Novitas Solutions Presents: Medicare Updates and What's Trending

MD AAHAM Meeting

November 5, 2021

NOVITAS SOLUTIONS

Your Presenter

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Education Specialist

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Today's Presentation

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- Agenda
  - Novitas Initiatives
  - Medicare Updates
  - COVID-19 Updates
  - Prior Authorization for Hospital Outpatient Department Services Updates
  - Education and Training Events
- Objectives
  - Provide the latest news and updates
  - Stay updated on Medicare initiatives
  - Take advantage of the various self-service options available

Acronym List

Acronym	Definition
APC	Ambulatory Payment Classifications
CMS	Centers for Medicare & Medicaid Services
COVID-19	Coronavirus Disease 2019
CPT	Current Procedural Terminology
CY	Calendar Year
DOS	Date of Service
HCPCS	Healthcare Common Procedure Coding System
I/OCE	Integrated Outpatient Code Editor
IPPS	Inpatient Prospective Payment System
IVR	Interactive Voice Response
mAb	Monoclonal Antibody
MAC	Medicare Administrative Contractor
MS-DRG	Medicare Severity Diagnosis-Related Group

Acronym List Two

Acronym	Definition
NCD	National Coverage Determination
OPD	Outpatient Department
OPPS	Outpatient Prospective Payment System
PA	Prior Authorization
PAR	Prior Authorization Request
PHE	Public Health Emergency
SNF	Skilled Nursing Facility

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Novitas Initiatives

Join Novitas E-Mail List!

- Receive current updates via email directly from Novitas Solutions:
  - Part A and Part B News
  - Issued every Tuesday and Friday
  - CMS MLN Connects issued Thursdays
- Subscribing is quick and easy:
  - Click the Join E-Mail List from our website tool bar (JH) (JL)

Ask the Contractor (ACT) Webinar

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- Restructured interactive format:
  - Two to three topics reviewed:
    - ✓ Topics are created by suggestions obtained through a provider survey
  - Question and Answer (QA) intervals between topics for open discussion
- Spread the word about this opportunity to interact with your Medicare Administrative Contractor (MAC)

Save the Date	
JL Part A	November 17, 2021
JL Part B	November 18, 2021
JH Part A	December 15, 2021
JH Part B	December 16, 2021

Avoid the Wait!

- Submit initial enrollment, change of information and revalidation applications **electronically** using:
  - PECOS - a CMS established internet-based system to facilitate the online enrollment process
  - Enrollment Gateway (JH) (JL) - online submission method to submit paper-based applications
- Visit our website for everything you need to know about electronic submissions initially enrolling and reporting changes for your Medicare enrollment (JH) (JL)

Are You Using the Correct Form?

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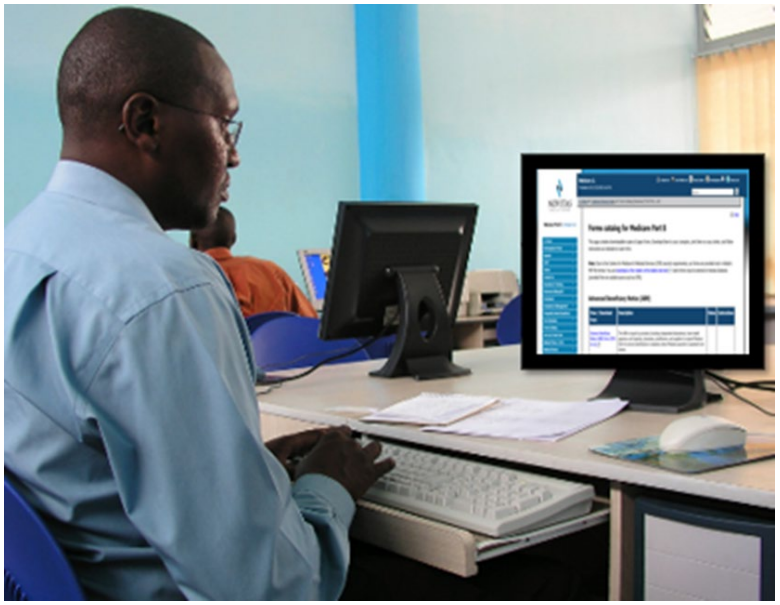
- Submission of old or outdated forms can cause a delay or rejection of your request
- Review our Forms Catalog to ensure you are using the up-to-date version of the form:
  - Part A (JH) (JL)
  - Part B (JH) (JL)
- Visit our website to see which forms can be submitted electronically to help avoid submission errors:
  - Part A (JH) (JL)
  - Part B (JH) (JL)



EDI Gateway - Connecting to the Future

- Novitas Solutions, Inc is pleased to announce a new and improved EDI Gateway solution. This new EDI Gateway will replace the current secure file transfer protocol (SFTP) connection to Novitas Solutions made available through a Network Service Vendor (NSV). Novitasphere connections are not impacted.

- Please visit the EDI Gateway – Connecting to the Future webpage for details on what actions are required. A link to this webpage is found on the Novitas Solution's EDI Home page

IMPORTANT:
Actions are required for all SFTP customers!

