Novitas Solutions
Medicare Part A and B Presents: Medicare Updates

NJ AAHAM Semi Annual Billing Seminar
March 19, 2015
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- Education specific to providers in Medicare Administrative Contractor (MAC) Jurisdiction L (JL) include: Delaware, District of Columbia, Maryland, New Jersey, and Pennsylvania.

- Education specific to providers in Medicare Administrative Contractor Jurisdiction H (JH) include: Arkansas, Colorado, Louisiana, Mississippi, New Mexico, Oklahoma, and Texas.

- This education contains specific contractor guidance.

- If you are not a provider in JL or JH, please contact your Medicare contractor for specific guidance.
Agenda

- Quarterly Updates
- Preventive Services
- Novitas Initiatives
- Comprehensive Error Rate Testing Program (CERT)
- Self-Service
Objectives

- Identify and understand the current Medicare changes
- Learn how to apply the new guidelines
- Identify and utilize the educational resources and information
# Acronym List

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Quarterly Updates
Update to Medicare Deductible, Coinsurance, and Premium Rates for 2015

• Change Request # 8982
  o Effective: January 1, 2015
  o Implementation: January 5, 2015

• Key Points
  o 2015 Part A – Hospital Insurance
    ▪ Deductible: $1,260.00
  o 2015 Part B – Medical Insurance
    ▪ Deductible: $147.00
    ▪ Standard Premium: $104.90

• Reference
Sequestration Update

- Mandatory Payment Reduction of 2% Continues through March 31, 2016, for the Medicare Fee For Service Program

- For more information

- Frequently Asked Questions
  - JL
Medicare Fee-For-Service International Classification of Diseases, 10th Edition (ICD-10) Testing Approach

• Special Edition # SE1409
  o Effective: October 1, 2015
  o Revised: December 8, 2014
• Key Points
  o CMS internal testing of its claims processing system
  o Provider initiated Beta testing tools
  o Acknowledgement testing
  o End-to-end testing
    ▪ January 26-30, 2015
    ▪ April 27-May 1, 2015
    ▪ July 20-14, 2015
• Reference

- **Special Edition # SE1501**
  - Revised: January 6, 2015

- **Key Points**
  - Frequently Asked Questions (FAQs) for those participating in acknowledgement testing and those selected to participate in ICD-10 end-to-end testing weeks

- **Reference**
Updates to International Classification of Diseases, 10th Edition (ICD-10) Local Coverage Determinations

• Special Edition SE1421

• Key Points
  o Advises how to access International Classification of Diseases, 10th Edition (ICD-10) Local Coverage Determinations (LCDs) in the Centers for Medicare & Medicaid Services (CMS) Medicare Coverage Database (MCD)

• Reference
Institutional Services Split Claims Billing
Instructions for Fee-For-Service Claims that
Span the ICD-10 Implementation Date

• Special Edition SE1325
• Key Points
  o Clarifies the policy for processing institutional claims spanning the October 1, 2015, ICD-10 start date
  o Related to SE1408
• Reference
Key Points

- Only claims that span this single implementation date (October 1, 2015) will be impacted.
- Split claims for an encounter spanning the ICD-10 implementation date, maintain all charges with the same Line Item Date of Service (LIDOS) on the correct corresponding claim for the encounter.
- Single item services whose time-frame cross over midnight on September 30, 2015 (e.g., Emergency Room Visits and Observation), are not split into 2 separate charges, rather the single item service should be placed in the claim based upon the LIDOS.

Reference

Incorporation of Certain Provider Enrollment Policies in CMS-4159-F into Pub. 100-08, Program Integrity Manual (PIM), Chapter 15

• Change Request # 8901
  o Effective: March 18, 2015
  o Implementation: March 18, 2015
• Key Points
  o CMS-855 approval of Reactivation Application or Reactivation Certification Package for Part B non-certified suppliers effective date will be the date the MAC received the application and a new Provider Transaction Access Number (PTAN) will be issued
  o CMS may deny or revoke a physician’s or eligible professional’s CMS-855 enrollment application if
    ▪ Physician’s or eligible professional’s DEA Certificate of Registration to dispense a controlled substance is currently suspended or revoked
    ▪ Applicable state licensing or administrative body has suspended or revoked the physician’s ability to prescribe drugs if it is in effect during the application process
  o CMS may revoke a physician’s or eligible professional’s enrollment if there is a pattern or practice of prescribing Part D drugs that falls into one of the listed categories below
    ▪ Pattern or practice is abusive or represents a threat to the health and safety of Medicare beneficiaries or both
    ▪ Pattern or practice of prescribing fails to meet Medicare requirements.
• Reference
Notice of New Interest Rate for Medicare Overpayments and Underpayments – 2nd Qtr. Notification for FY 2015

• Change Request # 9089
  o Effective: January 21, 2015
  o Implementation: January 21, 2015

• Key Points
  o Medicare contractors will use an interest rate of 10.50% for both overpayments and underpayments

• Reference
Therapy Cap Values for Calendar Year (CY) 2015

• Change Request # 8970
  o Effective: January 1, 2015
  o Implementation: January 5, 2015

• Key Points
  o Therapy caps for outpatient therapy services
    ▪ $1,940 – Physical and Speech Language Pathology
    ▪ $1,940 – Occupational Therapy

