Medicare Updates and What's Trending in the Medicare Program

MD AAHAM

March 6, 2020

INNOVATION IN ACTION

Disclaimer

- All Current Procedural Terminology (CPT) only are copyright 2019 American Medical Association (AMA). All rights reserved. CPT is a registered trademark of the American Medical Association. Applicable Federal Acquisition Regulation/ Defense Federal Acquisition Regulation (FARS/DFARS) Restrictions Apply to Government Use. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.
- The information enclosed was current at the time it was presented. Medicare policy changes frequently; links to the source documents have been provided within the document for your reference. This presentation was prepared as a tool to assist providers and is not intended to grant rights or impose obligations.
- Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services.
- Novitas Solutions' employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this guide.
- This presentation is a general summary that explains certain aspects of the Medicare program, but is not a legal document. The official Medicare program provisions are contained in the relevant laws, regulations, and rulings.
- Novitas Solutions does not permit videotaping or audio recording of training events.

INNOVATION IN ACTION

Agenda

- Novitas Initiatives
- Medicare Updates
- Part A East (PAE) Qualified Independent Contractor (QIC) Demonstration
- Overview of Hospital Off-Campus Outpatient Department Reporting Requirements
- Credit Balance Reporting
- Preventive Services
- Education and Training Events

Acronym 1

Acronym	Definition
ALJ	Administrative Law Judge
AUC	Appropriate Use Criteria
CDSM	Clinical Decision Support Mechanism
CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology
CY	Calendar Year
FISS	Fiscal Intermediary Standard System
HCPCS	Healthcare Common Procedure Coding System
IVR	Interactive Voice Response
MAC	Medicare Administrative Contractor
MBI	Medicare Beneficiary Identifier
NCCI	National Correct Coding Initiative

Acronym 2

Acronym	Definition
NCD	National Coverage Determination
NPI	National Provider Identifier
OPPS	Outpatient Prospective Payment System
OT	Occupational Therapy
PAE	Part A East
PECOS	Provider Enrollment, Chain and Ownership System
PT	Physical Therapy
PTAN	Provider Transaction Access Number
QIC	Qualified Independent Contractor
RTP	Return to Provider
SNF	Skilled Nursing Facility

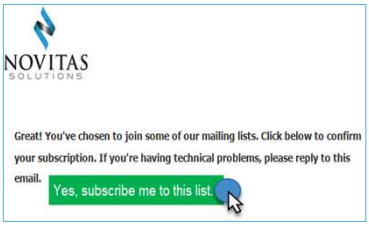
Novitas Initiatives

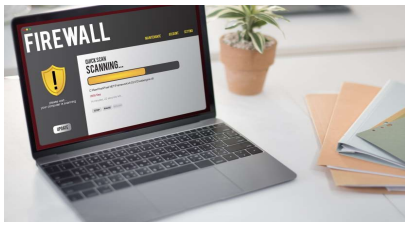
Subscribe to Novitas eNews!

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

Remain Enrolled

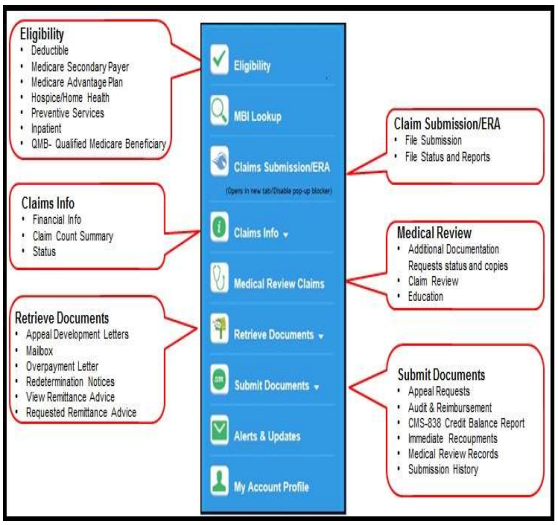
- A verification e-mail will be sent to you minutes after subscribing:
  - Click "Yes, subscribe me to the list"
- Didn't receive the verification or you stopped receiving eNews:
  - Your network firewall or spam filter is blocking us
  - Please alert your network IT personnel
  - Follow these simple steps to allow eNews:
    - ✓ https://mailchimp.com/about/ips/





Novitasphere

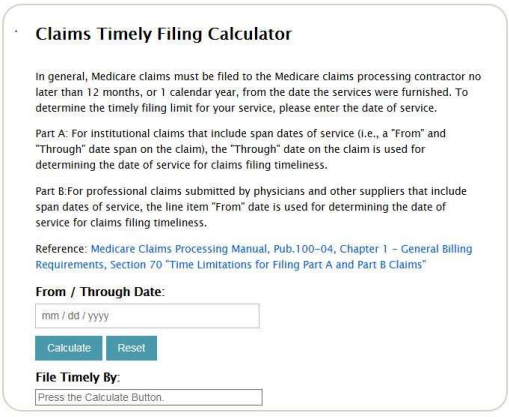
- Free, secured web-based portal
- Dedicated Help Desk- 1-855-880-8424
- For demonstrations and more information:
  - Novitasphere Portal webpage
- Part A features list:



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

Claims Timely Filing Calculator

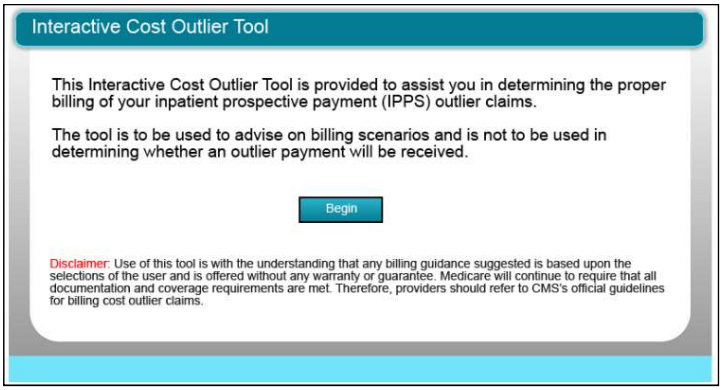
- The Claims Timely Filing Calculator (JH) (JL) is a new Self-Service Tool (JH) (JL) provided to assist in determining the timely filing limit for your service



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

Part A: Interactive Cost Outlier Tool

- The Interactive Cost Outlier Tool is a new Self-Service Tool provided to assist in determining the proper billing of inpatient prospective payment system (IPPS) outlier claims



New to Medicare?

- Medicare Welcome Center

Top Claim Errors

- Top Claim Submission/Reason Code Errors:

Reason Code	Description	Resolution
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. When adjusting claims with medically denied line items, do not move the charges to covered or remove the denial from the line to prevent this error from occurring.
18402	The principal procedure code must be within the statement covers 'from' and 'through' dates on the claim.	Verify dates associated with principal procedure. Correct and resubmit. If no procedure codes on the claim then procedure date field is blank.
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.

Top MSP Error: Reason Code 31102

- Description:
  - The following requirements must be met in order to consider processing as a conditional/secondary payment:
    - ✓ OC 01, 02, 03, 04, or 33 must be present with associated MSP VC
    - ✓ MSP VC 12, 13, 14, 15, 16, 41, 42, 43, or 47 must be present
    - ✓ Associated MSP value code amount must contain all zeros
    - ✓ OC 24 is reported
    - ✓ Appropriate insurance name, policy holder name, policy holder number, and patient relationship code must be present
    - ✓ Insurance address must be present
    - ✓ Remarks must justify reason why the primary payer has not paid on this claim
    - ✓ MSP type submitted on the claim should match existing/open CWF MSP auxiliary record
- Resolution:
  - Verify, correct, and resubmit
  - If coverage needs added or has changed, contact the Benefits Coordination and Recovery Center (BCRC) at 1-855-798-2627 to have information updated
- Reason Code 31102 and 31361 Resolution (JH) (JL)

Open Claim Issues

- Open Claim Issues for Medicare Part A:

Providers Impacted	TOBs	Description	Proposed Resolution/Action Required
Outpatient	13x	The United States District Court for the District of Columbia issued instructions for CMS to immediately cease the clinic visit provided at excepted off-campus PBDs payment reduction for CY 2019 implemented with the Final Rule	Revised Hospital OPPS Pricer installed 11/4/2019 being applied to claims with a line item date of service of January 1, 2019, and after. Novitas will do mass adjustments.
MD SNF and Outpatient Therapy Facilities	22x 23x 74x	Claims for MD SNFs and outpatient therapy facilities, provider numbers starting with 215xxx or 216xxx, not receiving reimbursement on various services, primarily services that are paid at the MPFS, such as therapy.	Correction installed 1/6/2020 I/OCE software. Claims not previously paid due to this issue have been identified and will be reprocessed

Medicare Updates

Medicare Beneficiary Identifier (MBI) is Here!

NOVITAS SOLUTIONS

- January 1, 2020, claims submitted to Medicare require the beneficiary's MBI number
- Use MBI now for all Medicare transactions
- 3 ways to get the MBI:
  - Ask your patient for their card
  - Use your Medicare Administrative Contractor's look up tool:
    - ✓ Sign up for the Portal to use the tool
  - Check the remittance advice:
    - ✓ MBI is returned on the remittance advice if a valid and active Health Insurance Claim Number is submitted
- Get Your New Medicare Card
- Beneficiaries who did not receive their card can:
  - Sign into MyMedicare.gov:
  - Call 1-800-MEDICARE (1-800-633-4227)
  - TTY users can call 1-877-486-2048

INNOVATION IN ACTION

January 1, 2020, and After

NOVITAS SOLUTIONS

- Claims submitted with the old Medicare number will reject with limited exceptions
- Electronic claims reject codes:
  - Claims Status Category Code of A7- acknowledgment rejected for invalid information
  - Claims Status Code of 164 - entity's contract/member number
  - Entity Code of IL – subscriber
- Paper claims paper notice:
  - Claim Adjustment Reason Code (CARC) 16 "Claim/service lacks information or has submission/billing error(s)"
  - Remittance Advice Remark Code (RARC) N382 "Missing/incomplete/invalid patient identifier"
- Claims must be resubmitted with the MBI

