

Novitas Solutions Presents: Medicare Updates and What's Trending

MD AAHAM
March 31, 2021

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Today's Presentation



- 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
AAP	Accelerated and Advance Payments
APC	Ambulatory Payment Classifications
AR	Accounts Receivable
CAH	Critical Access Hospital
CMS	Centers for Medicare & Medicaid Services
COVID-19	Coronavirus Disease 2019
CPT	Current Procedural Terminology
CY	Calendar Year
DOS	Date of Service
FAQ	Frequently Asked Questions
FFS	Fee-for-Service
HCPCS	Healthcare Common Procedure Coding System
I/OCE	Integrated Outpatient Code Editor

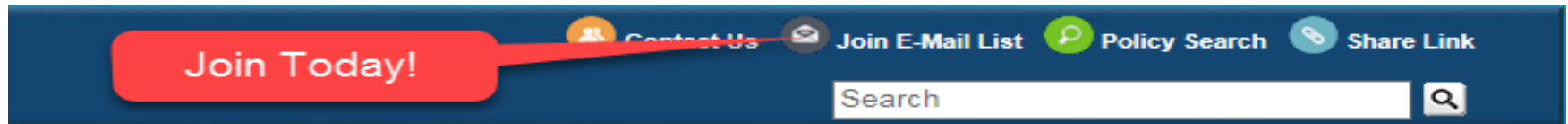
Acronym List Two



Acronym	Definition
IPPS	Inpatient Prospective Payment System
IVR	Interactive Voice Response
mAb	Monoclonal Antibody
MAC	Medicare Administrative Contractor
MS-DRG	Medicare Severity Diagnosis-Related Group
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

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](#))

Social Media Launch!



- With the start of the New Year, Novitas Solutions is launching into 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](#)
- In February 2021, check out our new [YouTube](#) channel
- Coming soon, Facebook and Twitter



Self-Paced Courses – Education on Your Schedule!



- Novitas Solutions On-Demand education is growing! Did you know that we now offer the following **free [On-Demand](#)** education? Continue to monitor the pages below for updates!
 - ***Webinar Recordings***
 - ✓ Webinar recordings are now available! Continue to monitor our [Webinar Recordings](#) page for additional recording options!
 - ***Click and Play Videos***
 - ✓ Looking for help now? Novitas Solutions offers a variety of tutorials aimed at helping you navigate forms, billing, enrollment and so much more. Visit our [Training Videos](#) page to see a full list of videos.
 - ***Online Training Courses***
 - ✓ Want to learn about a Medicare topic, but want to do it on your time? Participate in our self-paced, free online courses when and where it is most convenient for you! View the full course listing on our [Online Course Catalogue](#).



Coming March 2021

- New satisfaction surveys:
 - Live events
 - Training videos
 - Web-based trainings (self-paced)
 - Webinar recordings
 - Provider Outreach and Education (POE) website material
- Share your experience on the services POE provides you!



Top Claim Errors and Open Claim Issues



- Top Claim Submission/Reason Code Errors:

Reason Code	Description	Resolution
31300	Payer ID is not equal to A, B, C, D, E, F, G, H, L, or Z. -Or- Payer ID is equal to I, value code 42 is present, and the type of bill is not 11X, 18X, 21X, or 41X.	Please verify the payer code billed; correct and resubmit.
12206	The sum of covered and noncovered days does not equal the days calculated between the statement covers "from" and "through" date.	Verify the covered and noncovered days, the statement covers 'from' and 'through' dates and patient status. If reporting patient status code 30, add an additional day.
30940	A provider is not permitted to adjust a partially or fully medically denied claim. This reason code will edit when medically denied lines are moved into a covered status or medically denied lines are altered.	If you disagree with the medical denial and have records to support the services, submit a redetermination request following the established protocol.

Open Claim Issues for Part A



■ Open Claim Issues for Medicare Part A

Date Reported	Provider Type Impacted	Workload Impacted	Reason Code	Description/ Claim Coding Impact	Proposed Resolution/ Fix/ Action Required
2/9/2021	Outpatient Type of Bills (TOB) 74x, 75x, 12x and 13x	Various Therapy Services	36136 and 36381	<p>An issue is occurring with various therapy HCPCS codes.</p> <p>Outpatient Rehabilitation Facility Claims, TOB 74x and 75x, are incorrectly receiving reason code 36136 and suspending to status location S MHCP1.</p> <p>Outpatient hospital claims billed with various therapy HCPCS, TOB 12x and 13x, are incorrectly receiving reason code 36381 and suspending to status location S MHCTR.</p>	<p>The issue with the therapy HCPCS codes has been reported to the Centers for Medicare & Medicaid Services (CMS) and the Fiscal Intermediary Shared System (FISS). We are currently waiting for a resolution.</p> <p>Update 3/11/2021: A workaround has been provided that is allowing claims to be released. Claims will be periodically released in batches to allow them to process until a permanent fix is implemented. The tentative correction date, for the permanent fix, is scheduled for April 19, 2021.</p>

