Medicare Updates and What’s Trending for 2019

Texas Lone Star & Oklahoma Healthcare Financial Management Association
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<td>Acute Care Hospital</td>
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<td>CAH</td>
<td>Critical Access Hospital</td>
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<td>CMS</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
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<td>EDI</td>
<td>Electronic Data Interchange</td>
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<td>FISS</td>
<td>Fiscal Intermediary Shared System</td>
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<td>IRF</td>
<td>Inpatient Rehab Facility</td>
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<td>LTCH</td>
<td>Long Term Care Hospital</td>
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<td>MBI</td>
<td>Medicare Beneficiary Identifier</td>
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<td>OIG</td>
<td>Office of Inspector General</td>
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<td>OPPS</td>
<td>Outpatient Prospective Payment System</td>
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Today’s Presentation

- **Agenda:**
  - Medicare Updates and Reminders
  - Novitas Initiatives
  - Comprehensive Error Rate Testing (CERT)
  - Targeted Probe & Educate (TPE)

- **Objectives:**
  - Identify and understand the current Medicare updates and reminders
  - Identify and utilize the educational resources and information
  - Explore the Medicare guidelines regarding CERT and TPE services
Medicare Updates and Reminders
MM11318:
- Effective: July 1, 2019
- Implementation: July 1, 2019

Key Points:
- Changes to and billing instructions for various payment policies for OPPS providers
- Summary of modifications:
  - New Temporary C-Code Established Effective July 1, 2019
  - New CPT Category III Codes Effective July 1, 2019
  - CPT Proprietary Laboratory Analyses (PLA) Coding Changes Effective July 1, 2019
  - Myocardial Imaging by Magnetocardiography (MCG)
  - Drugs, Biologicals, and Radiopharmaceuticals:
    - New HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals
    - New Established HCPCS Codes for Separately Payable Drugs and Biologicals as of July 1, 2019
    - Descriptor Change for the HCPCS code J9355, Effective July 1, 2019
    - Drugs and Biologicals with Payments Based on Average Sales Price (ASP)
  - Reassignment of Skin Substitute Products from the Low Cost Group to the High Cost Group
  - New CPT Category I Vaccine Code Effective July 1, 2019
  - Status Indicator Revision for CPT Code 90689
  - Status Indicator Revision for HCPCS Code A4563
New Waived Tests

- **MM11231:**
  - Effective: July 1, 2019
  - Implementation: July 1, 2019

- **Key Points:**
  - List of newly approved tests by the Food and Drug Administration (FDA) as waived tests under the Clinical Laboratory Improvement Amendments (CLIA)

- **Reference:**
  - Medicare Claims Processing Manual, Pub. 100-04, Chapter 16 – Clinical Laboratory Improvement Amendment (CLIA) Requirements Section 70.8 Certificate of Waiver
Remittance Advice Updated Codes

- **CR11252:**
  - Effective: October 1, 2019
  - Implementation: October 7, 2019

- **Key Points:**
  - This Change Request (CR) provides notification indicating updates to Claim Adjustment Reason Codes (CARC) and Reason and Remark Code (RARC) lists which are available on the [Washington Publishing Company](http://example.com) website.
  - This recurring update notification applies to [Medicare Claims Processing Manual](http://example.com) chapter 22, sections 40.5, 60.1, and 60.2 of Pub. 100-04.
October 2019 - Quarterly Average Sales Price (ASP)

- **CR11343**:  
  - Effective: October 1, 2019  
  - Implementation: October 7, 2019

- **Key Points:**  
  - October 2019 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files  
  - CMS will supply the contractors with the ASP and not otherwise classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis.
ICD-10 and Other Coding Revisions to NCDs

- **MM11392:**
  - Effective: January 1, 2020
  - Implementation: January 6, 2020

- **Key Point:**
  - Maintenance update of ICD-10 and other coding updates to NCDs due to newly available codes:
    - NCD20.7 Percutaneous Transluminal Angioplasty
    - NCD110.18 Aprepitant
    - NCD110.23 Stem Cell Transplantation
    - NCD150.3 Bone Mineral Density Studies
    - NCD220.4 Mammography
    - NCD220.13 Percutaneous Image-Guided Breast Biopsy
    - NCD270.3 Blood Derived-Products for Chronic, Non-Healing Wounds
Medicare Plans to Modernize Payment Grouping and Code Editor Software

- **SE19013**
  - CMS modernizing its grouping and code editor software
    - ✓ Sub-systems are antiquated programming:
      - Medicare Code Editor (MCE)
      - Inpatient Grouper (MS-DRG)
      - Integrated Outpatient code Editor (IOCE)
    - ✓ Protect CMS from future quality and integration risks
Hospital Off-Campus Outpatient Department Reporting