INNOVATION IN ACTION

Exceptions for Submitting Old Medicare Number

- Exceptions for Fee-for-Service claims:
  - For audits:
    - ✓ Use either the old Medicare number or the MBI for audit purposes
  - For appeals:
    - ✓ Use either old Medicare number or the MBI for appeals and related forms
  - For claim status query:
    - ✓ Use either the old Medicare number or the MBI if the earliest date of service is before January 1, 2020
    - ✓ Status of dates of service after January 1, 2020 you must use the MBI
  - 11X Inpatient Hospital, 32XHome Health and 41X-Religious Non-Medical Health Care Institution:
    - ✓ If patient starts receiving services before December 31, 2019 but stops receiving those services after December 31, 2019:
      - ➢ Use either the old Medicare number or the MBI (even if the claim is submitted after December 31, 2019)

MBI Reason Codes

- Reason Code 30995:
  - Description:
    - ✓ Your claim was received after the new Medicare card transition period and the wrong identifier was submitted
  - Resolution:
    - ✓ Resubmit the claim with a valid MBI
- Reason Code 30993:
  - Description:
    - ✓ A claim has been submitted with an MBI and the MBI/HIC combination was not found on the CWF MBI Crosswalk
  - Resolution:
    - ✓ Verify the MBI reported on the claim with the patient's Medicare card; correct and resubmit

Reminders About Using the Old or New MBIs

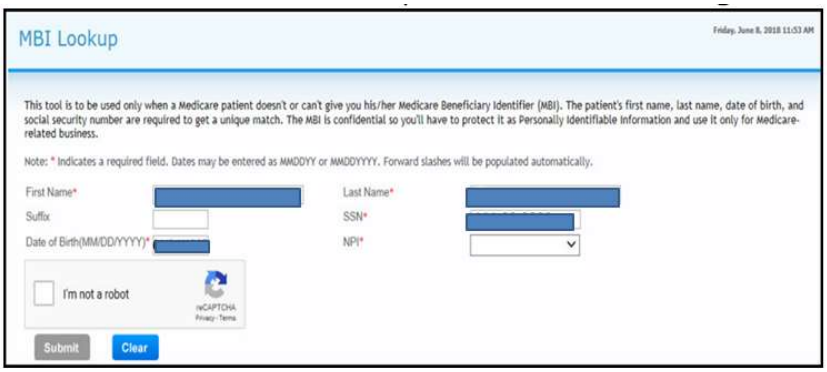
- Fee-For-Service (FFS) claims submissions with:
  - Dates of service before the MBI change date - use old or new MBIs
  - Span-date claims with a "From Date" before the MBI change date - use old or new MBIs
  - Dates of service that are entirely on or after the effective date of the MBI change - use new MBIs
- FFS eligibility transactions when the:
  - Inquiry uses new MBI - we will return all eligibility data
  - Inquiry uses the old MBI and request date or date range overlap the active period for the old MBI - we will return all eligibility data. We will also return the old MBI termination date
  - Inquiry uses the old MBI and request date or date range are entirely on or after the effective date of the new MBI - we will return an error code (AAA 72) of "invalid member ID"

There Are Times When an MBI May Change

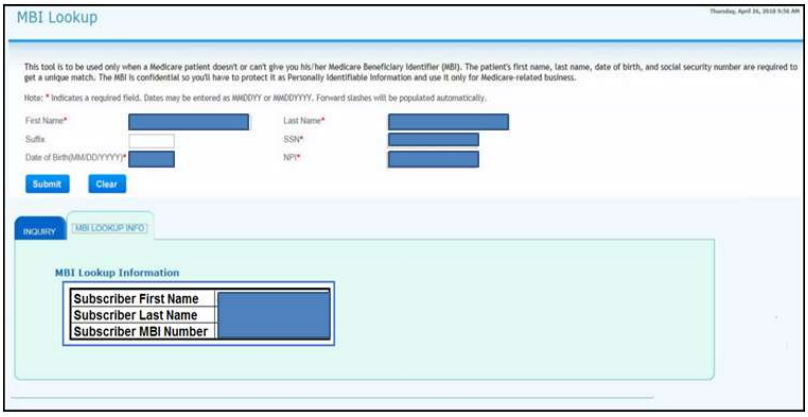
- Medicare beneficiaries or their authorized representatives can ask to change their MBIs:
  - Example, if the MBIs are compromised
- CMS can change MBIs
- CMS does NOT issue temporary MBIs
- CMS does NOT require a beneficiary to activate a new MBI
- It is possible for a beneficiary to seek and get care before getting a new card with the new MBI in the mail
- Eligibility transaction error code AAA 72 of “invalid member ID,” indicates the beneficiary’s MBI may have changed
- A historic eligibility search will indicate the termination date of the old MBI
- Get the new MBI from the secure MBI look-up tool

