

Novitas Solutions Presents: Medicare Updates and Changes

MD AAHAM

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Your Presenters



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Today's Presentation



- Agenda:
 - Novitas Initiatives
 - CY and FY Final Rule Updates
 - Medicare Updates and Reminders
 - COVID-19 Updates
 - Prior Authorization for Hospital Outpatient Department (PA HOPD) Services
 - Preventive Services
- Objectives:
 - Stay updated on Medicare initiatives
 - Provide the latest news and updates from Novitas and CMS
 - Explore the most current information on COVID-19
 - Discuss information about PA HOPD services
 - Review preventive services

Acronym List



Acronym	Definition
ASC	Ambulatory Surgical Center
ASP	Average Sales Price
CMS	Centers for Medicare & Medicaid Services
COVID-19	Coronavirus Disease 2019
CPT	Current Procedural Terminology
CWF	Common Working File
CY	Calendar Year
DOS	Date of Service
EUA	Emergency Use Authorization
FDA	Food and Drug Administration
FY	Fiscal Year
HCPCS	Healthcare Common Procedure Coding System
ICD-10	International Classification of Diseases, Tenth Revision

Acronym List Two



Acronym	Definition
IPPS	Inpatient Prospective Payment System
LTCH	Long-Term Care Hospital
mAb	Monoclonal Antibody
MSP	Medicare Secondary Payer
NPI	National Provider Identifier
OPD	Outpatient Department
OPPS	Outpatient Prospective Payment System
PA	Prior Authorization
PAR	Prior Authorization Request
PHE	Public Health Emergency
POS	Place of Service
TOB	Type of Bill

Novitas Initiatives

Avoid the Wait!



- Don't forget! You can avoid the wait and submit Medicare correspondence to Novitas Solutions electronically. Learn more today by using our [Online Electronic Submission Tools](#)



FastTrack to Medicare Coverage Policies Tool



- Do you find it challenging to identify a Medicare coverage policy concerning a particular item or service?
- Novitas has the answer: the FastTrack to Medicare Coverage Policies tool provides easy steps to follow and useful links to resources to help find your Medicare coverage answers
- [FastTrack to Medicare Coverage Policies](#)

FastTrack to Medicare Coverage Policies



Open Claim Issues for Part A



Date Reported	Provider Type Impacted	Workload Impacted	Reason Code	Description/ Claim Coding Impact	Proposed Resolution/ Fix/ Action Required
10/28/22	Outpatient Hospitals, Critical Access Hospitals and Community Mental Health Centers	Partial Hospitalization Program (PHP) outpatient claims	38204	Reason code 32804 is editing incorrectly on incoming prior hospitalization interim bills.	A correction has been developed and is tentatively scheduled to be installed on 11/28/22. We will post an update confirming when the correction is successfully installed. Providers will be able to resubmit claims after that date.
10/25/22	End Stage Renal Dialysis (ESRD)	Type of Bill (TOB) 72x	N/A	<p>The ESRD Treatment Choices (ETC) Model Performance Payment Adjustment (PPA) - Facility Component, was implemented with the July 2022 release for Part A Fiscal Intermediary Shared System (FISS).</p> <p>It was discovered that the claims of ESRD facilities participating in the ETC model are receiving the Home Dialysis Payment Adjustment (HDP) applied in error. This is the result of a logic error in the FISS coding for ETC Demonstration Code 94, which is causing the incorrect payment adjustment to be applied to the facility claim. Claims are being overpaid with the HDP being applied.</p>	A correction was installed on October 13, 2022. Claims with date of service July 1, 2022, and after will be automatically reprocessed. No provider action is needed.

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Vacating Differential Payment Rate for 340B-Acquired Drugs in 2022 Outpatient Prospective Payment System (OPPS) Final Rule with Comment Period







- On September 28, 2022, the United States District Court for the District of Columbia vacated the ASP minus 22.5% drug payment rate in the Medicare OPPS system for 340B-acquired drugs with respect to its prospective application:
 - The reimbursement rate will revert to the default payment rate (generally ASP plus 6%) under the Medicare statute
 - Claims paid on or after September 28, 2022, will be automatically adjusted
 - Providers may submit adjustments on any claim submitted with the modifier JG with DOS in 2022 that was paid prior to September 28, 2022:
 - ✓ TOB xx7 with condition code D9 and remarks indicating “340B adjustment”
- Reference:
 - [CMS MLN Connects Thursday, October 13, 2022](#)

Check Out Our Events Calendar



- Join us for one of our free powerful educational events hosted by Novitas Solutions:
 - Learn more about the Medicare program
 - Discover ways to improve the accuracy and efficiency of your Medicare billing process
- Register in the [Novitas Learning Center](#)
- Monthly webinars and events:
 - Combined [Part A and Part B Calendar](#)
 - New Provider designation for providers new to the Medicare program

