2018 Medicare Part B Updates

New York State Clinical Laboratory Association – NYSCLA

June 7, 2018

Today's Presenters

Jim Bavoso

Manager, Provider Outreach & Education

Disclaimer

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PATIENTS OVER PAPERWORK

CMS goals for 2018

1. Empower patients and clinicians to make decisions about their health care.
2. Usher in a new era of state flexibility and local leadership.
3. Support innovative approaches to improve quality, accessibility, and affordability.
4. Improve the CMS customer experience.

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Provider Outreach and Education

POE Outreach: 2018 Focus- Workload Avoidance

Get the claims processed correctly the 1st time

Data analysis for workload avoidance:

A critical focus for POE activity in 2018

Monthly analysis:

- Claim denials and submission errors
- Appeals
- Telephone Inquiries

– One on One Targeted Education

– New Reason Code Denial tool in development

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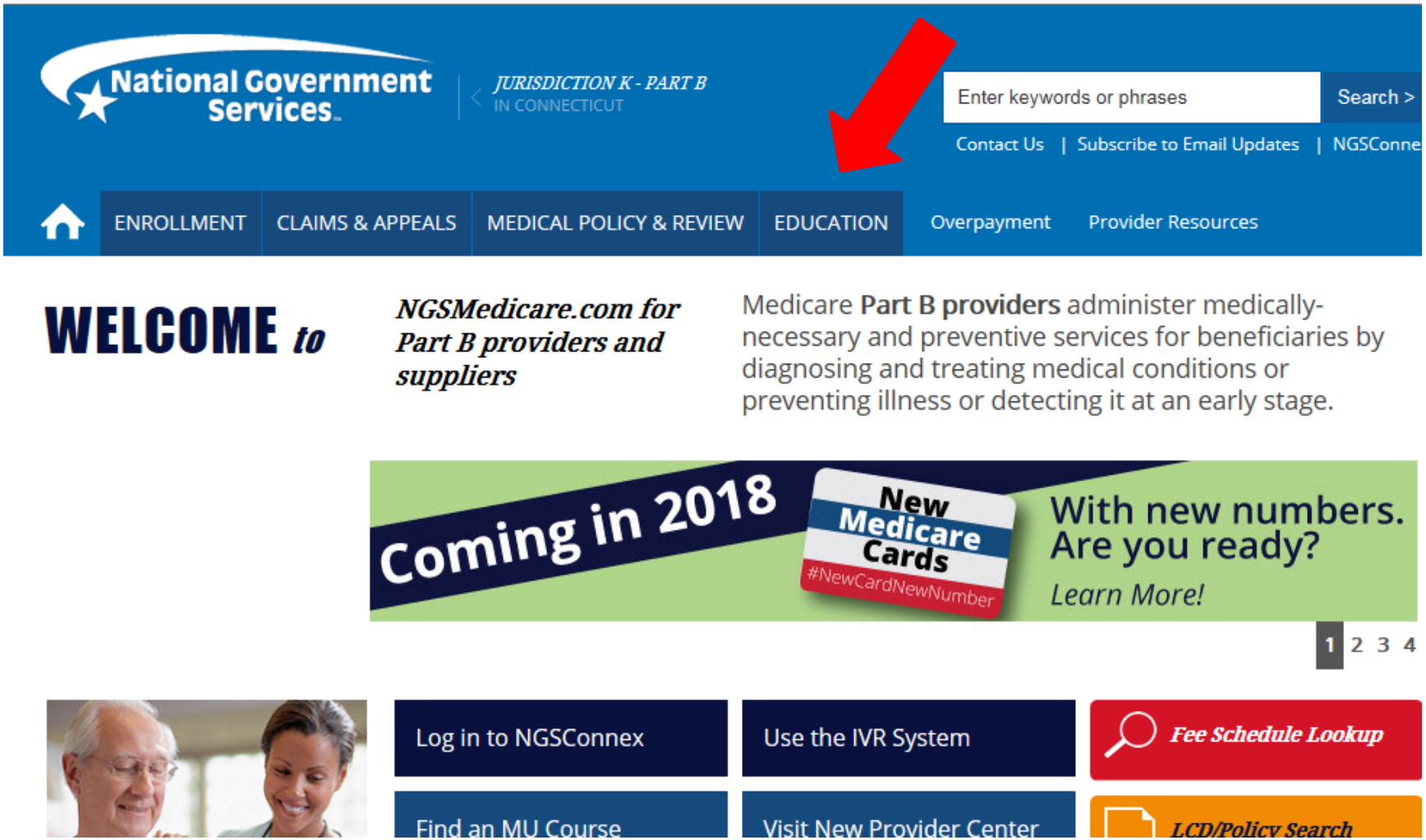
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ENROLLMENT
CLAIMS & APPEALS
MEDICAL POLICY & REVIEW
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Overpayment
Provider Resources
WELCOME to
NGSMedicare.com for Part B providers and suppliers
Medicare Part B providers administer medically-necessary and preventive services for beneficiaries by diagnosing and treating medical conditions or preventing illness or detecting it at an early stage.
Coming in 2018
New Medicare Cards
#NewCardNewNumber
With new numbers. Are you ready?
Learn More!
1 2 3 4
Log in to NGSConnex
Use the IVR System
Fee Schedule Lookup
Find an MU Course
Visit New Provider Center
LCD/Policy Search

