Medicare Updates and What's Trending for 2018

MD AAHAM
March 23, 2018

INNOVATION IN ACTION

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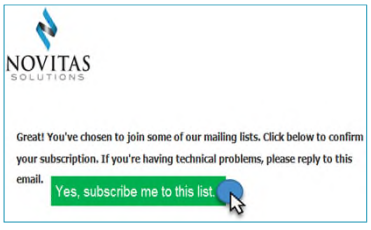

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Acronym List

Acronym	Definition
ADR	Additional Documentation Request
CERT	Comprehensive Error Rate Testing
CMS	Centers for Medicare & Medicaid Services
CR	Change Request
DCN	Document Control Number
DDE	Direct Data Entry
EDI	Electronic Data Interchange
FISS	Fiscal Intermediary Standard System
MAC	Medicare Administrative Contractor
MBI	Medicare Beneficiary Identifier

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Acronym List 2

Acronym	Definition
MLN	Medicare Learning Network
MSP	Medicare Secondary Payer
NCD	National Coverage Determination
QMB	Qualified Medicare Beneficiary
RA	Remittance Advice
TPE	Targeted Probe and Educate

Today's Presentation

- Agenda:
  - Comprehensive Error Rate Testing (CERT) Program
  - Accuracy Matters
  - Medicare Updates
  - Targeted Probe and Educate
  - Credit Balance Reporting
  - Novitas Initiatives
  - Website Features
- Objectives:
  - Identify and understand the current Medicare changes
  - Learn how to apply the new guidelines
  - Identify and utilize the educational resources and information
  - Self Service Options

Comprehensive Error Rate Testing (CERT) Program

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Comprehensive Error Rate Testing (CERT)

- Program developed by Centers for Medicare & Medicaid Services (CMS) to monitor the accuracy of claims processing
- Designed to protect the Medicare trust fund and determine error rates nationally and regionally
- Random audits conducted on a monthly basis
- AdvanceMed request medical records for claims selected as part of the monthly random sample
- Medical record documentation supporting claim must be returned in designated time frame
- Part A CERT Center
- Part B CERT Center

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CERT Error Rates Final Report- November 2017

Claims sampled July 2015 – June 2016

Claim Type	Error Rate	Projected Improper Payment	Claims Sampled
National Overall	9.5%	$33,064,036,666	39,001

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Monetary Loss Errors vs. "Unknown" Loss Errors

- Monetary Loss Errors:
  - Medical necessity
  - Incorrect coding
  - Other errors
- Unknown Loss Errors:
  - No documentation
  - Insufficient documentation:
    - ✓ Payment lack the appropriate supporting documentation
    - ✓ Their validity as correct or a true loss cannot be determined
    - ✓ More documentation is needed to determine if the claims were payable or if they should be considered monetary losses to the program
- Correcting insufficient documentation errors is the focus in 2018

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Medical Record Signature Reminders

- Categorized as “Insufficient Documentation” errors:
  - Missing signatures
  - Illegible handwritten signatures
  - Electronic signatures not dated
  - Attestation statements do not match the date of service
- Records must be signed and dated
- Include signature logs to determine handwritten signatures
- Complete attestation statements when records are not signed
- Do not add late signatures
- CMS Complying with Medicare Signature Requirements

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Part A - Key Points

- Major Part A error drivers continue to be Inpatient Rehab Facility (IRF) and Skilled Nursing Facility (SNF) claims
- Specifically, documentation missing from the full complement of required elements as outlined in the regulations:
  - Missing documentation of prognosis on the plan of care
  - Missing progress notes
  - Missing or delayed certifications
  - Missing required MD signatures
- Hospital Outpatient claims have emerged as a high Improper Payment category with a large percentage of overall error for Insufficient Documentation of services
- Complete and proper documentation is the key to supporting these services

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Part B – Key Points

- Evaluation & Management Services:
  - Documentation is not supporting the level of service billed on the claim:
    - ✓ One or more of key components required are not documented to the appropriate level
    - ✓ Non-physician practitioner and physician shared visits are not appropriately documented
  - Signatures:
    - ✓ Illegible signatures with no attestation statement
    - ✓ Missing signatures on documentation
- Ambulance – BLS:
  - 50/50 errors between Medical Necessity and Insufficient Documentation:
    - ✓ Submitted documentation not supporting the medical necessity of the transport, i.e., treatment received was of a type such that transport by ambulance to receive it was not necessary.
    - ✓ Insufficient documentation to support the reason(s) that a patient could not have been safely transported via any other method than ambulance

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Part B – Key Points (Cont.)

