Medicare Part A Presents: Medicare Updates

NJ AAHAM
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<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
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<tbody>
<tr>
<td>CERT</td>
<td>Comprehensive Error Rate Testing</td>
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<tr>
<td>CMS</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
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<tr>
<td>CR</td>
<td>Change Request</td>
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<tr>
<td>EDI</td>
<td>Electronic Data Interchange</td>
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<td>ESRD</td>
<td>End Stage Renal Disease</td>
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<td>FY</td>
<td>Fiscal Year</td>
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<tr>
<td>HCPCS</td>
<td>Healthcare Common Procedure Coding System</td>
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<td>ICD</td>
<td>International Statistical Classification of Diseases</td>
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<td>LCD</td>
<td>Local Coverage Determination</td>
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<td>LTCH</td>
<td>Long-Term Care Hospital</td>
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<td>MAC</td>
<td>Medicare Administrative Contractor</td>
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<td>MLN</td>
<td>Medicare Learning Network</td>
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# Acronym List 2

<table>
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<tr>
<th>Acronym</th>
<th>Definition</th>
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<tbody>
<tr>
<td>NCD</td>
<td>National Coverage Determination</td>
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<tr>
<td>NPI</td>
<td>National Provider Identifier</td>
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<tr>
<td>OMB</td>
<td>Office of Management and Budget</td>
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<td>OPPS</td>
<td>Outpatient Prospective Payment System</td>
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<tr>
<td>PTAN</td>
<td>Provider Transaction Access Number</td>
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<tr>
<td>PHI</td>
<td>Personal Health Information</td>
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<tr>
<td>QMB</td>
<td>Qualified Medicare Beneficiary</td>
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<tr>
<td>TBD</td>
<td>To Be Determined</td>
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Today’s Presentation

- **Agenda:**
  - Quarterly Updates
  - Credit Balance Reporting Errors
  - Novitas Initiatives
  - Website Features
  - Preventive Services
  - Important Reminders
  - Comprehensive Error Rate Testing (CERT) Program
  - Self-Service Options

- **Objectives:**
  - Identify and understand the current Medicare changes
  - Learn how to apply the new guidelines
  - Identify and utilize the educational resources and information
Quarterly Updates
October 2016 Update of the Hospital Outpatient Prospective Payment System (OPPS)

- **Change Request # 9768:**
  - Effective: October 1, 2016
  - Implementation: October 3, 2016

- **Key Points:**
  - New Separately Payable Procedure Code
  - Smoking Cessation Codes
  - Reporting for Certain Outpatient Department Service (That Are Similar to Therapy Services) (Non-Therapy Outpatient Department Services) That Are Adjunctive to Comprehensive APC Procedures
  - Advanced Care Planning (ACP)
  - Drugs, Biologicals, and Radiopharmaceuticals:
    - Drugs and Biologicals with Payments Based on Average Sales Price (ASP)
    - Drugs and Biologicals Based on ASP Methodology with Restated Payment Rates
    - Drugs and Biologicals with OPPS Pass-Through Status
    - Revised Status Indicator for Biosimilar Biological Product
  - Changes to OPPS Pricer Logic
  - Outpatient Coinsurance Cap Logic as ASP Payment for Drugs
  - Pass-through Drug Offset Moves
  - Coverage Determinations

- **Reference:**
2017 Annual Update of HCPCS for SNF Consolidated Billing

- Change Request # 9735:
  - Effective: January 1, 2017
  - Implementation: January 3, 2017

- Key Points:
  - Annual updates of HCPCS Codes for SNF Consolidated Billing available the first week in December 2016:
    - ✓ New code files for Part B processing
    - ✓ New excel and PDF files for Part A processing

- Reference:
2016-2017 Influenza (Flu) Resources for Health Care Professionals

- Special Edition Article SE1622
- Key Points:
  - Annual Part B deductible and coinsurance amounts do not apply
  - All physicians, non-physician practitioners, and suppliers who administer the influenza virus vaccination and the pneumococcal vaccination must take assignment on the claim for the vaccine
  - Fee schedule:
- Reference:
Billing for Influenza: New CPT Code 90674

- New CPT code 90674 for influenza vaccine Flucelvax:
  - Effective August 1, 2016
  - Medicare claims processing systems will not be able to accept the new code until January 1, 2017
  - Institutional claims will be implemented on February 20, 2017
  - Providers should hold their claims until this time