General Inquiries and Appeals P.O. Box Changes Effective November 1, 2021

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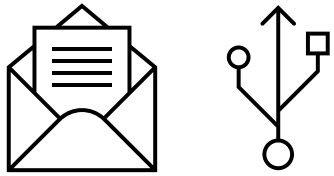
- JH Part B General Written Inquiries and Appeals:
  - P.O. Box 3110 Mechanicsburg, PA 17055-1826
  - Applicable to all states within JH (Louisiana, Arkansas, Colorado, New Mexico, Oklahoma, Texas and Mississippi)
- JL Part B General Written Inquiries and Appeals:
  - P.O. Box 3413 Mechanicsburg, PA 17055-1852
  - Applicable to all states within JL (Maryland, District of Columbia Metropolitan Area, Delaware, New Jersey and Pennsylvania)
- Avoid the wait and submit electronically claims, medical records and other correspondence



Medicare Physician Fee Schedule (MPFS)

- Calendar year (CY) 2022 MPFS and Participation
  - Novitas Solutions Fee Schedules webpage (JH) (JL)
  - Displayed after publication of Final Rule
    - ✓ Information regarding participation open enrollment for CY 2022
    - ✓ CY 2022 fee schedules/reimbursement rates

Duplicate Claim Rejections

- Claim edits were created to prevent incorrect payment for duplicate services when multiple claims are submitted for the same:
  - Service,
  - Patient, and
  - Date of service
- Process to follow for a duplicate rejection:
  - Verify the claim status of the original claim submission to determine if it processed or requires a claim correction
    - ✓ Novitasphere
    - ✓ Fiscal Intermediary Standard System (FISS)
    - ✓ Interactive voice response
    - ✓ Remittance advice
- Adjust the claim if allowable electronically through:
  - Vendor/clearinghouse
  - Our free software (PC-ACE)
  - DDE/FISS
- For additional details refer to What's the Status of my Claim?

Appeals Status Inquiry Tools

- Novitasphere:
  - Free, secure internet portal provides detailed information regarding the status of appeals
  - Allows you to view the outcome of the appeal and the decision letter (if applicable)
- Appeals Status Inquiry Tool:
  - For first level appeals
  - Verifies receipt of the appeal and indicates if the appeal is currently pending, processing, or finalized

Top Claim Errors

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- Top Claim Submission/Reason Code Errors:

Reason Code	Description	Resolution
38119	A skilled nursing facility (SNF) claim or a non-prospective payment system (PPS) inpatient claim submitted. However, the statement covers from date is greater than the admission date and there is no claim pending with a through date one day less than this claim from date.	SNF and non-PPS providers are required to bill in sequential order. This claim cannot process until the prior bill(s) is processed. Resubmit this claim once the previous month's claims have processed.
30725	Patient relationship code 39 (organ donor) is present, but occurrence code 36 (dates of inpatient hospital discharge for covered transplant patient) is missing.	Please verify that occurrence code 36 with appropriate dates is present on the claim. Correct and resubmit.
38038	This outpatient prospective payment system (OPPS) date of service is overlapping or the same day as another processed OPPS claim for the same provider number.	Verify dates and coding; correct and resubmit. If the second claim is a separate and distinct visit, identified by a visit revenue code (i.e., 045X, 051X), add condition code G0 (zero). If the second claim is not a separate and distinct visit, adjust the paid claim and add the late charges if within timely filing limits. If the second claim is a demand bill, add condition code 20 and F9 back into the system. If billing for a denial notice for another insurer, add condition code 21 and F9 back into the system. If reporting condition code 07, only splints, casts, and antigens will be paid under OPPS. For type of bill 75X, only vaccines and their administration are paid under OPPS.

Open Claim Issues for Part A

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- Open Claim Issues for Medicare Part A

Date Reported	Provider Type Impacted	Workload Impacted	Reason Code	Description/ Claim Codding Impact	Proposed Resolution/ Fix/ Action Required
10/20/21	Outpatient	Various	32415 and 31498	Novitas identified an issue for claims billed with monoclonal antibodies HCPCS codes Q0240, M0240, M0241, M0244, M0246, Q0247, M0247, M0248, Q0249, M0249, and M0250. These services are being returned to providers (RTP) with reason code 32415 or 31498 in error	The issue has been resolved and claims should no longer RTP for this issue. Providers impacted by this issue should resubmit the claims for processing.
7/26/21	Outpatient	TOB 12X and 13X	N/A	CMS has been made aware of an issue with cost sharing applying on COVID-19 vaccine and monoclonal antibodies claims with Condition Codes (CC) MA and 78 when HCPCS codes 0001A, 0002A, 0011A, 0012A, 0031A, M0239, M0243, M0244, M0245 and M0246 are present on TOB 12X or 13X. Coinsurance or deductible should not be applied to these HCPCS codes.	Update 7/28/21: Any claims incorrectly processed prior to the hold location being established will be identified and automatically reprocessed after the correction is installed in October. No provider action is needed. Update 10/20/21: All held claims(SMTQ88) were released for processing. There were no claims identified that needed to be reprocessed that had coinsurance or deductible incorrectly applied.

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Medicare Updates

Medicare Fee-for-Service Coverage of Costs for Kidney Acquisitions in Maryland Waiver Hospitals for Medicare Advantage Plan Beneficiaries

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- MM12206:
  - Effective: January 1, 2021 - *for claims we receive on or after October 1, 2021*
  - Implementation: October 4, 2021
- Key Points:
  - CY 2021 Medicare Parts C & D final rule (85 FR 33796, 33824) specifies that Medicare will cover kidney acquisition costs for MA plan beneficiaries
  - Maryland Waiver hospitals currently include kidney acquisition charges along with other solid organ acquisition charges with the applicable organ transplant charges are paid at 92.3 percent of those charges instead of paying through the Medicare cost report
  - To comply with policy requirements a new value code was created to ensure that that kidney acquisition charges are appropriately tracked and paid at 92.3 percent:
    - ✓ Value code 91

Billing with Value Code 91

- Medicare will only allow value code 91 on the following claims:
  - Covered Type of Bill (TOB) is equal to 11X (excluding 110)
  - Condition Code 04 is present
  - Provider is Maryland Waiver
  - Claim admission date is on or after January 1, 2021
  - Revenue Code 081X is present (excluding 0815 and 0819)
  - Value Code '91' value amount is greater than zero
- All other claims will edit and Return to Provider (RTP)
- MACs report payer only value code QK:
  - Will display the calculated payment amount for kidney acquisition charges

