AUC Program G codes G1000 — G1024 or modifiers MA — MH and QQ
  - CMS will no longer qualify provider-led entities (PLEs) or Clinical Decision Support Mechanism (CDSMs) and removed this information from the AUC website
  - CMS plan is to end the above described HCPCS G codes and modifiers, effective December 31, 2024, to assist in claims processing and data analysis
- Reference:
  - Medicare Learning Network (MLN) Matters Article: MM13485 "Appropriate Use Criteria for Advanced Diagnostic Imaging: CY 2024 Update"

JZ and JW Modifier Clarification

- Hospitals, including MD waiver hospitals, should report the JW and JZ modifiers as appropriate
- JW modifier- Drug amount discarded/not administered to any patient:
  - Effective January 1, 2017, required on all claims for drugs and biologicals (hereafter, drug) separately payable under Medicare Part B with unused and discarded amounts (hereafter, discarded amounts) from single-dose containers or single-use packages (hereafter, single-dose containers)
  - Providers must document the amount of discarded drugs in the beneficiary's medical record
- JZ modifier - Zero drug amount discarded/not administered to any patient:
  - Effective July 1, 2023, providers and suppliers are required to report the JZ modifier on all claims that bill for drugs from single-dose containers that are separately payable under Medicare Part B when there are no discarded amounts
- References:
  - Drugs and biologicals Part A – Using the JW and JZ modifiers
  - FAQ: Billing – Medications
  - CMS Medicare Program Discarded Drugs and Biologicals – JW Modifier and JZ Modifier Policy Frequently Asked Questions

CY 2024 Telehealth Updates

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CY 2024 Telehealth Services Updates

- Continued coverage and payment of telehealth services until December 31, 2024:
  - COVID-19 Public Health Emergency (PHE) Expansions
- List of Telehealth Services:
  - HCPCS codes 0591T-0593T (health and well being coaching services) were added on temporary (provisional) basis
  - HCPCS code G0136 (social determinants of health risk assessment) added on a permanent basis
- Temporary expansion of the scope of telehealth originating sites for services provided via telehealth to include any site in the U.S. where the patient is at the time of the telehealth service
- Delayed the requirement for in-person visit with the physician or practitioner within six months prior to initiating mental health telehealth services, and, again, at subsequent intervals
- Reference:
  - MM13452 Medicare Physician Fee Schedule Final Rule Summary: CY 2024
  - MLN Fact Sheet: Telehealth Services

Additional CY 2024 Telehealth Services Updates

- Removed frequency limitations for:
  - Subsequent inpatient visits
  - Subsequent nursing facility visits
  - Critical care consultation
- Teaching physicians can continue to use audio or video real-time communications technology when resident provides telehealth in all residency training locations through end of CY 2024
- CMS updated Medicare originating site facility fee Q3014 amount for CY 2024 to be $29.96:
  - Only billable based on original telehealth guidelines:
    - Beneficiary is located within a hospital and receives a Medicare telehealth service from an eligible distant site practitioner
- References:
  - Telehealth Services
  - MLN Fact Sheet: Telehealth Services

Payment for Outpatient Therapy, DSMT and Medical Nutritional Therapy (MNT) Services

- Institutional providers should continue to bill for PT, OT, SLP, DSMT and MNT services provided remotely in the same way they could during the PHE and through the end of CY 2023
- Beginning January 1, 2024, modifications include:
  - Hospitals and other providers of PT, OT, SLP, DSMT and MNT services remaining on the Medicare Telehealth Services List can continue to bill for these services when provided remotely in the same way as during the PHE and the remainder of CY 2023, except:
    - For outpatient hospitals, patients' homes no longer need to be registered as provider-based entities to allow for hospitals to bill for these services
    - For critical access hospitals (CAHs) electing Method II, the 95 modifier is required on claims from all providers