Novitasphere MBI Lookup

- Select the MBI Lookup from the left navigation



MBI Lookup Results

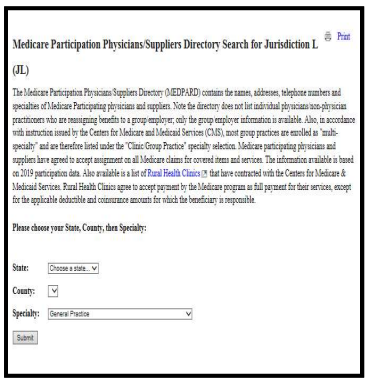


Update to Medicare Deductible, Coinsurance and Premium Rates for 2020

- 2020 Part A – Hospital Insurance:
  - Deductible: $1408.00
  - Coinsurance:
    - ✓ $352.00 a day for 61st-90th day
    - ✓ $704.00 a day for 91st-150th day (lifetime reserve days)
    - ✓ 176.00 a day for 21st-100th day (Skilled Nursing Facility (SNF) coinsurance)
- 2020 Part B –Medical Insurance:
  - Deductible: $198.00 a year
  - Coinsurance: 20 percent
- Reference:
  - 2020 Medicare Parts A & B Premiums and Deductibles Fact Sheet

2020 Medicare Participation Physicians/Suppliers Directory (MEDPARD)

- 2020 MEDPARD is available (JH) (JL)


Medicare Participation Physicians/Suppliers Directory Search for Jurisdiction L

Print

(JL)

The Medicare Participation Physicians/Suppliers Directory (MEDPARD) contains the names, addresses, telephone numbers and specialties of Medicare Participating physicians and suppliers. Note the directory does not list individual physicians/non-physician practitioners who are reassigning benefits to a group/employer; only the group/employer information is available. Also, in accordance with instruction issued by the Centers for Medicare and Medicaid Services (CMS), most group practices are enrolled as "multi-specialty" and are therefore listed under the "Clinic/Group Practice" specialty selection. Medicare participating physicians and suppliers have agreed to accept assignment on all Medicare claims for covered items and services. The information available is based on 2019 participation data. Also available is a list of Rural Health Clinics that have contracted with the Centers for Medicare & Medicaid Services. Rural Health Clinics agree to accept payment by the Medicare program as full payment for their services, except for the applicable deductible and coinsurance amounts for which the beneficiary is responsible.

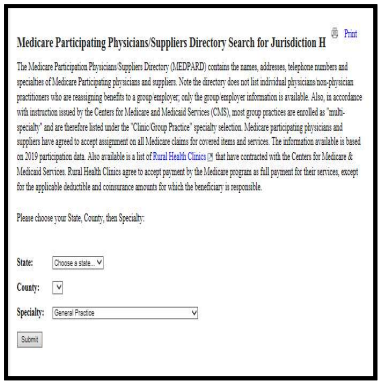
Please choose your State, County, then Specialty:

State: Choose a state...

County:

Specialty: General Practice

Submit


Medicare Participating Physicians/Suppliers Directory Search for Jurisdiction H

Print

The Medicare Participation Physicians/Suppliers Directory (MEDPARD) contains the names, addresses, telephone numbers and specialties of Medicare Participating physicians and suppliers. Note the directory does not list individual physicians/non-physician practitioners who are reassigning benefits to a group/employer; only the group/employer information is available. Also, in accordance with instruction issued by the Centers for Medicare and Medicaid Services (CMS), most group practices are enrolled as "multi-specialty" and are therefore listed under the "Clinic/Group Practice" specialty selection. Medicare participating physicians and suppliers have agreed to accept assignment on all Medicare claims for covered items and services. The information available is based on 2019 participation data. Also available is a list of Rural Health Clinics that have contracted with the Centers for Medicare & Medicaid Services. Rural Health Clinics agree to accept payment by the Medicare program as full payment for their services, except for the applicable deductible and coinsurance amounts for which the beneficiary is responsible.

Please choose your State, County, then Specialty:

State: Choose a state...

County:

Specialty: General Practice

Submit

INNOVATION IN ACTION

2020 Annual Update of Per-Beneficiary Threshold Amounts

NOVITAS SOLUTIONS

- MM11532:
  - Effective: January 1, 2020
  - Implementation: January 6, 2020
- Key Points:
  - For CY 2020, the KX modifier threshold amounts are:
    - ✓ $2,080 for Physical Therapy (PT) and Speech-Language Pathology (SLP) services combined, and
    - ✓ $2,080 for Occupational Therapy (OT) services.
  - 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
  - The targeted medical review process lowered threshold amount of $3,000