October 2021 Update of the Hospital Outpatient Prospective Payment System (OPPS)

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- MM12436:
  - Effective date: October 1, 2021
  - Implementation date: October 4, 2021
- Key Points:
  - New Covid-19 CPT Administration Codes:
    - ✓ CPT code 0003A - service to administer third dose of Pfizer vaccine
  - New COVID-19 HCPCS Vaccine Administration Code for Administering in the Beneficiary's Home:
    - ✓ M0201 may be billed in addition to the existing COVID-19 vaccine administration CPT codes
  - Changes for COVID-19 Monoclonal Antibody Therapy Product and Administration Codes:
    - ✓ New COVID-19 mAb Therapy and Administration codes for Sotrovimab:
      - ➢ HCPCS codes M0247, M0248, and Q0247
    - ✓ Changes for COVID-19 mAb combination product Casirivimab and Imdevimab:
      - ➢ HCPCS code Q0244 for updated dosing regime
      - ➢ HCPCS code M0240 and M0241 for repeat administrations
      - ➢ HCPCS code Q0240 for new dosage
      - ➢ Updated descriptors for HCPCS codes M0243 and M0244
    - ✓ New COVID-19 mAb therapy and administration codes for Tocilizumab:
      - ➢ HCPCS codes M0249, M0250, and Q0249

October 2021 OPPS Updates Continued

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- CPT Proprietary Laboratory Analyses (PLA) Coding Changes Effective October 1, 2021:
  - Deleted 2 PLA codes - 0139U and 0168U
  - Revised 1 PLA code - 0051U
  - Established 30 new PLA codes effective October 1, 2021
    - ✓ CPT codes 0255U through 0284U
- Multianalyte Assays with Algorithmic Analyses (MAAA) CPT Coding Change, Effective October 1, 2021:
  - CPT code 0018M
- New HCPCS Code Describing the Endoscopic Submucosal Dissection (ESD) Procedure
  - HCPCS code C9779
- New HCPCS Code Describing a Procedure Utilizing the Surfacer Inside-Out Access Catheter System
  - HCPCS coded C9780
- New device Pass-Through Categories:
  - One new device pass-through category effective October 1, 2021 – HCPCS code C1761
- Device Offset Payment:
  - APCs 5115 and 5116 are associated with costs of the device category described by HCPCS code C1831:
    - ✓ Always bill the device(s) in the category described by HCPCS code C1831 with 1 of the primary CPT codes 22558, 22586, 22612, 22630, or 22633 and addon code 22853 or 22854
  - Updated list for in the category described by HCPCS code C1761 with 1 of the following codes: CPT code 92933, CPT code 92943, CPT code C9602, HCPCS code C9607, CPT code 92928, or HCPCA code C9600
- Transitional Pass-Through Payments for Designated Devices:
  - Certain designated services are eligible for payment based on the reasonable cost of the new device reduced by the amount included in the APC for the procedure that reflects the packaged payment for device(s) used in the procedure
- Alternative Pathway for Devices that have an FDA Breakthrough Designation
  - An alternative pathway to qualify for device pass-through payment status under which devices wouldn't be evaluated in terms of the current substantial clinical improvement criterion for the purposes of determining device pass-through payment status

October 2021 OPPS - Drugs, Biologicals, and Radiopharmaceuticals

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- Five new drugs and biological codes created for hospital outpatient receiving drug pass-through status starting October 1, 2021
- Three existing HCPC codes used to report drugs, biologicals, and radiopharmaceuticals in the hospital outpatient setting will receive drug pass-through status starting October 1, 2021
- Three HCPCS codes for certain drugs, biologicals, and radiopharmaceuticals in the outpatient setting that will have their pass-through status end on September 30, 2021
- Twenty new drug, biological, and radiopharmaceutical HCPCS codes will be established on October 1, 2021
- Long descriptors for HCPCS codes J1443 and J2407 are changing on October 1, 2021
- Twelve drug, biological, and radiopharmaceutical HCPCS codes will be deleted on October 1, 2021
- Status indicators (SI) for HCPCS code A9593 and A9594 effective July 1, 2021, retroactively from SI = “N” to SI = “G” in the October I/OCE update
- Drugs and biologicals with payments based on Average Sales Price (ASP):
  - Updated on a quarterly basis
  - Updated payment rates, effective October 1, 2021, are in the October 2021 update of the OPPS Addendum A and Addendum B website
- Drugs and biologicals based on ASP methodology with restated payment rates:
  - Retroactive corrections occur on a quarterly basis
  - List available first date of the quarter
- For a complete listing of codes see Attachment A of CR12436

Additional October 2021 OPPS Updates

- Skin Substitutes New Products:
  - Three new skin substitute HCPCS codes that will be active as of October 1, 2021
  - Two skin substitute HCPCS codes (Q4228 and Q4236) that will be deleted as of October 1, 2021
- Vaccine CPT code Status Indicator Change Effective October 1, 2021:
  - CPT code 90677 (Pneumococcal conjugate vaccine, 20 valent (PCV20), for intramuscular use) will change from SI “E1” to “L”
- New Blood Product HCPCS Codes Effective October 1, 2021:
  - Two new blood product HCPCS codes - P9025 and P9026
- Coverage Determinations

October 2021 Integrated Outpatient Code Editor (I/OCE)