- Changes to editing for appropriate reporting of off-campus outpatient department locations will impact all providers
- Payment impacts only applies to those providers paid under OPPS
- System related editing set to turn with the October 2019 Quarterly Release
- Prepare by ensuring 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 PECOS
- Ensure that the practice locations are linked to the NPI that is being reported on the claim submission

**Hospital Off-Campus Outpatient Department Reporting Requirements**
Activation of Systematic Validation Edits for OPPS Providers with Multiple Service Locations

- **SE19007:**
  - Conveys the activation of systematic validation edits to enforce the requirements for submitting claims for providers that have multiple service locations in the Medicare Claims Processing Manual, Chapter 1, Section 170:
    - Requirements discussed in MM9613 - Implementing Provider File Updates and PECOS to FISS Interface Via Extract File Updates to Accommodate Section 603 Bipartisan Budget Act of 2015 and MM9907- Implementing FISS Updates to Accommodate Section 603 Bipartisan Budget Act of 2015 - Phase 2
    - For MPFS and OPPS payments to be accurate, CMS uses the service facility address of the off-campus, outpatient, provider-based department of a hospital facility to determine the locality in these cases:
      - Non-excepted services provided at an off-campus, outpatient, provider-based department of a hospital are paid under the MPFS
    - Implementation postponed until October 2019 Quarterly Release
Validating Provider Practice Location

- Medicare systems will validate service facility location to ensure services are provided in a Medicare enrolled location:
  - Validation will be **exact matching** based on the information on the Form CMS-855A submitted by the provider and entered into PECOS
    - Must match, word for word, including abbreviations and punctuation
  - Ensure claims data matches provider enrollment information
  - Applies to OPPS and Non-OPPS (MD Waiver and IHS) providers
- 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
- Providers who need to add a new or correct an existing practice location address will need to submit a new 855A enrollment application in PECOS

SE19007 Activation of Systematic Validation Edits for OPPS Providers with Multiple Service Locations
Part A East (PAE) QIC Demonstration
Demonstration Background

- In 2015, CMS authorized the QIC (C2C) to conduct the Telephone Discussion Demonstration:
  - Selected 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
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
  - 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](#)
  - [C2C Website for PAE Appeals Demonstration](#)
C2C Website for PAE Demo

- Overview of the Appeals Demonstration

The Appeals Demonstration has been expanded to include Part A East providers

Overview of the Appeals Demonstration

On Jan. 1, 2016, CMS launched the QIC Telephone Discussion and Reopening Process Demonstration to test whether further engagement between Durable Medical Equipment (DME) suppliers and the DME QIC would improve the understanding of the cause of appeal denials and, over time, result in more proper claim submission at the DME MAC level from suppliers participating in the Demonstration. The Demonstration initially focused on oxygen and glucose/diabetic testing strip supplies. However, since initial implementation, CMS further expanded the Demonstration activities to include all DME claim types within DME MAC Jurisdictions A, B, C, and D, with exception to claims or suppliers that were already subject to another Centers for Medicare & Medicaid Services (CMS) initiative (e.g., Prior Authorization for Power Mobility Devices (PMDs), Settlement Conference Facilitation (SCF)) and for claims for glucose/diabetic testing strip supplies submitted within DME MAC Jurisdictions A and B. Effective January 1, 2019, CMS is further expanding the Demonstration activities to the Part A East (PAE) QIC Jurisdiction. Under the expanded Demonstration, the PAE QIC shall offer telephone discussions and/or reopenings to providers within MAC Jurisdictions H, J, K, L, M, and N, and home health and hospice (HHH) related appeals within MAC Jurisdictions J6 and J15. Reconsiderations for service terminations, hospital discharge reviews and claims or providers that are already involved in another CMS initiative (e.g., SCF) are not eligible for telephone discussions and/or reopenings under the Demonstration.
Medicare Beneficiary Identifier (MBI) Updates
MBI is coming! Are you ready?

- Effective January 1, 2020, claims submitted to Medicare will require the beneficiary’s MBI number
- Is your office or facility prepared for the MBI transition?
- 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) for assistance
  - TTY users can call 1-877-486-2048
Is Your Vendor/Clearinghouse Submitting Your Claims With the MBI?

- If you send the MBI to your vendor/clearinghouse on your Medicare claim for payment, but you see both the Health Insurance Claim Number and the MBI on your remittance advice:
  - Your vendor/clearinghouse is not using the MBI to submit your claims
  - Contact your vendor/clearinghouse today and ask about their process to submit Medicare claims
- Starting January 1, 2020, Medicare will reject claims with the Health insurance Claim Number, with a few exceptions
- For more information, see the MLN Matters Article
Novitas Initiatives
Clerical Error Reopenings (CER) Beyond One Year

- Effective May 1, 2019, requests to conduct a CER will be limited to one year from the initial determination date
- CER submissions beyond one year are excepted if:
  - Report an overpayment
  - Show good cause:
    - According to the Centers for Medicare & Medicaid Services (CMS) Internet Only Manual (IOM) Publication 100-04 Medicare Claims Processing Manual, Chapter 34, Reopening and Revision of Claim Determinations and Decisions, Section 10.11
- Decision to not reopen a claim is not appealable

[Clerical Error Reopenings (CER) Beyond One Year](#)
What is Novitasphere?