Telehealth Finalized Policies for DSMT Services

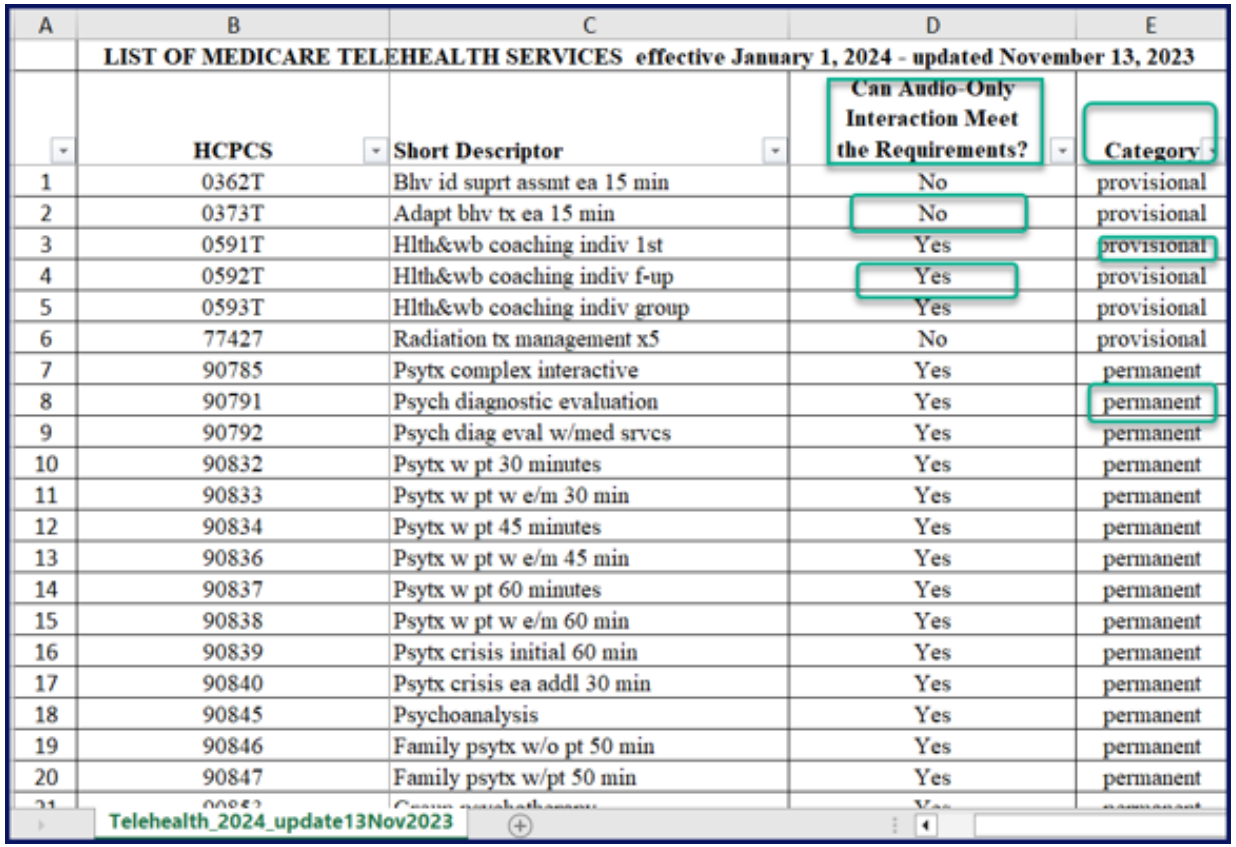
- CMS will allow distant site practitioners who can appropriately bill for DSMT services:
  - Includes registered dietitians (RDs), nutrition professionals, physicians, nurse practitioners (NPs), physician assistants (PAs), and clinical nurse specialists (CNSs), who personally provide the services as part of the DSMT entity
- Injection training for insulin-dependent beneficiaries:
  - DSMT insulin injection training (for initial or follow-up training) is allowed to be provided via telehealth when it aligns with clinical standards, guidelines, or best practices
- Reference:
  - Medicare Claims Processing Manual, Pub. 100-04, Chapter 12 – Physician and Non-Physician Practitioners, Section 190.3.6, "Payment for Diabetes Self Management Training (DSMT) as a Telehealth Service"

Telehealth Reporting of Home Location

- Flexibility extended through December 31, 2024:
  - Practitioners allowed to render telehealth services from their home without reporting their home address on their Medicare enrollment while continuing to bill from their currently enrolled location
- Note: a physician or physician practitioner providing telemedicine must be enrolled and be licensed in the state the physician or practitioner is located:
  - Similarly, an organization providing telemedicine must be enrolled in the state the organization is located

List of Telehealth Services

- CMS updated the List of Telehealth Services for CY 2024
- New categories:
  - Provisional (formally temporary)
  - Permanent
- Periodically check the telehealth listing for updates