• Reference
2015 Annual Update to The Therapy Code List

- Change Request # 8985
  - Effective: January 1, 2015,
  - Implementation: January 5, 2015

- Key Points
  - This CR updates the therapy code list with two "sometimes therapy" codes and deletes two current codes for CY 2015 as follows:
    - Sometimes therapy codes
      - Add: 97607 –
      - Delete: G0456
        - Note: 97607 replaces current code G0456 effective 1/1/2015
      - Add: 97608 –
      - Delete: G0457
        - Note: 97608 replaces current code G0457 effective 1/1/2015
    - Report GN, GO, or GP when performed by a therapist specialty

- Reference
  - http://www.cms.gov/Medicare/Billing/TherapyServices/AnnualTherapyUpdate.html

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Ambulance Inflation Factor for 2015

- Change Request # 8895
  - Effective: January 1, 2015
  - Implementation: January 5, 2015

- Key Points
  - The ambulance inflation factor for 2015 is 1.4 percent
  - Deductible and coinsurance requirements apply to payments under the Ambulance Fee Schedule
    - [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AmbulanceFeeSchedule/index.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AmbulanceFeeSchedule/index.html)

- References
Remittance Advice Remark and Claims Adjustment Reason Code and Medicare Remit Easy Print and PC Print Update

• Change Request #9004
• Effective: April 1, 2015
• Implementation: April 6, 2015
• Key Points
  o Recurring update to the CARC and RARC lists
  o Instructions to update MREP and PC Print
• Reference
Correct Coding for Venipuncture Collection

- New England Benefit Integrity Support Center (NEBISC), program safeguard contractor, reported an increase in venipuncture coding errors
- CPT code 36415
  - Collection of venous blood by venipuncture
  - Commonly referred to as “routine” venipuncture
- CPT code 36410
  - Venipuncture, performed on an individual over 3 years of age, that requires a physician's skill
  - Must be supported in the medical documentation
- Findings
  - Code 36410
    - Improperly billed instead of code 36415
    - Documentation does not support use
    - Pays a higher rate than code 36415
- IOM 100-04 Chapter 16 Section 60

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Specific Modifiers for Distinct Procedural Services

• Change Request # 8863
  o Effective: January 15, 2015
  o Implementation: January 5, 2015
• Key Points
  o Four new modifiers to define specific subsets of the -59 modifier
    ▪ XE Separate Encounter
    ▪ XS Separate Structure
    ▪ XP Separate Practitioner
    ▪ XU Unusual Non-Overlapping Service
• Reference
Continued Use of Modifier 59 after January 1, 2015

• Special Edition # SE1503
  o Effective: January 1, 2015
  o Implementation: January 5, 2015

• Key Points
  o Providers may continue to use Modifier 59 when appropriate
  o Modifiers XE, XP, XS or XU may be used in place of Modifier 59
  o Additional guidance and education forthcoming from CMS
  o Inquiries about the new X modifiers
    ▪ NCCIPTPMUE@cms.hhs.gov

• Reference
Modifier 59 and New Modifiers XE, XS, XP, XU

• Until CMS provides official guidance, Novitas offers suggestions in this article for the use of the -X {EPSU} modifiers, should you decide to use them

• Article with examples
Revised Modification to the Medically Unlikely Edit (MUE) Program

• Change Request # 8853
  o Effective: January 1, 2015
  o Implementation: January 5, 2015

• Key Points
  o New data field to the MUE edit table termed “MUE adjudication indicator” or “MAI”
  o MUEs for codes with a MAI of “1” will continue to be adjudicated as a claim line edit
  o MUEs for codes with a MAI of “2” are absolute date of service edit. These are “per day edits based on policy”
  o MUEs for codes with a MAI of “3” are date of service edits. These are “per day edits based on clinical benchmarks”

• Reference
New Timeframe for Response to Additional Documentation Requests (ADR)

• Change Request # 8583
  o Effective: April 1, 2015
  o Implementation: April 6, 2015

• Key Points
  o For prepayment review providers and suppliers have 45 calendar days to respond to an ADR letter
  o Failure to respond within 45 days of a pre-payment review ADR will result in denial of the claim(s) related to the ADR

• Reference
Part A Only Updates
January 2015 Update of the Hospital Outpatient Prospective Payment System (OPPS)

- Change Request # 9014
  - Effective: January 1, 2015
  - Implementation: January 5, 2015
- Key Points
  - New Service
  - New Device Pass-Through Categories
  - Comprehensive APCs
    - Identified by a new Status Indicator, J1
  - Billing for Corneal Tissue
  - Billing for Mobile Cardiac Telemetry Monitoring Services
  - Billing for “Sometimes Therapy” Services that May be Paid as Non-Therapy Services for Hospital Outpatients
  - New Laboratory HCPCS G-codes
  - Coding Guidance for Intraocular or Periocular Injections of Combinations of Anti-Inflammatory Drugs and Antibiotics
  - Drugs, Biologicals, and Radiopharmaceuticals
- Reference:
Moratorium on Classification of Long-Term Care Hospitals (LTCH) or Satellites/Increase in Certified LTCH Beds

• Change Request # 9025
  o Effective: April 1, 2014
  o Implementation: February 10, 2015