- Psychiatric Treatment:
  - Documentation is insufficient to support the length of time for billed psychotherapy
- Chiropractic Treatment:
  - Missing chiropractic treatment plan to support a plan of care:
    - ✓ treatment plan that includes duration, frequency of visits, specific treatment goals and objective measures to evaluate treatment effectiveness
  - Documentation of specific regions of the spine that were manually manipulated
- Physical Therapy claims:
  - Lack documented plan of care
  - Initial and/or subsequent patient evaluations
  - Minutes or units billed
  - Signatures

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17

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Accuracy Matters

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- **Did you know that Novitas receives 1.7 million claim corrections requests per year?**
  - Claim corrections or clerical error reopenings are corrections to minor errors or omissions on your submitted Medicare Part B claim
  - This extra work costs your office extra time and money:
    - ✓ Reduce rework and the accompanying costs by submitting your Medicare claims accurately the first time

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Achieve Accuracy Using Our Online Self-Service Tools and Resources

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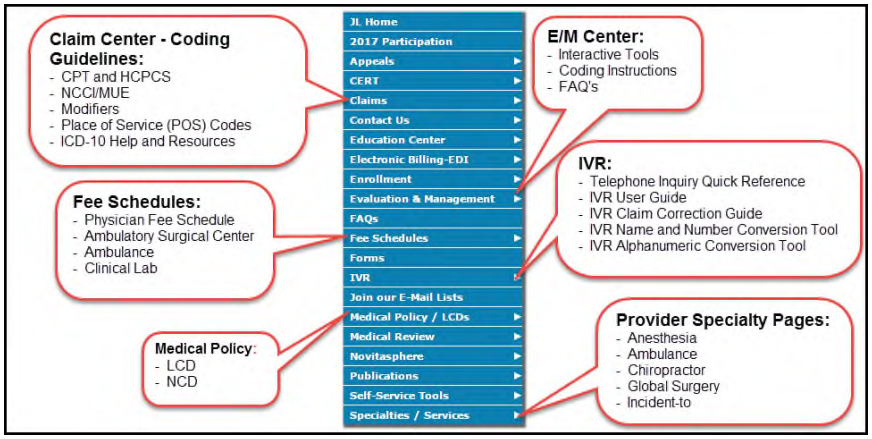

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Medicare Updates

20

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Spring 2018 CMS National Provider Enrollment Conference

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- CMS National Provider Enrollment Conference
  - April 24-25, 2018
  - San Diego Convention Center
    111 West Harbor Drive
    San Diego, CA 92101
  - Registration deadline March 30th, 2018
- Learn more and register today!
- Interact directly with CMS and MAC Provider Enrollment experts:
  - Comprehensive enrollment sessions:
    - ✓ Enrollment 101
    - ✓ Independent Diagnostic Testing Facilities (IDTFs)
    - ✓ Clinic/Group Practices
    - ✓ Certified Providers and Suppliers
    - ✓ Durable Medical Equipment Prosthetics, Orthotics and Supplies (DMEPOS)
    - ✓ Submitting Your Enrollment Online
    - ✓ And more!

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Important Dates For The New Medicare Card

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- CMS to remove Social Security Numbers (SSNs) from all Medicare cards by **April 2019**
- The transition period will run from **April 2018 through December 31, 2019**
- **October 2018** through the end of the transition period, when a valid and active Medicare Number is submitted on Medicare fee-for-service claims both the Medicare Number and the MBI will be returned on the remittance advice
- Find more information on the New Medicare Card on the CMS website on the New Medicare Card home page

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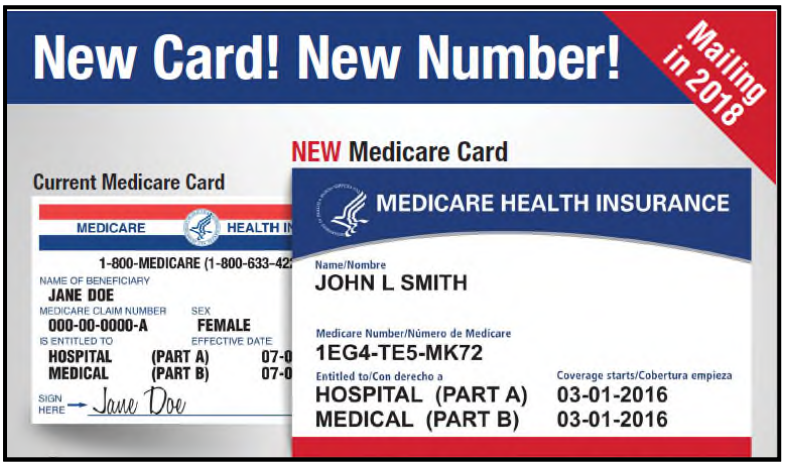
Newly Designed Medicare Card



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New Medicare Card Mailing Waves