	A	B	C	D	E
		LIST OF MEDICARE TELEHEALTH SERVICES effective January 1, 2024 - updated November 13, 2023			
		HCPCS	Short Descriptor	Can Audio-Only Interaction Meet the Requirements?	Category
1		0362T	Bhv id suprt assmt ea 15 min	No	provisional
2		0373T	Adapt bhv tx ea 15 min	No	provisional
3		0591T	Hlth&wb coaching indiv 1st	Yes	provisional
4		0592T	Hlth&wb coaching indiv f-up	Yes	provisional
5		0593T	Hlth&wb coaching indiv group	Yes	provisional
6		77427	Radiation tx management x5	No	provisional
7		90785	Psytx complex interactive	Yes	permanent
8		90791	Psych diagnostic evaluation	Yes	permanent
9		90792	Psych diag eval w/med srvcs	Yes	permanent
10		90832	Psytx w pt 30 minutes	Yes	permanent
11		90833	Psytx w pt w e/m 30 min	Yes	permanent
12		90834	Psytx w pt 45 minutes	Yes	permanent
13		90836	Psytx w pt w e/m 45 min	Yes	permanent
14		90837	Psytx w pt 60 minutes	Yes	permanent
15		90838	Psytx w pt w e/m 60 min	Yes	permanent
16		90839	Psytx crisis initial 60 min	Yes	permanent
17		90840	Psytx crisis ea addl 30 min	Yes	permanent
18		90845	Psychoanalysis	Yes	permanent
19		90846	Family psytx w/o pt 50 min	Yes	permanent
20		90847	Family psytx w/pt 50 min	Yes	permanent

Telehealth_2024_update13Nov2023

Place of Service Codes and Modifier 95 – Telehealth

- Continue billing telehealth claims with the place of service (POS) code if service been done in person as well as modifier 95 for telehealth services through dates of service December 31, 2023
- Dates of service on and after January 1, 2024, use:
  - POS 02 – Telehealth to indicate you provided the billed service as a professional telehealth service when the originating site is other than the patient's home
  - POS 10 – Telehealth for services when the patient is in home:
    - Pays at the non-facility rate
  - When using POS 10, use modifier 95 through December 31, 2024, when:
    - The clinician is in the hospital and the patient is in the home
    - Outpatient therapy provided via telehealth by PT, OT, and SLPs
- References:
  - Telehealth Service MLN Fact Sheet
  - Place of Service Codes

Telehealth – Issues Identified

Date reported	Providers impacted	Workload impacted	Description/Claim coding impact	Proposed resolution/fix/action required	Status
02/13/2024	JL/JH Psychologists	Claims processing issue	An issue was identified were telehealth services claims submitted by psychologists denied in error.	Claims denied in error will be reprocessed.	Open
02/13/2024	JL/JH Providers	Claims pricing issue	An issue was identified with telehealth services claims and place of service 10 pricing incorrectly. The claims priced at the facility rate regardless of provider specialty.	This issue is currently being investigated. Please continue to monitor our open claims issues for the future appropriate corrective actions.	Open

- Access the Open claim issues - Part B for updates on these issues

Part A Claim Errors

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Reason Code 34963: Attending Physician is Invalid

- CMS implemented a new consistency system edit in April 2023 that validates the attending provider NPI on institutional claims
- Institutional providers must indicate the attending provider name and NPI for the patient's medical care and treatment on institutional claims for any services other than nonscheduled transportation claims:
  - Refer to MLN Matter Article (MM) 12889 New Fiscal Intermediary Shared System Edit to Validate Attending Provider NPI – Phase 2 for a list of physician and non-physician practitioner (NPP) specialties eligible as an attending physician and who must be enrolled in PECOS in an approved status
- Claims will return with reason code 34963 for one of the following reasons:
  - The attending physician on claim page 03 is invalid
  - The attending physician NPI is present, but the first four digits of the last name do not match PECOS
  - The claim has a through date of service equal or greater than the termination date of the physician