Local Coverage Determination (LCD) and Local Coverage Articles (LCA) Updates



- Effective March 12, 2021:
 - [Billing and Coding: Hydration Therapy \(A56634\)](#)
 - [Billing and Coding: Independent Diagnostic Testing Facility \(IDTF\) \(A53252\)](#)
 - [Billing and Coding: Treatment of Chronic Venous Insufficiency of the Lower Extremities \(A55229\)](#)
- Effective March 22, 2021:
 - [Blepharoplasty, Blepharoptosis Repair and Surgical Procedures of the Brow \(L35004\)](#)
 - ✓ [Billing and Coding: Blepharoplasty, Blepharoptosis Repair and Surgical Procedures of the Brow \(A57618\)](#)
 - [Botulinum Toxins \(L38809\)](#)
 - ✓ [Billing and Coding: Botulinum Toxins \(A58423\)](#)
 - [Diagnostic Colonoscopy \(L38812\)](#)
 - ✓ [Billing and Coding: Diagnostic Colonoscopy \(A58428\)](#)
- Effective April 25, 2021:
 - [Cardiology Non-emergent Outpatient Stress Testing \(L35083\)](#)
 - ✓ [Billing and Coding: Cardiology Non-emergent Outpatient Stress Testing \(A56423\)](#)
 - [Facet Joint Interventions for Pain Management \(L34892\)](#)
 - ✓ [Billing and Coding: Facet Joint Interventions for Pain Management \(A56670\)](#)

Medicare Updates

Update to Medicare Deductible, Coinsurance and Premium Rates for 2021



- [MM12024](#):
 - Effective: January 1, 2021
 - Implementation: January 4, 2021
- Key Points:
 - 2021 Part A – Hospital Insurance:
 - ✓ Deductible: \$1484.00
 - ✓ Coinsurance:
 - \$371.00 a day for 61st-90th day
 - \$742.00 a day for 91st-150th day (lifetime reserve days)
 - 185.50 a day for 21st-100th day (Skilled Nursing Facility coinsurance)
 - 2021 Part B –Medical Insurance:
 - ✓ Deductible: \$203.00 a year
 - ✓ Coinsurance: 20 percent

2021 Annual Update of Per-Beneficiary Threshold Amounts



- [MM12014:](#)
 - Effective: January 1, 2021
 - Implementation: January 4, 2021
- Key Points:
 - For CY 2021, the KX modifier threshold amounts are:
 - ✓ \$2,110 for Physical Therapy (PT) and Speech-Language Pathology (SLP) services combined, and
 - ✓ \$2,110 for Occupational Therapy (OT) services.
 - The targeted medical review process (first established through Section 202 of the Medicare Access and CHIP Reauthorization Act of 2015) but at a lower threshold amount of \$3,000
 - This threshold amount is now termed the Medical Record (MR) threshold amount – one MR threshold amount for PT and SLP services combined and another for OT services – remains at \$3,000 until CY 2028 at which time it will be updated by the Medicare Economic Index (MEI)

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2021 Annual Update to the Therapy Code List



- [MM12126:](#)
 - Effective: January 1, 2021
 - Implementation: January 6, 2021
- Key Points:
 - HCPCS CPT codes made permanent and no longer restricted by the effectiveness timeline of the PHE:
 - ✓ G2250 (replacing G2010), G2251 (replacing G2012), and 98970-98972 (replacing codes G2061-G2063)
 - HCPCS G-codes removed from the therapy code list for dates of service on or after January 1, 2021:
 - ✓ G2010, G2012, G2061, G2062 and G2063
 - The therapy code listing is available at:
<http://www.cms.gov/Medicare/Billing/TherapyServices/index.html>

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April 2021 Hospital Outpatient Perspective Payment System (OPPS)



- [MM12175](#):
 - Effective: April 1, 2021
 - Implementation: April 5, 2021
- Key Points:
 - Changes to and billing instructions for various payment policies for OPPS providers
 - Summary of modifications:
 - ✓ Revised APC assignments for Pfizer-BioNTech and Moderna COVID-19 CPT administration codes:
 - 9397 -Covid-19 Vaccine Administration Dose 1 of 2
 - 9398 - Covid-19 Vaccine Administration Dose 2 of 2 or Single Dose Product
 - ✓ Janssen/Johnson & Johnson COVID-19 vaccine and vaccine administration code:
 - 0031A – administration/immunization code
 - 91303 – vaccine/product code
 - ✓ New monoclonal antibody therapy product and administration codes:
 - M0245 and Q0245 effective February 9, 2021