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- MM12432:
  - Effective: October 1, 2021
  - Implementation: October 4, 2021
- Key Points:
  - Instructions and specification for the I/OCE under OPPS and non-OPPS outpatient departments, CMHCs, and all non-OPPS providers:
    - ✓ Official instruction in CR12432
    - ✓ I/OCE Quarterly Release Files
- Summary of quarterly release modifications include (not an all-inclusive list):
  - Edit updates for APCs, HCPCS, diagnosis coding, etc. being added, deleted or modified
  - Implement version 27.3 of the NCCI
  - HCPCS/APC/SI changes as specified by CMS in the following tables and lists:
    - ✓ MAP_ADDON_TYPE I
    - ✓ MAP_OFFSET_CODEPAIR
    - ✓ DATA APC
    - ✓ DATA_CAPC
    - ✓ OFFSET_HCPCS
    - ✓ DATA_HCPCPS
    - ✓ DATA_DX10
    - ✓ DATA_REVENUE

Fiscal Year (FY) 2022 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital (LTCH) Rates Final Rule (CMS-1752-F)

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- FY 2022 IPPS Final Rule Home Page:
  - Annual updates for FY 2022 Fiscal Year IPPS tables and files
- Key points include:
  - Priorities to close health care equity gaps
  - Support great access to life-saving diagnostics during the COVID-19 PHE and beyond
  - Hospital readiness for future public health threats
  - Enhance workforce in rural and underserved communities
  - Revise scoring, payment and public quality data reporting methods to lessen the adverse impacts of the pandemic and future unplanned events
  - Updates Medicare fee-for-service payment rates and policies for inpatient hospitals and LTCHs for FY 2022
  - Repeal market-based MS-DRG relative weight policy
- References:
  - FY 2022 Medicare Hospital IPPS and LTCH Rates Final Rule Fact Sheet
  - Federal Register Provisions

Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Updates for Fiscal Year (FY) 2022

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- MM12417:
  - Effective: October 1, 2021
  - Implementation: October 4, 2021
- Key Points:
  - Annual updates to and billing instructions for various payment policies for IPF PPS
  - Summary of modifications:
    - ✓ Under 42 CFR 412.428, the annual update includes revisions to:
      - Federal per diem base rate
      - Hospital wage index
      - ICD-10-CM Coding and Diagnosis-Related Groups (DRGs) classification changes discussed in the annual update to the hospital Inpatient Prospective Payment System (IPPS) regulations
      - Electroconvulsive therapy (ECT) payment per treatment
      - Fixed dollar loss threshold amount
      - National urban and rural cost-to-charge medians and ceilings

Changes to Laboratory NCD Edit Software for October 2021

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- MM12384:
  - Effective date: October 1, 2021
  - Implementation date: October 4, 2021
- Key Points:
  - ICD-10 revisions for clinical laboratory NCDs:
    - ✓ 190.12 Urine Culture, Bacterial
    - ✓ 190.14 Human Immunodeficiency Virus (HIV) Testing
    - ✓ 190.15 Blood Count
    - ✓ 190.16 Partial Thromboplastin Time (PTT)
    - ✓ 190.17 Prothrombin Time (PT)
    - ✓ 190.18 Serum Iron Studies
    - ✓ 190.20 Blood Glucose Testing
    - ✓ 190.28 Tumor Antigen by Immunoassay CA 125
    - ✓ 190.32 Gamma Glutamyl Transferase
    - ✓ 190.33 Hepatitis Panel/Acute Hepatitis panel
    - ✓ 190.34 Fecal Occult Blood Test

NCD Removal

- MM12254
  - Effective date: January 1, 2021
  - Implementation date: June 22, 2021; October 4, 2021
- Key Points:
  - CMS removed six NCDs from the Medicare NCD Manual, Pub. 100-03:
    - ✓ NCD 20.5 Extracorporeal Immunoadsorption (ECI) Using Protein A Columns
    - ✓ NCD 30.4 Electrosleep Therapy
    - ✓ NCD 100.9 Implantation of Gastrointestinal Reflux Devices
    - ✓ NCD 110.19 Abarelix for the Treatment of Prostate Cancer
    - ✓ NCD 220.2.1 Magnetic Resonance Spectroscopy
    - ✓ NCD 220.6.16 FDG PET for Inflammation and Infection
  - The final rule also makes a non-substantive conforming change to NCD 220.6 Positron Emission Tomography (PET) Scans

ICD-10 Revisions to National Coverage Determinations (NCDs) – October 2021

- MM12279
  - Effective: October 1, 2021
  - Implementation: October 4, 2021
- Key Point:
  - ICD-10 quarterly maintenance updates impact several National Coverage Determinations (NCD):
    - ✓ 30.3.3 – Acupuncture for Chronic Low Back Pain
    - ✓ 20.33 – Transcatheter Mitral Valve Repair/Transcatheter Edge-to-Edge Repair

Quarterly Update to NCCI Procedure to Procedure (PTP) Edits, Version 27.3

- MM12340:
  - Effective date: October 1, 2021
  - Implementation date: October 6, 2021
- Key Points:
  - CMS developed NCCI to promote national correct coding methodologies and to control improper coding
  - NCCI and PTP edits are updated quarterly; this represents the fourth quarterly update for 2021
- Reference:
  - Medicare Claims Processing Manual, Pub 100-04, chapter 23 – Fee Schedule Administration and Coding Requirements, section 20.9
  - CMS NCCI Website

Revisions to NCD 270.3 Blood-Derived Products for Chronic, Non-Healing Wounds

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- MM12403:
  - Effective: April 13, 2021
  - NCD implementation: November 9, 2021
  - Claims processing system implementation: January 3, 2022
- Key Points:
  - Services performed on or after April 13, 2021, CMS will cover autologous PRP for the treatment of chronic non-healing diabetic wounds for a duration of 20 weeks:
    - ✓ Must report both an ICD-10 diagnosis code for Diabetes Mellitus and an ICD-10 diagnosis code for Chronic Ulcer
  - Coverage for treatment beyond 20 weeks will be determined by MACs:
    - ✓ Chronic non-healing diabetic wounds beyond 20 weeks when you include the –KX modifier on the claim
    - ✓ All other chronic non-healing, non-diabetic wounds
  - MACs will adjust claims brought to their attention