Resolving Reason Code 34963

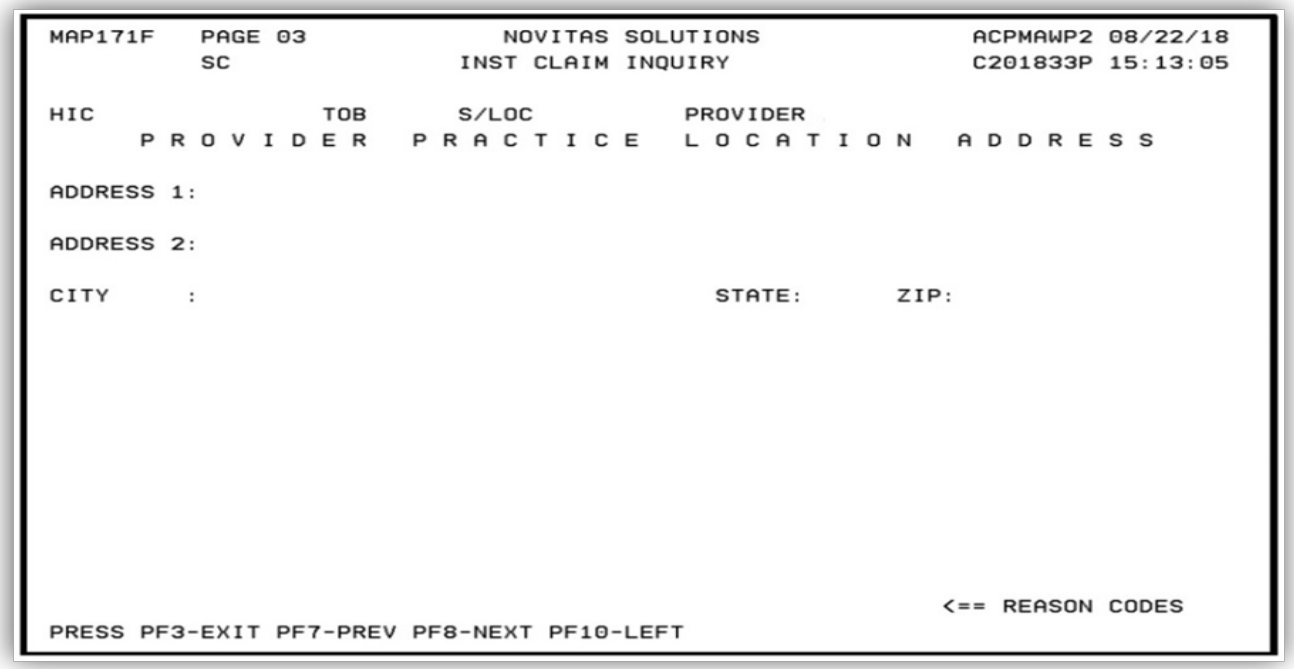
- Confirm the attending provider's name is the physician or non-physician practitioner (NPP) who certified the plan of care for the services on the claim and then validate the provider's name and NPI in PECOS
- If you don't have PECOS access, you can use the order and referring data set at data.cms.gov to verify the physician's name and spelling as seen in PECOS:
  - It is recommended to search by the provider's NPI to correctly display the information
  - Use PECOS or data.cms.gov only for validation to obtain the correct information for editing
  - Example 1:
    - Provider's NPI: XXXXXXXXX
    - Provider's name: John Smith
    - System editing: J Smit
  - Example 2:
    - Provider's NPI: XXXXXXXXX
    - Provider's name: John Smith Jones or Smith-Jones
    - System editing: J Smit
- Correct the reported physician information and resubmit your institutional claim
- References:
  - New Fiscal Intermediary Shared System (FISS) consistency edit to validate attending physician NPI (JH) (JL)
  - Reason code 34963
  - Resolve claim return reason code 34963 for outpatient therapy services

Reason Code 34977

- Definition:
  - A hospital claim is submitted with a service facility location that was not included in PECOS or on the CMS 855A enrollment form or the location reported does not exactly match the information from the CMS 855A
- Resolution:
  - The Provider Practice Address Query (option 1D) is available in FISS/DDE:
    - Displays the provider practice information from PECOS/CMS 855A form
  - Providers should review PEOCS/CMS 855A or the FISS/DDE screen to determine how to report the practice location or verify its valid for the service date reported
  - Validate address submitted on the claim and ensure it is an exact match to what is entered in PECOS:
    - Must match, word for word, including abbreviations and punctuation:
      - For example: Road vs. Rd, Suite vs. Ste., etc.
    - Include special characters if listed in the address, for example, &, (),+, *, -, etc.
    - Includes full 9-digits of the ZIP code
  - Resubmit claim with the address matching exactly as listed in PECOS; or
  - Providers who need to add a new or correct an existing practice location address will need to submit a new CMS-855A enrollment application or update in PECOS prior to correcting claim
- References:
  - SE18002 - Billing Requirements for OPPS Providers with Multiple Service Locations
  - SE19007 - Activation of Systematic Validation Edits for OPPS Providers with Multiple Service Locations
  - Hospital Off-Campus Outpatient Department Reporting Requirements