Wave	States Included	Cards Mailing
1	Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia	April – June 2018
2	Alaska, American Samoa, California, Guam, Hawaii, Northern Mariana Islands, Oregon	April – June 2018
3	Arkansas, Illinois, Indiana, Iowa, Kansas, Minnesota, Nebraska, North Dakota, Oklahoma, South Dakota, Wisconsin	After June 2018
4	Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Rhode Island, Vermont	After June 2018
5	Alabama, Florida, Georgia, North Carolina, South Carolina	After June 2018
6	Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Texas, Utah, Washington, Wyoming	After June 2018
7	Kentucky, Louisiana, Michigan, Mississippi, Missouri, Ohio, Puerto Rico, Tennessee, Virgin Islands	After June 2018

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Get Ready for the New MBI

- Patient may not get a new card if their address with Social Security is not correct
- Verify your patients addresses:
  - If the address you have on file is different than the address you get in electronic eligibility transaction responses, ask your patients to contact Social Security and update their Medicare records
- Beneficiaries contact:
  - Social Security:
    - ✓ 1-800-772-1213
    - ✓ Access *my* **Social Security** account
  - Railroad Retirement Board:
    - ✓ 1-877-772-5772

Be Prepared

- Participate in CMS quarterly open door forums
- Sign up for weekly MLN Connects® newsletter
- Obtain technical information from your regular communication channels
- Test your systems
- Work with your billing office staff to be sure you are ready for the new MBI format
- Check the Providers page on the CMS website for more details

CMS Products

- Product ordering
- Fact sheet
- Poster
- Tear off pad
- CMS Published Flyer

Reinstating the Qualified Medicare Beneficiary Indicator in the Medicare Fee-For-Service Claims Processing System from CR9911

- MM10433:
  - Effective: July 1, 2018
  - Implementation: For claims processed on or after July 2, 2018
- Key Points:
  - Reintroduce QMB information in the RA without impeding claims processing by secondary payers:
    - ✓ Retain the display of patient liability amounts needed by secondary payers to process QMB cost-sharing claims:
      - ➢ Claim Adjustment Group Code "PR" along with CARCs 1, 2, 66, 247, and 248, as applicable, with monetary values on Medicare 835 ERAs and SPRs, as applicable
      - ➢ Revised alert RARCs N781 and N782
  - Changes to the MSN by including QMB messages and reflecting $0 cost-sharing liability for the period beneficiaries are enrolled in QMB

RA Messages for QMB

- RARC Codes:
  - N781 - Alert: Patient is a Medicaid/ Qualified Medicare Beneficiary. Review your records for any wrongfully collected deductible. This amount may be billed to a subsequent payer.
  - N782 – Alert: Patient is a Medicaid/ Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance. This amount may be billed to a subsequent payer.

Adjustments to Qualified Medicare Beneficiary (QMB) Claims Processed Under CR 9911

- CR10494:
  - Effective Date: 270 days from issuance for MCS users; 180 days from issuance for FISS users
  - Implementation Date: 180 days from issuance for FISS users; 270 days from issuance for MCS users
- Key Points:
  - Directs MACs to initiate non-monetary mass adjustments for claims impacted by the CR 9911 QMB RA changes
  - Enables MACs to generate "replacement" RAs without the CR 9911 changes in order to facilitate re-processing of QMB cost-sharing claims by secondary payers:
    - ✓ Note that although mass-adjusted claims may not cross over, this solution targets affected providers
    - ✓ Goal is to produce “replacement” Medicare RAs that providers can submit to supplemental payers to coordinate benefits as necessary

Therapy Cap Values for Calendar Year (CY) 2018

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- MM10341:
  - Effective: January 1, 2018
  - Implementation: January 2, 2018
- Key Points:
  - Outpatient therapy limits for:
    - ✓ Physical Therapy (PT) and Speech-Language Pathology (SLP) combined is $2,010.00
    - ✓ Occupational Therapy (OT) is $ 2,010.00

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Outpatient Therapy Cap Exception

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- Section 50202 of the Bipartisan Budget Act of 2018 repeals Medicare provisions affecting the outpatient therapy caps:
  - Once the $2010 therapy cap is met, the provider will need to attest that the services meet the requirements for an exception by appending the KX modifier:
    - ✓ Following claims no longer subject to the therapy cap:
      - ➢ Outpatient therapy hospital
      - ➢ Critical Access Hospital (CAH) therapy
  - Claims for therapy services above certain threshold levels of incurred expenses will be subject to targeted medical review:
    - ✓ Medical review threshold for therapy services in 2018 is $3,000
- Reference:
  - Medicare Expired Legislative Provisions Extended and Other Bipartisan Budget Act of 2018 Provisions

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Updated Editing of Always Therapy Services

NOVITAS SOLUTIONS

- MM10176:
  - Effective: January 1, 2018
  - Implementation: January 2, 2018
- Key Points:
  - "Always therapy" codes and modifiers are not always used in a correct and consistent manner
  - Professional claims for "always therapy" codes were reported without the required modifiers GN, GO and GP or multiple modifiers were reported
  - Claims will be rejected for the "always therapy" procedure code that does not also contain the appropriate "modifier of GN, GO, or GP