2020 Annual Update to the Therapy Code List

NOVITAS SOLUTIONS

- MM11501:
  - Effective: January 1, 2020
  - Implementation: January 6, 2020
- Key Points:
  - The CPT Editorial Panel updated the following:
    - ✓ Two new biofeedback codes to replace CPT code 90911
    - ✓ CPT codes 97129 and 97130 to replace CPT code 97127, which CMS did not recognize. These new codes will effectively replace HCPCS code G0515, which will be deleted, effective January 1, 2020
  - Deleted the following codes for manual muscle testing for Calendar Year (CY) 2020:
    - ✓ CPT codes 95831, 95832, 95833, and 95834
  - The following 42 HCPCS Level II G-codes are deleted for dates of service after December 31, 2019:
    - ✓ HCPCS codes G8978 through G8999; G9158 through G9176; and G9186
      - ➢ These codes were used for Functional Reporting of therapy services for CY 2013 through 2018, but were retained for CY 2019
  - The therapy code listing is available at: http://www.cms.gov/Medicare/Billing/TherapyServices/index.html

New Modifiers to Identify OT and PT Services Provided by a Therapy Assistant

- CR11362:
  - Effective: January 1, 2020
  - Implementation: January 6, 2020
- Key Points:
  - New modifiers have been developed to identify the PT and OT services provided in whole or in part by a therapy assistant and established the following timeline that requires the new therapy modifier:
    - ✓ CQ modifier: Outpatient physical therapy services furnished in whole or in part by a Physical Therapist Assistant (PTA)
    - ✓ CO modifier: Outpatient occupational therapy services furnished in whole or in part by an Occupational Therapy Assistant (OTA)
    - ✓ Note: The GP or GO therapy modifiers will need to be submitted to identify those PTA and OTA services furnished under a PT or OT plan of care

Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging – Educational and Operations Testing Period - Claims Processing Requirements

- MM11268
  - New program to increase the rate of appropriate advanced diagnostic imaging services furnished to Medicare beneficiaries
  - Educational and Operations Testing Period is expected to last for one year (January 1, 2020 – December 31, 2020)
  - Full program implementation is expected January 1, 2021
- Key Points:
  - When an advanced imaging service is ordered for a Medicare beneficiary, the ordering professional will be required to consult a qualified Clinical Decision Support Mechanism (CDSM):
  - The CDSM will provide the ordering professional with a determination of whether that order adheres to AUC, does not adhere to AUC, or if there is no AUC applicable in the CDSM consulted
  - HCPCS/CPTs for advanced diagnostic imaging service, AUC modifiers, and G-codes for the CDSM are listed in the article
  - **MD Waiver- Waiting for CMS guidance**

AUC for Advanced Diagnostic Imaging – Approval of Using the K3 Segment for Institutional Claims

- SE20002
  - Effective: January 1, 2020
  - Implementation: January 6, 2020
- Key Points:
  - Guidance for processing claims for certain institutional claims that are subject to the AUC program for advanced diagnostic imaging services
  - The K3 segment will be used to report line level ordering professional information on institutional claims
  - For additional AUC Program reporting guidance refer to:
    - ✓ MM11268 - AUC for Advanced Diagnostic Imaging – Education and Operation Testing Period – Claims Processing Requirements

Hospital Price Transparency Requirements

- CY 2020 Hospital OPPS policy changes per the final rule includes:
  - Effective date extended to January 1, 2021 to ensure hospital compliance with these regulations
  - Definitions of "hospital," "standard charges," and "items and services"
  - Requirements for making public all standard charges for all items and services in a machine-readable format
  - Requirements for displaying shoppable services in a consumer-friendly manner:
    - ✓ Hospitals must display payer-specific negotiated charges, de-identified minimum and maximum negotiated charges, and discounted cash prices for at least 300 shoppable services, including 70 CMS-specified shoppable services and 230 hospital-selected shoppable services
  - Monitoring and enforcement
- References:
  - Fact Sheet
  - Final Rule
  - Hospital Price Transparency Final Rule Call (December 3, 2019)
  - Questions and concerns:
    - ✓ Email PriceTransparencyHospitalCharges@cms.hhs.gov

Positron Emission Tomography (PET) Scan Tracer Codes in the FISS

- MM11537:
  - Effective Date: January 1, 2018
  - Implementation Date: April 6, 2020
- Background:
  - NCD policy for PET scans recognizes HCPCS codes Q9982 and Q9983 as valid radiopharmaceutical tracer codes for specific body parts:
    - ✓ FISS reason code 32440 does not recognize HCPCS Q9982 and Q9983 as valid radiopharmaceutical tracer codes:
      - ➢ HCPCS Q9982 and Q9983 are valid PET tracer codes effective July 1, 2016
    - ✓ Claims are incorrectly Returned to Provider (RTP) or rejected
  - MACs will suspend claims in SMT067 location until April 2020
  - MACs can override the reason code 32440 and reprocess claims:
    - ✓ MACs will only correct claims brought to their attention

Office of Inspector General (OIG) Findings on Polysomnography Services

- The OIG conducted a review for polysomnography services from January 1, 2014, through December 31, 2015:
  - Based on that review, OIG estimates that Medicare made overpayments of $270 million for polysomnography services during the audit period
  - OIG Report Findings:
    - ✓ Questionable Billing for Polysomnography Services
    - ✓ Medicare Payments to Providers for Polysomnography Services Did Not Always Meet Medicare Billing Requirements