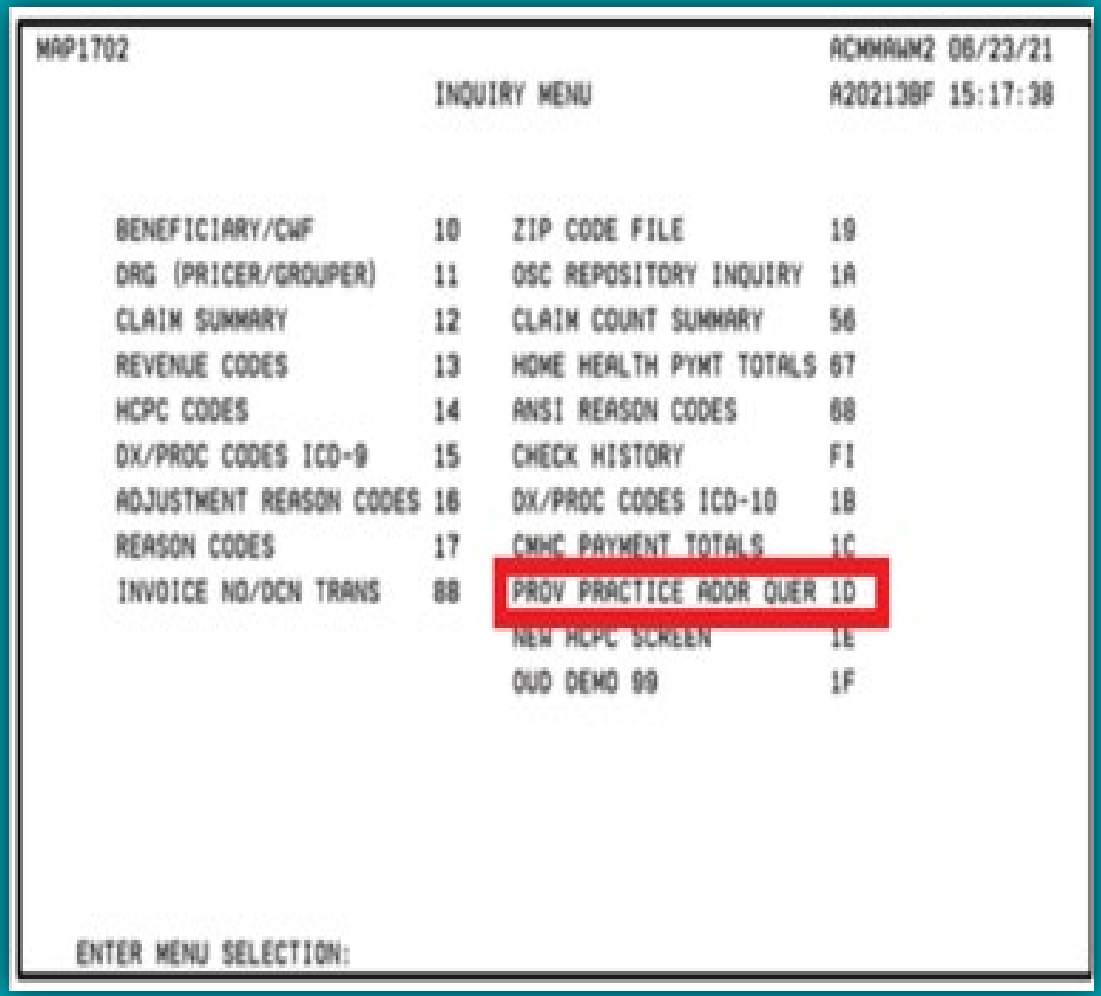
FISS Claim Page 3 Provider Practice Location Address