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April 2021 Hospital OPPS



- CPT Proprietary Laboratory Analyses (PLA) coding changes:
 - Effective April 1, 2021, six (6) new PLA codes (CPT codes 0242U through 0247U)
- New HCPCS code describing the application of intraoperative near-infrared fluorescence imaging using indocyanine green on the extrahepatic ducts:
 - HCPCS code C9776 effective April 1, 2021
- New HCPCS describing esophageal mucosal integrity testing by electrical impedance:
 - HCPCS code C9777 effective April 1, 2021
- Change to the long descriptor for HCPCS code descriptor for C9761
- Status indicator (SI) corrections for HCPCS codes G2061-G2063 and CPT codes 98970-98972 effective January 1, 2021:
 - HCPCS codes G2061-G2063 – deleted effective December 31, 2020, therefore SI changed to D in [April 2021 I/OCE](#) retroactively
 - CPT codes 98970, 98971, and 98972 replaced these codes – assigned SI A effective January 1, 2021 in April 2021 I/OCE

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April 2021 Hospital OPPS continued



- SI corrections for HCPCS codes G2010, G2012, and G2211 effective January 1, 2021:
 - HCPCS codes G2010 and G2012 were replaced by HCPCS codes G2250 and G2252 and the SI changed from A to B
 - HCPCS code G2211 was corrected in the April I/OCE
- Advanced diagnostic laboratory tests (ADLT) under the Clinical Lab Fee Schedule (CLFS):
 - CPT code 81529 is assigned to OPPS status indicator A, effective January 1, 2021:
 - ✓ DecisionDX-Melanoma test is now described by this CPT Editorial Panel:
 - CPT 81599 SI change to E1 in the April 2021 I/OCE release
- Therapeutic intra-vascular ultrasound system (TIVUS™) for pulmonary artery denervation in patients with pulmonary arterial hypertension:
 - CPT code 0632T change SI changed from SI E1 to SI J1 and assigning it to APC 5194 (Level 4 Endovascular Procedures) effective April 1, 2021

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Drugs, Biologicals, and Radiopharmaceuticals



- New CY 2021 HCPCS codes and dosage descriptors for certain drugs, biologicals, and radiopharmaceuticals receiving pass-through status:
 - Three new HCPCS (C9074, J7212, and Q5122) codes effective April 1, 2021
- Existing HCPCS codes for certain drugs, biologicals, and radiopharmaceuticals with pass-through status ending on March 31, 2021:
 - 10 HCPCS codes with SI changing from G to K effective April 1, 2021
 - ✓ See [Table 11 of CR 12175](#)
- Newly established HCPCS codes for drugs, biologicals, and radiopharmaceuticals as of April 1, 2021:
 - Seven new HCPCS codes - [Table 12 of CR 12175](#)
- HCPCS codes for drugs, biologicals, and radiopharmaceuticals deleted as of April 1, 2021:
 - Two HCPCS codes - [Table 13 of CR 12175](#)
- Drugs and biologicals that will retroactively change from non-payable status to separately payable status from January 1, 2021, to March 31, 2021:
 - HCPCS code Q5122 will be changed retroactively from SI E2 to K in the April I/OCE
- Drugs and biologicals with payments based on Average Sale Price (ASP):
 - Updated payment rates effective April 1, 2021, are in the April 2021 update of the [OPPS Addendums A and B](#)
- Drugs and biologicals based on ASP methodology with restated payment rates

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FAQs on the 3-Day Payment Window for Services Provided to Outpatients Who Later Are Admitted as Inpatients



- [SE20024](#):
 - Release Date: December 3, 2020
- Key Points:
 - Further explains the billing procedures and provides additional resources to avoid incorrect billing for outpatient services within 3 days before date of admission and on the date of admission
 - Resulting from an Office of Inspector General (OIG) May 2020 report:
 - ✓ [Medicare Made \\$11.7 Million in Overpayments for Nonphysician Outpatient Services Provided Shortly Before or During Inpatient Stays](#)
 - Includes responses to FAQs about the 3-day payment window:
 - ✓ Answer to FAQs as they relate to Medicare Physician Fee Schedule (MPFS) services

Review of Hospital Compliance with Medicare's Transfer Policy with the Resumption of Home Health Services and the Use of Condition Codes



- [SE20025](#):
 - Article Release Date: December 1, 2020
- Key Points:
 - When a hospital transfers a Medicare beneficiary to a setting subject to the post-acute-care transfer policy, its claim should reflect the patient discharge status code for the type of post-acute-care setting
 - In addition to the correct discharge status code, the IPPS hospital may add one of the following condition codes to the claim, as appropriate, to receive the full MS-DRG payment:
 - ✓ Condition Code 42- used if a patient is discharged to home with HH services, but the continuing care is not related to the condition or diagnosis for which the individual received inpatient hospital services
 - ✓ Condition Code 43 – used if the continuing care is related, but no HH services are furnished within 3 days of hospital discharge.