ABN Section 50 in Chapter 30 of Publication 100-04 Manual Updates

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- MM12242:
  - Effective date: October 14, 2021
  - Implementation date: October 14, 2021
- Key Points:
  - Financial Liability Protections (FLP) provisions protect patients, health care providers, and suppliers under certain circumstances from liability for charges that Medicare doesn't pay
  - Article reorganizes, makes edits, and other changes to ABN section in Medicare Claims Procession Manual, Chapter 30, Section 50:
    - ✓ General notice preparation requirements for ABN
    - ✓ Period of effectiveness of ABN for repetitive or continuous non-covered care
    - ✓ How FLP applies to dually eligible individuals (QMB Program or Medicaid coverage)
    - ✓ Information on ambulance transports
    - ✓ Events that cause home health agencies to issue ABN

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

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- By November 1, 2021, CMS will begin reprocessing claims for outpatient clinic visit services provided at excepted off-campus Provider-Based Departments (PBDs) so they're paid at the same rate as non-excepted off-campus PBDs for those services under the Physician Fee Schedule (PFS). T:
  - Affects certain claims with DOS between January 1 - December 31, 2019
  - MACs will reprocess affected claims
  - Providers must refund the coinsurance difference to patients (or payers) who paid the higher coinsurance rates based on new remittance advice information
- For more information review the CMS MLN Connects 09/09/2021

Targeted Probe and Educate (TPE) Restarting

- On August 12, 2021, CMS announced the restart of the Targeted Probe and Educate (TPE) Program to help educate providers and reduce future denials and appeals
- Visit the Novitas TPE website under the Medical Review Center for additional information on the specific TPE topics, education and review results

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COVID-19 Vaccines and mAb Infusion Administration

Coronavirus (COVID-19)

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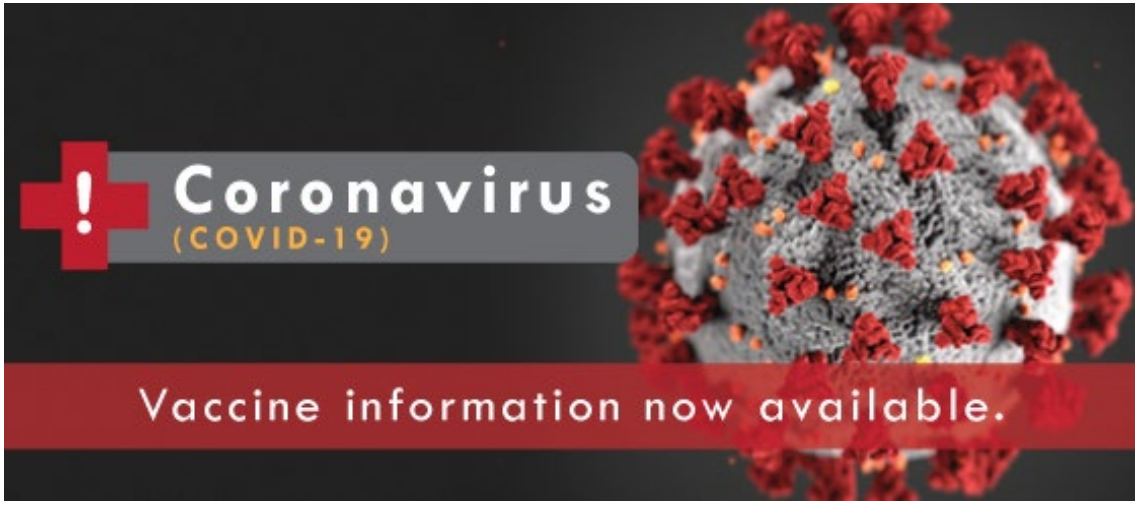
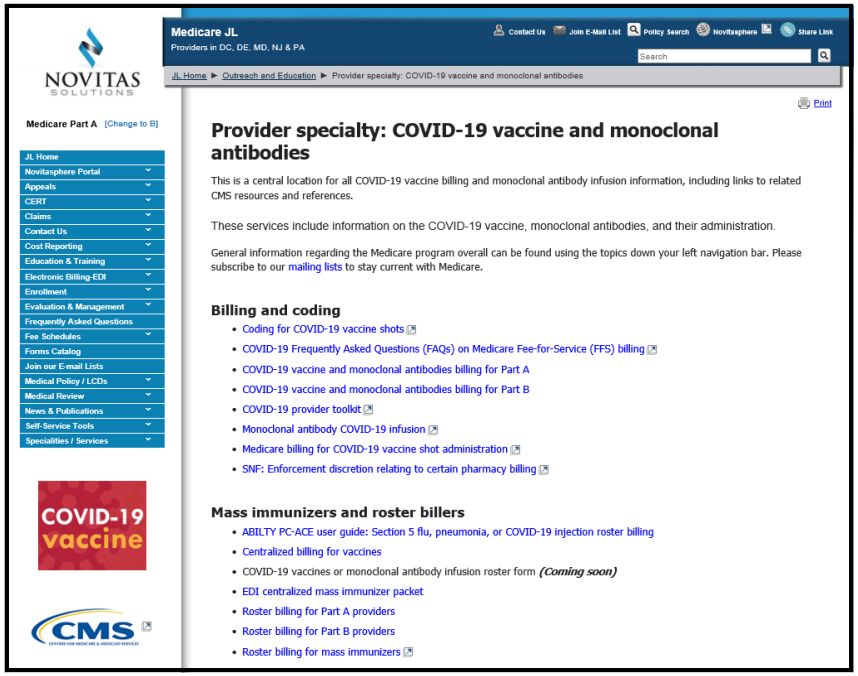
- COVID-19 Stay Informed (JH) (JL)
- CMS Coronavirus Current Emergencies
- CMS Coronavirus Waivers and Flexibilities
- COVID-19 Vaccines and Monoclonal Antibody Administration (JH) (JL)