- For more information:
Medicare Coverage of Diagnostic Testing for Zika Virus

- Special Edition Article SE1615:
- Key Points:
  - Medicare Part B pays for clinical diagnostic laboratory tests for diagnosis and treatment of a person’s illness or injury
  - No specific HCPCS code for testing Zika virus
  - Provide resources and cost information as requested by MAC to establish appropriate payment amounts for the tests
- Reference:
JW Modifier: Drug Amount Discarded/Not Administered to Any Patient

- Change Request # 9603:
  - Effective: January 1, 2017
  - Implementation: January 3, 2017

- Key Points:
  - Use of the JW modifier is required to identify unused drugs or biologicals that are appropriately discarded
  - Providers are required to document the discarded drug or biological in the patient's medical record

- Reference:
Coding Revisions to National Coverage Determinations (NCDs)

- Change Request # 9631:
  - Effective: October 1, 2016
  - Implementation: October 3, 2016

- Key Points:
  - Many NCDs will be updated with revisions to ICD-10 coding:
    - 20.4 – Implantable Automatic Defibrillators
    - 20.7 – Percutaneous Transluminal Angioplasty (PTA)
    - 20.9 – Artificial Hearts
    - 20.29 – Hyperbaric Oxygen Therapy

- Reference:
Ninth Maintenance Update to NCD ICD-10 Conversions

- Change Request # 9751:
  - Effective: January 1, 2017
  - Implementation: January 3, 2017

- Key Points:
  - Edits to ICD-10 and other coding updates specific to NCD’s will be included in subsequent quarterly releases
  - Policy related changes to NCD’s continue to be implemented via the current long standing NCD process

- Reference:
National Site Visit Verification Initiative

- Special Edition Article SE1520
- Key Points:
  - National Site Visit Contractor (NSVC) will conduct unannounced site visits:
    - Observational site visit or
    - Detailed review
  - Verify site visit through Novitas Enrollment
  - Verify inspector through NSVC:
    - 1-855-220-1071
- Reference:
Protecting Patient Personal Health Information

- Special Edition Article SE1616
- Key Points:
  - Reminds physicians of the HIPAA requirement to protect the confidentiality of the PHI of their patients
  - Remember that a covered entity must notify the Secretary of Health and Human Services if it discovers a breach of unsecured protected health information
  - Keep abreast of any issues that your business associates, especially those entities that provide you with hardware and/or software support for your patient electronic health records
  - Report any actual or potential security breaches to you, especially threats that compromise patient PHI
  - CMS is providing this information in response to a recent report from the Cyber Health Working Group

- Reference:
Social Security Number Removal Initiative

- The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS to remove Social Security Numbers (SSNs) from all Medicare cards by April 2019.

- Medicare Beneficiary Identifier (MBI) will replace the SSN-based Health Insurance Claim Number (HICN) on the new Medicare cards:
  - 11-characters in length
  - Made up only of numbers and uppercase letters (no special characters)

- Transition period:
  - Will begin no earlier than April 1, 2018 and run through December 31, 2019:
    - Either the HICN or the MBI can be used
    - Use the MBI or the HICN to check Medicare eligibility, after transition period ends use only the MBI
    - Use the beneficiary identifier (MBI or HICN) you used to submit the claim that’s under appeal, even after the transition period
What Providers Need to Know on The Social Security Number Removal Initiative

- **How will providers get MBIs?:**
  - During the transition period, the MBI will be on the remittance advice when you submit a claim using your patient’s HICN
  - In the message field on the eligibility transaction responses it will let you know when a new Medicare card has been mailed to each person with Medicare
  - Your systems must be ready to accept the MBI by April 2018:
    - No earlier than April 2018 Medicare cards will be sent, people new to Medicare will only be assigned an MBI

- **Claim forms:**
  - Not changing:
    - During the transition period, you can use either the HICN or the MBI
    - Once the transition period ends, you must use the MBI

- Get more information about the SSNRI:
  - [https://www.cms.gov/Medicare/SSNRI/Index.html](https://www.cms.gov/Medicare/SSNRI/Index.html)
Interest Rate for Overpayments and Underpayments- 4th Qtr. FY 2016

- Change Request # 9750:
  - Effective: July 18, 2016
  - Implementation: July 18, 2016

- Key Point:
  - Implement interest rate of 9.625% for Medicare overpayments and underpayments

- Reference:
Enforcement of the PHP 20 Hours per Week Billing Requirement

- Special Edition Article SE1607 – Revised 7/7/16
- Key Points:
  - CMS suspended the July 2016 edits, which included enforcing weekly billing requirements for PHPs
  - As a reminder, PHP service requirement for a minimum of 20 hours per week remains in effect
- Reference:
Medicare Coverage of Substance Abuse Services