Update to Vaccine Services Editing



- [MM11975](#):
 - Effective: for claims received on or after April 1, 2021
 - Implementation: April 5, 2021
- Key Points:
 - Allows an inpatient SNF claim that contains a “From” DOS that overlaps only the “Through” date of a vaccine or telehealth outpatient claim for the same beneficiary
 - Instructs MACs to pay HCPCS codes G0008, G0009, and G0010 claims with a DOS in CY 2020 based on the CY 2019 national payment amounts for immunization administration services
 - Modifies current editing to allow vaccines and their administration when they are the only services on a 12X claim where the service date is equal to the discharge date of an inpatient claim for the same provider and the service date is equal to the "From" date of another inpatient claim with condition code B4 for the same provider

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ICD-10 Revisions to National Coverage Determinations (NCDs)



- [MM12027](#):
 - Effective: April 1, 2021
 - Implementation: April 5, 2021
- Key Point:
 - ICD-10 quarterly maintenance updates impact several NCDs:
 - ✓ 110.10 IV Iron Therapy
 - ✓ 110.21 ESA in Cancer
 - ✓ 110.23 Stem Cell Transplants
 - ✓ 160.18 VNS
 - ✓ 180.1 Medical Nutritional therapy
 - ✓ 190.3 Cytogenetic Studies
 - ✓ 20.33 TMVR
 - ✓ 20.5 Extracorporeal Immunoabsorption
 - ✓ 210.3 Screening for Hepatitis B
 - ✓ 220.13 Percutaneous Image Guided Breast Biopsy
 - ✓ 220.4 Mammogram
 - ✓ 220.6.17 PET for Oncologic Conditions
 - ✓ 260.1 Adult Liver Transplantation

Common Working File (CWF) Edits for Medicare Telehealth Services and Manual Update



- [MM12068](#):
 - Effective: January 1, 2021
 - Implementation: July 6, 2021
- Key points:
 - For subsequent nursing facility care services, Medicare had limited the patient's admitting physician or non-physician practitioner to one telehealth visit every 30 days
 - CMS is changing this limitation to once every 14 days
 - Applies to the following codes when billed with the GT or GQ modifier or place of service code 02 for dates of services on or after January 1, 2021, processed on or after July 6, 2021:
 - ✓ 99307
 - ✓ 99308
 - ✓ 99309
 - ✓ 99310
 - Frequency editing also applies when these services are span-dated on the claim

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Sequestration



- Medicare FFS claims: 2% payment adjustment (sequestration) suspended through March 31, 2021
- Reference:
 - [MLN Connects Special Edition Monday, December 28, 2020](#)

Clinical Diagnostic Laboratory Tests (CDLTs)



- Effective January 1, 2021 updates have been made the CDLTs codes:
 - New add-on code U0005 is defined as:
 - ✓ Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique, CDC or non-CDC, making use of high throughput technologies, completed within two calendar days from date and time of specimen collection
 - ✓ **This code should be list separately in addition to either HCPCS code U0003 or U0004**
 - Payment amounts have been updated:
 - ✓ U0003 and U0004 - reimbursed at \$75
 - ✓ U0005 - reimbursed at \$25
 - U0005 – claims have been denying in error for ordering/referring NPIs requirements:
 - ✓ Claims that were denied in error will be automatically adjusted
- References:
 - New Codes for Laboratory Tests for COVID-19 ([JH](#)) ([JL](#))
 - [COVID-19 Frequently Asked Questions \(FAQs\) on Medicare Fee-for-Service \(FFS\) Billing](#):
 - ✓ Section C. Serology Testing
 - ✓ Section D. High Throughput COVID Testing

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Clinical Laboratory Fee Schedule – Medicare Travel Allowance Fees for Collection of Specimens



- [MM12140](#):
 - Effective date: January 01, 2021
 - Implementation date: No later than March 19, 2021
- Key Points:
 - For calendar year 2021, travel allowance has been revised for billing:
 - ✓ Per mileage basis using HCPCS code P9603:
 - Use the per mile travel allowance in situations where the average trip to the patients' homes is longer than 20 miles round trip
 - Prorated in situations where specimens are drawn from non-Medicare patients in the same trip
 - The allowance is computed using the Federal mileage rate of \$0.56 per mile plus \$0.45 per mile to cover the technician's time and travel costs
 - MACs have option of establishing per mile rate in excess of the minimum of \$1.01 per mile if local conditions warrant it
 - ✓ Flat rate basis using HCPCS code P9604:
 - Per flat-rate trip basis travel allowance is \$10.10
 - Medicare Part B allows payment for a specimen collection fee and travel allowance, when medically necessary, for a laboratory technician to draw a specimen from either a nursing home patient or homebound patient under Section 1833(h)(3) of the Act
 - Payment for these services is made based on the Clinical Laboratory Fee Schedule (CLFS)
- Reference:
 - Travel Allowance for Collection of Specimens ([JH](#)) ([JL](#))