Novitas Solutions COVID-19 Vaccine and mAb Infusion Specialty Page



- COVID-19 Vaccine and mAb Specialty Page :
  - Central location for all COVID-19 vaccine and mAb infusion billing information, including links to related CMS resources and references:
    - COVID-19 vaccine and mAb billing for Part A and Part B
    - Roster billing for Part A and Part B providers
    - COVID-19 vaccines or mAb infusion roster form
    - COVID-19 vaccine and mAb FAQs
    - COVID-19 vaccine and mAb billing alerts
    - 2020 and 2021 vaccine and mAb reimbursements
    - Enrollment guidelines for billing COVID-19 vaccine administrations
    - CMS COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing:
      - BB. Drugs & Vaccines under Part B

New Codes for Additional Doses for COVID-19 Vaccine

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- Effective with DOS on and after August 12, 2021 , the FDA issued an updated EUAs for the Pfizer BioNTech COVID-19 vaccine and the Moderna COVID-19 vaccine which allows for the administration of an additional dose in immunocompromised patients
- Reference:
  - MLN Connects Special Edition August 16, 2021:
    - COVID-19 Vaccine Additional Doses: Codes & Payment

Code	Description	Labeler name	Vaccine/Procedure name	Effective date	Dosing interval
0003A	Adm Sarcov2 30MCG/0.3ML 3RD	Pfizer	Pfizer-Biontech COVID-19 vaccine administration – third dose	8/13/2021	28 days
0013A	Adm Sarcov2 100MCG/0.5ML 3RD	Moderna	Moderna COVID-19 vaccine administration- third dose	8/13/2021	28 days

New Booster Dose of Pfizer Vaccine

- The FDA amended the EUA for the Pfizer-BioNTech COVID-19 vaccine to allow for use of a single booster dose for certain populations.
- Effective for DOS on and after September 22, 2021, a new code describing the service to administer a booster dose of Pfizer BioNTech COVID-19 vaccine has been established
- Reference:
  - MLN Connects Special Edition September 24, 2021:
    - ✓ CMS Will Pay for COVID-19 Booster Shots, Eligible Consumers Can Receive at No Cost
  - COVID-19 Vaccines and Monoclonal Antibodies

Code	Description	Labeler name	Vaccine/Procedure name	Effective date
0004A	Adm Sarscov2 30MCG/0.3ML BST	Pfizer	Pfizer-Biontech COVID-19 vaccine administration – booster	9/22/2021

Booster Dose of Moderna and Janssen (Johnson & Johnson)

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- The FDA amended the EUA for the Moderna and Janssen (Johnson & Johnson) COVID-19 vaccines to allow for use of a single booster dose for certain populations
- Effective for DOS on and after October 20, 2021, new codes describing the service to administer a booster dose of Moderna and Johnson &Johnson have been established
  - MLN Connects Special Edition October 22, 2021:
    - ✓ COVID-19: Moderna & Jansen (J&J) Booster Shots
    - ✓ COVID-19 Vaccines and Monoclonal Antibodies

Code	Description	Labeler name	Vaccine/Procedure name	Effective date
0034A	Adm Sarscov2 vac AD26 .5ML B	Janssen	Janssen COVID-19 vaccine administration - booster	10/20/2021
0064A	Adm Sarscov2 50MCG/0.25 ML BST	Moderna	Moderna COVID-19 vaccine (low dose) administration - booster	10/20/2021

Medicare Advantage Beneficiaries

- If the patient is enrolled in a Medicare Advantage plan, submit your COVID-19 claims to Original Medicare for all patients enrolled in Medicare Advantage in 2020 and 2021
  - Submit claim using the MBI for processing and payment
    - ✓ If the patient does not have a Medicare card with their MBI, you can obtain the MBI by using our MBI Look-up, available in Novitasphere (JH) (JL)
  - For Part A claims:
    - ✓ Required to report the CC 78 to avoid the claim from rejecting:
      - ➢ This is in addition to reporting the CC A6 for the COVID-19 vaccine
    - ✓ Do not submit roster billing since FISS/DDE does not allow CC 78
- Reference:
  - Toolkit on COVID-19 Vaccine: Health Insurance Issuers and Medicare Advantage Plans
  - COVID-19 vaccine and monoclonal antibodies billing for Part A (JH) (JL)

SNF – Enforcement Discretion to Certain Pharmacy Billing

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- A SNF may either administer the vaccine directly to a resident who's in a covered Part A stay or under arrangement pursuant to which the SNF pays an outside immunizer to administer the vaccine:
  - In these situations, the SNF must bill Medicare based on SNF CB provisions
- **During the PHE**, CMS exercises **enforcement discretions** to certain pharmacy billing:
  - CMS allows Medicare enrolled immunizers, including but not limited to pharmacies, who are not under arrangement with the SNF to vaccinate Medicare SNF residents and bill directly to get reimbursed from Medicare
  - Review the enforcement discretion notice (PDF) for more information for a resident in a noncovered stay, either the SNF or the immunizer not under arrangement may bill for the shot.
- Effective as of September 20, 2021, CMS includes vaccinating SNF residents with the seasonal influenza vaccine and pneumococcal vaccine (including for vaccine administration and product) whether these vaccines are administered at the same time (co-administered) with a COVID-19 vaccine or if they are administered at different times with respect to SNF CB
- Reference:
  - SNF: Enforcement Discretion Relating to Certain Pharmacy Billing

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Prior Authorization (PA) Program for Certain Hospital Outpatient Department (OPD) Services