• Key Points
  o To qualify for an exception under the moratorium to establish a new LTCH or LTCH satellite facility between April 1, 2014, and September 30, 2017, a hospital must meet one of the following three exceptions
    ▪ For a new LTCH, an existing hospital must have begun its qualifying period for payment as a long-term care hospital under 42 CFR 412.23
    ▪ Prior to April 1, 2014 the LTCH has a binding written agreement with an outside, unrelated party for the actual construction, renovation, lease, or demolition for an LTCH or LTCH satellite, as applicable, and has expended, prior to April 1, 2014, at least 10 percent of the estimated cost of the project or, $2,500,000, whichever amount is less
More On Moratorium on Classification of Long-Term Care Hospitals (LTCH) or Satellites/Increase in Certified LTCH Beds

- Key Points
  - An entity has obtained prior to April 1, 2014 an approved certificate of need (CON) in a State where one is required
    - This exception applies to a hospital or entity that was actively engaged in developing an LTCH
- Reference
Clarification of the End Stage Renal Disease (ESRD) Prospective Payment System (PPS) Low Volume Adjustment

- Change Request # 8898
- Effective: January 1, 2011
- Implementation: January 5, 2015
- Key Points
  - Two areas of clarification are needed to ensure proper application of the Low Volume Payment Adjustment (LVPA)
    - Hospital-based ESRD facilities meeting the requirement of furnishing less than 4,000 dialysis treatments in each of the 3 cost reporting years preceding the payment year
    - ESRD facility that has a change of ownership but does not obtain a new provider transaction access number (PTAN)
  - CMS realizes that these two clarifications may change the outcome for some ESRD facilities requesting the LVPA
  - ESRD facilities that wish to attest for the LVPA may submit attestations for each year applicable between 2011 and 2015
- Resource
Implementation of Changes in the End-Stage Renal Disease Prospective Payment System (ESRD PPS) for Calendar Year (CY) 2015

• Change Request # 8978
  o Effective: January 1, 2015
  o Implementation: January 5, 2015

• Key Points
  o ESRD facilities will begin reporting the composite rate drugs itemized on the consolidated billing list when provided
  o The CY 2015 ESRD PPS base rate is $239.43
  o The adjusted average outlier service Medicare Allowable Payment (MAP) amount per treatment:
    ▪ For adult patients is $51.29, and for pediatric patients is $43.57

• Reference
Elimination of the 50/50 Payment Rule for Laboratory Services on End Stage Renal Disease Claims

- **Change Request # 8957**
  - Effective: April 1, 2015
  - Implementation: April 6, 2015

- **Key Points**
  - With the implementation of the ESRD Prospective Payment System (PPS), ESRD laboratory services are no longer paid in accordance with the 50/50 rule
  - ESRD facilities will no longer be required to submit the 50/50 rule modifiers CD, CE, and CF
    - CD to indicate if the laboratory test was included in the composite rate
    - CE to indicate the laboratory test exceeded the frequency of the composite rate
    - CF to indicate the laboratory test was not included in the composite rate
  - ESRD PPS requires that all renal dialysis laboratory services be paid in the ESRD facility bundled payment and therefore may only be billed by the ESRD facility

- **Reference**
Proper use of ‘Medicare Treatment Authorization’ Field

• Starting January 5, 2015 the “Medicare Treatment Authorization” field must contain blanks or valid Medicare data, or the claim will be returned to the provider (RTP) for correction
  o For direct data entry (DDE) and hardcopy claims must contain blanks or valid Medicare data in the first 14 bytes of the treatment authorization field
  o Valid data for the ASC X12 837 claim (electronic) is located at the loop 2300 REF02 (REF01=G1) segment
  o The claim will be returned to the provider (RTP) for correction with reason code 30729

• Reference
Valid data entered on the claim may be any of the following:

- **Unique Tracking Number (UTN)**
  - First two positions of the UTN must be alpha-numeric and not contain spaces, third position of UTN is an A or H, last 11 positions of UTN must be numeric and not contain spaces
  - TRIAL 49
  - SPN66
  - 64
  - 56
  - A/B REBILLING
  - 54
  - SPN65
  - 07
  - 08
  - Valid 18-byte OASIS Treatment Number
    - Home Health claims
Implementing the Payment Policies Related to Patient Status from CMS 1599-F

• Change Request # 8959
  o Effective: October 1, 2013
  o Implementation: February 10, 2015

• Key Points
  o Incorporates changes to the Medicare Claims Processing Manual related to payment policies regarding Patient Status from final rule CMS-1599-F
    ▪ Payment of Medicare Part B inpatient services
    ▪ Medical review criteria for payment of hospital services under Medicare Part A

• References
Modifying FISS Part B Claims Overlap Edits Related to CMS 1599-F

• Change Request # 8820
  o Effective: January 1, 2015
  o Implementation: January 5, 2015

• Key Points
  o For claims received on or after January 1, 2015, FISS will bypass duplicate edits if a Type of Bill (TOB) 13x ‘through’ date and TOB 12x ‘from’ date are the same

• Reference
Automation of the Request for Reopening Claims Process

• Change Request # 8581
  o Effective: Claims received on or after October 1, 2015
  o Implementation: October 5, 2015