- To access Claim Page 03 MAP171F press F11 two times from Claim Page 03 MAP1719
- Enter the provider practice location address in the fields provided on this page
- Reference:
  - FISS Manual Chapter 3 – Claims, Claim Page 03: Provider practice location address



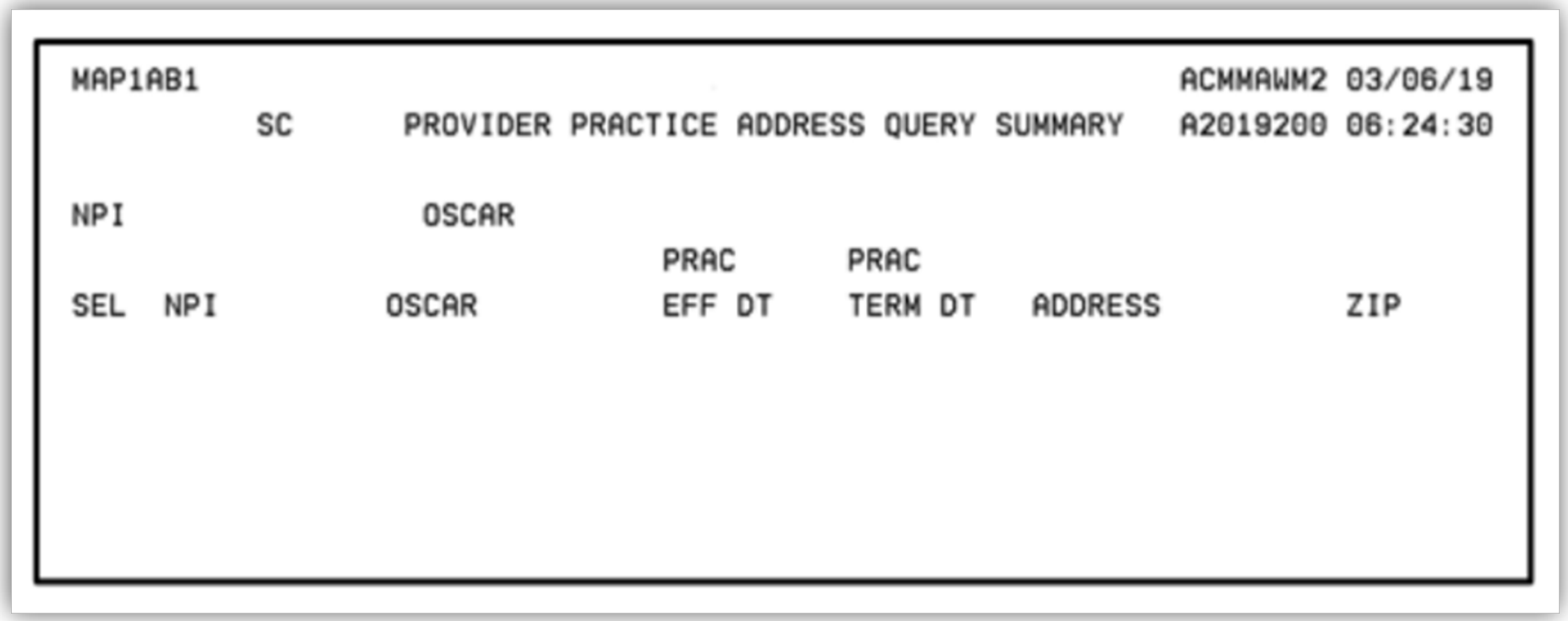
Provider Practice Address Query Screen

- Practice location screen received from the PECOS is available in DDE:
  - Compare this file to ensure claims submitted for the practice location is an exact match
  - Select the Provider Practice Address Query menu selection 1D from the Inquiry Menu
- Reference:
  - FISS Manual Chapter 4 - Inquiry menu applications, 4.14 Provider practice address query (1D) (JH) (JL)