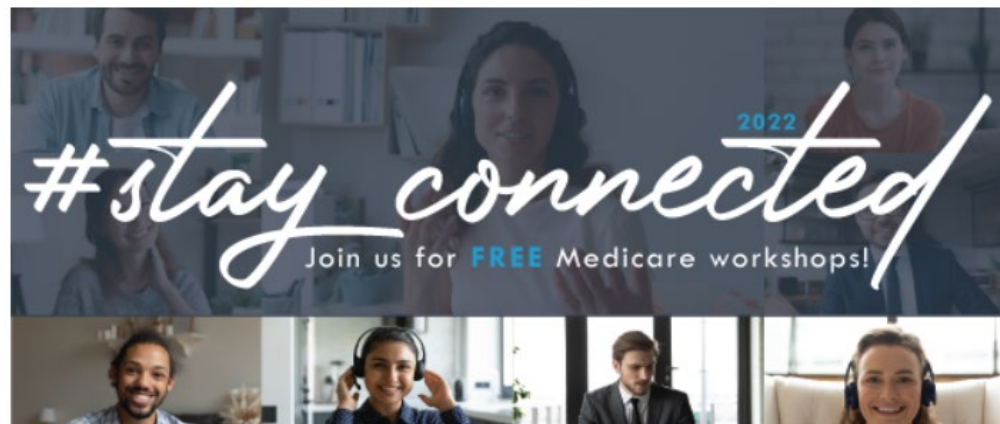
A - Part A **B** - Part B  - New Provider

A B	Tuesday, November 15, 2022	10:00 a.m.	12:00 p.m.	<p>Understanding COVID-19 Vaccine, Monoclonal Antibody Infusion Billing and Coding and Over the Counter COVID-19 Tests</p> <p>This webinar will review the most recently updated billing and coding guidelines for the COVID-19 vaccine, monoclonal infusions and an overview of the Over the Counter COVID-19 tests for Medicare Part A and Part B providers. We will briefly review provider enrollment and reimbursement; however, our primary focus will be on billing for these services.</p>	2.0	Webinar	Register 
A	Wednesday, November 16, 2022	10:00 a.m.	11:00 a.m.	<p>JL Part A Ask-the-Contractor (ACT) Webinar</p> <p>Be the first to hear about upcoming Novitas Solution's initiatives, including changes to our event registration process and access to CEUs to make it easier, faster and better.</p>	1.0	Webinar	Register 
B	Thursday, November 17, 2022	10:00 a.m.	11:00 a.m.	<p>JL Part B Ask-the-Contractor (ACT) Webinar</p> <p>Be the first to hear about upcoming Novitas Solution's initiatives, including changes to our event registration process and access to CEUs to make it easier, faster and better.</p>	1.0	Webinar	Register 
A	Thursday, November 17, 2022	1:00 p.m.	2:30 p.m.	<p>Understanding Inpatient Rehabilitation Facility (IRF) Requirements</p> <p>This webinar will review Inpatient Rehabilitation Facility (IRF) coverage and medical necessity criteria including documentation requirements. We will discuss IRF billing and explore various IRF-related medical reviews, audits, and frequent errors. We will provide valuable resources and review IRF-related billing scenarios.</p>	1.5	Webinar	Register 

#StayConnected Workshops



Month	Workshop Topic
November 29 – December 2	New Provider Workshop
December 13 – December 15	Portal Workshop



CY and FY Final Rule Updates

Press release

HHS Finalizes Physician Payment Rule Strengthening Access to Behavioral Health Services and Whole-Person Care

Rule includes expanded cancer screening coverage in support of President Biden's Cancer Moonshot and promotes innovation and coordinated care in Medicare

Nov 01, 2022

→

Press release

HHS Continues Biden-Harris Administration Progress in Promoting Health Equity in Rural Care Access Through Outpatient Hospital and Surgical Center Payment System Final Rule

Critical Access Hospitals and Small Rural Hospitals Can Convert to Rural Emergency Hospitals, Allowing Them to Remain Open to Serve Their Communities

Nov 01, 2022

→

Fact sheet

CY 2023 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule (CMS 1772-FC) Rural Emergency Hospitals – New Medicare Provider Type

Rural Emergency Hospitals (REHs) are a new provider type established by the Consolidated Appropriations Act, 2021 to address the growing concern over closures of rural hospitals.

Nov 01, 2022

→

Fact sheet

CY 2023 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule with Comment Period (CMS 1772-FC)

On November 1, 2022, the Centers for Medicare & Medicaid Services (CMS) finalized Medicare payment rates for hospital outpatient and ambulatory surgical center (ASC) services.

Nov 01, 2022

→

Fact sheet

Calendar Year (CY) 2023 Medicare Physician Fee Schedule Final Rule

On November 01, 2022, the Centers for Medicare & Medicaid Services (CMS) issued a final rule that includes updates and policy changes for Medicare payments under the Physician Fee Schedule (PFS), and other Medicare

Nov 01, 2022

→

Press release

HHS Approves Arkansas' Medicaid Waiver to Provide Medically Necessary Housing and Nutrition Support Services

Arkansas will use its Medicaid demonstration to test health-related social needs interventions as key components of overall health for certain groups of Medicaid beneficiaries

Nov 01, 2022

→

Fiscal Year (FY) 2023 Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital (LTCH) PPS Changes



- Rate updates for IPPS and LTCH PPS payments:
 - IPPS – 4.3% increase
 - LTCH – 2.4% increase
- New Technology Add-On Payment Policy:
 - 25 technologies eligible for NTAP
 - Discontinuation of NTAP for technologies in the marker for 3 years and those technologies that received an extension in FY2022
- MS-DRGs:
 - No new MS-DRGs
 - Reclassification of laser interstitial thermal therapy (LITT) procedures
 - implementation of the “three-way split criteria” will be further delayed
- Graduate Medical Education (GME):
 - Policy modification
 - Increased flexibility for rural hospitals to participate in Rural Training Programs (RTPs)