• Key Points
  o Institutional reopenings must be submitted with a “Q” frequency code to identify them as a Reopening
  o To assist providers with coding a request to reopen claims that are beyond the filing timeframes a Special Edition Article, SE1426, has been developed
    ▪ That article contains some additional information on this process as well as condition codes and billing scenarios

• Reference
Medicare Shared Systems Modifications Necessary to Capture Various HIPAA Compliant

• Change Request # 8384
  o Effective: April 01, 2015
  o Implementation: April 06, 2015

• Key Points
  o Updating the Direct Data Entry (DDE) screens to allow entry of three Patient Reason for Visit Codes
  o Updating the DDE screens to allow entry of a nine-digit ZIP code for the service facility

• Reference
Quarterly Updates for Skilled Nursing Facility (SNF)


- Medicare Part A Skilled Nursing Facility (SNF) Prospective Payment System (PPS) Pricer Update FY 2015
Part A Quarterly/Annual Updates

- Inpatient Rehabilitation Facility (IRF) Annual Update: Prospective Payment System (PPS) Pricer Changes for FY 2015

- Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Fiscal Year (FY) 2015

- January 2015 Integrated Outpatient Code Editor (I/OCE) Specifications Version 16.0
More Part A
Quarterly/Annual Updates

• Quarterly Update to the Correct Coding Initiative (CCI) Edits, Version 21.1, Effective April 1, 2015

• Calendar Year (CY) 2015 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment

• Claim Status Category and Claim Status Codes Update
Part B Only Updates
Summary of the 2015 Medicare Physician Fee Schedule Updates

• Change Request # 9034
  o Effective: January 1, 2015
  o Implementation: January 5, 2015

• Key Points
  o Medicare Physician Payment Update
    ▪ 0 percent update for claims with dates of service on or after January 1, 2015, through March 31, 2015
  o Screening and Diagnostic Digital Mammography
    ▪ Payment will be made for 3D mammography using the add-on codes in addition to the 2D mammography
  o Primary Care and Chronic Care Management
    ▪ Chronic care management can be billed once a month per qualified beneficiary
  o Anesthesia Related to Screening Colonoscopies
    ▪ Revised definition of a “screening colonoscopy” includes separately provided anesthesia as part of the screening services
    ▪ Coinsurance and deductible do not apply to anesthesia for screening colonoscopy
  o Potentially Misvalued Services
    ▪ Radiation Therapy and Gastroenterology
    ▪ New G Codes

• Reference
Posting the Limiting Charge after Applying the Electronic Health Record (EHR) and Physician Quality Reporting System (PQRS) Negative Adjustments

- Change Request # 8667
  - Effective: January 1, 2015
  - Implementation: October 6, 2014
- Key Points
  - EHR and PQRS negative adjustments will be published on the Novitas Website
    - EHR Limiting Charge
    - PQRS Limiting Charge
    - EHR/2014 eRx Limiting Charge
    - EHR + PQRS Limiting Charge; and
    - EHR/2014 eRx + PQRS Limiting Charge
- Reference
Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

• Change Request # 8912
  o Effective: January 1, 2015
  o Implementation: January 5, 2015

• Key Points
  o Instructs Medicare Administrative Contractors (MACs) to download and implement the January 2015 average sales price (ASP) drug pricing files for Medicare Part B drugs
  o Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after January 5, 2015, with dates of service January 1, 2015, through March 31, 2015
  o MACs will not search and adjust claims that have already been processed unless brought to their attention

• Reference
New Physician Specialty Code for Interventional Cardiology

• Change Request # 8812
  o Effective: January 1, 2015
  o Implementation: January 5, 2015

• Key Points
  o New specialty codes created:
    ▪ Physician Specialty for Interventional Cardiology: C3
    ▪ Non-physician specialty code for Restricted Use: C4
  o Specialty codes updated to align name to intended use:
    ▪ 62 updated to remove ‘Clinical’ from the description
    ▪ 88 updated to Unknown Provider
    ▪ 95 updated to Unknown Supplier

• Reference
Reporting the Service Location National Provider Identifier (NPI) on Anti-Markup and Reference Laboratory Claims

• Change Request # 8806
  o Effective: January 1, 2015
  o Implementation: January 1, 2015

• Key Points
  o Item 32a (or electronic equivalent) must contain the NPI of the physician or supplier who actually performed the service
  o Applies to all claims

• Reference
Provider Enrollment Requirements for Writing Prescriptions for Medicare Part D Drugs

• Special Edition SE1434
• Key Points
  o CMS finalized CMS-4159-F “Medicare Program; Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs” on May 23, 2014
  o This rule requires physicians and, when applicable, other eligible professionals who write prescriptions for Part D drugs to be enrolled in an approved status or to have a valid opt-out affidavit on file for their prescriptions to covered under Part D
  o The final regulation stated that the effective date for this requirement would be June 1, 2015. However, CMS is announcing that it will delay enforcement of the requirements in 42 CFR 423.120(c)(6) until December 1, 2015. Nevertheless, prescribers of Part D drugs must submit their Medicare enrollment
• Reference
Remittance Advice Remark and Claims Adjustment Reason Code and Medicare Remit Easy Print and PC Print Update

• Change Request # 9004
  o Effective: April 1, 2015
  o Implementation: April 6, 2015

• Key Points
  o Recurring update to the CARC and RARC lists
  o Instructions to update MREP and PC Print

