



Novitas Solutions Presents: Medicare Updates and What's Trending for 2018

Annual Critical Access Hospital
Conference
Little Rock, AR
August 9, 2018



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


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Today's Presentation



- Agenda
 - Medicare Updates and Reminders
 - New Medicare Card
 - Targeted Probe and Educate (TPE)
 - Credit Balance
 - Outpatient Services Provided to Inpatients of Other Facilities
- Objectives
 - Identify and understand the current Medicare changes
 - Identify and utilize the educational resources and information
 - Review important Medicare updates and reminders

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

Acronym List



Acronym	Definition
ACH	Acute Care Hospital
ADR	Additional Documentation Request
CMS	Centers for Medicare & Medicaid Services
CAH	Critical Access Hospital
CPT	Current Procedural Terminology
DME	Durable Medical Equipment
FISS	Fiscal Intermediary Standard System
HCPCS	Healthcare Common Procedure Coding System
ICD	International Statistical Classification of Diseases
IPF	Inpatient Psychiatric Facility
IPPS	Inpatient Prospective Payment System

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Acronym List 2



Acronym	Definition
IRF	Inpatient Rehab Facility
LTCH	Long Term Care Hospital
MAC	Medicare Administrative Contractor
MBI	Medicare Beneficiary Identifier
NCD	National Coverage Determination
OPPS	Outpatient Prospective Payment System
QMB	Qualified Medicare Beneficiary
TPE	Targeted Probe and Educate

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



Medicare Updates and Reminders

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

Institutional Billing for No Cost Items



- [MM10521](#):
 - Effective Date: January 1, 2009
 - Implementation Date: June 29, 2018
- Key Points:
 - Billing instruction clarification specific to drugs provided at no cost when claims processing edits prevent drug administration charges from being billed when the claim does not contain a covered/billable drug charge:
 - ✓ Drugs provided at no cost in the hospital outpatient department (OPPS claims):
 - Report the applicable drug HCPCS code and appropriate units with a token charge of less than \$1.01 for the item in the covered charge field and mirror this less than \$1.01 amount reported in the non-covered charge field
 - Bill the corresponding drug administration charge with the appropriate drug administration CPT or HCPCS code

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

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



- [MM10295](#):
 - Effective Date: May 25, 2017
 - Implementation Date: July 2, 2018
- Key Points:
 - CMS issued the NCD to cover SET for beneficiaries with Intermittent Claudication (IC) for the treatment of symptomatic PAD
 - Up to 36 sessions over a 12-week period are covered if all of the components of a SET program are met:
 - Beneficiaries must have a face-to-face visit with the physician responsible for PAD treatment to obtain the referral for SET
 - At this visit, the beneficiary must receive information regarding cardiovascular disease and PAD risk factor reduction, which could include:
 - Education,
 - Counseling
 - Behavioral interventions
 - Outcome assessments
 - SET program must be provided in:
 - Physician's office (place of service 11) for Part B claims
 - Type of Bills (TOB) 13X or 85X for Part A institutional claims

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Prohibition Billing Dually Eligible Individuals Enrolled in the QMB Program Continued



- Important reminders concerning QMB Billing requirements:
 - Original Medicare and MA providers must not charge individuals enrolled in the QMB program for Medicare cost sharing;
 - ✓ May bill State Medicaid programs for these costs, but States can limit Medicare cost-sharing payments under certain circumstances
 - Providers cannot charge individuals enrolled in QMB even if their QMB benefit is from a different State than the State where they get care
 - Individuals enrolled in QMB cannot elect to pay Medicare deductibles, coinsurance, and copays, however, a QMB who also receives full Medicaid may have a small Medicaid copay

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

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

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

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.

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

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



- [MM10494](#):
 - Effective Date: September 20, 2018, for Part A and DME MAC claims; December 20, 2018, for Part B MAC claims
 - Implementation Date: September 20, 2018, for Part A and DME MAC claims; December 20, 2018, for Part B MAC claims
- 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:
 - ✓ 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

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

Global Surgical Days for Critical Access Hospital (CAH) Method II



- [MM10425](#)
 - Effective Date: July 1, 2018
 - Implementation Date: July 2, 2018
- Key Points:
 - CAH Method II providers should follow the same guidelines as per Part B physician services that are available in the [Medicare Claims Processing Manual, Pub. 100-04, Chapter 12 -Physicians/Nonphysician Practitioners, Section 40 "Surgeons and Global Surgery"](#)
 - Applies when physicians and non-physician practitioners bill:
 - ✓ TOB 85X
 - ✓ Report Revenue codes 96x, 97x and/or 98x is reported
 - Medicare will reject line items that contain an E&M CPT code that is covered by the global period using the following remittance codes:
 - ✓ Group code of CO - Contractual Obligation
 - ✓ CARC 97 – Payment is included in the allowance for another service/procedure
 - ✓ RARC M144 – Pre-/post-operative care payment is included in the allowance for the surgery/procedure
 - ✓ Reason Code c7714
 - Medicare will allow E&M services rendered during the global period when submitted with modifier 24 or 25, as appropriate

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Physician's Fee Schedule Look-Up



- [Physician's Fee Schedule Look-Up](#) will indicate if the code is subject to the global surgery policy:
 - Global surgery values:
 - ✓ 000 = same day as surgery
 - ✓ 010 = same day as surgery plus 10 days after the surgery
 - ✓ 090 = same day as the surgery plus 90 days after the surgery AND 1 day prior to the surgery
 - ✓ XXX = Global concept does not apply.
 - ✓ YYY = A/B MAC (Part A) determines whether global concept applies and establishes postoperative period, if appropriate, at time of pricing.