Common Errors of Polysomnography Services

- Most common type of error:
  - Incomplete medical record documentation
- Other types of errors included:
  - Documentation was missing or not provided:
  - Attending technologist did not have required credentials or training certification
  - Payments for duplicative services
  - Incorrectly coded line of service
- To accurately bill polysomnography services the following resources should be utilized:
  - Provider Compliance Tips for Polysomnography (Sleep Studies) Fact Sheet
  - Medicare Benefits Policy Manual, Pub. 100-02, Chapter 15 - Covered Medical and Other Health Services, Section 70 "Sleep Disorder Clinics"
  - Novitas Independent Diagnostic Testing Facility (IDTF) Specialty Page
  - Diagnostic Testing for Sleep Disorders

Part A East (PAE) Qualified Independent Contractor (QIC) Demonstration

PAE QIC Demonstration

- Demonstration Background:
  - In 2015, CMS authorized the QIC (C2C) to conduct the Telephone Discussion Demonstration:
    - ✓ Selected Durable Medical Equipment (DME) suppliers had the opportunity to participate in a formal recorded telephone discussion to offer verbal testimony
- In 2019, CMS authorized C2C to conduct the Telephone Discussion Demonstration for Part A East:
  - The Phone Discussion and Reopening Process will be conducted the same as DME
  - Providers will receive a letter requesting phone discussion with C2C:
    - ✓ Phone discussions are voluntary
    - ✓ Reviews can take 120 days instead of traditional 60 day time frame
- Participation in demonstration will not impact subsequent appeal rights

Benefits of Demonstration

- Selected provider who elect to participate in the demonstration will have the opportunity for direct interaction with the reconsideration decision maker to:
  - Provide verbal testimony
  - Submit any missing/critical documentation needed to further support a favorable decision
  - Receive feedback/education on CMS policies and requirements
  - Improve proper claim submission
- C2C will conduct an analysis on completed unfavorable claims currently pending a decision at the ALJ:
  - ✓ For potential claim reopening
- References:
  - Part A East Appeals Demonstration (JL)
  - C2C Website for PAE Appeals Demonstration

Provider Discussion Request

- Indicate in writing at the top of reconsideration form requesting a phone discussion
- If reconsideration request has already been submitted contact via fax or email:
  - ADemoFeedback@c2cinc.com
  - Fax: 904-224-2732
- Not all requests can be granted a phone discussion:
  - C2C will determine eligibility
  - Notification will be sent if appeal criteria is not met

Overview of Hospital Off-Campus Outpatient Department Reporting Requirements

Hospital Off-Campus Outpatient Department Reporting

- Changes to editing for appropriate reporting of off-campus outpatient department locations will impact all providers:
  - To ensure correct payment for services provided at a hospital off-campus provider-based departments, CMS will be enacting changes for OPPS providers that have multiple practice locations
  - Payment impacts only applies to those providers paid under OPPS
- System related editing set to activated with the **April 2020 Quarterly Release:**
  - Requirements for correct provider practice location reporting was effective back in 2017, however, systematic edits were not put in place at that time
- Prepare by verifying that enrollment information is up to date and any claim submissions reflect the practice locations **EXACTLY** as it appears from the practice location address screen which is received from the Provider Enrollment, Chain and Operating System (PECOS)
- Ensure that the practice locations are linked to the NPI that is being reported on the claim submission
- References:
  - Hospital Off-Campus Outpatient Department Reporting Requirements
  - SE190007 - Activation of Systematic Validation Edits for OPPS Providers with Multiple Service Locations

Validating Provider Practice Location

- Medicare systems will validate the service facility location to ensure services are provided in a Medicare enrolled location:
  - Validation will be **exact matching** based on the information on the CMS-855A form submitted by the provider and entered into PECOS:
    - ✓ Must match, word for word, including abbreviations and punctuation
  - Ensure claims data matches provider enrollment information
- Claims 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
  - Note: FISS system will automatically capitalize all letters, so capitalization is not something that will cause a claim to receive reason code 34977
- Providers who need to add a new or correct an existing practice location address will need to submit a new CMS-855A enrollment application in PECOS

FISS Claim Page 3 Provider Practice Location Address

- To access Claim Page 03 MAP171F press F11 from Claim Page 03 MAP1719
- Enter the provider practice location address in the fields provided on this page

```
MAP171F   PAGE 03            NOVITAS SOLUTIONS              ACPMAWP2 08/22/18
          SC               INST CLAIM INQUIRY               C201833P 15:13:05

HIC              TOB      S/LOC          PROVIDER
     P R O V I D E R   P R A C T I C E   L O C A T I O N   A D D R E S S

ADDRESS 1:

ADDRESS 2:

CITY     :                                  STATE:      ZIP:

                                                          <== REASON CODES
PRESS PF3-EXIT PF7-PREV PF8-NEXT PF10-LEFT
```