• Reference
Medicare Part B Quarterly Updates

- Medicare Physician Fee Schedule Database (MPFSDB)

- Correct Coding Initiative (CCI) edits

- Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

- Influenza Vaccine Payment Allowances - Annual Update for 2014-2015 Season
CMS Video Resources

• A full description of the videos are available on the MLN Connects™ Videos web page

• MLN Connects™ Videos are a part of the Medicare Learning Network®
Preventive Services
Medicare Learning Network (MLN) Products for Preventive Services

- Help Keep Your Medicare Patients Healthy In 2015!
- Ensure your patients take advantage of Medicare-covered preventive services
- Medicare covers a wide array of preventive services for eligible beneficiaries, including cancer screenings, certain immunizations, among others
- The Medicare Learning Network (MLN) Preventive Services Educational Products Web Page provides descriptions and ordering information for MLN preventive services educational products and resources for health care professionals and their staff
Preventive Services and Screenings Covered by Medicare

- Abdominal Aortic Aneurysm Screening
- Alcohol Misuse Screening and Behavioral counseling Intervention in Primary Care
- Annual Wellness Visit (Including Personalized Prevention Plan Services)
- Bone Mass Measurements
- Cancer Screenings
  - Breast Cancer (mammograms and clinical breast exam)
  - Cervical and Vaginal Cancer (pap test and pelvic exam [includes the clinical breast exam])
  - Colorectal Cancer
    - Fecal Occult Blood Test
    - Flexible Sigmoidoscopy
    - Colonoscopy
    - Barium Enema
  - Prostate (Prostate Specific Antigen blood test and Digital Rectal Exam)
- Cardiovascular Disease Screening
- Depression Screening in Adults
- Diabetes Screening
- Diabetes Self-Management Training
- Glaucoma Screening
- Human Immunodeficiency Virus (HIV) Screening
- Immunizations (Seasonal Influenza, Pneumococcal, and Hepatitis B)
- Initial Preventive Physical Examination (IPPE) (also commonly referred to as the “Welcome to Medicare” Preventive Visit)
- Intensive Behavioral Therapy for Cardiovascular Disease
- Intensive Behavioral Therapy for Obesity
- Medical Nutrition Therapy (for beneficiaries with diabetes or renal disease)
- Sexually Transmitted Infections (STIs) Screening and High-Intensity Behavioral Counseling (HIBC) to prevent STIs
- Tobacco-Use Cessation Counseling
Preventive and Screening Services Update

- Change Request # 8874
  - Effective: January 1, 2015
  - Implementation: January 5, 2014
- Key Points
  - Intensive Behavioral Therapy for Obesity
    - New code G0473, face-to-face behavioral counseling for obesity, group
    - Beneficiary coinsurance and deductible do not apply
  - Digital Breast Tomosynthesis
    - New code 77063, screening digital breast tomosynthesis; bilateral
    - Beneficiary coinsurance and deductible do not apply
  - Anesthesia Furnished in Conjunction with Colonoscopy
    - Modifier 33 billed on anesthesia code 00810 waives deductible and coinsurance
    - Codes G0105 or G0121 have to be billed in conjunction with code 00810
- Reference
Modifications to Medicare Part B Coverage of Pneumococcal Vaccinations

- Change Request # 9051
  - Effective: September 19, 2014
  - Implementation: February 2, 2015

- Key Points
  - Modifications to the coverage of Pneumococcal Vaccinations
    - An initial pneumococcal vaccine to all Medicare patients who have never received the vaccine under Part B
    - A different, second pneumococcal vaccine
      - One year after the first was administered
      - Full 11 months have passed following the month in which the last pneumococcal vaccine was given

- Reference
Coverage of Ultrasound Screening for Abdominal Aortic Aneurysms (AAA) and Screening Fecal-Occult Blood Tests (FOBT)

• Change Request # 8881
  o Effective: January 27, 2014
  o Implementation: November 18, 2014

• Key Points
  o FOBT written order may also be supplied by the beneficiary’s attending physician assistant, nurse practitioner, or clinical nurse specialists
  o Eliminating the one year time limit for referrals for AAA screening
  o Allows coverage of the AAA screening for eligible beneficiaries without requiring them to receive a referral as part of the Initial Preventive Examination (IPPE), Welcome to Medicare Visit
  o Only need referral from their physician, physician assistant, nurse practitioner, or clinical nurse specialist

• Reference
Screening for Hepatitis C Virus (HCV) in Adults

• Change Request # 8871
  o Effective: June 2, 2014
  o Implementation: January 5, 2015

• Key Points
  o CMS will cover screening for HCV with the following conditions
    ▪ Adults at high risk for HCV infection
    ▪ Adults who were born from 1945 through 1965

• References
March is Colorectal Cancer Awareness Month

- Medicare covers several types of colorectal cancer screening tests to help find precancerous growths or find cancer early
- One or more of these tests may be covered per Medicare guidelines
  - Copayment/coinsurance and deductible waived
    - Screening colonoscopy
    - Screening fecal occult blood test
    - Screening flexible sigmoidoscopy
  - Copayment/coinsurance applies but deductible waived
    - Screening barium enema
Preventive Services

• Quick Reference Chart for Medicare Preventive Services
  o https://www.cms.gov/Medicare/Prevention/PreventionGenInfo/Downloads/MPS_QuickReferenceChart_1.pdf