Status Indicators	
Surgery & Procedures	
Professional/Technical Component	0.00
Global Days	090
Pre-Operative %	0.11
Intra-Operative %	0.76
Post-Operative %	0.13
Multiple Procedures	2
Bilateral Surgery	0
Assistant at Surgery	7

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

ICD-10 and Other Coding Revisions to NCDs



- [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 Immunoabsorption (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)

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

Proper Billing for Intensity-Modulated Radiation Therapy (IMRT) Planning Services



- Definition:
 - IMRT is a procedure that uses advanced computer programs to plan and deliver radiation to treat difficult to reach tumors
- Purpose:
 - IMRT is provided in two treatment phases:
 - ✓ Planning phase - a multistep process in which imaging, calculations, and simulations are performed to develop an IMRT treatment plan
 - ✓ Delivery phase- radiation is delivered to a beneficiary's treatment site (example, a tumor) at the various levels prescribed in the IMRT treatment plan
- Billing and payment:
 - Payment for services identified with Current Procedural Terminology (CPT) codes 77014, 77280-77295, 77305-77321, 77331, 77336, and 77370 are included in the bundled payment when they are performed as part of developing an IMRT plan reported with CPT code 77301:
 - ✓ These codes should not be billed in addition to CPT code 77301
- For more information:
 - [Proper Billing for Intensity-Modulated Radiation Therapy \(IMRT\) Planning Services](#)

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Medicare Cost Report e-Filing (MCR eF) - CMS New Cost Reporting Portal



- Effective July 2, 2018, you must use MCR eF if you choose electronic submission of your cost report
- CMS goals:
 - Standardize, automate, and streamline the Medicare Cost Report processes related to provider submission and MAC receipt, acceptance, and subsequent handling
 - Increase CMS access to data
- System Login:
 - <https://mcref.cms.gov>
- References:
 - [CMS Announcement New Option for Submission of Cost Reports](#)
 - [Medicare Cost Report e-Filing system \(MCR eF\) Presentation](#)
 - [Medicare Cost Report e-Filing \(MCR eF\) System Video](#)

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

Novitas Solutions Annual Recertification of Part A FISS Users



- CMS requires annual recertification of every user who has access to FISS
- In the beginning of July, Novitas began mailing letters to providers with active access:
 - Mailed in staggered time periods due to volume
- Authorized or delegated official on file must recertify each of the individual user's within 30 days of the date of the letter
- For more information:
 - [Novitas Solutions Annual Recertification of Part A FISS Users](#)

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

Part A Novitasphere



- [Novitasphere](#) is a FREE, secure internet portal for the provider community to use to easily connect directly to Novitas Solutions to:
 - Obtain beneficiary eligibility
 - Utilize Medicare Beneficiary Identifier (MBI) lookup tool
 - Submit medical review records
 - Submit your electronic claim files
 - Retrieve electronic claim reports
 - Submit redetermination requests
 - View redetermination notices
 - Obtain ADR status
 - Retrieve ADR letters
 - Determine medical review claim status
 - File immediate recoupments
 - View overpayment letters
 - Submit CMS-838 credit balance reports
- [Novitasphere User Guides and Instructions](#)
- Live Chat feature
- Dedicated Help Desk: 1-855-880-8424

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

Open Claim Issues for Medicare Part A



- [Open Claim Issues for Medicare Part A](#)