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Changes to Laboratory NCDs Edit Software for July 2021



- [MM 12171](#)
 - Effective: July 1, 2021
 - Implementation: July 6, 2021
- Key points:
 - Announces changes in July quarterly release of edit module for clinical diagnostic laboratory services
 - ✓ Changes are result of coding analysis decisions and biannual updates of ICD-10
 - ✓ Access listing of affected NCDs:
 - <https://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/July2021.zip>

Accelerated and Advance Payments

What is an Accelerated and Advance Payment



- Background:
 - Effective March 28, 2020, CMS expanded the accelerated and advance payment program for Medicare participating health care providers and suppliers, to ensure they have the resources needed to combat the 2019 Novel Coronavirus (COVID-19)
- Purpose:
 - Provided emergency funding and address cash flow issues based on historical payments when there is disruption in claims submission and/or claims processing

Accelerated and Advance Payments (AAP) Repayment Process

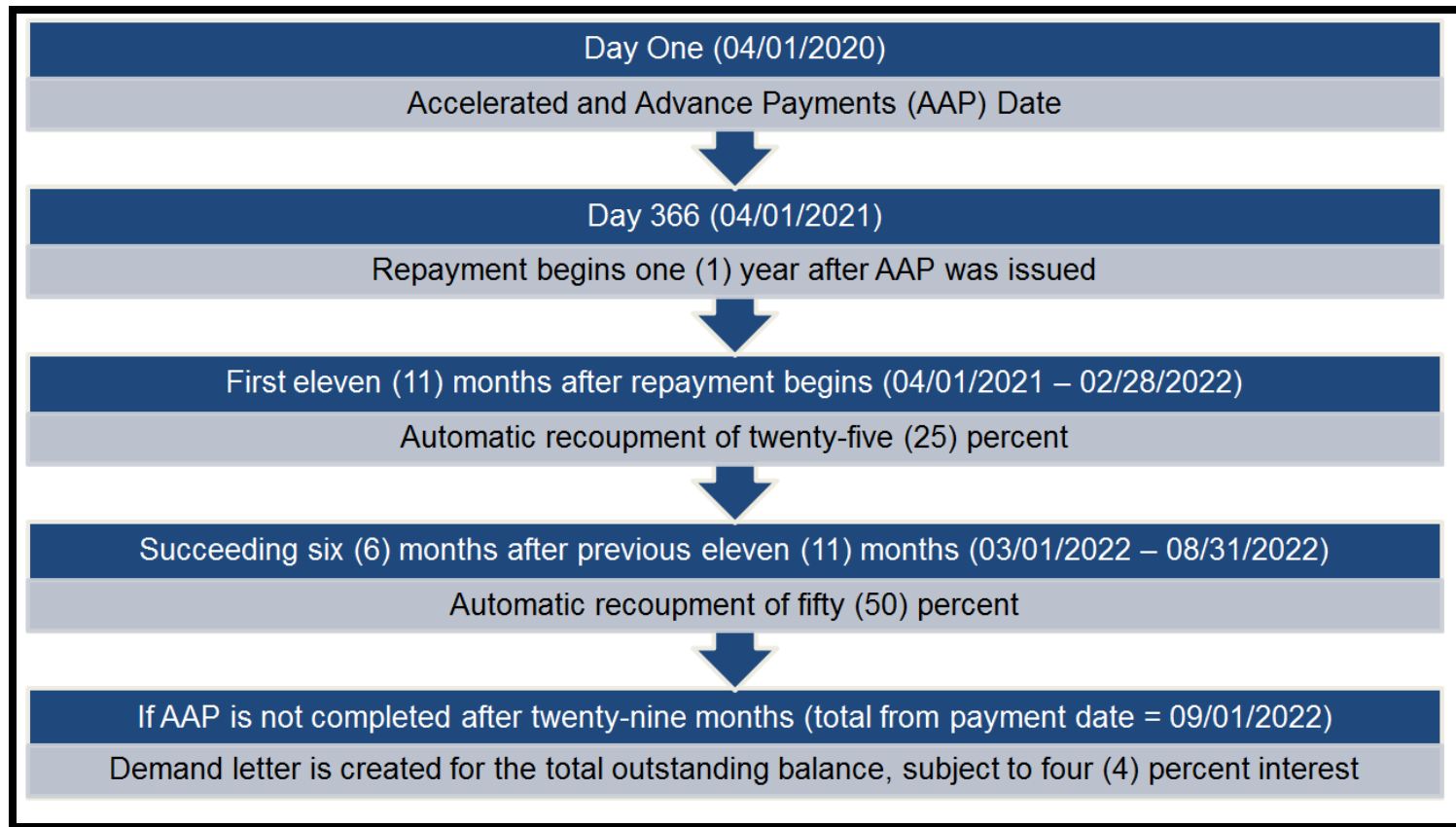


- Congress enacted amended repayment terms for the AAP through the Continuing Appropriations Act, 2021 and Other Extensions Act:
 - Repayment will now begin one year after the date of the issuance of the payment.
 - During the first 11 months after repayment begins, repayment will occur through an automatic recoupment of 25 percent of Medicare payments otherwise owed to you.
 - During the succeeding six months, repayment will occur through an automatic recoupment of 50 percent of Medicare payments otherwise owed to you.
 - If you are unable to repay the total amount of the accelerated or advance payment through recoupment within 29 months, you will receive a demand letter requiring repayment of any outstanding balance, subject to an interest rate of four percent.
- Repayment process will begin automatically

Example of AAP Repayment



- Example shows repayment terms for a provider that was issued an AAP on April 1, 2020:



AAP Letters and Tracking



- Providers were sent a letter in October 2020 with the following details:
 - Payment dollar amount
 - Repayment start date
 - Account Receivable (AR) number:
 - ✓ Starts with CVD
- Providers are encouraged to create a way to track:
 - Claims submitted
 - Reimbursement received
 - Reimbursement recouped

AAP Repayment Reminders



- Repayment does not impact patient accounts:
 - Withhold is taken from final net provider payment
- Offset will occur with “WO” and the AR number on provider’s letter:
 - AR number will not change
 - Provider’s may have multiple AR numbers if high dollar amount was received:
 - ✓ If provider has multiple AAP AR numbers there are not multiple offsets:
 - Only 25%, 50%, etc. total will occur
- Claim related offsets can occur on same remittance advice:
 - Providers will see financial control number (FCN) and AAP AR number on separate lines

Return of Monies Form for AAP



- Providers have the ability to return all or some monies owed from AAP prior to **start** of recoupment process
- 17 - Other – Please Specify:
 - Recommended comment AAP
- Cannot accept checks for more than \$70M

Reason Code for Claim Adjustment

17-Other-Please Specify:



Claim Billed Amount

Additional Info. field

Accelerated and Advance Payment

Immediate Recoupment for AAP



- Complete Immediate Recoupment Form
- In Demand Letter Numbers indicate:
 - COVID-19 AAP
 - Dollar amount of the payment
- Must be done BEFORE automatic recoupment starts

Provider Name:

Provider's Medicare and/or National Provider Identifier (NPI):

Demand Letter Number(s): **COVID-19 AAP \$275,870.00**

FAQs on Recoupment Process



- Can providers still submit a request for an AAP payment?
 - Effective October 8, 2020, MACs are no longer accepting payment request forms from providers. Any applications received on or after this date shall be declined
- Will I be allowed to repay the accelerated/advance payment as one lump sum as opposed to individual recoupments on remittance advices?
 - Yes, you will be able to repay as one lump sum.
- Do provider/suppliers have any appeal rights?
 - Providers/suppliers do not have administrative appeal rights related to these payments. However, administrative appeal rights would apply to the extent CMS issued overpayment determinations to recover any unpaid balances on accelerated payments.
- Will interest accrue on my account?
 - If all monies have not been paid at the end of the total 29-month time-frame, a demand letter will be issued with a total amount of monies still owed. Interest will begin to accrue at that time at four percent.

AAP Resources



- Learn about CMS' Amended Repayment Process for Accelerated and Advance Repayments ([JH](#)) ([JL](#))
- [Fact Sheet: Repayment Terms for Accelerated and Advance Payments Issued to Providers and Supplies During COVID-19 Emergency](#)
- [Accelerated and Advance Payment Repayment and Recovery Frequently Asked Questions](#)

COVID-19 Vaccines and mAb Infusion Administration

Coronavirus (COVID-19)

- 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



A screenshot of the Medicare J.L. website. The page title is "Provider specialty: COVID-19 vaccine and monoclonal antibodies". The main content area includes sections for "Billing and coding" with links to various resources like "Coding for COVID-19 vaccine shots" and "COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) billing". There is also a section for "Mass immunizers and roster billers" with links to "ABILITY PC-ACE user guide" and "Centralized billing for vaccines". A left-hand navigation menu lists various services like "Appeals", "Claims", and "Specialties / Services". A "COVID-19 vaccine" banner is visible at the bottom left of the page content.