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Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD)

NOVITAS SOLUTIONS

- MM10295:
  - Effective: May 25, 2017
  - Implementation: July 2, 2018
- Key Points:
  - NCD Coverage for SET:
    - ✓ For beneficiaries with intermittent claudication
    - ✓ For treatment of PAD
    - ✓ 36 sessions over 12 week period

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April 2018 Update of the Hospital Outpatient Prospective Payment System (OPPS)

NOVITAS SOLUTIONS

- MM10515:
  - Effective: April 1, 2018
  - Implementation Date: April 2, 2018
- Key Points:
  - Describes changes to and billing instructions for various payment policies implemented in the April 2018 OPPS update:
    - ✓ New separately payable procedure code
    - ✓ Mulitanalyte assay with algorithmic analyses (MAAA) and proprietary laboratory analyses (PLA) CPT coding changes effective January 1, 2018
    - ✓ Reassignment of skin substitute product from the low cost group to the high cost group
    - ✓ Drugs and biologicals:
      - Payments based on average sales price (ASP)
      - OPPS pass through status
      - Restated payment rates based on ASP methodology
      - Changes to biosimilar product HCPCS codes and modifiers
    - ✓ Use of modifier FY:
      - Clarification the payment adjustment applies to an imaging service that is an X-ray taken using computed radiography technology where the X-ray taken using computed radiography technology is not combined with digital radiography in the same imaging service

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ICD-10 and Other Coding Revisions to NCDs - April

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- MM10318:
  - Effective: April 1, 2018
  - Implementation: January 29, 2018 for local MAC edits, April 2, 2018 for shared system edits (except for FISS NCDs), July 2, 2018 for FISS only for NCDs 1, 8, 12, 19, 21
- Key Points:
  - ICD-10 maintenance and other coding updates for approximately 21 NCDs due to:
    - ✓ Newly available codes
    - ✓ Coding revisions
    - ✓ Coding feedback received
  - Spreadsheets attached to Change Request detail each NCD revision

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NCDs Included in Coding Changes

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1. NCD20.9 Artificial Hearts
2. NCD20.9.1 Ventricular Assist Devices (VADs)
3. NCD20.16 Cardiac Output Monitoring by Thoracic Electrical Bioimpedance (TEB)
4. NCD20.29 Hyperbaric Oxygen (HBO) Therapy
5. NCD20.30 Microvolt T-Wave Alternans (MTWA)
6. NCD20.33 Transcatheter Mitral Valve Repair (TMVR)
7. NCD40.1 Diabetes Self-Management Training (DSMT)
8. NCD80.2, 80.2.1, 80.3, 80.3.1 Photodynamic Therapy, OPT, Photosensitive Drugs, Verteporfin
9. NCD110.18 Aprepitant
10. NCD110.21 Erythropoiesis Stimulating Agents (ESAs) in Cancer
11. NCD110.23 Stem Cell Transplants
12. NCD160.27 Transcutaneous Electrical Nerve Stimulation (TENS) for Chronic Low Back Pain (CLBP)
13. NCD190.3 Cytogenetic Studies
14. NCD190.11 Home Prothrombin Time/International Normalized Ratio (PT/INR) for Anticoagulation Management
15. NCD220.4 Mammograms
16. NCD220.6.17 Positron Emission Tomography (FDG) for Solid Tumors
17. NCD260.1 Adult Liver Transplantation
18. NCD220.13 Percutaneous Image-Guided Breast Biopsy
19. NCD270.1 Electrical Stimulation/Electromagnetic Therapy (ES/ET) for Wounds
20. NCD270.3 Blood-Derived Products for Chronic Non-Healing Wounds
21. NCD80.11 Vitrectomy

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ICD-10 and Other Coding Revisions to NCDs - July

NOVITAS SOLUTIONS

- MM10473:
  - Effective: July 1, 2018
  - Implementation: April 2, 2018 for MAC; July 2, 2018 for shared system
- Key Point:
  - Maintenance update of ICD-10 and other coding updates to NCDs due to newly available codes:
    - ✓ 205 Extracorporeal Immunoadsorption (ECI) Using Protein A columns
    - ✓ 110.18 Aprepitant
    - ✓ 110.21 Erythropoiesis Stimulating Agent (ESAs)
    - ✓ 150.3 Bone Mineral Density Studies
    - ✓ 190.1 PT/INR
    - ✓ 210.3 Colorectal Cancer Screening
    - ✓ 210.4.1 Counseling to Prevent Tobacco Use
    - ✓ 210.6 Hepatitis B Virus Screening
    - ✓ 220.4 Mammograms
    - ✓ 220.6.17 PET for Solid Tumors
    - ✓ 250.4 Actinic Keratosis (AKs)