FY2023 IPPS and LTCH PPS Changes - Continued



- **Wage Index Policies:**
 - CMS will continue the low-wage index hospital policy and the related budget neutrality adjustment for FY 2023
 - Decreases to a hospital's wage index from the prior fiscal year will be capped at 5%
 - Wage index rural floor will be calculated as it was before FY 2020:
 - ✓ Wage data of hospitals that have reclassified from urban to rural will be included in the calculation of the rural floor and wage index for rural areas in the state where the hospital's county is located
- **Disproportionate Share Hospital (DSH) Payment:**
 - Payment adjustment and additional payment for uncompensated care
 - Revise the DSH regulation to further limit the inclusion in the Medicaid fraction of the DSH calculation of inpatient days for patients who are made eligible for Medicaid through a Section 1115 expansion waiver
- **Condition of Participation (CoP) Requirements for Hospitals and Critical Access Hospitals (CAHs) to Report Data Elements to Address any Future Pandemics and Epidemics as Determined by the Secretary:**
 - Continue COVID-19 reporting requirements until April 30, 2024 (unless the Secretary determines an earlier end date)

FY2023 IPPS and LTCH PPS Changes

- Hospital Quality Reporting



- Hospital Inpatient Quality Reporting (IQR) Program:
 - Adopting ten new measures and refining two current measures
 - Changes to the existing Electronic Clinical Quality Measures (eCQM) reporting and submission requirements
- Quality Requests for Information (RFIs)
 - Maternal Health Quality Designation and Equity:
 - ✓ Birthing-friendly designation to reduce maternal morbidity and mortality and provide high quality maternity care (roll out Fall 2023)
 - Overarching Principles for Measuring Healthcare Quality Disparities Across Quality Program
 - Climate Change:
 - ✓ How to better prepare for harmful impacts of climate change and what CMS can do to support these efforts
 - Trusted Exchange Framework and Common Agreement
- Medicare Promoting Interoperability (PI) Program
- Reduction of Hospital Payments for Excess Readmissions:
 - Resuming all six readmission measures with some refinements to include those with history of COVID-19
- Hospital Value-Based Purchasing (VBP) Program and Hospital-Acquired Condition (HAC) Reduction Program:
 - Pausing to for FY 2023, due to the effects of COVID-19

CY 2023 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule with Comment Period (CMS 1772-FC)



- Updates to OPPS and ASC payment rates meeting quality reporting requirements by 3.8%
- Establish new Medicare provider type effective January 1, 2023, Rural Emergency Hospitals (REH) for eligible critical access hospitals and small rural hospitals:
 - For more information review the [CMS fact sheet on REHs](#)
- Finalized a general payment rate of ASP plus 6% for drugs and biologicals acquired through the 340B Program in light of the Supreme Court decision made on September 28, 2022
- Separate payment in the ASC setting for five non-opioid pain management drugs that function as surgical supplies, including certain local anesthetics and ocular drugs, that meet the criteria in 42 CFR 416.174
- Continue payment for remote behavioral health services beyond the end of the PHE:
 - Payment may only be made if the beneficiary receives an in-person service within 6 months prior to the first-time hospital clinical staff provides the behavioral health services remotely, and that there must be an in-person service without the use of communications technology within 12 months of each behavioral health service furnished remotely by hospital clinical staff

CY 2023 Medicare OPPS and ASC Payment System Final Rule with Comment Period (CMS 1772-FC) continued



- Payment adjustments under the IPPS and OPPS that would reflect, and offset, the additional marginal resource costs that hospitals face in procuring domestically made NIOSH-approved surgical N95 respirators:
 - Payments provided biweekly as interim lump-sum payments to the hospital and would be reconciled at cost report settlement
- Exempt rural sole community hospitals (SCHs) from the site-neutral clinic visit cuts:
 - Pay for clinic visits furnished in grandfathered (excepted) off-campus provider-based departments (PBDs) of these hospitals at the full OPPS rate
- Supporting organ procurement and research which includes a method of accounting for research organs that will improve payment accuracy and maintain organ availability for the research community
- Adding facet joint interventions to the list of services requiring prior authorization for certain hospital outpatient department services effective July 1, 2023
- Revising the inpatient-only (IPO) list to remove 11 services and add eight services
- For PHP, CMS will maintain the existing rate structure, with a single PHP Ambulatory Payment Classification (APC) for each provider type, for days with three or more services per day
- CMS is clarifying that a hospital could bill for non-PHP outpatient services furnished to a PHP patient

CY 2023 Medicare Physician Fee Schedule Final Rule



- CY 2023 PFS rate setting and conversion factor is \$33.06
- Revised coding and updated guidelines for Other E/M visits, effective January 1, 2023
- Creation of Medicare-specific coding for payment of Other E/M prolonged services:
 - Reported with the separate Medicare-specific G codes
- A year-long delay of the split (or shared) visits policy established in rulemaking for 2022 to define the substantive portion of a split (or shared) visit based on the amount of time spent by billing provider
- Allowing behavioral health clinicians like licensed professional counselors and marriage and family therapists to offer services under general (rather than direct) supervision of the Medicare practitioner for behavioral health services
- Policies to pay for clinical psychologists and licensed clinical social workers to furnish integrated behavioral health care as part of a primary care team
- New HCPCS codes G3002 and G3003 for chronic pain management and treatment services
- Medicare will pay Opioid Treatment Programs (OTPs) that use telecommunications with patients to initiate treatment with buprenorphine
- OTPs can bill for opioid use disorder treatment services provided through mobile units, such as vans, in accordance with Substance Abuse and Mental Health Services Administration (SAMHSA) and Drug Enforcement Administration (DEA) guidance