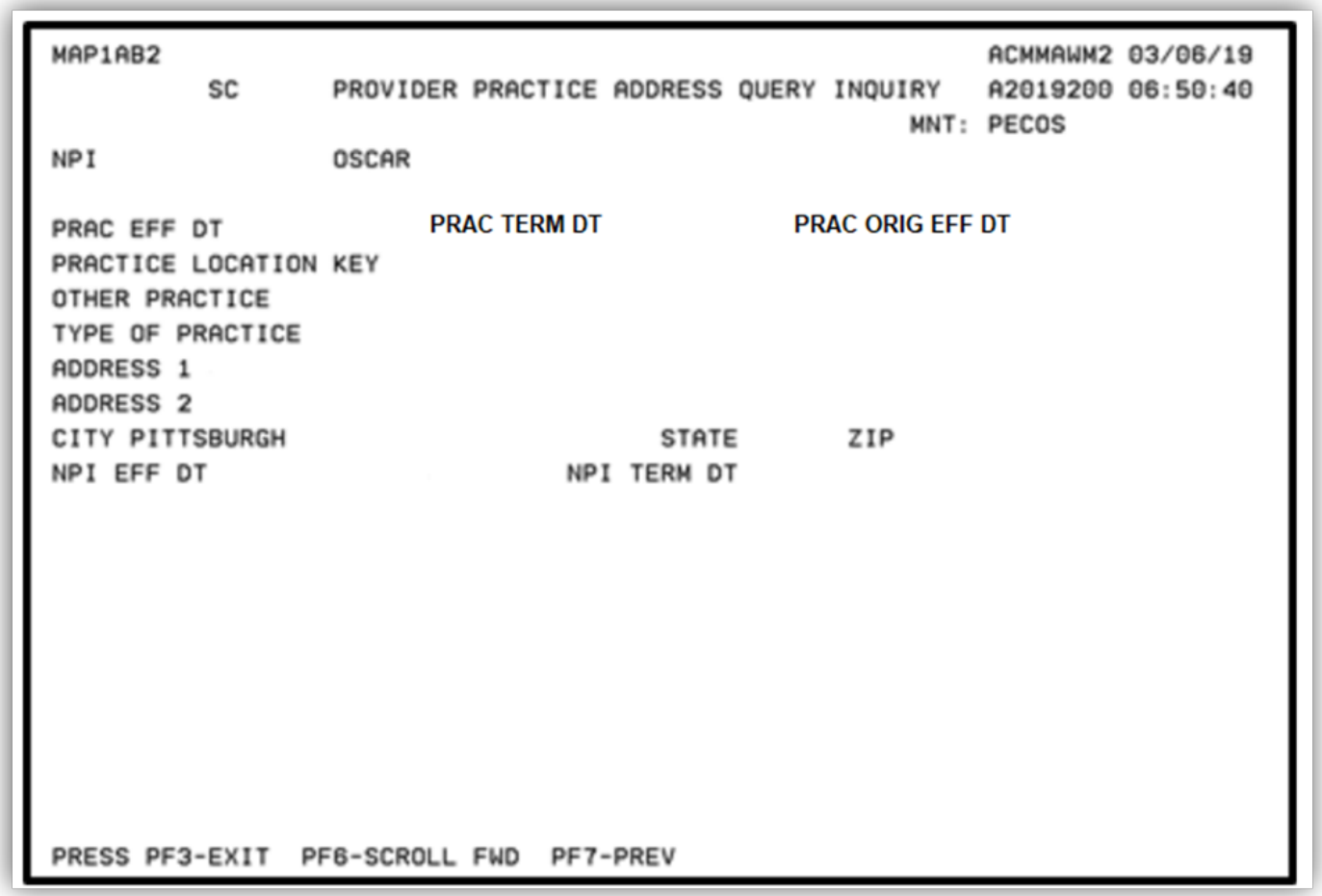
Provider Practice Address Query Summary

- Provider Practice Address Query Summary MAP1AB1:
  - Type ‘S’ in the SEL field and press enter to go to the Provider Practice Address Query Inquiry Screen



Provider Practice Address Query Inquiry

- Provider Practice Address Query Inquiry MAP1AB2



Updating Provider Practice Locations Using PECOS or Paper CMS-855A Enrollment Applications

- To add a new or revise an existing location, complete a change of information enrollment application:
  - Online through PECOS
  - Paper-based Medicare Enrollment Application - Institutional Providers (CMS-855A)
- In the hospital practice location section, there is a field to indicate your type of practice location:
  - Provide the appropriate practice location type
  - If the type is not listed, mark Other and provide the correct type of practice location in the free-form field:
    - For example: emergency department, off-campus department, on-campus, remote location of a hospital, non-OPPS department, etc.:
      - Note: Non-OPPS department includes Rural emergency hospital (REH); opioid treatment program (OTP); therapy; ESRD; certain hospitals in Maryland that are paid under Maryland waiver provisions; and Critical Access Hospitals (CAHs)
- References:
  - Hospital off-campus outpatient department enrollment requirements
  - SE19007 - Activation of Systematic Validation Edits for OPPS Providers with Multiple Service Locations