- **Definition:**
  - Free, secured web-based Portal which allows enrolled users access to **time-saving features**

- **Purpose:**
  - Allows enrolled users access to Eligibility, MBI Lookup, Remittance Advice, Appeal Requests, Medical Review Records and more
  - Available to JH and JL Part A/B providers, billing services and clearinghouses
  - Live Chat feature
    - Dedicated Help Desk: 1-855-880-8424
    - Available from 8:00AM-5:00 PM ET

- [Novitasphere User Guides and Instructions](#)

- For demonstrations and more information visit our [Novitasphere](#) webpage
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

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<tr>
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<th>Warning Letter Mailed</th>
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Medicare Administrative Contractor (MAC)

Targeted Probe and Educate (TPE)
Medical Review (MR)

- Novitas Solutions’ MR Department is one component of overall MIP.
- MR works in collaboration with other MIP contractors to minimize potential future losses to the Medicare Trust Fund.
- MR activities support the primary goal of the MIP:
  - Pay claims correctly.
  - Reduce the claims payment error rate.
- MR pursues every opportunity, through Targeted Probe and Educate (TPE), to process claims using the Medicare approved reimbursement amount for covered, medically necessary, and correctly coded services rendered to eligible beneficiaries by legitimate providers.
Targeted Probe and Educate (TPE) 
Background

- **CR10249**
  - Effective: October 1, 2017
  - Implementation: October 1, 2017

- **Key Points:**
  - CMS has authorized MACs to conduct the TPE review process and MACs will select the topics for review
  - MACs 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
  - The TPE process includes three rounds (if warranted) of review with education:
    - Sample limited for each probe “round” to a minimum of twenty (20) and a maximum of forty (40) claims
Targeted Probe and Educate (TPE)

- **Goals:**
  - TPE will help Medicare providers/suppliers learn through education to quickly improve and lower claim denials and appeals
  - TPE provides opportunity to educate providers 1:1 before, during and after the probe
  - TPE will reduce provider burden and correct easily curable errors that are found during review

- **Program Overview:**
  - TPE program will allow for time after education to correct errors before the next round occurs
  - Automated reviews and prior authorizations are not part of the TPE program
Topics For Review

- All topics for review are published on the Novitas Solutions’ 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:
  - Part A TPE Topics for Review
  - Part B TPE Topics for Review
Initial Letter and Education

- Initial letter will include:
  - Topic being reviewed
  - Reason for the selection which will be supported by data analysis
  - Number of claims requested for review
  - Documentation checklist
  - Review process
  - Contact information for the Targeted Education Specialist or reviewer assigned to the probe

- Initial education:
  - Targeted Education Specialist or a Nurse Reviewer will call to:
    - Establish a contact person
    - Educate on the documentation requirements
    - Discuss educational tools available on our website:
      - Part A TPE
      - Part B TPE
Provider Notification

- Providers/suppliers selected for review will be notified with an initial letter.
- Additional Documentation Request (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 correspondence address in Fiscal Intermediary Standard System (FISS).
    - ADRs may also be printed or viewed in FISS.
  - Part B providers will receive ADRs mailed to the correspondence address.
Additional Development Request

- When a claim is selected for prepayment medical review, it is placed in a hold location.

- Once the claim sample is met the ADRs will be generated:
  - The ADR contains all of the necessary information to respond to the review.
  - The claims selected for review/generated ADR are placed in a suspense/hold location to allow time for the provider to respond to the request.

- When claims are selected for post-payment medical review, a record request letter will be sent for all claims selected for review:
  - The letter along with individual cover sheets for each claim selected for review is the ADR.
  - The letter and cover sheets contain all of the necessary information to respond to the review.
Comprehensive Error Rate Testing (CERT) Program
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
- CERT Page
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
- [Complying with Medicare Signature Requirements Fact Sheet](#)
Summary

- Identified the current Medicare updates and reminders
- Provided educational resources and information
- Explored the Medicare guidelines regarding CERT and TPE services
Thank You for Attending

- **Contact Information:**
  - Teresa Tatum  
    Education Specialist  
    [Teresa.Tatum@novitas-solutions.com](mailto:Teresa.Tatum@novitas-solutions.com)  
    Phone: (717) 526-6357  
  - Stephanie Portzline  
    Manager, Provider Engagement  
    [Stephanie.Portzline@novitas-solutions.com](mailto:Stephanie.Portzline@novitas-solutions.com)  
    Phone: (717) 526-6317  
  - Janice Mumma  
    Supervisor Provider Outreach and Education  
    [janice.mumma@novitas-solutions.com](mailto:janice.mumma@novitas-solutions.com)  
    717-526-6406