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Transcatheter Aortic Valve Replacement (TAVR) Coverage Reminder

- NCD 20.32 provides TAVR coverage under Coverage with Evidence Development (CED)
- Prior to claim submission, verify participation as an approved TAVR study location
- Billing TAVR claims is different from Investigational Device Exemptions (IDEs) that require Novitas or CMS approval prior to billing for associated routine costs:
  - Transcatheter Aortic Valve Replacement Claim Submission

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

Targeted Probe and Educate

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What is Targeted Probe and Educate (TPE)

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- CMS is now moving towards a more targeted approach
- CMS believes the results of this program have been favorable, based on evidence of decreased claim errors
- The TPE process provides opportunity to educate providers before, during and after the probe
  - Providers will be notified of the review and receive education before ADRs are sent
  - Education will continue during the probe if easily curable issues are found and can be corrected eliminating the need for appeal
  - End of the probe the reviewer will offer an educational teleconference to provide detailed education on individual claim errors found during the probe
- The TPE process will consist of three rounds of prepayment probe review with education – if error rates warrant
- Visit CR10249 for more information

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TPE Rounds of Review Process

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TPE Process	Round 1 Initial Probe	Round 2	Round 3	CMS Corrective Actions After Round 3
Provider Notification	X	X	X	N/A
Pre-Probe Education	X	X	X	N/A
ADR request	X	X	X	N/A
Medical Review (education if necessary)	X	X	X	N/A
Results letter	X	X	X	N/A
Post-Probe Education	X	X	X	N/A
Referral (if applicable)	N/A	N/A	X	N/A
Extrapolation, referral to ZPIC, UPIC or RA or 100% prepay review	N/A	N/A	N/A	X

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Medical Review Process Change

- Novitas Solutions has initiated a Targeted Probe and Educate (TPE) under the direction of CMS to reduce provider burden
- Medical review process has moved to TPE:
  - Proved successful in lowering providers payment error rates
  - Involves the review of 20-40 claims per provider/supplier, per item or service
  - Will allow for time after education to correct errors before next "round"
- Novitas will focus on specific providers/suppliers:
  - That bill a particular item or service rather than all providers/suppliers billing a particular item or service
  - Who have the highest claim denial rates or who have billing practices that vary significantly from their peers:
    - ✓ Based on Data Analysis & CERT error rates
- Automated reviews and prior authorizations are not part of the TPE program

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Provider Notification

- Providers/suppliers targeted for review will be notified with an initial letter
- ADR letters will be generated on each claim selected for review:
  - ADRs will be generated per the usual process
  - Part A providers will receive ADRs mailed to the address in FISS
    - ✓ ADRs may also be printed or viewed in FISS
  - Provider has 45 days to respond to the contractor with medical records
  - No response counts as a denial for no records received and will affect the error rate of the entire probe:
    - ✓ Non-responders could be referred to the Zone Program Integrity Contractor (ZPIC), Unified Program Integrity Contractor (UPIC), or Recovery Auditor (RA) contractor

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Topics For Review

- All topics for review are listed in a chart on the website with a link to education that will assist in ensuring a successful review
- These lists will be continually updated as new topics are added
- Not all providers will be subject to review
- TPE Topics for Review

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Credit Balance Reporting

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Important Medicare Credit Balance Report Dates

- 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

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Credit Balance Tips

- Credit balance tips:
  - Providers must first attempt to make their own adjustments:
    - ✓ Submit adjustments as soon as you identify the credit balance once that particular quarter begins
  - Do not forget to include your UB-04 with your report
  - Submit the correct version of the CMS-838 form
  - Providers must complete the entire CMS-838 detail page when reporting credit balances
  - Ensure that your provider number on the certification page matches the detail page
  - Do not include claims you have indicated on a prior quarter
  - No need to mail hard copy once a certification has been faxed
  - Three attempts are made to contact the provider regarding questions:
    - ✓ If the provider does not return the telephone call then Novitas will offset the amount reported on the credit balance report
    - ✓ Claim will not show an adjustment in the Fiscal Intermediary Shared Systems
- Visit our website for more details on Credit Balance Reporting

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Novitas Initiatives

MSP Tips to Avoid Errors for Part A Claims

- Verify eligibility and MSP files prior to submitting claims
- Remarks need to be specific and avoid abbreviations because they can be interpretive
- Assign the correct Patient relationship codes to the proper payer
- Do not assume policy number for other insurance is the Medicare Number or Social Security Number
- Avoid abbreviations for payer name (BCBS is okay)
- Provide a term date in remarks if possible for benefits exhaust
- Diagnosis codes for auto, no fault/liability, workers comp:
  - If diagnosis is not related, indicate in remarks not related and claim will suspend for review
- Very important to report correct date when using OC 01, 02, 03, 04, or 05
- Beneficiary refuses to provide other insurance information bill with CC 08 not as conditional billing