Affect on Non-OPPS Providers

- Non-OPPS providers include:
  - Rural emergency hospital (REH)
  - Opioid treatment program (OTP)
  - Therapy
  - ESRD
  - Maryland waiver
  - Critical Access Hospitals (CAHs)
  - Indian Health Service hospitals
  - Hospitals located in American Samoa, Guam, and Saipan; and hospitals located in the Virgin Islands

- Hospital providers are required to include all practice locations in PECOS or on the CMS-855A enrollment form:
  - Claim will RTP with reason code 34977 if:
    - Hospital claim is submitted with a service facility location that was not included in PECOS or on the CMS-855A enrollment form; or
    - Location reported does not exactly match the information from the CMS-855A
  - Applies to TOBs 13x and 14x
- Non-OPPS providers are exempt from reporting the modifiers PN, PO, or ER as payments will not change due to off-campus practice locations
- Non-OPPS providers only have to ensure the off-campus location is reported correctly

Reason Code 34978

- Definition:
  - OPPS providers are required to report one of the appropriate modifiers, PN, PO or ER, when reporting an off-campus practice location:
    - Claim will RTP if:
      - An inappropriate modifier is reported; or
      - Practice location is reported and no modifier is reported
- Resolution:
  - Ensure the claim line contains the appropriate modifier PN, PO, or ER
  - Correct or add the appropriate modifier to the line items
  - Resubmit claim
- References:
  - SE18002 - Billing Requirements for OPPS Providers with Multiple Service Locations
  - Hospital Off-Campus Outpatient Department Reporting Requirements

Reason Codes 34984, 34985, and 34986

- Reason code 34984 description:
  - Modifier ER is not present on the claim and practice location reported is a dedicated emergency department (ED)
- Reason code 34985 description:
  - Modifier PO is not present on the claim and a practice location is reported
- Reason code 34986 description:
  - Modifier PN is not present on the claim and a practice location is reported that has a practice effective date on/after 11/2/15
- Resolution:
  - Refer to Medicare Learning Network (MLN) Matters Article: MM SE18002 "Billing Requirements for OPPS Providers with Multiple Service Locations"
  - Correct or add the appropriate modifier to the line items
  - Resubmit claim
- Reference:
  - Hospital Off-Campus Outpatient Department Reporting Requirements

Reporting Line Level Information: Off-Campus Practice Location Modifiers

- OPPS providers are required to report one of the appropriate modifiers when reporting an off-campus practice location:
  - PO - Services, procedures and/or surgeries provided at off-campus provider-based outpatient departments:
    - For all excepted items for services reported with a HCPCS furnished
  - PN - Non-excepted service provided at an off-campus, outpatient, provider-based department of a hospital:
    - For all non-excepted items and services
    - Triggers a payment rate under the Medicare Physician Fee Schedule (MPFS)
  - ER - Items and services furnished by a provider-based off-campus emergency department
- References:
  - Medicare Learning Network (MLN) Matters Article: MM9907 "Implementing FISS Updates to Accommodate Section 603 Bipartisan Budget Act of 2015 - Phase 2"
  - Medicare Learning Network (MLN) Matters Article: MM11099 "January 2019 Update of the Hospital Outpatient Prospective Payment System (OPPS)"
  - SE18002 - Billing Requirements for OPPS Providers with Multiple Service Locations

Key Takeaways

- Reviewed Novitas initiatives
- Addressed the Change Healthcare cybersecurity incident
- Provided important Medicare updates including CY 2024 telehealth updates
- Explained top Part A claims errors and how to avoid or resolve them

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Thank You for Attending!

We look forward to seeing you at future events

Please visit our Calendar of Events for upcoming webinars (JL)

- Janice Mumma
  - Supervisor, Provider Outreach and Education
  - Janice.mumma@novitas-solutions.com
- Stephanie Portzline
  - Manager, Provider Outreach and Education
  - Stephanie.portzline@novitas-solutions.com