Open Claim Issues for Medicare Part A						
Date Reported	Provider Type Impacted	Workload Impacted	Reason Code	Description/Claim Coding Impact	Proposed Resolution / Fix / Action Required	Status
7/24/18	Critical Access Hospitals (CAH)	Outpatient Type of Bill (TOB) 85x	W7020, W7040, W7106, W7107	CAH outpatient claims are incorrectly processing with Integrated Outpatient Code Editor (IOCE) reason codes W7020, W7040, W7106, W7107 or W7108.	A correction has been developed and is tentatively scheduled for October 1, 2018. Until then, a workaround is being implemented to allow the claims to be processed. Claims with lines that have been rejected in error can be adjusted by the provider.	Open
7/24/18	All	All	3715X	A large volume of claims have suspended to status location SMOVFX with reason code 3715X.	This issue has been reported to the Fiscal Intermediary Shared System (FIS) and they are currently researching. This is only impacting claims that were in process during the first week of July. This is not an ongoing issue. We are not able to process these claims at this time and no provider action is needed.	Open
7/19/18	All	All	U5800 and U6906	A high volume of claims have suspended to status location SMOUPS with reason code U5800 or SMOUPS with reason code U6906.	This issue has been reported to the Fiscal Intermediary Shared System (FIS) and they are currently researching. We are actively working through the suspended claims. We will post additional information as it becomes available.	Open
7/12/18	Maryland (MD) Waiver Hospitals	Outpatient Type of Bill (TOB) 13x	W7020, W7040, 32284	MD Waiver claims received on and after July 1, 2018, are receiving National Correct Coding Initiative (NCCI) line level reason code W7020 or W7040 incorrectly. Certain claims that are receiving line level reason code W7040, are resulting in the entire claim returning to Provider (RTF) with reason code 32284.	This issue has been reported to the Fiscal Intermediary Shared System (FIS) and they are currently researching.	Open
6/28/18	Various	Outpatient	32440	Positron Emission Tomography (PET) claims containing certain radiopharmaceutical Healthcare Common Procedure Coding System (HCPCS) codes are returning to provider (RTF) in error with dates of service on or after January 1, 2018. These HCPCS codes are: A9553, A9568, A9567, and A9568.	A correction has been developed and is tentatively scheduled to be installed on October 1, 2018, with CR10622. A workaround is in place and providers are able to resubmit or P9 claims that have incorrectly returned for reason code 32440.	Open
6/22/18	Various	Various	Various Medicare Secondary Payer (MSP) reason codes	Medicare claims related to various MSP reason codes are not able to be processed appropriately at this time.	The issue was reported to the Fiscal Intermediary Shared System (FIS) and a correction has been developed. The correction is tentatively scheduled for July 23, 2018. Claims are being held in status location S AMBEX and will be released when the correction is successfully installed. No provider action is needed. Update 7/24/18: Additional issues were discovered and claims could not be released for processing. FIS has developed a new correction that is tentatively scheduled for August 28, 2018.	Open

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



New Medicare Card

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


Important Dates For The New Medicare Card




- CMS to remove Social Security Numbers from all Medicare cards by **April 2019**
- Transition period for issuing Medicare cards will run from **April 2018 through December 31, 2019**
- **Beginning October 2018** through the end of the transition period, the remittance advice will contain both the Medicare number and the MBI
- Participate in [CMS New Medicare Card Open Door Forums](#) to learn more about the MBI transition

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New Medicare Card



- New Medicare card:
 - Health and Human Services (HHS) logo
 - Gender and signature line removed
- Railroad Retirement MBI card:
 - Railroad Retirement Board logo will be the key identifier
 - Mailing will began June 2018



MEDICARE HEALTH INSURANCE

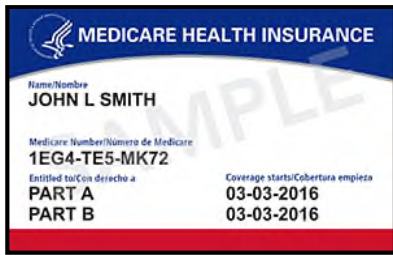
Name/Nombre
JOHN L SMITH

Medicare Number/Número de Medicare
1EG4-TE5-MK72

Entitled to/Con derecho a
HOSPITAL (PART A) Coverage starts/Cobertura empieza
03-01-2016

MEDICAL (PART B) **03-01-2016**

RAILROAD RETIREMENT BOARD



MEDICARE HEALTH INSURANCE

Name/Nombre
JOHN L SMITH


Medicare Number/Número de Medicare
1EG4-TE5-MK72

Entitled to/Con derecho a
PART A Coverage starts/Cobertura empieza
03-03-2016

PART B **03-03-2016**

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

New Medicare Card Mailing Waves



Wave	States Included	Cards Mailing
Newly Eligible People with Medicare	All – Nationwide	April 2018 - ongoing
1	Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia	Beginning May 2018 COMPLETE
2	Alaska, American Samoa, California, Guam, Hawaii, Northern Mariana Islands, Oregon	Beginning May 2018
3	Arkansas, Illinois, Indiana, Iowa, Kansas, Minnesota, Nebraska, North Dakota, Oklahoma, South Dakota, Wisconsin	Beginning 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

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

Get Ready for the New MBI



- Beneficiaries will receive their new Medicare card in the mail
 - Beneficiaries should ensure their address with SSA is correct
 - Beneficiaries should contact either:
 - ✓ Social Security:
 - 1-800-772-1213
 - www.ssa.gov/myaccount
 - ✓ Railroad Retirement Board:
 - 1-877-772-5772
- Verify your patient's address:
 - If the address you have on file is different than the address you observe in electronic eligibility transaction responses, ask your patients to contact Social Security and update their Medicare records

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

Be Prepared



- Participate in [CMS New Medicare card 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 [CMS New Medicare Card Home](#) for updated information
- MLN Fact Sheet [Transition To New Medicare Numbers And Cards](#)
- [SE18006](#) New Medicare Beneficiary Identifier (MBI) Get It, Use It
- [CMS New Medicare Card Project Frequently Asked Questions \(FAQs\)](#)