CY 2023 Telehealth Services Updates



- [List of Telehealth Services](#) updated descriptors include:
 - Temporary Addition for the PHE; Expires with PHE plus 151 days
 - Temporary Added xx/xx/xxxx for PHE; Expires with PHE plus 151 days
 - Available Through December 31, 2023
- Physicians and practitioners continue to bill with the POS that would have been reported had the service been furnished in-person through the later of the end of CY 2023 or end of the year in which the PHE ends:
 - Report modifier 95 to identify services furnished as telehealth
- Medicare originating site facility fee for CY 2023 is \$28.64
- Reference:
 - [Calendar Year \(CY\) 2023 Medicare Physician Fee Schedule Final Rule fact sheet](#)

List of Telehealth Services



	A	B	C	D	E
1		LIST OF MEDICARE TELEHEALTH SERVICES effective January 1, 2023 - updated November 1, 2022			
2	Code	Short Descriptor	Status	Can Audio-only Interaction Meet the Requirement	Medicare Payment Limitations
84	94005	Home vent mgmt supervision	Available Through December 31, 2023		Bundled code
85	94625	Phy/qhp op pulm rhb w/o mntr	Available Through December 31, 2023		
86	94626	Phy/qhp op pulm rhb w/ mntr	Available Through December 31, 2023		
87	94664	Evaluate pt use of inhaler	Temporary Added 04/30/2020 for PHE; Expires with PHE plus 151 days		
88	95970	Alys npgt w/o prgrmg	Available Through December 31, 2023		
89	95971	Alys smpl sp/pn npgt w/prgrm	Temporary Added 10/14/2020 for PHE; Expires with PHE plus 151 days		
90	95972	Alys cplx sp/pn npgt w/prgrm	Temporary Added 10/14/2020 for PHE; Expires with PHE plus 151 days		
91	95983	Alys brn npgt prgrmg 15 min	Available Through December 31, 2023		
92	95984	Alys brn npgt prgrmg addl 15	Available Through December 31, 2023		
93	96105	Assessment of aphasia	Available Through December 31, 2023		
94	96110	Developmental screen w/score	Available Through December 31, 2023		Non-covered service
95	96112	Devel tst phys/qhp 1st hr	Available Through December 31, 2023		
96	96113	Devel tst phys/qhp ea addl	Available Through December 31, 2023		
97	96116	Nubhvl xm phys/qhp 1st hr		Yes	
98	96121	Nubhvl xm phy/qhp ea addl hr		Yes	
99	96125	Cognitive test by hc pro	Temporary Added 03/30/2021 for PHE; Expires with PHE plus 151 days		
100	96127	Brief emotional/behav asmnt	Available Through December 31, 2023	Yes	
101	96130	Psycl tst eval phys/qhp 1st	Available Through December 31, 2023	Yes	

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CY 2023 Medicare Physician Fee Schedule Final Rule Continued



- Audiology service policy to allow beneficiaries direct access to an audiologist without an order from a physician or non-physician practitioner (NPP) for non-acute hearing conditions:
 - Use of new modifier AB
- CMS plans a Town Hall in CY 2023 to address concerns on the methodology for payment of skin substitute products
- Dental services that are an integral part of a specific treatment of the beneficiary's primary medical condition are eligible for payment
- Dental exams and necessary treatments prior to organ transplants, cardiac valve replacements, and valvuloplasty procedures are eligible for payment
- For colorectal cancer screening, reducing the minimum age payment and coverage limitation from 50 to 45 years
- Medicare will now cover as a preventive service a follow-on screening colonoscopy after a non-invasive stool-based test returns a positive result, which means that beneficiaries will not have out-of-pocket costs for both tests

Additional Information CY 2023

Medicare Physician Fee Schedule Final Rule



- The Infrastructure Investment and Jobs Act requires drug manufacturers to provide a refund to CMS for certain discarded amounts from a refundable single-dose container or single-use package drug:
 - Starting Jan. 1, 2023, for the purpose of calculating the refund amount during a relevant quarter, the JW modifier must be used to determine the total number of billing units of the HCPCS code of a refundable single-dose container or single-use package drug that were discarded
 - Beginning no later than July 1, 2023, CMS also will require use of a separate modifier, JZ, in cases where no billing units of such drugs were discarded and for which the JW modifier would be required if there were discarded amounts
- Refinements to the payment amount for preventive vaccine administration under the Medicare Part B vaccine benefit, which includes the influenza, pneumococcal, hepatitis B, and COVID-19 vaccine and their administration
- Continue the additional payment for at-home COVID-19 vaccinations for CY 2023
- Permanently cover and pay for covered monoclonal antibody products used as pre-exposure prophylaxis for prevention of COVID-19 under the Medicare Part B vaccine benefit

Medicare Updates and Reminders

Medicare Deductible, Coinsurance & Premium Rates: Calendar Year 2023 Update



- [MM12903](#)
 - Effective: January 1, 2023
 - Implementation: January 3, 2023
- Key Points:
 - 2023 Part A – Hospital Insurance:
 - ✓ Deductible: \$1600.00
 - ✓ Coinsurance:
 - \$400.00 a day for 61st-90th day
 - \$800.00 a day for 91st-150th day (lifetime reserve days)
 - \$200.00 a day for 21st-100th day (Skilled Nursing Facility coinsurance)
 - 2023 Part B –Medical Insurance:
 - ✓ Deductible: \$226.00 a year
 - ✓ Coinsurance: 20 percent