- [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

COVID-19 Vaccine Administration Coding



- [COVID-19 Frequently Asked Questions \(FAQs\) on Medicare Fee-for-Service \(FFS\) Billing](#)
 - Section BB. Drugs & Vaccines under Part B:
 - ✓ NOTE: Vaccine/infusion not separately payable when obtained free of charge:
 - Administration is separately payable
- [COVID-19 Vaccines and Monoclonal Antibodies](#) webpage

Vaccine/ Infusion	Administration	Effective Date
91300	0001A (first dose) and 0002A (second dose)	12/11/2020
91301	0011A (first dose) and 0012A (second dose)	12/18/2020
91302	0021A (first dose) and 0022A (second dose)	TBD
91303	0031A (single dose)	2/27/2021
Q0239	M0239	11/10/2020
Q0243	M0243	11/21/2020
Q0245	M0245	2/9/2021

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How to Bill for COVID-19 Vaccine and mAb Administration



- Instructions are being provided on:
 - How to bill single claims for COVID-19 vaccines and mAb infusions
 - Roster and centralized billing:
 - ✓ Additional information on roster and centralized billing available on the [CMS Medicare billing for COVID-19 vaccine shot administration](#) page
- **When COVID-19 vaccine and mAb doses are provided by the government without charge, only bill for the vaccine administration:**
 - **Don't include the vaccine codes on the claim when the vaccines are free**
 - Note: If your software requires you to submit the vaccine or infusion drug codes with the administrations, submit the billed amount as \$0.01.
- Beneficiary coinsurance and deductible will be waived
- These codes will not apply to SNF consolidated billing (SNF CB) edits
- References:
 - Roster billing for Part A providers ([JH](#)) ([JL](#))
 - COVID-19 vaccine and monoclonal antibodies billing for Part A ([JH](#)) (J)

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
 - ✓ **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](#))

Part A COVID-19 Vaccine and mAb Administration Billing Requirements



- Billable on the CMS-1450 (UB-04) form or electronic equivalent
- Applicable TOBs:
 - Inpatient Part B:
 - Hospital - 12X
 - SNF - 22X
 - Outpatient:
 - Hospital - 13X
 - SNF - 23X
 - End stage renal disease - 72X
 - Comprehensive outpatient rehabilitation facility - 75X
 - Critical access hospital - 85X
- HCPCS codes – see lists
- Revenue codes:
 - 0771 - preventive care services, vaccine administration
 - 0636 - pharmacy, drugs requiring detailed coding:
 - Do not bill when vaccine is free of charge
- Condition codes:
 - A6 - 100% payment
 - 78 - New coverage not implemented by Medicare Advantage:
 - Billed on claims for Medicare Advantage beneficiaries only
- Diagnosis codes
 - Z23 - Required as primary diagnosis
 - U071 - May be reported as a second diagnosis for the mAb
- Attending physician

Opioid Treatment Program Updates (OTP)

OTP Updates



- Effective January 1, 2021, Medicare Part B covers outpatient OTP services provided by OTP enrolled hospitals, CAHs, and free-standing OTP facilities
- OTPs must be certified by the Substance Abuse and Mental Health Services Administration (SAMHSA) and accredited by an independent, SAMHSA-approved accrediting body prior to Medicare Program participation
- For enrollment review the [Enrollment Fact Sheet](#):
 - Enroll through the [Provider Enrollment, Chain and Ownership System \(PECOS\)](#) or the paper-based [CMS-855A Institutional Providers](#) application:
 - ✓ Contact our Provider Enrolment helpdesk at 1-877-235-8073 (option 4) if you need assistance
 - ✓ Reference:
 - [OTP Medicare Billing and Fact Sheet](#)
- Upcoming webinar on April 19, 2021 at 1:00 p.m. ET (registration coming soon)

Institutional OTP Service Billing



- Reporting Requirements:
 - TOB:
 - ✓ 013X – Hospital
 - ✓ 085X – CAH
 - ✓ 087X – Free-standing OTP Facility
 - Revenue code and charge
 - HCPCS and units
 - Line-item dates of service per revenue code line:
 - ✓ Not required for CAHs
 - Report condition code 89 (Opioid Treatment Program/indicates the claim is for OTP services):
 - ✓ Not required for Free-Standing OTP facilities
- Note: No copayment for opioid use disorder treatment services, however, deductible will apply

Acceptable Revenue Codes



- OTP service revenue codes: 090X – 091X, 0949, and 0953

Revenue Code	Description
0636	Drugs Requiring Detailed Coding
0900	Behavioral Health Treatment/Services
0914	Individual Therapy
0915	Group Therapy
0916	Family Therapy
0918	Behavioral Health/Testing
0919	Other Behavioral Health Treatments
0940	General Classification
0944	Drug Rehabilitation
0949	Other Therapeutic Service
0953	Chemical Dependency (Drug and Alcohol)