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

Novitasphere MBI Lookup



- MBI crosswalk tool in Novitasphere now available

- Eligibility
- MBI Lookup
- Claims Submission/ERA
(Opens in new tab/Opens pop-up window)
- Medical Review Claims
- Retrieve Documents
- Submit Documents
- Alerts & Updates
- My Account Profile

MBI Lookup

Thursday, June 7, 2018 11:28 AM

This tool is to be used only when a Medicare patient doesn't or can't give you his/her Medicare Beneficiary Identifier (MBI). The patient's first name, last name, date of birth, and social security number are required to get a unique match. The MBI is confidential so you'll have to protect it as Personally Identifiable Information and use it only for Medicare-related business.

Note: * indicates a required field. Dates may be entered as MM/DD/YY or MM/DD/YYYY. Forward slashes will be populated automatically.

First Name*


Suffix

Date of Birth(MM/DD/YYYY)*

Last Name*


SSN*

NPI*

I'm not a robot 

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

MBI Lookup Results



- MBI lookup results

- Eligibility
- MBI Lookup
- Claims Submission/ERA
(Opens in new tab/Opens pop-up window)
- Medical Review Claims
- Retrieve Documents
- Submit Documents
- Alerts & Updates
- My Account Profile

MBI Lookup

Thursday, April 26, 2018 9:06 AM

This tool is to be used only when a Medicare patient doesn't or can't give you his/her Medicare Beneficiary Identifier (MBI). The patient's first name, last name, date of birth, and social security number are required to get a unique match. The MBI is confidential so you'll have to protect it as Personally Identifiable Information and use it only for Medicare-related business.

Note: * indicates a required field. Dates may be entered as MM/DD/YY or MM/DD/YYYY. Forward slashes will be populated automatically.

First Name*

Suffix

Date of Birth(MM/DD/YYYY)*

Last Name*

SSN*

NPI*

INQUIRY
[MBI LOOKUP INFO]

MBI Lookup Information

Subscriber First Name	FNAME
Subscriber Last Name	LNAME
Subscriber MBI Number	MBI #

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

New Medicare Card – Remittance Notice



- Starting October 1, 2018, updates will be made to the remittance advice to include the MBI when you submit a claim with a valid and active Medicare number:
 - [Medicare Remit Easy Print \(MREP\)](#)
 - [PC Print](#)
 - Standard Paper Remits:
 - ✓ [FISS Standard Paper Remittance](#)
 - ✓ [MCS \(Medicare Part B/Professionals\)](#)
- Comprehensive information on the New Medicare Card [CMS Website](#)

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

FISS Standard Paper Remittance Advice Example with MBI



- Beginning October 1, 2018 through transition period:
 - MID field will reflect the Medicare identification submitted
 - MBI field will reflect the MBI when a valid and active Medicare number is submitted

FISS Standard Paper Remittance Advice Example

Beginning October 1, 2018, through the transition period:

- The **MID field** (line 32) will show the Medicare ID submitted on the claim
- The **MBI field** (line 66) will show the Medicare Beneficiary Identifier (MBI) when a provider submits a valid and active HICN

1 MEDICARE PART A	2 STREET ADDRESS	3 CITY	4 ST 5 999999999	6 VER# 5010
7 CONTACT NAME	8 PHONE: 000-000-0000 9 EXT:	10 FAX:	11 EXT:	12 EMAIL:
13 NPI#	14 PROVIDER NAME	15 PROVIDER ADDRESS	16 CITY	17 ST 18 999999999
20 PAID DATE: MM/DD/YYYY	21 REMIT#10	22 PAGE		
23 PATIENT NAME	24 PATIENT CTRL NUMBER	25 RC 26 REMI7DRG#	28 DRG OUT AMT 29 COINSURANCE 30 PAT REFUND	31 CONTRACT ADJ
32 MID	33 ICH NUMBER	34 RC 35 REM 36 OUTCD	37 NEW TECH/ECT 38 COVD CHGS	39 ERSD NET ADJ 40 PATIENT REED
41 FROM DT	42 THRU DT 43 HICN 44TOB	45 RC 46 REM 47 PROF COMP	48 MSP PAYMT 49 NCOVD CHGS	50 INTEREST 51 PROC CD AMT
52 CLM STATUS	53 COST 54 COVDY 55 NCOVDY	56 RC 57 REM 58 DRG AMT	59 DEDUCTIBLES 60 DENIED CHGS	61 FRE PAY ADJ 62 NET REIMB
66 MBI		63 SEQUESTRATION	64 FBP REDUCT	65 ISLET ADD ON

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



Targeted Probe and Educate (TPE)

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

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
 - TPE review process includes three rounds (if warranted) of probe review with education:
 - ✓ Sample limited for each probe "round" to a minimum of twenty (20) and a maximum of forty (40) claims

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

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](#)