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

Provider Practice Address Query Screen

- Practice location screen received from the PECOS is available in Direct Data Entry (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

```
MAP1702                                                  ACMMAWM2 03/08/19
                              INQUIRY MENU               A2019200 08:20:31


     BENEFICIARY/CWF          10   ZIP CODE FILE          19
     DRG (PRICER/GROUPER)     11   OSC REPOSITORY INQUIRY 1A
     CLAIM SUMMARY            12   CLAIM COUNT SUMMARY    5G
     REVENUE CODES            13   HOME HEALTH PYMT TOTALS 67
     HCPC CODES               14   ANSI REASON CODES      68
     DX/PROC CODES ICD-9      15   CHECK HISTORY          FI
     ADJUSTMENT REASON CODES  16   DX/PROC CODES ICD-10   1B
     REASON CODES             17   DMHC PAYMENT TOTALS    1C
     INVOICE NO/DCN TRANS     88   PROV PRACTICE ADDR QUER 1D




  ENTER MENU SELECTION:

   PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
```

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

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

```
MAP1AB1                                                  ACMWAWM2 03/06/19
          SC      PROVIDER PRACTICE ADDRESS QUERY SUMMARY   A2019200 08:24:30

NPI                OSCAR
                                    PRAC      PRAC
SEL  NPI           OSCAR            EFF DT    TERM DT   ADDRESS          ZIP




     PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
```


Provider Practice Address Query Inquiry

- Provider Practice Address Query Inquiry MAP1AB2

```
MAP1AB2                                                  ACMWAWM2 03/06/19
          SC      PROVIDER PRACTICE ADDRESS QUERY INQUIRY   A2019200 06:50:40
                                                      MNT: PECOS
NPI                OSCAR

PRAC EFF DT                        PRAC TERM DT
PRACTICE LOCATION KEY
OTHER PRACTICE
TYPE OF PRACTICE
ADDRESS 1
ADDRESS 2
CITY PITTSBURGH                          STATE       ZIP
NPI EFF DT                         NPI TERM DT




PRESS PF3-EXIT  PF8-SCROLL FWD  PF7-PREV
```

Address Example 1

- An address in the practice address query screen is listed as:
  - ADDRESS 1: 123 Apple St. #34
  - ADDRESS 2:
  - CITY: Nowheretown STATE: JD ZIP: 12345-1234
- In order to not receive reason code 34977 for invalid location on the claim submission:
  - Word “street” must be abbreviated as it appears on the screen as “St.” with the appropriate punctuation
  - The “#34” must also appear in the address 1 field:
    - ✓ It cannot be moved to the address 2 line
  - Address 2 line must remain blank
  - Zip code must be reported with the full five digits plus the additional four exactly as they appear
- If any element does not exactly match, the system will not be able to match the exact address and the claim will RTP for reason code 34977

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.
- Claim will RTP with reason code 34978 if:
  - An inappropriate modifier is reported;
  - A practice location is reported and no modifier is reported

Affect on Non-OPPS Providers

- Non-OPPS providers include Maryland (MD) waiver and Indian Health Service (IHS) providers
- 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

Updating FISS Editing for Practice Locations to Bypass Mobile Facility and/or Portable Units and Services Rendered in the Patient's Home

- MM11470:
  - Effective: January 1, 2017
  - Implementation: April 6, 2020
- Key Points:
  - Claims submitted with a service facility location that was not included as a practice location on the CMS Medicare enrollment application (CMS-855A) will RTP until the CMS 855A enrollment form and claims processing system are updated
  - Exceptions to hospital claims for which the service facility location is not at a hospital owned location include services provided in:
    - ✓ Mobile facility and/or portable units
    - ✓ Patient's home
  - Claims meeting the exception will bypass the service facility location matching performed between the provider's claim and the provider's practice location file:
    - ✓ Report Condition Code A7 on claims for services provided in a Mobile Facility or with Portable Units for claims received on or after April 1, 2020 with date of service on or after January 1, 2017

NOVITAS SOLUTIONS

Credit Balance Reporting

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

Important Medicare Credit Balance Report Dates

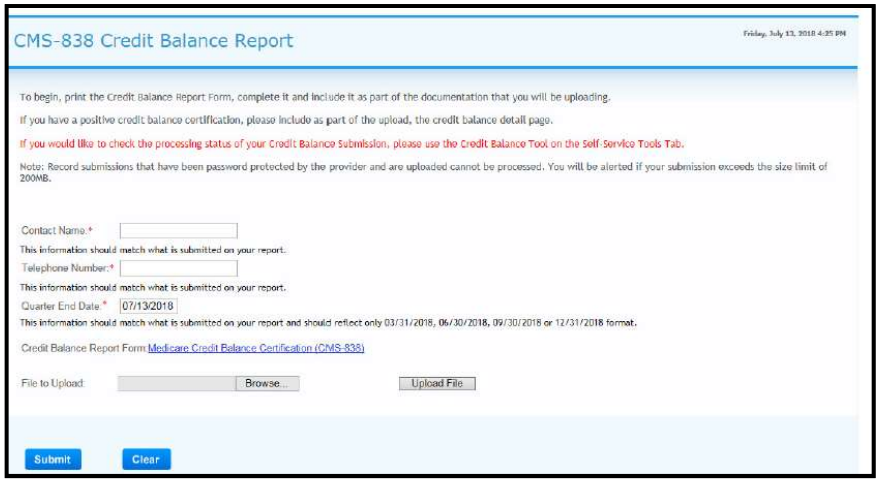
NOVITAS SOLUTIONS

- Due each quarter ending
- Medicare Credit Balance Report must be submitted within 30 days after the close of each calendar quarter