- Special Edition Article SE1604
- Key Points:
  - Services for substance abuse disorders that are covered by Medicare includes:
    - Inpatient treatment
    - Outpatient treatment
    - Partial Hospitalization Program (PHP)
    - Substance abuse treatment by supplier of services
    - Screening, Brief Intervention, and Referral to Treatment (SBIRT) Services:
    - Drugs used to treat opioid dependence
- Reference:
Sequestration Update

- Mandatory Payment Reduction of 2% continues until further notice for the Medicare Fee For Service Program
- For more information:
  - https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2016-03-03-Enews.html
- Frequently Asked Questions:
Part A Quarterly/Annual Updates

- Update-Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Fiscal Year (FY) 2017:

- October 2016 Integrated Outpatient Code Editor (I/OCE) Specifications Version 17.3:

- 2017 Annual Update of Healthcare Common Procedure Coding System (HCPCS) Codes for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Update:

- October Quarterly Update to 2016 Annual Update of HCPCS Codes Used for Skilled Nursing Facility Consolidated Billing Enforcement:
More Part A Quarterly/Annual Updates

- Quarterly Update to the Correct Coding Initiative (CCI) Edits, Version 22.3, Effective October 1, 2016:

- Changes to the Laboratory National Coverage Determination (NCD) Edit Software for July 2016:

- Claim Status Category and Claim Status Codes Update:

- October 2016- Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files:

- Influenza Vaccine Payment Allowances - Annual Update for 2015-2016 Season:
Additional Part A Quarterly/Annual Updates

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

- Interest Rate for Overpayments and Underpayments- 4th Qtr. FY 2016:
Credit Balance Reporting Errors
Certification Page Errors

- Invalid PTANs:
  - Using NPI
  - Using PTAN from another MAC
  - Enter only 4 – 5 digits

- Blocks at the bottom of the Certification Page not checked:
  - Largest error on the Certification Page for the quarter
Detail Page Errors

- Column 11 – Method of payment:
  - Providers are indicating method of payment as check (Option C) and are not sending the check and Credit Balance Report together
  - One check per Credit Balance Report
  - Providers are submitting multiple checks for one PTAN
  - Providers are submitting one check for multiple PTANs
  - Include PTAN on check

- Column 13 – Reason for credit balance:
  - Providers are selecting the wrong option
  - Providers are selecting option 3 (Other) and entering a value code in column 14

- Column 14 – Value Code:
  - Value codes are missing or incorrect

- Column 15 – Billing name and address:
  - Full name and address of the primary payer are not being reported when a value code is identified in column 14
Fax Errors

- Multiple facilities on one fax:
  - One facility one fax

- Faxing separate Part A and Part B of a credit balances with separate Certification Page:
  - Providers are also not separating Part A from Part B of A

- Faxing Credit Balance Reports when paying by check:
  - When paying by check the Credit Balance Report must be mailed

- Providers are faxing and mailing Credit Balance Report:
  - Fax or mail not both
Helpful Hints

- 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
- Please do not use staples
- No need to mail hard copy once a certification has been faxed
- JL Providers:
Preventive Services
Medicare Learning Network (MLN) Products for Preventive Services

- Help Keep Your Medicare Patients Healthy In 2016!

- 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)
  - Lung Cancer
- Cardiovascular Disease Screening
- Depression Screening in Adults
- Diabetes Screening
- Diabetes Self-Management Training
- Glaucoma Screening
- Hepatitis C
- 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
Editing Update for Screening for Sexually Transmitted Infections

- Change Request # 9719:
  - Effective: October 1, 2016
  - Implementation: January 3, 2017

- Key Points:
  - 072X type of bill (TOB) claims containing Healthcare Common Procedure Coding System (HCPCS) codes for Sexually Transmitted Infections (STIs) and diagnosis code V74.5 or 73.89, are incorrectly being denied in full
  - Editing should have been written as line level denial rather than claim level denial
  - Revising diagnosis code requirements for STI’s

- Reference:
Screening for the Human Immunodeficiency Virus (HIV) Infection

- **Change Request # 9403:**
  - Effective: April 13, 2015
  - Implementation: January 3, 2017

- **Key Points:**
  - CMS has determined that screening of HIV infection is reasonable and necessary for:
    - Individuals between the ages of 15-65 years
    - Individuals entitled to benefits under Part A or enrolled in Part B
  - Must meet coverage criteria listed in NCD manual
  - HCPCS code:
    - G0475 – HIV antigen/antibody, combination assay, screening