Edit	Topic	Documentation Needed	Helpful Hints	Round 1 Dates	Round 2 Dates	Round 3 Dates
5LKW1	E41 and E43- Severe Malnutrition	Checklist: Documenting Malnutrition (E41 and E43)	Contact assigned Clinical Reviewer if selected	Start Date: 10/23/2017 End Date: 4/30/2018 Results	Start Date: 7/1/2018 Results: TBD	TBD

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TPE Rounds of Review Process



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 UPIC or RA or 100% prepay review	X	X	X	X

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

Provider Responses to ADRs



- Provider has 45 days to respond to the contractor with medical records
- Options for sending in medical records:
 - Novitasphere (free)
 - Faxing (free)
 - esMD (cost)
 - CD/DVD submission (cost)
 - US Mail, FedEx or UPS (cost)

Medical Review Record Submission Tuesday, July 31, 2017 2:14 PM

Please enter the required information in the fields below. When submitting the requested documentation please ensure that you have placed the first page of the corresponding ADR or fax cover sheet on top of the documentation associated with the identified claim number.
 Note: Record submissions that have been password protected by the provider and are uploaded cannot be processed. You will be alerted if your submission exceeds the size limit of 200MB.
 *Indicates a required field.

Claim Number (ICN) [Clear](#)

File to upload [Browse...](#) [Add More Documentation](#)

Comment:

[Submit](#) [Reset Form](#)

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TPE Results



- Providers will have 45 days between rounds to implement any changes necessary after education to correct identified billing errors
- Results for each round will be posted on the Novitas website including:
 - Common denial reasons
 - Total major, moderate, and minor probe results

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Credit Balance

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

What is a Medicare Credit Balance?



- Definition:
 - Improper or excess payment made to a provider as a result of patient billing or claims processing error
- Purpose:
 - Provider determines a credit is due to Medicare for an overpayment
 - Medicare credit balances include money due to the program regardless of its classification in a provider's accounting records
 - Credit balances are reported through the completion of the CMS-838 Form at the end of each quarter
- Examples:
 - Overpayments
 - Duplicate payments
 - Payment received for services not performed
 - Payment received for non-covered services
 - Payment received for outpatient services that should have been bundled to inpatient

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Medicare Credit Balance Reporting Requirements



- Credit balance documentation:
 - Identify whether the patient is an eligible Medicare beneficiary
 - Identify other liable insurers and the primary payer
 - Adhere to applicable Medicare payment rules
 - Ensure that a credit balance is due to Medicare and the credit is refundable to the Medicare program
- The CMS-838 Certification and Detail page must be submitted:
 - Failure to submit a complete and/or accurate detail page will result in the return of the credit balance report:
 - ✓ Rejected reports, those deemed invalid, are not considered received until they are submitted without errors
 - ✓ Failure to file a quarterly report by the due date may result in the suspension of all Medicare payments
- If your credit balance amount is ZERO at the end of the quarter:
 - Required to sign, date and return the Medicare Credit Balance Report Certification Page

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Medicare Credit Balance Report Due Dates



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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CMS-838 Credit Balance Report



Provider Audit & Reimbursement Form

Monday, July 16, 2018 8:44 AM

Please enter the required information in the fields below. Cost reports are processed within 30 business days of receipt.
Note: You will be alerted if your submission exceeds the size limit of 200MB.

* Indicates a required field.

Fiscal Period:

If you cannot locate the provider fiscal period you are searching for, please email the following contact:

- JL Providers: settlement@novitas-solutions.com
- JH Providers: JHsettlement@novitas-solutions.com

Supporting Documentation:

Add More Documentation

Comment:


Requester Name:

Electronic signature

I certify the information I provided on and in connection with this submission is true, accurate, and correct.

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Credit Balance Status Tool



- Confirm receipt and check the status of quarterly reports by using the Medicare Credit Balance Status Tool:
 - Allow two to three days after receipt for zero balance certifications to appear in the toll
 - Allow up to two weeks after receipt for credit balance reports to be added to the tool
- [Credit Balance Tool](#)

Credit Balance Status Search Criteria

PTAN:

Quarter Date(MM/DD/YYYY):

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Medicare Credit Balance CMS- 838 Form and Resources



- [Medicare Credit Balance Form](#)
- [Tutorial How to Complete Form CMS-838](#)
- [Frequently Asked Questions \(FAQs\)](#)
- [Credit Balance Podcast](#) :
 - An informative interview on the Medicare Credit Balance Report which includes a tutorial on Medicare Credit Balance Reporting
- [Medicare Financial Management Manual, Pub. 100-06, Chapter 12 – Instructions for Medicare Credit Balance Report Activities](#)