• Improve Your Patients’ Health with the Initial Preventive Physical Examination (IPPE) and Annual Wellness Visit (AWV)
Novitas Initiatives
Website Improvements

• Based on your feedback we continue to update our website

• Recent Improvements
  o Better Page Navigation
  o Major Performance Upgrades
  o Page Titles
  o Minor enhancements to web search
  o Rolling banner
  o Website Navigation Video
    ▪ https://www.youtube.com/watch?v=JQwXOJt1YeA
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- The Medicare Administrative Contract (MAC) Jurisdiction L (L), which spans Pennsylvania, New Jersey, Maryland, Delaware, and Washington D.C.;
- The Medicare Administrative Contract (MAC) Jurisdiction H (H), which spans Colorado, Oklahoma, New Mexico, Texas, Arkansas, Louisiana, Mississippi, Indian Health Service (IHS) and Veterans Affairs (VA); and
- The payment processing for the Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens contract, as authorized under Section 1011 of the 2008 Medicare Modernization Act.

Click one of the images below to visit our provider websites for each of our contracts:

**Medicare Administrative Contract Jurisdiction L**

**Medicare Administrative Contract Jurisdiction H**

**Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens Section 1011**

**Career Opportunities**

View and apply to open Novitas positions here.

INNOVATION IN ACTION
Thank you for visiting the Novitas Solutions, Inc. provider website. This website is intended **exclusively** for Medicare **providers** and health care industry professionals to find the latest Medicare news. To enable us to present you with customized content, please select your preferences below.

**Which best describes your area of interest:**

- [ ] Part A: Hospitals & other Facilities
- [ ] Part B: Physicians & other health care professionals

[Set Preference]
We'd welcome your feedback!

Thank you for visiting Novitas Solutions, Inc. You have been selected to participate in a brief customer satisfaction survey to let us know how we can improve your experience. The feedback you provide will help Novitas Solutions enhance its Web site and serve you better in the future.

The survey is designed to measure your entire experience, please look for it at the conclusion of your visit.

This survey is conducted by an independent company ForeSee, on behalf of the site you are visiting.

No, thanks

Yes, I'll give feedback
Policy Search Application

• New customized “Policy Search Application”
• Search current, retired or draft policies
• Search criteria
  o Policy number
  o Healthcare Common Procedure Coding System (HCPCS)
  o Keyword
  o Local Coverage Determination (LCD) Title
• Search results based on criteria entered
• Searching LCDs Video
  o JL
    • http://www.novitas-solutions.com/webcenter/spaces/MedicareJL/page/pagebyid?contentId=00082787
• Policy Search
  o JL
    • http://www.novitas-solutions.com/webcenter/spaces/MedicareJL/page/LcdSearch
Policy Search Application

- New customized “Policy Search Application”
- Search current, retired or draft policies
- Search criteria
  - Policy number
  - Healthcare Common Procedure Coding System (HCPCS)
  - Keyword
  - Local Coverage Determination (LCD) Title
- Search results based on criteria entered
- Stayed tuned for additional information and upcoming educational opportunities
  - [http://www.novitas-solutions.com](http://www.novitas-solutions.com)
JL Local Coverage Determinations (LCDs)

• Effective April 9, 2015
  o Human Skin Equivalents (HSE)- Use in the Treatment of Chronic Cutaneous Ulcer Wounds (L27549)
    ▪ Future title: Application of Bioengineered Skin Substitutes to Lower Extremity Chronic Non-Healing Wounds
  o Blood Glucose Monitoring in a Skilled Nursing Facility (SNF) (L27475)
  o Co-Management of Surgical Procedures (L27481)
  o Coverage of Services and Procedures in Nursing Facilities (L27485a0
  o Evaluation and Management Services Provided in a Nursing Facility (L27496)
  o Hemophilia Factor Products (L33658)
  o Speech-Language Pathology (SLP) Services: Communication Disorders (L27531)
  o Speech-Language Pathology (SLP) Services: Dysphagia: Includes VitalStim® Therapy (L27537)
JL Local Coverage Determinations (LCDs)

- Effective April 9, 2015
  - Application of Bioengineered Skin Substitutes to Lower Extremity Chronic Non-Healing Wounds (L27549) (formerly titled Human Skin Equivalents (HSE - Use in the Treatment of Chronic Cutaneous Ulcer Wounds)
  - Blood Glucose Monitoring in a Skilled Nursing Facility (SNF) (L27475)
  - Co-Management of Surgical Procedures (L27481)
  - Coverage of Services and Procedures in Nursing Facilities (L27485)
  - Diagnostic Abdominal Aortography and Renal Angiography (L32709)
  - Evaluation and Management Services Provided in a Nursing Facility (L27496)
  - Hemophilia Factor Products (L33658)
  - Hydration Therapy (L32738)
  - Lower Extremity Major Joint Replacement (Hip and Knee) (L35594)
  - Non-Coronary Vascular Stents (L32641)
  - Speech-Language Pathology (SLP) Services: Communication Disorders (L27531)
  - Speech-Language Pathology (SLP) Services: Dysphagia; Includes VitalStim® Therapy (L27537)
  - Thoracic Aortography and Carotid, Vertebral, and Subclavian Angiography (L32673)
  - Monitored Anesthesia Care (L32628)
JL LCD and Article Revisions