Claim Correction Within Timely Filing Limit (Part A only)

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- Claim correction needed on claim **within** timely filing limit:
  - Submit adjustment claim on TOB XX7:
    - ✓ DDE adjustment is preferred over hardcopy
  - Adjustments can only be made to paid or rejected claims in a post pay location:
    - ✓ S/LOC P B9997, R B9997, R B7550
  - Claim cannot be adjusted if it was medically reviewed and denied
  - Provider must bill:
    - ✓ Condition code to identify change (D0-D4, D7-D9, E0)
    - ✓ DCN of original claim being adjusted on hardcopy adjustment
    - ✓ Adjustment reason code
    - ✓ Make the necessary changes
    - ✓ Remarks indicating the reason for the adjustment:
      - ➢ Required when using condition code D9
- Reference:
  - FISS Manual Chapter 4

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Claim Correction Beyond Timely Filing Limit (Part A only)

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- Claim correction needed on claim **beyond** the timely filing limit:
  - Adjustment bill (TOB XX7) is not allowed
  - Utilize **XXQ** reopening process:
    - ✓ Provider must bill:
      - ➢ Applicable reopening condition code (R1 – R6)
      - ➢ Condition code to identify change
      - ➢ Condition code W2
      - ➢ Reopening Adjustment Reason Code for DDE Claims Only
      - ➢ Remarks that require “Good Cause” with description
  - Additional charges or services not previously billed will not be accepted
- Reference:
  - Automation of the Request for Reopening Claims Process

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EDI Enrollment Form Reminders

- As of March 2, 2018, EDI will return all forms with a revision date older than R11-17:
  - Outdated EDI Enrollment Forms article
- Ensure that the Authorized Official or Delegated Official as listed on the CMS-855 sign the EDI forms:
  - Check PECOS to verify name

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

Helpful Electronic Remittance Advice (ERA) Tips

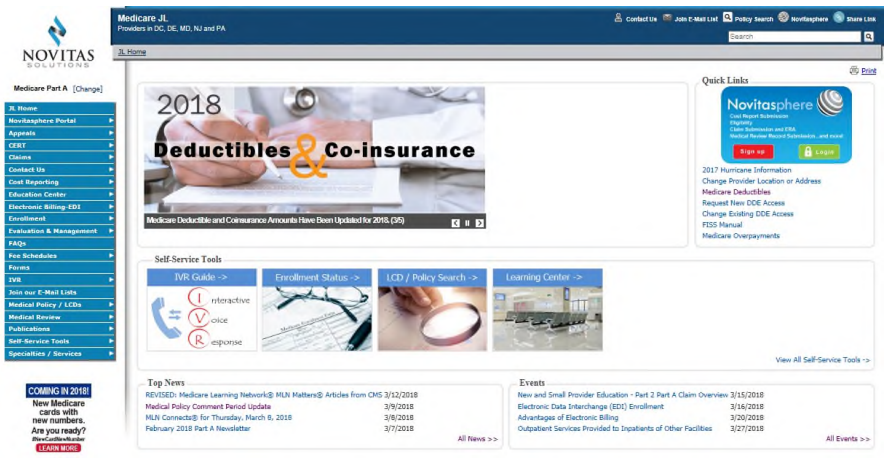
- If you are enrolled to receive your remittances via 835 ERA, review these helpful tips for successfully managing your remittance files:
  - ERA is generated 14 days from the date the file was submitted:
    - ✓ File is available to retrieve for 45 days
  - When you retrieve your ERA, save it to location on your system where you can easily locate it in the future if necessary
  - Those saved ERA files can be translated by your claim software, or by one of our free software products: Medicare Remit Easy Print (MREP) for Part B, PC Print for Part A, or ABILITY | PC-ACE for Part A or Part B:
    - ✓ These software products have the ability to print one or more patients as needed to send to a secondary insurance
  - Get into the habit of retrieving ERAs each day so you don't miss any important information
  - Training modules are offered to help you retrieve and read your ERA files:

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

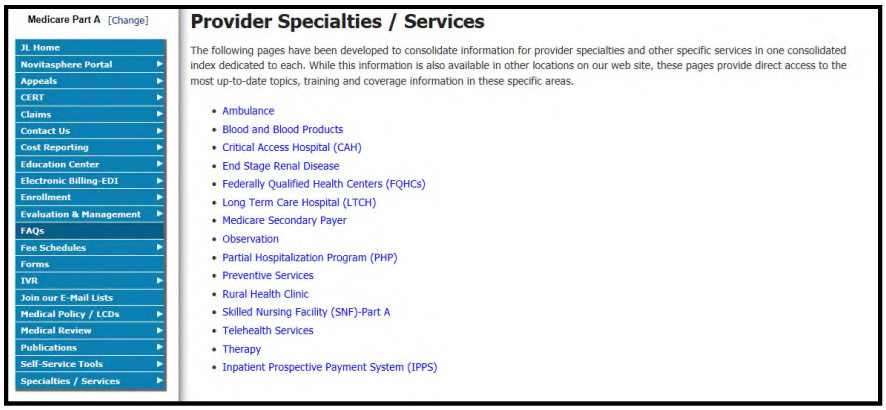
Website Features

55

Novitas-Solutions Homepage

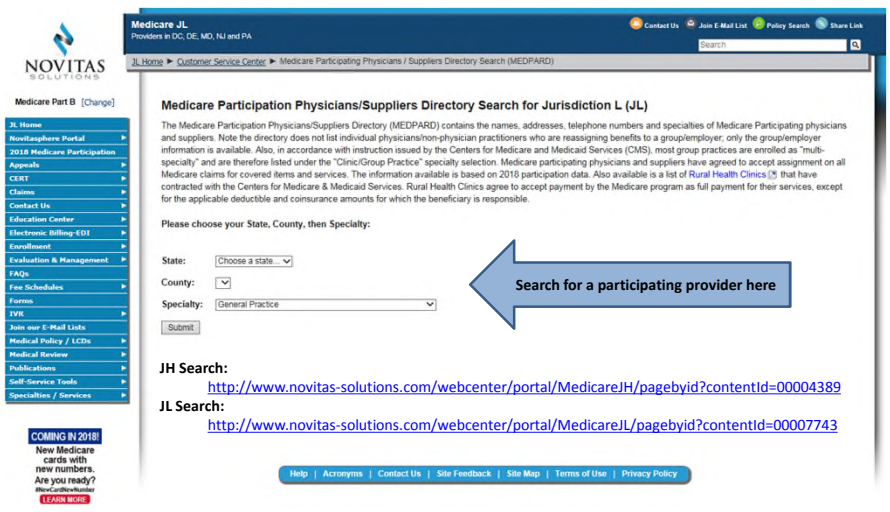


Provider Specialties / Services



INNOVATION IN ACTION

MEDPARD Directory



INNOVATION IN ACTION

Novitasphere

- Free, secured web-based portal
- Access to Eligibility, Claim Submission with File Status, Electronic Remittance Advice (ERA), Medical Review Record Submission, and Audit and Reimbursement Cost Reports Submission
- Live Chat feature
- Dedicated Help Desk- 1-855-880-8424
- For demonstrations and more information visit the homepage:
  - Novitasphere for Part A
  - Novitasphere for Part B

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

Novitasphere Roles and Responsibilities

Office Approver (OA) *Does not have to be the Provider/Owner*	**Office Back-up Approver (OBA)** *Does not have to be the Provider/Owner*	**End User**
Has access to all features	Has access to all features	Has access to all features
Must be listed as the OA on the EDI Portal Enrollment form	**Must** be listed as the OBA on the EDI Portal Enrollment form	Should **NOT** be listed on the EDI Portal Enrollment form
Responsible for creating the Organization in EIDM	Will enroll in EIDM after the OA has been approved	Will enroll in EIDM after the OA has been approved
Responsible for approving all End Users access request	Responsible for approving all End Users access request	Access is granted by the OA or OBA
Responsible for certifying all End User access annually	Responsible for certifying all End User access annually	Annual Certification completed by OA/OBA

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

Novitas Self-Service – Maintain Your Accesses

- Novitasphere:
  - All Office Approvers, Office Back-Up Approvers, and End Users are required to change their password in the CMS Enterprise Portal at least once every 60 days
- Novitas Medicare Learning Center:
  - Access at least every 60 days to prevent de-activation:
    - ✓ If you are de-activated and locked:
      - ➢ Do not attempt to register a new account
      - ➢ Send an email to **education @novitas solutions.com** to re-activate existing account with a statement that your account needs unlocked/re-activated, along your first and last name, user name (if you remember it), and the e-mail address you used to register
- FISS:
  - Initial access to activate your RACF ID and password must be completed within 30 days of the RACF ID being created to prevent being revoked
  - Non-use of a RACF ID after 90 days will be deleted

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

Question 1

- What is your interpretation of the 24 hour observation rule as defined by DHMH? Payers tend to refer to facilities to the DHMH ruling, but each payer seems to interpret the ruling differently resulting in outright denials. Where can providers find written guidelines regarding your policy on this issue?
  - Novitas has a specialty page for Part A providers on Observation
  - Note that the CMS guidelines state:
    - ✓ Observation services must also be reasonable and necessary to be covered by Medicare. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours. In the majority of cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours.
    - ✓ CMS Publication 100-04 Chapter 4 Section 290.1