Medicare FFS Claims: 2% Payment Adjustment (Sequestration) Changes



- The Protecting Medicare and American Farmers from Sequester Cuts Act impacts payments for all Medicare Fee-for-Service (FFS) claims:
 - No payment adjustment through March 31, 2022
 - 1% payment adjustment April 1 – June 30, 2022
 - **2% payment adjustment beginning July 1, 2022**
- Reference:
 - [MLN Connects December 16, 2021](#)

Appropriate Use Criteria (AUC) Program



- Protecting Access to Medicare Act (PAMA) of 2014, Section 218(b):
 - Established a new program to increase the rate of appropriate advanced diagnostic imaging services furnished to Medicare beneficiaries
 - Advanced diagnostic imaging services includes:
 - ✓ Computed tomography (CT)
 - ✓ Positron emission tomography (PET)
 - ✓ Nuclear medicine
 - ✓ Magnetic resonance imaging (MRI)
- Educational and operations testing period:
 - **Continued until further notice**
- Program implementation:
 - **The payment penalty phase will not begin January 1, 2023, even if the PHE for COVID-19 ends in 2022**
 - **CMS is unable to forecast when the payment penalty phase will begin**
 - Upon full implementation:
 - ✓ AUC consultations with qualified Clinical Decision Support Mechanisms (CDSMs) are required to occur along with reporting of consultation information on the furnishing professional and furnishing facility claim for the advanced diagnostic imaging service
 - ✓ Claims that fail to append this information will not be paid
- References:
 - [Appropriate Use Criteria Program](#)
 - [Appropriate use criteria \(AUC\) program for advanced diagnostic imaging services](#)
 - [Webinar recording](#)

Significant Updates to Internet Only Manual (IOM) Publication (Pub.) 100-05 Medicare Secondary Payer (MSP) Manual, Chapter 5



- [MM12765](#):
 - Effective: October 13, 2022
 - Implementation: October 13, 2022
- Key Points:
 - Updates to Chapter 5 of the [Medicare Secondary Payer \(MSP\) Manual](#):
 - ✓ **CMS now refers to the Benefits Coordination & Recovery Center (BCRC) as the MSP Contractor** (section 10)
 - ✓ Situations where claim services are not related to accident or injury for liability, no-fault, or workers' compensation even though diagnosis on claim is within family of diagnosis on the MSP non-group health plan record (section 20.4.2) :
 - Send evidence to show services performed are unrelated
 - ✓ Claims submitted to Medicare as primary payer on a claim:
 - Assume that you correctly showed there's no other primary coverage and process the claim accordingly (section 30.2)

Additional Significant Updates to IOM Pub. 100-05 MSP Manual, Chapter 5



- Medicare is the secondary payer throughout the entire 30-month end stage renal disease (ESRD) coordination period when a patient is eligible for, or entitled to, Medicare on the basis of ESRD (section 30.3.1)
- Benefits denied because all or part of the services are reimbursable under the Black Lung program, by virtue of the diagnosis codes you submitted (section 30.4.):
 - Send claim to:
 - U.S. Department of Labor OWCP/DCMWC
 - P.O. Box 8307
 - London, KY 40742-8307
- Claim Adjustment Reason Codes are used to see why a claim wasn't paid by the no-fault insurer and whether we should make a Medicare payment (section 30.5.2)

More Significant Updates to IOM Pub. 100-05 MSP Manual, Chapter 5



- If a group health plan (GHP) may be the primary payer, claim will be returned for you to ascertain whether primary GHP benefits are payable (section 40.1.):
 - If so, bill GHP for primary benefits
 - Remittance advice will advise that if a GHP has denied its claim for primary benefits, you must note on the claim the reason for the denial based on the CARC that applies:
 - ✓ No attachment is needed
- Part B claim submitted without a GHP's explanation of benefits (EOB), or the appropriate primary payment information isn't on an 837 claim, will deny (section 40.3.):
 - Examples of acceptable reasons why the GHP can't pay are:
 - ✓ A deductible applies
 - ✓ The patient isn't entitled to benefits
 - ✓ Benefits under the plan are exhausted for particular services
 - ✓ The services aren't covered under the plan

Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Edits, Version 28.3



- [CR12795](#):
 - Effective date: October 1, 2022
 - Implementation date: October 3, 2022
- Key Points:
 - CMS developed the NCCI:
 - ✓ Promote national correct coding methodologies
 - ✓ Control improper coding that leads to inappropriate payment in Part B claims
 - The PTP edits are updated quarterly; this recurring update represents Version 28.3
- References:
 - [On-Demand Training NCCI Program Overview](#)
 - [Medicare Claims Processing Manual, Pub 100-04, chapter 23 – Fee Schedule Administration and Coding Requirements, section 20.9](#)
 - [CMS NCCI Website](#)

New National Correct Coding (NCCI) Procedure to Procedure (PTP) Lookup Tool



- Save research time by using our new [NCCI PTP Lookup tool](#)
- Our tool will assist with easy identification of proper code pair selection and modifier reporting
- Use of the tool is quick and easy:
 - Enter a procedure code from your code pair and date of service
 - Results will show if a modifier is valid for the code pair
- Also review the [NCCI associated modifiers](#)



NCCI procedure-to-procedure lookup

The National Correct Coding Initiative (NCCI) was implemented to promote national correct coding methodologies and to control improper coding leading to inappropriate payment. This application is intended to provide a means of identifying when certain codes are subject to the automated NCCI prepayment edits.