Hospital OPD Services Requiring PA

- As a condition of payment for date if service (DOS) on or after July 1, 2020, a prior authorization request (PAR) **is required** for the following hospital OPD services:
  - Blepharoplasty, eyelid surgery, brow lift, and related services
  - Botulinum toxin injections
  - Panniculectomy, excision of excess skin and subcutaneous tissue (including lipectomy), and related services
  - Rhinoplasty and related services
  - Vein ablation and related services
- As a condition of payment for DOS on or after July 1, 2021, a PAR is required for:
  - **Cervical fusion with disc removal**
  - **Implanted spinal neurostimulators**
- CMS provides a list of the HCPCS codes included in the OPD PA program
- Reference:
  - CY 2021 OPPS/ASC Final Rule (CMS-1736-FC)
  - OPD Operational Guide

PAR Submission/Scheduling/Coding Issues

- ***Do not schedule surgery until an approved prior authorization is received***
- Expedited PAR issues:
  - Expedited PARs are only to be submitted if the beneficiary's life or functional status is in jeopardy
  - Use the correct PAR cover sheet:
    - ✓ Significant volume of expedited cover sheets have been submitted for service that are scheduled for 5+ days out:
      - ➢ This does not meet the expedited criteria
- **PA has 10 business days to make a determination:**
  - Do not call the PA customer service line prior to this timeframe to check for status:
    - ✓ Calling on day 7 or 8 will no accelerate the process
- Verify the code(s) being requested are on the list of services requiring PA

PA Program for Certain Hospital OPD Services Webpage

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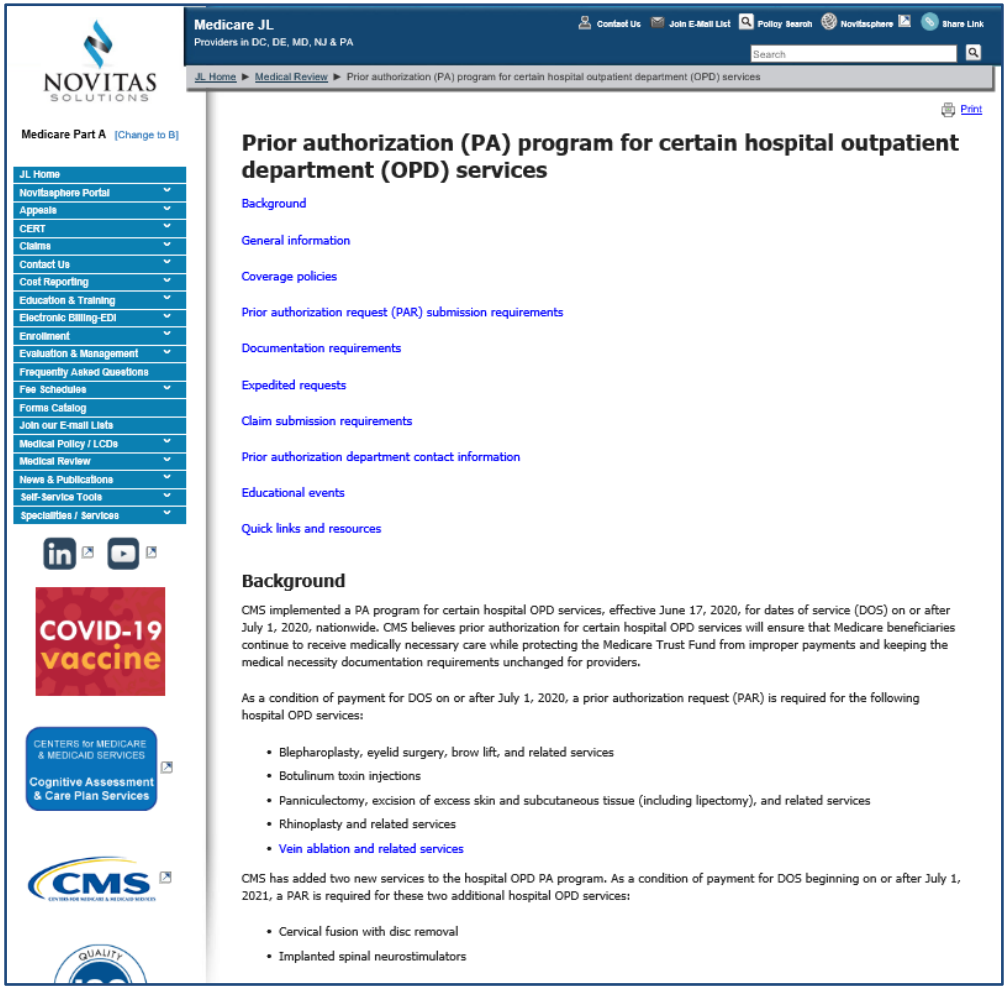
- For details, links, and submission guidelines refer to the Prior Authorization (PA) Program for Certain Hospital Outpatient Department (OPD) Services (JH) (JL) webpage
- Dedicated PA customer service:
  - 1-877-439-5479



New Resources Added

- Hospital outpatient department (OPD) prior authorization (PA) claims submission guidelines:
  - Hospital OPD must report unique tracking number (UTN) on the 13X TOB
  - Non-affirmed decision on file or no PA on file:
    - ✓ Claim will deny and then appeal rights are available
- Two new articles developed by the A/B Medicare Administrative Contractor Prior Authorization Collaboration Workgroup:
  - Vein ablation and related services
  - Implantation of spinal neurostimulator

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Keep Your Patients Healthy!