- **Reference:**
Screening for Cervical Cancer With Human Papillomavirus (HPV) Testing

- **Change Request # 9434:**
  - Effective: July 9, 2015
  - Implementation: January 3, 2017

- **Key Points:**
  - For individuals entitled to benefits under Medicare Part A and Medicare Part B
  - Adding HPV testing under specified conditions:
    - Reasonable and necessary for the prevention or early detection of cervical cancer
    - Testing allowed once every five years as an additional preventive service
    - Applies to beneficiaries aged 30 to 65 years in conjunction with the Pap smear test

- **Reference:**
Updated Diagnosis Code List for Colorectal Cancer Screening

- CMS is adding 44 ICD-10 diagnosis codes to NCD 210.3, Colorectal Cancer Screening that were originally in CR 8691 and inadvertently omitted in CR 9252 Coding Revision to NCD:
  - All of these CRs are ICD-10 coding and other changes contained in NCDs
- Colorectal Cancer Screenings performed for any of the additional codes effective for claims with dates of services on and after October 1, 2015 are payable under NCD 210.3 and other policy guidelines
- Reference:
Preventive Services Resources

- Quick Reference Chart for Medicare Preventive Services:

- Improve Your Patients’ Health with the Initial Preventive Physical Examination (IPPE) and Annual Wellness Visit (AWV):
Important Updates and Reminders
Centers for Medicare & Medicaid Services (CMS)

- CMS Internet Only Manuals (IOMs):
  - Offers day-to-day operating instructions, policies, and procedures based on statutes and regulations, guidelines, models, and directives

- Medicare Learning Network (MLN) Matters Articles:
  - Your destination for health care professional education products

- Open Door Forums:
  - Provides an opportunity for live dialogue between CMS and the stakeholder community at large

- Quarterly Provider Updates:
  - Published quarterly for providers, suppliers, and the general public

- http://www.cms.gov/
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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
- JL CERT page:
Trending Errors- Part A

- Insufficient documentation:
  - Missing valid physician’s order
  - Missing documentation to support minimum 15 hours per week of combined therapy
  - Diagnosis insufficient to support procedure or service billed
  - Missing Skilled Nursing Facility (SNF) 3 day qualifying stay
  - Missing or illegible documentation and/or physician signature
  - No valid certification for therapy services

- Medical necessity errors:
  - Documentation did not support inpatient stay

- Other errors:
  - Incorrect Diagnosis Related Group (DRG) billed
  - Discharge disposition code
  - Resource Utilization Group (RUG)
  - Laboratory services billed incorrectly
  - Debridement codes
CERT Appeals vs. Claim Adjustments (Part A)

- Part A providers may not cancel or adjust claims selected in the CERT review process
- Notify CERT if an error has been made on a claim, do not cancel or adjust claims
- Novitas initiate adjustments for necessary denials
- CERT adjustments in FISS appear as XXH bill type
- Appeal denials on XXH bill type as a means of submitting corrections to claims using the Medicare Part A Redetermination Request form
- JL Article:
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:
CERT Identification Online Tool

- Provides status information for sampled claims using the Claim Identification Number (CID) where a decision has been made by the CERT contractor:
  - Claim in Error - CERT error was assessed or not
  - Status Date - last date that CERT updated/reviewed the case
  - Status Decision - where the claim is with the CERT Review Contractor
  - Appealed - if an appeal was initiated and the appeal status
  - Error Code - errors assessed

CERT CID Tool

CID Number: [Search CID]

CERT Identification Results
No data to display.

Please Note: The CERT CID is always a 7 digit number.
Self-Service Options
Novitasphere

- Free Web-based portal
- Part A – Access to Eligibility, Medical Review Record Submission, and Audit and Reimbursement Cost Reports Submission
- Part B - Access to Eligibility, Claim Information and Remittance Advice, Claim Submission with File Status, Electronic Remittance Advice (ERA), Claim Correction, Secure Messaging and a MailBox
- Live Chat feature
- Dedicated Help Desk- 1-855-880-8424
- For demonstrations and more information:
Providers are required to use the IVR unit to obtain:

- Claim Status
- Patient Eligibility
- Check/Earnings
- Remittance inquiries

Customer Contact Center- 1-877-235-8073
Provider Teletypewriter- 1-877-235-8051

JL Self-Service Tools:


Patient / Medicare Beneficiary:

- 1-800-MEDICARE (1-800-633-4227)
Provider Outreach and Education Contact Information

- Denise Church
  - Provider Outreach and Education Manager
  - 412-802-1739
  - Denise.Church@novitas-solutions.com

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Thank You for Your Participation