• Revised February 12, 2015
  
  o LCDs
    ▪ Services That Are Not Reasonable and Necessary L31686
    ▪ Upper Gastrointestinal Endoscopy (Diagnostic and Therapeutic) L34745
  
  o Article
    ▪ NCD Coding Article for Positron Emission Tomography (PET) Scans Used for Oncologic Conditions A49325
Novitas is now accepting Part A Appeal Request forms by Fax

• Here are some important reminders for providers when faxing Part A Redeterminations/Clerical Reopening requests to Novitas
  o Fax is available 24 hours, 7 days a week: 1-888-541-3829
  o Complete our on-line form, Part A Redetermination and Clerical Error Reopening (Form 1000)
    ▪ Fill in ALL required fields
  o Submit one form for each claim in question
  o Do not copy the form
  o Complete form on website, print and sign
  o Do not submit more than 1,500 pages per fax
• For complete instructions, please reference the online tutorial, completing the Part A Redetermination/Clerical Error Request form
New Fiscal Intermediary Standard System Training Manual (FISS)

- The New FISS Training Manual replaces the FISS User Guide
- Everything you need to navigate within FISS is now organized in a more user-friendly format with Chapters and Sections
- No more scrolling through a large document to find what you need
- JL
Novitas Educational Tips and Tools (NETTs)

• NETTs are documents created to “catch” important Medicare information, claims processing points, and provide details in a manner that is easy to understand and easy to follow

• These documents will explain the issue; give you a resolution along with tips, background and links to reference information thus providing you, our customer, the necessary tools and access to information with just the click of a mouse

• JL
Forms Decision Tree

• Having trouble choosing the correct form?
• The Forms Decision Tree can help guide you in making the right choice
• Link to the decision tree
  o JL
Stay Up-to-Date

• Electronic Mailing List
  o Daily E-mail of the latest Medicare Updates
  o Subscribe JL

• Podcast
  o Weekly podcast of the latest Medicare Updates and other informative topics
  o Subscribe JL

• Educational Videos and Tutorials
  o JL
Novitas Medicare Learning Center

• Features
  o Create an individualized education account
  o Register for webinars, teleconferences, and workshops
  o Download your Continuing Education Unit (CEU) Certificates
  o Be placed on a waitlist if the educational event you register for is closed

• Benefits
  o Centralized location for all educational materials
  o Track all of the educational events you’ve attended
  o Access Medicare education 24 hours a day, 7 days a week with web-based training modules

• JL
Calendar of Events

• Our Education and Training Center offers a wide variety of education

• Join us for Workshops, Teleconferences, and Webinars

• The most current calendar of events
  o JL Part A
  o JL Part B
IACS System Access

Changes to EIDM

• The CMS IACS system will be changing to a new platform called Enterprise Identity Management (EIDM)

• CMS has established the EIDM website to provide our Business Partners with a means to apply for, obtain approval, and receive a single User ID they can use to access one or more CMS applications

• All applications formally supported by IACS will be supported by EIDM

• The transition from IACS to EIDM began Saturday, February 07, 2015

• February 4, 2015 EDI Bulletin Overview of IACS to EIDM System Changes for Part B Novitasphere Portal Users
  
Novitasphere Part B

• What Can You Do With Novitasphere?

• Novitasphere is our free Part B Provider Portal which allows providers, including those providers that use a billing services or clearinghouses, to connect via the internet directly to Novitas Solutions to
  o Obtain beneficiary eligibility status
  o Check claim status
  o Submit claims
  o Retrieve and print remittance advices
  o Perform Claim Corrections/Reopenings

• Additional information including how to enroll can be found under the Novitasphere-Portal link on the left side bar of the Novitas Solutions website
  o JL
Novitasphere Registration

- Step 1: Determine who the Security Official, or primary person from your office responsible for accessing the application, will be.

- Step 2: Complete the Electronic Data Interchange (EDI) Portal Enrollment form (8292P/8292PJH) found in the Enrollment section of the Novitasphere Center of our website

- Fax the completed form to 1-877-439-5479

- Step 3: Once the EDI enrollment form is approved, you will receive instructions to apply for a User ID for the Security Official, and the required next steps to set up access for your organization and End Users
Termination of the Common Working File - Delayed

- The HIPAA (Health Insurance Portability and Accountability Act) Eligibility Transaction System (HETS) will replace Common Working File (CWF) eligibility inquiries
  - Access to Health Insurance Query Access (HIQA) and CWF inquiry menu option 10 will be terminated
- For more information
  - MLN Matters Article MM8248
  - Special Edition Article SE1249
Provider Enrollment

• Advantages of Internet- Bases Provider Enrollment Chain and Ownership System (PECOS)
  o Processed Faster
  o It’s easy
  o Submissions are more Accurate and Complete
    ▪ Less development
    ▪ Quicker turn around time
  o Electronically signed
  o Status is readily available
  o Enrollment record can be reviewed and updated online
• Provider Enrollment Status Inquiry Tool
  o JL
• Upcoming Revalidation Mailings
  o http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Revalidations.html
Comprehensive Error Rate Testing (CERT)
Comprehensive Error Rate Testing (CERT)