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



Outpatient Services Provided to Inpatients of Other Facilities

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Background



- [Section 1812](#) of the Social Security Act indicates inpatient hospital services provided to Medicare beneficiaries are reimbursed under Medicare Part A:
 - Includes inpatient stays at LTCHs, IPFs, IRFs and CAHs
- All hospitals are reimbursed by a prospective payment system or reasonable cost:
 - ACHs are paid through the IPPS
 - Facilities excluded from IPPS but paid under their respective PPS:
 - ✓ IRFs and units
 - ✓ LTCH
 - ✓ IPFs and units
 - ✓ Children's hospitals
 - ✓ Cancer hospitals
 - ✓ Skilled Nursing Facilities
 - CAHs are not subject to the IPPS and are, instead, paid on a reasonable cost basis
- [Provider Specialties/Services](#)

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

Under Arrangement Policy



- Medicare does not pay any provider other than the inpatient hospital for services provided to the beneficiary while the beneficiary is an inpatient of the hospital:
 - All items and non-physician services provided to inpatients must be furnished:
 - ✓ Directly by the hospital
 - ✓ Billed by the hospital under arrangements through the submission of the Part A claim to Medicare
 - Applies to all hospitals, regardless of whether they are subject to PPS

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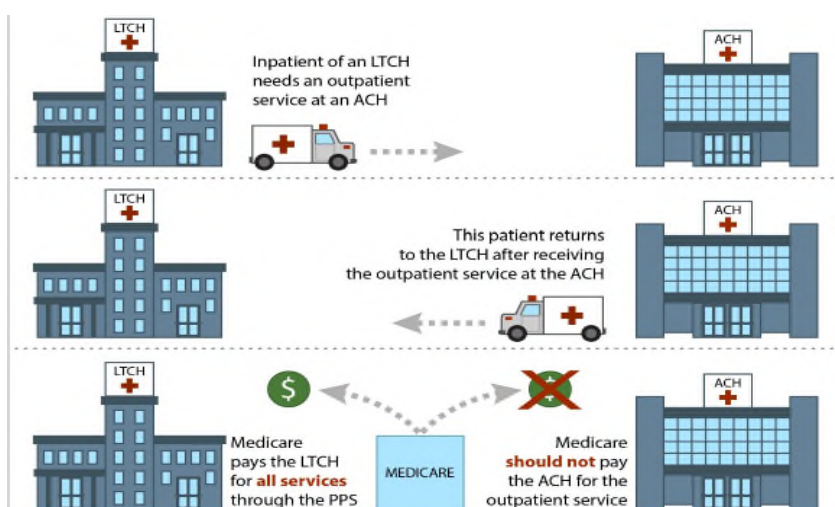
Under Arrangement Policy – Billing Guidelines



- Inpatient claim should include:
 - All services rendered to the beneficiary directly, or
 - All services provided under arrangement, on an outpatient basis, at another hospital
- Inpatient hospital will reimburse the other hospital and transportation provided the amount that was determined and agreed upon by all parties involved
- Outpatient services may not be separately billed by the other hospital or the transportation provider:
 - If outpatient services are paid separately this could result in increased cost-sharing for the beneficiary
- [Medicare Learning Network \(MLN\) Matters Special Edition Article: SE17033 - Medicare Does Not Pay Acute-Care Hospitals for Outpatient Services They Provide to Beneficiaries in a Covered Part A Inpatient Stay at Other Facilities](#)

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

Beneficiary Receives an Outpatient Service at an ACH While Still an Inpatient of a LTCH



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

Part B Services Covered under Part A When Furnished to Inpatients



- The following medical items, supplies, and services furnished to inpatients are covered under Part A:
 - They are covered by prospective payment rate or reimbursed as reasonable costs under Part A to hospitals excluded from PPS:
 - ✓ Laboratory services (excluding anatomic pathology services and certain clinical pathology services)
 - ✓ Pacemakers and other prosthetic devices including lenses, and artificial limbs, knees, and hips
 - ✓ Radiology services including CT scans furnished to inpatients by a physician's office, other hospital, or radiology clinic
 - ✓ Total Parenteral Nutrition (TPN) services
 - ✓ Transportation, including transportation by ambulance, to and from another hospital or freestanding facility to receive specialized diagnostic or therapeutic services not available at the facility where the patient is an inpatient

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Part B Services Covered under Part A When Furnished to Inpatients - Exceptions



- Pneumococcal vaccine, influenza virus vaccine and hepatitis B vaccine and their administration are reimbursed under Part B only:
 - Regardless of the setting furnished
- Ambulance service:
 - When the patient is transferred from one hospital to another, and is admitted as an inpatient to the second, the ambulance service is payable under Part B:
 - ✓ Hospital owned and operated ambulance:
 - Hospital bills separately
 - ✓ Hospital arranges for the ambulance transportation with an ambulance operator:
 - Hospital bills separately
- Part B inpatient services, where Part A benefits are not payable, payment may be made to the hospital under Part B