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

Initial OPD Services



- As a condition of payment for DOS on or after July 1, 2020, a 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
- CMS provides a [list](#) of the HCPCS codes included in the OPD PA program

Additional Hospital OPD Services



- CMS added two new services to the hospital OPD PA program
- Novitas will begin accepting PARs on June 17, 2021, for services provided beginning on or after July 1, 2021 as a condition of payment for the following hospital OPD services:
 - Cervical Fusion with Disc Removal
 - Implanted Spinal Neurostimulators
- Reference:
 - [CY 2021 OPPS/ASC Final Rule \(CMS-1736-FC\)](#)
 - [OPD Operational Guide](#)

PA Program for Certain Hospital OPD Services Webpage



- For details, links, and submission guidelines refer to the Prior Authorization (PA) Program for Certain Hospital Outpatient Department (OPD) Services ([JH](#)) ([JL](#)) webpage

Medicare JL
Providers in DC, DE, MD, NJ & PA

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

News & Alerts

Background

The Centers for Medicare & Medicaid Services (CMS) is implementing a Prior Authorization (PA) program for certain hospital outpatient department (OPD) services for dates of service (DOS) on or after July 1, 2020, nationwide. CMS believes prior authorization for certain hospital OPD services will ensure that Medicare beneficiaries continue to receive medically necessary care while protecting the Medicare Trust Fund from improper payments and keeping the medical necessity documentation requirements unchanged for providers.

As a condition of payment for DOS on or after July 1, 2020, a Prior Authorization Request (PAR) is required for the following hospital OPD services:

- Blepharoplasty
- Botulinum toxin injections
- Panniculectomy
- Rhinoplasty
- Vein ablation

CMS provides a [list](#) of the specific Healthcare Common Procedure Coding System (HCPCS) codes that are included in the OPD Prior Authorization program.

Quick Links

- [CMS Prior Authorization for Certain Hospital Outpatient Department \(OPD\) Services](#)
- [CMS Final List of Outpatient Services That Require Prior Authorization](#)

General Information

Question	Answer
WHO	Hospital OPD when rendering certain OPD services for Medicare beneficiaries that bill Medicare Part A can receive prior authorization.
WHAT	The Hospital OPD (also known as the requestor) will be responsible to submit a Prior Authorization Request (PAR) and all documentation for five groups of services and their related services before the services are provided to Medicare beneficiaries and before the provider can submit claims for payment under Medicare for these services. The five groups of hospital OPD services are Blepharoplasty, Botulinum Toxin Injections, Panniculectomy, Rhinoplasty, and Vein Ablation.
WHEN	The program will apply to hospital OPD services rendered on or after July 1, 2020.
WHERE	The program applies to all Jurisdictions.
WHY	CMS believes PA for certain hospital OPD services will ensure that Medicare beneficiaries continue to receive medically necessary care while protecting the Medicare Trust Fund from improper payments and keeping the medical necessity documentation requirements unchanged for providers. It is designed to ensure all relevant coverage, coding, payment rules, and medical record(s) requirements are met before the service is rendered to the beneficiary and the claim is submitted for payment.

Education and Training Events

Calendar of Events



- Please visit our [Calendar of Events](#) for upcoming webinars

Date/Time	Time	Name of Event	LOB
April 1, 2021	1:00 p.m. – 2:00 p.m.	Overpayment and Recoupment Process	AB
April 6, 2021	10:00 a.m. – 11:30 a.m.	Novitasphere Part B Overview	B
April 8, 2021	12:00 p.m. - 1:00 p.m.	Novitasphere Enrollment Overview	AB
April 12, 2021	10:00 a.m. – 11:00 a.m.	Novitasphere Claim Submission Overview	B
April 14, 2021	12:30 p.m. – 1:30 p.m.	Part B Medicare Updates	B
April 15, 2021	12:30 p.m. – 2:00 p.m.	Understanding COVID-19 Vaccine and Monoclonal Antibody Infusion Billing and Coding	AB
April 16, 2021	10:00 a.m. – 11:00 a.m.	Novitasphere Claim Correction	B
April 16, 2021	10:00 a.m. – 11:00 a.m.	Medicare Part A Updates	A

#StayConnected Workshop Series



- Stay connected with Medicare updates and requirements by attending the Novitas Solutions Workshop series
 - Medicare Secondary Payer (MSP) Series: April 6 – 8, 2021
 - Medicare Coverage: April 13 – 15, 2021
 - New Provider: April 19 – 22, 2021
- Monitor our [event calendar](#) for registration



Virtual Symposium



- 2021 Virtual Symposium dates:
 - May 19 - 21, 2021
 - December 8 - 10, 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?



I N N O V A T I O N I N A C T I O N

Thank You for Attending!



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