• What is it? A program developed by Centers for Medicare & Medicaid Services (CMS) to randomly audit claims monthly to determine if they processed correctly.
• Why does it matter? To protect the Medicare trust fund and determine error rates nationally and regionally.
• Who is involved? You. A request for medical records from AdvanceMed alerts you that one of your claims has been selected as part of the monthly random sample.
• How does it work? A letter will be sent to your office requesting the medical documentation. You need to comply in a timely manner with the request.
• JL
JL Part A Common Errors

• Insufficient documentation
  o No valid physician’s order
  o Inpatient stay
  o Missing or illegible documentation and/or physician signature
  o Procedure/service performed
  o No valid certification for therapy services
  o Skilled Nursing Facility (SNF) 3 day qualifying stay

• Medical necessity errors
  o Need for an inpatient stay
  o Related services

• Other errors
  o Diagnosis Related Group (DRG)
  o Discharge disposition code
  o Resource Utilization Group (RUG)
  o Laboratory services and
  o Debridement code
CERT Appeals vs. Claim Adjustments

• We are instructing providers to cease the practice of cancelling and adjusting claims that are selected in the CERT review process
  ○ Notify CERT if an error has been made on the claim DO NOT cancel or adjust claims
• When the CERT adjustment has been made in the FISS system, it will appear as an XXH Bill Type
  ○ Once finalized, proper appeals process should be followed to appeal CERT related claims
• Article
  ○ JL
JL Part B Common Errors

- Insufficient documentation
  - Procedure/service billed
  - Missing or illegible documentation and/or physician signature
  - No valid physician’s order
  - No physical therapy certified plan of care/treatment plan

- Incorrect coding errors
  - Evaluation and Management (E/M) codes
  - Critical care, discharge day management, physical therapy
  - Units of medication/infusion services
  - Laboratory services
Medicare Signature Requirements - Educational Resources for Health Care Professionals

• Special Edition SE1419
• Key Points
  o Medicare services provided/ordered must be authenticated by the author using an acceptable signature
  o Links to a variety of educational products to help you understand signature requirements for Medicare-covered services

• Reference
Comprehensive Error Rate Testing (CERT): Skilled Nursing Facility (SNF) Certifications and Recertifications

- Special Edition SE1428
- Key Points
  - Certification must contain the following information
    - Need for skilled nursing care or other skilled rehabilitation services
    - Is required on a daily basis
    - Can only be provided in a Skilled Nursing Facility (SNF) or swing-bed hospital on an inpatient basis
    - For ongoing condition for which the individual received inpatient care in a hospital
    - Dated signature of the certifying physician or non-physician practitioner (NPP)
    - Ensure the above is documented in the resident’s medical record
Acceptable Recertification Statement

• Recertification must contain the following information
  o Reasons for continued need for post hospital Skilled Nursing Facility (SNF) care
  o Estimated time needed to remain in the SNF
  o Plans for home care, if any
  o Reason for continued need for services must be indicated. (If condition arose after admission to the SNF and while being treated for an ongoing condition for which the individual received inpatient care in a hospital)
  o Dated signature of the recertifying physician or non-physician practitioners (NPP)
  o Ensure the above is documented in the resident’s medical record

• Reference
Self-Service Options
Jurisdiction L Customer Contact Information

**Provider**
- 1-877-235-8073
- Hours of Operation, Eastern Time (ET)
  - Monday - Friday: 8:00 am – 4:00 pm ET

**Interactive Voice Response (IVR)**
- Hours of Operation
  - Eligibility and General Information
    - 24 Hours a day 7 Days a week
  - Full IVR Options
    - Mon- Fri 6:00am – 9:00pm ET
    - Saturday 6:00am - 4:00pm ET

- Step-by-Step Guide
  - JL Part A
  - JL Part B
Beneficiary Contact Information

• Patient / Medicare Beneficiary
  ○ 1-800-MEDICARE (1-800-633-4227)
    ▪ http://www.medicare.gov/index.html
Fiscal Intermediary Standard System (FISS) Hours

• District of Columbia (DC), Maryland (MD), New Jersey (NJ), Pennsylvania (PA)
  o Monday – Friday
    ▪ 6 am – 9 pm, Eastern Time (ET)
  o Saturdays
    ▪ 6 am – 4 pm ET

• Delaware (DE)
  o Monday – Friday
    ▪ 6 am – 6 pm ET
  o Saturdays
    ▪ 6 am – 4 pm ET

• Colorado (CO), New Mexico (NM), Oklahoma (OK), Texas (TX)
  o Monday – Friday
    ▪ 6 am – 8 pm, Central Time (CT)
  o Saturdays
    ▪ 6 am – 3 pm CT

• Arkansas (AR), Louisiana (LA), Mississippi (MS)
  o Monday – Friday
    ▪ 6 am – 7 pm CT
  o Saturdays
    ▪ 6 am – 3 pm CT
Centers for Medicare & Medicaid Services (CMS)

- The CMS website offers valuable resources such as
  - CMS Internet Only Manuals (IOMs)
  - Medicare Learning Network (MLN) Matters Articles
  - Open Door Forum
Summary

- Discussed the current change requests, giving key points and links

- Reviewed the Novitas tools that are needed to keep providers updated

- Gave valuable resources from the Centers for Medicare & Medicaid Services (CMS) and Novitas websites
Thank You For Attending

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