Discuss Preventive Services With Your Patient

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- Definition:
  - Preventive services can be defined as patient counseling and screenings to prevent illness, disease, and other health-related problems
- Purpose:
  - Providers play a crucial role in promoting, providing, and educating Medicare patients about potentially life-saving preventive services and screenings:
    - ✓ Encourage your Medicare patients to take advantage of covered preventive services
    - ✓ Medicare covers many preventive services at little or no cost to your patients
- Resources:
  - CMS Preventive Services Page
  - CMS Preventive Services Video
  - Medicare Claim Processing Manual, Pub. 100-04, Chapter 18 – Preventive and Screening Services
  - Provider Resources on Preventive Services
  - Your Guide to Medicare's Preventive Services:
    - ✓ A guide for beneficiaries

Preventive Services and Screenings Covered by Medicare

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- Alcohol Misuse Screening & Counseling
- Annual Wellness Visit
- Bone Mass Measurements
- Cardiovascular Disease Screening Tests
- Colorectal Cancer Screening
- Counseling to Prevent Tobacco Use
- Depression Screening
- Diabetes Screening
- Diabetes Self-Management Training
- Glaucoma Screening
- Hepatitis B Virus Screening
- Hepatitis B Vaccine & Administration
- Hepatitis C Virus Screening
- HIV Screening
- Intensive Behavioral Therapy (IBT) for Cardiovascular Disease
- IBT for Obesity
- Influenza Virus Vaccine & Administration
- Initial Preventive Physical Examination
- Lung Cancer Screening
- Medical Nutrition Therapy
- Medicare Diabetes Prevention Program Expanded Model
- Pneumococcal Vaccine & Administration
- Prolonged Preventive Services
- Prostate Cancer Screening
- Screening for Cervical Cancer
- Screening for STIs and HIBC to Prevent STIs
- Screening Mammography
- Screening Pap Tests
- Screening Pelvic Examinations
- Ultrasound Screening for Abdominal Aortic Aneurysm (AAA)

Interactive Preventive Services Tool

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- Preventive Services Tool

Time to Vaccinate: Flu Season Ahead

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- All patients are covered for the influenza virus vaccine once per flu season but additional flu shots are allowed if medically necessary:
  - Flu and COVID-19 vaccines may be given during the same visit
- Use Seasonal Influenza Vaccines Pricing webpage to obtain the payment rate
- CMS developed a new Flu Shot page:
  - Flu Shot Coding – Find the right HCPCS, CPT, and ICD-10 codes
  - Institutional Providers: Additional Information – Get more information on facility and bill types
  - Roster Billing Mass Immunizers – Get coverage requirements, elements & centralized billing information if you're a mass immunizer and offer flu and pneumococcal shots to many people
  - Become a Centralized Biller – Get information on the enrollment process to become a centralized biller

Pneumococcal Conjugate Vaccine

- Medicare coverage for pneumococcal conjugate vaccine, 20 valent (90677) began on October 1, 2021:
- Billing and coding instructions:
  - Submit separate claims for vaccine
  - Part A will hold claims until the April 2022 system update
  - Part B began processing on October 4
  - Vaccines provided between July 1 – September 30 are non-covered and will deny
- References:
  - MLN Connects October 14, 2021
  - Provider specialty: preventive services Part A (JH) (JL)
  - Provider specialty: preventive services Part B (JH) (JL)

NCD 210.3 – Screening For Colorectal Cancer (CRC)-Blood-Based Biomarker Tests

- MM12280:
  - Effective date: January 19, 2021
  - Implementation date: October 4, 2021
- Key Points:
  - CMS determined blood-based biomarker test is appropriate colorectal cancer screening test based on specific criteria
  - Patient Criteria:
    - ✓ Age 50-85 years and:
      - ➢ Asymptomatic
      - ➢ At average risk of developing colorectal cancer
  - Blood-based biomarker screening test must have:
    - ✓ FDA market authorization with indication for colorectal cancer screening
    - ✓ Proven test performance with both sensitivity greater than or equal to 74% and specificity greater than or equal to 90% in colorectal cancer detection when compared to the recognized standard
  - Claims reporting:
    - ✓ HCPCS code G0327 Colorectal cancer screening; blood-based biomarker
    - ✓ Report at least one of the following diagnosis codes:
      - ➢ Z12.11 Encounter for screening for malignant neoplasm of colon
      - ➢ Z12.12 Encounter for screening for malignant neoplasm of rectum
- Colorectal Cancer Screening Tests (NCD 210.3)

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Education and Training Events

Calendar of Events

- Please visit our Calendar of Events for upcoming webinars

Date	Time	Name of Event	LOB
November 8, 2021	9:00 a.m. – 10:00 a.m.	Novitasphere Claim Corrections	B
November 16, 2021	1:00 a.m. – 2:30 p.m.	End Stage Renal Disease Updates and Claim Errors	A
November 22, 2021	10:00 a.m. -11:30 a.m.	Basics of Critical Access Hospital (CAH) Billing	A
November 23, 2021	9:00 a.m. – 10:00 a.m.	Novitasphere Hot Topics	A/B
November 23, 2021	10:00 a.m. – 12:00 p.m.	Increase Your Federally Qualified Health Center (FQHC) Billing Knowledge	A
November 23, 2021	1:00 a.m. – 2:30 p.m.	An Overview of Federally Qualified Health Centers (FQHCs) Requirements for Providing COVID-19 Services	A

#StayConnected Workshop Series

- Stay connected with Medicare updates and requirements by attending the Novitas Solutions Workshop series
  - Post Claim Submission: November 9 - 11, 2021
  - Wellness and Preventive Services: November 16 - 19, 2021
- Monitor our event calendar for registration

Customer Contact Information

- Providers are required to use the IVR unit to obtain:
  - Claim Status
  - Patient Eligibility
  - Check/Earning
  - Remittance inquiries
- Jurisdiction L:
  - Customer Contact Center- 1-877-235-8073
- Patient / Medicare Beneficiary:
  - 1-800-MEDICARE (1-800-633-4227)
  - http://www.medicare.gov

Any Questions?

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Thank You for Attending!

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