The National Correct Coding Initiative (NCCI) procedure-to-procedure (PTP) lookup tool is designed to help providers identify when certain codes are subject to the automated code pair edits. Search for coding pairs by entering a procedure code and the performing date(s) of service. The search results display two coding pair lists: refer to the Major-to-Minor and the Minor-to-Major tabs.

*** Required**

Procedure code * 20610

Date of service * 2/22/2022 **Note:** To ensure the correct data is returned, it is imperative that you search using the specific date of service.

Search **Reset**

PTP search results

Note: The column 2/minor code should not be reported with the column 1/major code unless documentation supports medical necessity for both services performed (same date of service / same provider), and the modifier policy indicator is equal to '1'. In this case, an appropriate modifier is appended to the Column 1 or Column 2.

Do not report column 2/minor or mutually exclusive codes when the modifier policy indicator is equal to '0'.

Note: Use the search box above each column to narrow the results. Press 'Enter' to launch your specific search. To clear the search fields, click on the eraser icon located at in the upper right-hand corner of the table.

Major-to-Minor **Minor-to-Major**

Major Code/Column 1	Minor Code/Column 2	Effective Date	Modifier/Policy Indicator
20610	29355	1999-01-01	1 - Allowed
20610	29365	1999-01-01	1 - Allowed
20610	29405	1999-01-01	1 - Allowed
20610	29425	1999-01-01	1 - Allowed
20610	29605	1999-01-01	1 - Allowed
20610	29515	1999-01-01	1 - Allowed
20610	29530	1999-01-01	1 - Allowed
20610	29540	1999-01-01	1 - Allowed
20610	29580	1999-01-01	1 - Allowed
20610	29581	2010-01-01	1 - Allowed

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Medically Unlikely Edits (MUEs)



- CMS developed MUEs to reduce the paid claims error rate for Part B claims:
 - An MUE for a HCPCS/CPT code is the maximum units of service a provider would report under most circumstances for a single beneficiary on a single date of service:
 - Units of service are determined by the MUE Adjudication Indicator (MAI):
 - ✓ MAI of 1 – claim line of service
 - ✓ MAI of 2 or 3 – you can bill up to the MUE per date of service
 - All HCPCS/CPT codes do not have an MUE
- Reference:
 - Quarterly MUE Version Update Changes
 - ✓ https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Version_Update_Changes.html
 - Medically Unlikely Edits
 - ✓ <https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html>

Changes to amount in controversy (AIC) for appeals in 2023



- The AIC is recalculated and published on an annual basis and is identified in your appeal notice of decision
- The AIC for appeals filed on or after January 1, 2023:
 - ALJ hearing will remain the same at \$180.00
 - Federal district court will increase to \$1,850.00
- The amount in controversy is calculated in the following manner:
 - Amount charged minus Medicare payments already made or awarded = subtotal balance
 - Subtotal balance minus any applicable deductible/coinsurance = AIC
- **Example:**
 - \$500 (amount charged) - \$0 (Medicare payment made) = \$500 (subtotal balance)
 - \$500 (subtotal balance) - \$100 (coinsurance) = \$400 (balance)
 - \$400 (balance) = \$400 (AIC)

ICD-10 Revision to NCDs – January 2023 Update



- MM12842
 - Effective: January 1, 2023
 - Implementation: January 3, 2023
- Key Points:
 - Maintenance update:
 - ✓ NCD 20.32 Transcatheter Aortic Valve Replacement (TAVR)
 - ✓ NCD 110.18 Aprepitant
 - ✓ NCD 110.23 Stem Cell Transplants
 - ✓ NCD 150.3 Bone Density Studies
 - ✓ NCD 160.18 Vagus Nerve Stimulation (VNS)
 - ✓ NCD 190.3 Cytogenetic Studies
 - ✓ NCD 210.6 Screening for Hepatitis B Vaccine
 - ✓ NCD 220.6.17 PET for Solid Tumors
 - ✓ NCD 220.6.20 PET Beta Amyloid for Dementia/Neurodegenerative Disease
 - ✓ NCD 260.1 Adult Liver Transplants
 - ✓ NCD 260.5 Intestinal/Multi-Visceral Transplant •
 - ✓ NCD 260.9 Heart Transplant

Inpatient Rehabilitation Facility (IRF) Annual Update: Prospective Payment System (PPS) Pricer Changes for FY 2023



- [MM12807](#):
 - Effective: October 1, 2022
 - Implementation: October 3, 2022
- Key Points:
 - Annual updates to the [IRF PPS rates](#) effective October 1, 2022 – September 30, 2023
 - For FY 2023:
 - ✓ Permanent 5 percent cap applies to you on any decrease to your final wage index from your prior FY final wage index
 - For subsequent years:
 - ✓ Wage index will be at least 95 percent of your prior FY calculated wage index
 - A new IRF will be paid:
 - ✓ Wage index for the area in which it's geographically located
 - ✓ Its first full or partial FY without a cap

Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Updates for FY 2023



- [MM12859](#):
 - Effective: October 1, 2022
 - Implementation: October 3, 2022
- Key Points:
 - Annual updates to and billing instructions for various payment policies for IPF PPS
 - Summary of changes based on the [IPF Final Rule](#) for discharges occurring from October 1, 2022 – September 30, 2023:
 - ✓ Market basket update
 - ✓ FY 2023 wage index
 - ✓ IPF Quality Reporting Program (IPFQR)
 - ✓ PRICER updates
 - ✓ Provider Specific File (PSF) updates
 - ✓ National urban and rural cost to charge ratios (CCRs)
 - ✓ ICD-10-CM/PCS updates
 - ✓ COLA adjustment
 - ✓ Rural adjustment

New Fiscal Intermediary Shared System (FISS) Edit



- [MM12889](#):
 - Effective: April 1, 2023
 - Implementation: April 3, 2023
- Key Points:
 - New consistency edit that validates the attending provider NPI:
 - ✓ Institutional providers are required to append an Attending Provider name and identifiers for beneficiary's medical care and treatment (excludes nonscheduled transport claims):
 - ✓ Outpatient claims require referring provider NPI and name when referring provider is different from attending provider
 - Organizational NPIs cannot be used in place of individual NPIs, unless exception conditions are met

Use of Billing Provider NPI Exceptions



- Billing provider NPI may be used in the following exceptions:
 - Roster Bill (condition code M1 is present)
 - Covid-19 vaccine, influenza and PPV shots and their administration (condition code A6 is present)
 - TOB is 71X (Rural Health Clinic)
 - TOB is 41X (Religious Non-Medical Healthcare Institutions)
 - Veterans Administration claims
 - Only Screening Mammography services are billed (revenue code 0403)
 - Cancel claims (transaction type equal to C)
 - Demo Code 31 is present on the claim
 - Home Health TOB 32X
 - TOB 13X, 22X, 23X, or 85X with Ambulance services only (revenue code 0540)
 - Critical Access Hospital Method II TOB 85X with only Professional services (revenue code 96X, 97X, 98X)
 - Any claim with no covered charges present
 - Foreign Providers (state codes 56, 59, and 99)
 - Military Treatment Facilities (6th position of CMS Certification Number is F)

COVID-19 Updates

Coronavirus (COVID-19)



- [Coronavirus COVID-19 information](#)
- [COVID-19 Frequently Asked Questions \(FAQs\) on Medicare Fee-for-Service \(FFS\) billing](#)
- [Current emergencies](#)
- [Waivers and flexibilities](#)
- Prepare for the end of the COVID-19 PHE:
 - Review the [August 18, 2022, MLN Connects article on Creating a Roadmap for the End of the COVID-19 Public Health Emergency](#)



Pfizer-BioNTech COVID-19 Vaccine and Moderna COVID-19 Vaccine Bivalent



Code	Vaccine/Product	Effective date
91312	Pfizer-BioNTech COVID-19 vaccine, bivalent product (aged 12 years and older) (gray cap)	08/31/2022
0124A	Pfizer-BioNTech COVID-19 vaccine bivalent (gray cap) administration – booster dose	08/31/2022
91313	Moderna COVID-19 vaccine, bivalent product (aged 12 years and older) (dark blue cap with gray border)	08/31/2022
0134A	Moderna COVID-19 vaccine, bivalent (aged 12 years and older) (dark blue cap with gray border) administration – booster dose	08/31/2022
91314	Moderna COVID-19 vaccine, bivalent product (aged 6 years through 11 years) (dark blue cap with gray border)	10/12/2022
0144A	Moderna COVID-19 vaccine, bivalent (aged 6 years through 11 years) (dark blue cap with gray border) administration – booster dose	10/12/2022
91315	Pfizer-BioNTech COVID-19 vaccine, bivalent product (aged 5 years through 11 years) (orange cap)	10/12/2022
0154A	Pfizer-BioNTech COVID-19 vaccine, bivalent product (aged 5 years through 11 years) (orange cap) administration – booster dose	10/12/2022

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Novavax Vaccine



Code	Vaccine/Product	Effective date
91304	Novavax Covid-19 vaccine, adjuvanted (aged 12 years and older)	07/13/2022
0041A	Novavax COVID-19 vaccine, adjuvanted administration - first dose	07/13/2022
0042A	Novavax COVID-19 vaccine, adjuvanted administration – second dose	07/13/2022
0044A	Novavax COVID-19 vaccine, adjuvanted administration – booster	10/19/2022

- NOTE: Providers should not bill for the product if they received it for free
- References:
 - [COVID-19 vaccine and monoclonal antibodies billing for Part A](#)
 - [COVID-19 vaccine and monoclonal antibodies billing for Part B](#)
 - [COVID-19 Vaccine and Monoclonal Antibodies](#)

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Payment Allowance Update for COVID-19 mAb Bebtelovimab (Q0222)



- Commercial distribution of COVID-19 mAb therapy Q0222 (bebtelovimab, 175 mg) began August 15, 2022, by drug manufacturer Eli Lilly:
 - CMS will pay 95 percent AWP or \$2394.00
 - Batch number on vial is D534422:
 - ✓ Watch for future batch numbers
- Effective for DOS on or after August 15, 2022, only bill Medicare for commercially purchased products:
 - Do not bill for product if purchased by US government
 - Bill administration (M0222 or M0223) for either type of product
- No cost sharing for beneficiary
- References:
 - [CMS MLN Connects Thursday, August 11, 2022](#)
 - [COVID-19 Monoclonal Antibodies](#) webpage
 - [COVID-19 Vaccine and Monoclonal Antibodies](#) ASP webpage