Quarter End	Medicare Credit Balance Report Due	Warning Letter Mailed	Placed on 100% Payment Withhold
March 31	April 30	May 15	June 03
June 30	July 30	August 15	September 03
September 30	October 30	November 15	December 03
December 31	January 30	February 15	March 03

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

CMS-838 Credit Balance Report



Helpful Hints for Successful Credit Balance Reporting

- Providers must first attempt to make their own claim adjustments:
  - Submit adjustments as soon as you identify the credit balance once that particular quarter begins
- Submit the correct version of the CMS-838 form:
  - Use of the electronic version is preferred, however paper copies are still acceptable
- Complete the entire CMS-838 detail page when reporting credit balances
- Ensure the PTAN on the certification page matches the detail page
- One refund check per Credit Balance Report
- Review your Credit Balance Report to verify all data is correct and matching before you submit it
- List appropriate contact person on the detail page
- Visit our website for more details on Credit Balance Reporting

Preventive Services

Preventive Services and Screenings Covered by Medicare

- 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

- Preventive Services Tool

Let's March into Health! March is Colorectal Cancer Awareness Month

- Colorectal cancer is the third most common cancer in the United States and the second leading cause of death from cancers that affect both men and women
- Colorectal Cancer Screening can often be prevented with regular screening tests
- Encourage beneficiaries over age 50 to take advantage of these Medicare-covered preventive services:
  - Colorectal cancer screening using multitarget sDNA test:
    - ✓ All Medicare beneficiaries who are age 50 to 85 years, asymptomatic, and are at average risk of developing colorectal cancer are eligible
  - Screening colonoscopies, fecal occult blood tests (FOBTs), flexible sigmoidoscopies, and barium enemas:
    - ✓ All Medicare beneficiaries who are 50 and older who are at normal risk of developing colorectal cancer or at high risk of developing colorectal cancer are eligible

Education and Training Events

Novitas Learning Center

- Novitas Learning Center (NLC):
  - Improved look and feel and streamlined navigation
  - More sophisticated design:
    - ✓ Intuitive dashboard provides quick view of learning customized for the learner
    - ✓ Learn anywhere, anytime on any device
    - ✓ Improved content library
  - Take the lead in your own professional development when seeking and accessing Medicare training opportunities

Webinars

- Register for upcoming webinars on Novitas' Calendar of Events page

Date	Time	Title	Line of Business
03/10/2020	11:00 – 12:00	Novitasphere Enrollment Overview	Part A/B
03/17/2020	12:00 – 1:00	Novitasphere Claim Correction Overview	Part A/B
03/17/2020	1:00 – 2:30	How To Avoid Top Claim Errors	Part A
03/18/2020	3:00 – 4:30	Novitasphere EIDM to IDM Transition Ask-the-Contractor Webinar	Part A/B
03/20/2020	10:00 – 11:00	Advantages of Electronic Data Interchange (EDI)	Part A/B
03/24/2020	11:00 – 12:00	EDI Enrollment	Part A/B

On-Demand Training

- Novitas offers self-paced training courses which allow you and your staff to train when and where it is most convenient for you

Title	Duration	Line of Business
Chiropractic Services	1 Hour	Part A/B
Drugs & Biologicals – Part A	1 Hour	Part A
Drugs & Biologicals – Part B	1 Hour	Part B
Evaluation and Management 101	1 Hour	Part B
Evaluation and Management 102	1 Hour	Part B
"Incident To" Services	1 Hour	Part B
NCCI Program Overview	1 Hour	Part A/B
SNF Consolidated Billing (CB) – Part A	1 Hour	Part A
Split/Shared Billing	1 Hour	Part B

Upcoming Live Medicare Events

- Novitas "Explore Medicare Education" Symposiums
- Free in-person Medicare education
- Providers can:
  - Meet Medicare representatives
  - Participate in live events and demos
  - Learn about upcoming changes and important reminders regarding Medicare
  - Attend specialty classes pertaining to enrollment, billing and compliance
  - Earn Continuing Education Units (CEUs)
- All office and facility staff, including admissions, compliance, billing and credentialing are welcome to attend

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

Thank You for Attending

- Diane Hess
  Education Specialist, Part A
  Diane.Hess@novitas-solutions.com
  Phone: (717) 526-6520
- Stephanie Portzline
  Manager, Provider Engagement
  Stephanie.Portzline@novitas-solutions.com
  Phone: (717) 526-6317
- Janice Mumma
  Supervisor, Provider Outreach and Education
  Janice.Mumma@novitas-solutions.com
  Phone: (717) 526-6406