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OIG Findings



- OIG released a report titled, [“Medicare Inappropriately Paid Acute-Care Hospitals for Outpatient Services They Provided to Beneficiaries Who Were Inpatients of Other Facilities”](#)
- The OIG reviewed a total of 129,790 claims with dates of service from January 1, 2013, through August 31, 2016:
 - Medicare inappropriately paid ACHs \$51.6 million for outpatient services, while the beneficiary was an inpatient at another facility
 - Beneficiaries were held responsible for \$14.4 million paid to the ACH for unnecessary deductibles and coinsurance
 - Medicare paid the ACH's outpatient claim before the inpatient facility's inpatient claim in 94 percent of the cases
 - Medicare paid the inpatient facility's inpatient claim before the ACH's outpatient claim in 6 percent of the cases

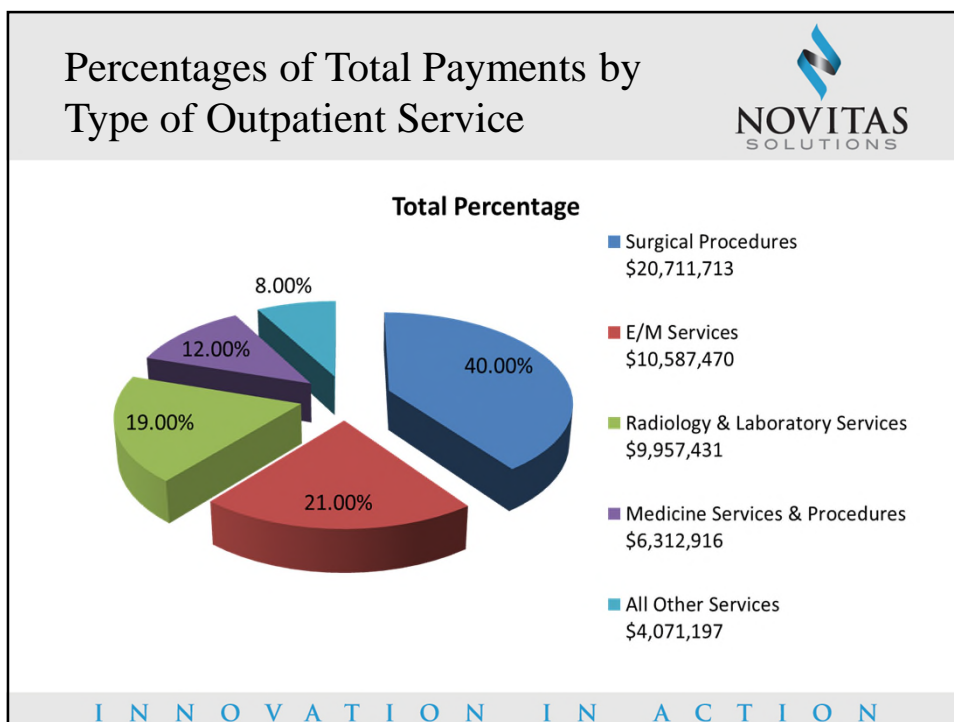
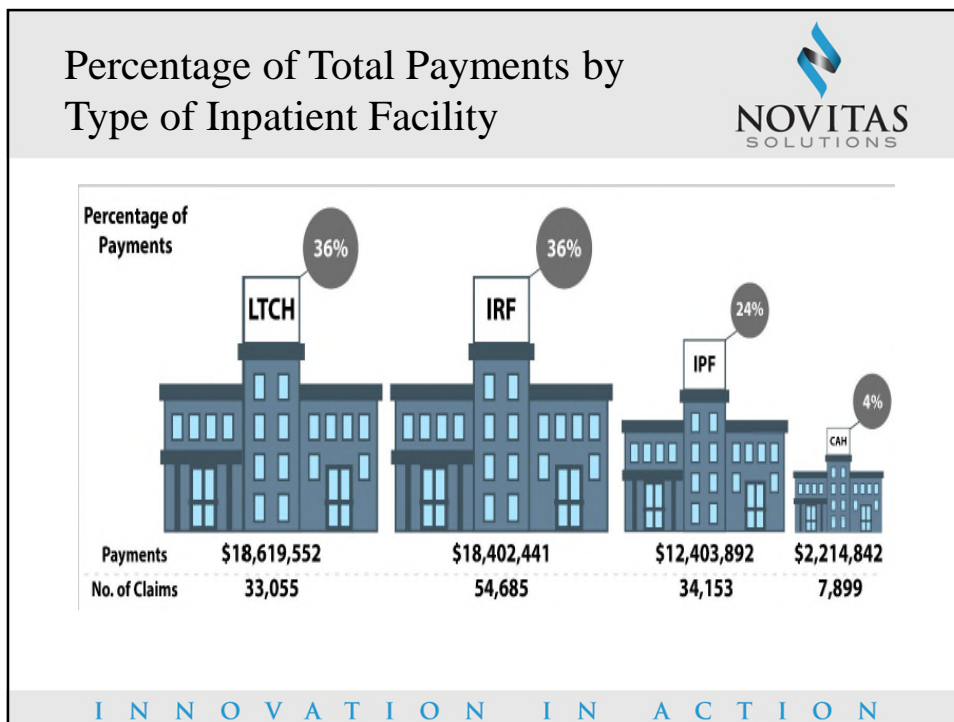
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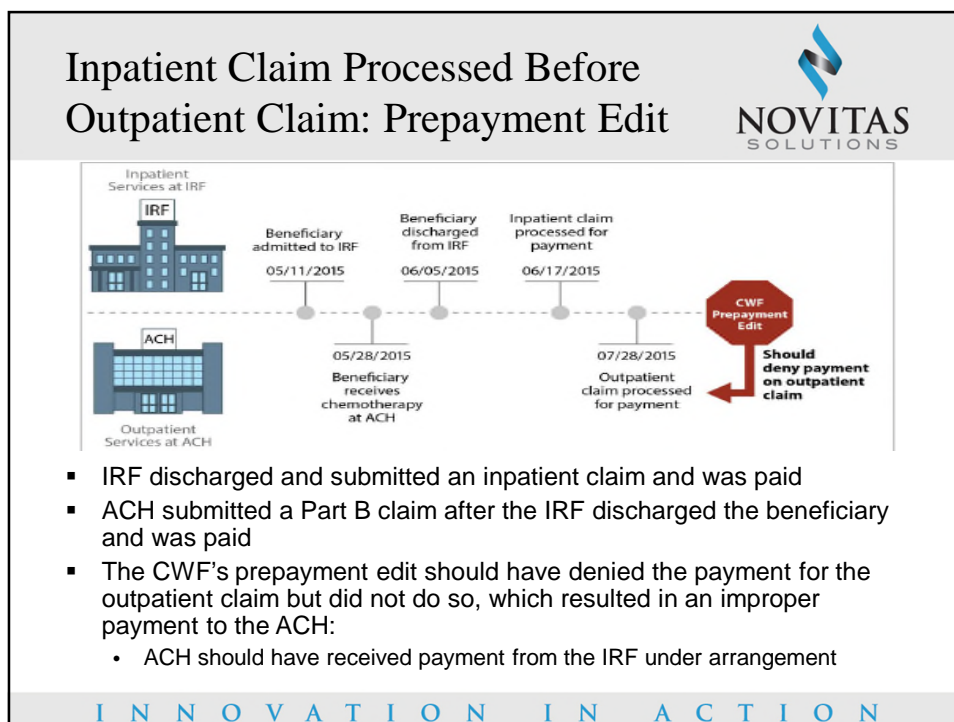
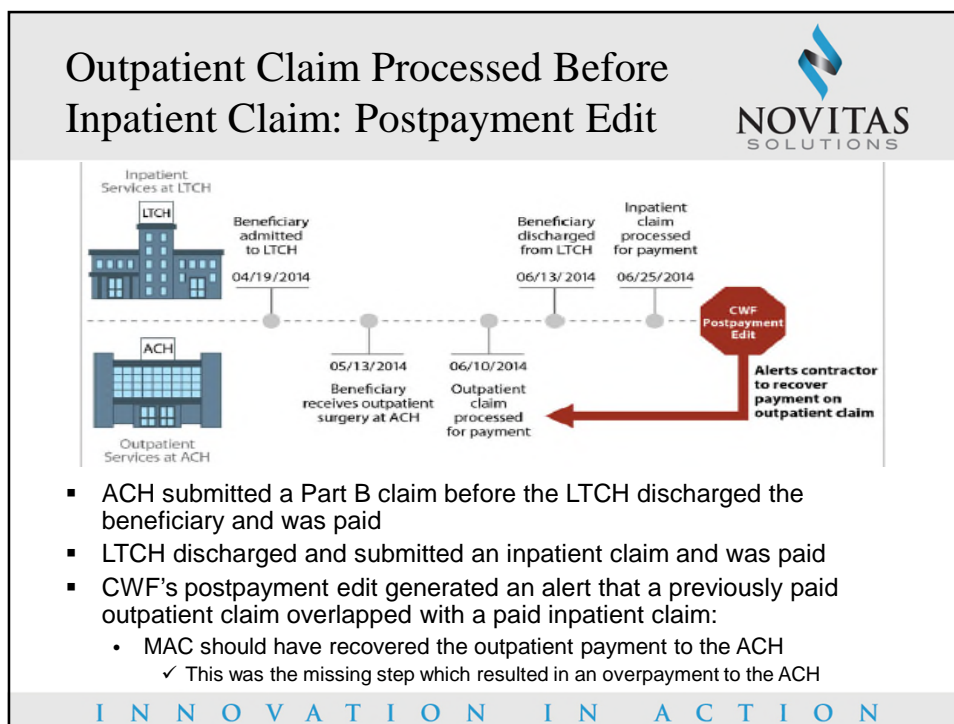
OIG Recommendations



- MACs were instructed to identify and recover any improper payments to ACHs
- ACHs were to refund to beneficiaries any deductibles and coinsurance amounts that were incorrectly collected from the beneficiary or from someone on their behalf

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Summary



- Gave key points and references to the latest Medicare updates
- Identify and understand the current Medicare changes
- Identify and utilize the educational resources and information

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Thank You for Attending!



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