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Prior Authorization for Hospital Outpatient Department Services Updates

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](#) webpage
- **PA customer service: 1-855-340-5975**
 - Hours of operation:
 - ✓ 8:00 a.m. –6 p.m. ET

The screenshot shows the Medicare JL website page for the Prior authorization (PA) program for certain hospital outpatient department (OPD) services. The page is titled "Prior authorization (PA) program for certain hospital outpatient department (OPD) services" and includes a navigation menu on the left with options like "JL Home", "Novitasphere Portal", "Appeals", "CERT", "Claims", "Contact Us", "Cost Reporting", "Education & Training", "Electronic Billing-EDI", "Enrollment", "Evaluation & Management", "Frequently Asked Questions", "Fee Schedules", "Forms Catalog", "Join our E-mail Lists", "Medical Policy / LCDs", "Medical Review", "News & Publications", "Self-Service Tools", and "Specialties / Services". The main content area includes a "Background" section, "General information", "Coverage policies", "Prior authorization request (PAR) submission requirements", "Documentation requirements", "Expedited requests", "Claim submission requirements", "Prior authorization department contact information", "Educational events", and "Quick links and resources". A "Background" section explains that CMS implemented a PA program for certain hospital OPD services, effective June 17, 2020, 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, 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 has added two new services to the hospital OPD PA program. As a condition of payment for DOS beginning on or after July 1, 2021, a PAR is required for these two additional hospital OPD services:

- Cervical fusion with disc removal
- Implanted spinal neurostimulators

PAR Submission/Scheduling/Coding Issues/Reminders



- *****Do not schedule surgery until an approved prior authorization is received***:**
 - If procedure already rendered at time of review, the PAR will be non-affirmed
 - Best practice – submit PAR at least two weeks prior to the procedure
 - Provisional affirmation of a PAR is valid for 120 days from the decision date
- When submitting PARs, be aware of response timeframes and documentation guidelines:
 - All fields on the [PAR cover sheet](#) must be completed as appropriate
 - [Don't wait too long to submit your prior authorization requests](#)
- **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:
- **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
- Verify the code(s) being requested are on the [list](#) of services requiring PA

Keep Your Patients Healthy!

Discuss Preventive Services With Your Patient



- 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

Interactive Preventive Services Tool



- [Preventive Services Tool](#)

Medicare Preventive Services

× Select a Service		FAQs			Resources	
Alcohol Misuse Screening & Counseling ^T	Annual Wellness Visit ^T	Bone Mass Measurements	Cardiovascular Disease Screening Tests	Cervical Cancer Screening	Colorectal Cancer Screening	Counseling to Prevent Tobacco Use ^T
Depression Screening ^T	Diabetes Screening	Diabetes Self-Management Training ^T	Flu Shot & Administration	Glaucoma Screening	Hepatitis B Screening	Hepatitis B Shot & Administration
Hepatitis C Screening	HIV Screening	IBT for Cardiovascular Disease ^T	IBT for Obesity ^T	Initial Preventive Physical Exam	Lung Cancer Screening ^T	Mammography Screening
Medical Nutrition Therapy ^T	Medicare Diabetes Prevention Program	Pap Tests Screening	Pneumococcal Shot & Administration	Prolonged Preventive Services ^T	Prostate Cancer Screening	STI Screening & HIBC to Prevent STIs ^T
Screening Pelvic Exams	Ultrasound AAA Screening					

Time to Vaccinate: Flu Season Ahead



- All patients are covered for the influenza virus vaccine once per flu season but additional flu shots are allowed if medically necessary
- 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

CMS Expands Coverage of Lung Cancer Screening with Low Dose Computed Tomography



- [MM12691](#)
 - Effective: February 10, 2022
 - Implementation: October 3, 2022
- Key Points:
 - Coverage expanded to improve health outcomes for people with lung cancer by:
 - ✓ Lowering starting age for screening from 55 to 50 years
 - ✓ Reducing tobacco smoking history from at least 30 packs per year to at least 20 packs per year.

Changes to Beneficiary Coinsurance for Additional Procedures Furnished During the Same Clinical Encounter As Certain Colorectal Cancer Screening Tests



- [MM12656:](#)
 - Effective Date: annuary 1, 2022
 - Implementation Date: January 1, 2023
- Key Points:
 - Effective January 1, 2022, when a screening colorectal cancer procedure, G0104, G0105 or G0121 is billed with a PT modifier and submitted with CPT code ranges 10000- 69999, G0500, 00811 or 99153 HCPCS codes G0404, G0105 and G0121 has become a diagnostic or therapeutic service, coinsurance is reduced or waived as follows:
 - ✓ Dates of service in calendar years 2023-2026, the reduced coinsurance is 15%
 - ✓ Dates of service calendar years 2027-2029 the reduced coinsurance is 10%
 - ✓ Dates of service on or after calendar year 2030, Medicare waives the coinsurance

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Summary



- Explored the latest Medicare Initiatives
- Provided the latest news and updates from Novitas and CMS
- Examined the COVID-19 updates
- Discussed information about PA Hospital OPD
- Reviewed preventive services

Customer Contact Information



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

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 - Part A and Part B News
 - Issued every Tuesday and Friday
 - CMS MLN Connects issued Thursdays
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- Didn't receive verification or stopped receiving email notifications?
 - Follow these [simple steps](#) to allow emails

Thank You for Attending!



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