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

Question 2

- What is your threshold for I-bill submission requests? Is there a dollar amount or specific diagnoses that will automatically generate an Ibill request? Where can providers go to access these guidelines?
  - Novitas does not have a specific list of services that have specific thresholds
    - ✓ Some services do have edits in place that will cause a claim to return to provider (RTP), deny, or reject
      - ➢ Example: A claim can RTP with reason code E61#U (yearly limits exceeded for non-blood services)

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

Question 3

- Where can providers find written policies and directions on your pre-authorization requirements? Is there a list of services that require pre-authorization and if so where is it located? What is your timeframe for retro authorization?
  - Under Medicare law, payment for services and supplies is based upon the reasonableness and necessity of the services performed and supplied, and is determined on a case-by-case basis
  - Novitas is unable to preauthorize coverage of an anticipated service or supply:
    - ✓ If a provider is in doubt as to whether Novitas will cover a service or supply for a specific patient, he/she may safeguard themselves by having the beneficiary sign a waiver of liability Advanced Beneficiary Notice (ABN) prior to having the service performed:
      - ➢ A waiver holds the beneficiary liable for the service should it be denied for medical necessity reasons
      - ➢ If an ABN is obtained, the service must be appended with a GA modifier
      - ➢ Medicare Advance Written Notices of Noncoverage

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

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
- Provider Teletypewriter- 1-877-235-8051
- Self-Service Tools:
- Patient / Medicare Beneficiary:
  - 1-800-MEDICARE (1-800-633-4227)
  - Medicare.gov

INNOVATION IN ACTION

2018 MAC Satisfaction Indicator (MSI) Survey

- This survey measures your satisfaction with our processes and service delivery so we can gain valuable insights and determine process improvements:
  - CFI Group is conducting the survey on behalf of CMS:
    - ✓ Evaluate our services in 10 minutes
    - ✓ Responses are kept confidential
    - ✓ Provide your name, telephone number and email address if you would like to be contacted about your survey responses
- Improvements based on 2017 MSI feedback:
  - Added a "Was this page helpful?" interaction to all content pages
  - Designed and debuted new information centers for Enrollment, Appeals and Claims
  - Enhanced and expanded data provided by many of our self-service lookup tools
- JL Provider MSI Survey

INNOVATION IN ACTION

Summary

- Gave key points and references to the latest quarterly updates
- Stay up to date with the latest Medicare changes by visiting the Novitas Solutions website
- Be aware of CERT documentation request and respond appropriately
- Take advantage of the various self service options available to the provider community

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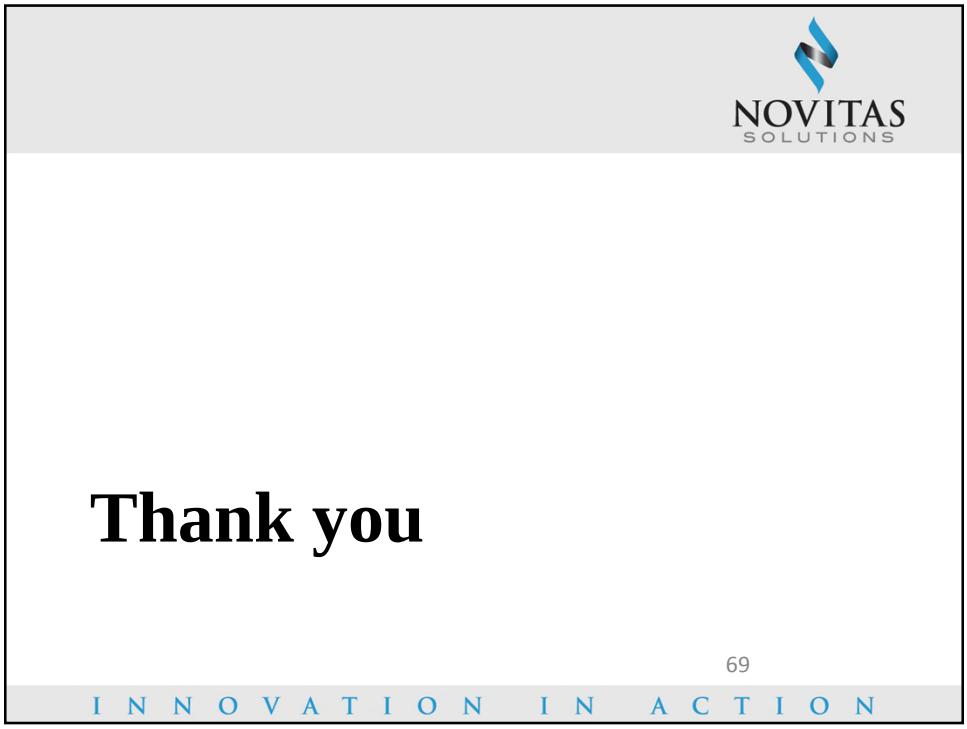
INNOVATION IN ACTION


NOVITAS
SOLUTIONS
Thank you
69
INNOVATION IN ACTION