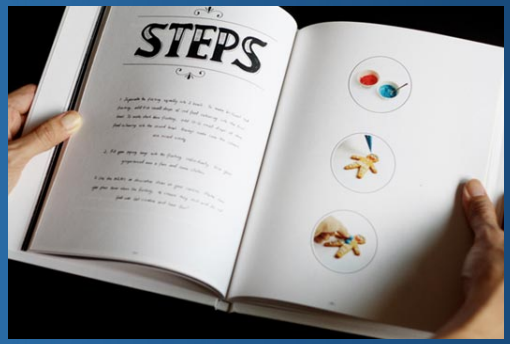
Free Webinars-Check Our Calendar!

- NGSConnex
- Provider Enrollment
- Reduce Claims Submissions Errors
- Around the Web Tour
- Preventive Services
- Medicare Fraud and Abuse
- Outpatient OTPT Coding and Billing
- Duplicate Claims
- Newsflash and more!

Manuals, Claims and Billing, Payment and Reimbursement, Provider Enrollment, Self Help Tools

Manuals

- Additional Development Request Letter Guide
- Ambulance Billing Guide
- Anesthesia Billing Guide
- Companion Document for 5010 Transactions PDF
- EDI E-Signature User Guide
- General Information Guide
- IDTF Billing Guide
- Medicare Coverage of Chiropractic Services
- Medicare Part B 101 Manual
- Medicare Secondary Payer Manual for Electronic Submitters/ANSI Specifications for 837P PDF
- Mental Health Billing Guide



Local Coverage Determinations (LCDs)

What are LCDs?

- LCDs are Medicare Regulations formulated on the concept of a Reasonable and Necessary Service
- There are two parts to the LCD:
  - The **LCD** itself
  - The **SIA** provides coding guidelines

ENROLLMENT | CLAIMS & APPEALS | MEDICAL POLICY & REVIEW | EDUCATION | Overpayment | Provider Resources

WELCOME *to*

NGSMedicare.com for Part B providers and suppliers

Medicare **Part B providers** administer medically-necessary and preventive services for beneficiaries by diagnosing and treating medical conditions or preventing illness or detecting it at an early stage.

Avoid additional fees. **Sign up for immediate offset.**

Learn more! Visit our *Request an Immediate Recoupment* web page.

1 2 3 4

Log in to NGSConnex

Use the IVR System

Find an MU Course

Visit New Provider Center

Take a Web Tour PDF

ICD-10-CM

Fee Schedule Lookup

LCD/Policy Search

LCD or article Search

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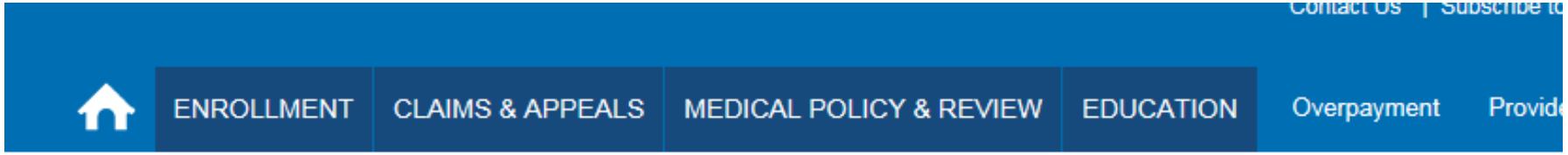
Medical Policy Center
Policy Education Topics
CERT
Fraud & Abuse
Medical Review
Recovery Audit
Top LCDs/Policies
Noninvasive Vascular Studies (L33627) EXT
Transthoracic Echocardiography (TTE) (L33577) EXT
Routine Foot Care and Debridement of Nails (L33636) EXT
Ophthalmology: Posterior Segment Imaging (Extended Ophthalmoscopy and Fundus Photography) (L33567) EXT
Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI) (L34380) EXT



MEDICAL POLICY CENTER

NATIONAL GOVERNMENT SERVICES LOCAL COVERAGE DETERMINATIONS

Search for LCDs and/or Supplemental Instructions/Medical Policy Articles Information

LCD or article | Search

Search for local coverage determinations and related articles by CMS Identifier (L number or A number), title, keyword, as well as HCPCS, CPT, or ICD-10 codes.

Welcome to the new Medical Policy Center. Below you will find the LCDs and Supplemental Instructions/Medical Policy Articles. The Supplemental Instructions/Medical Policy Articles can be found below the LCDs.

[View Draft Policies EXT | View Future Policies]

Local Coverage Determinations (LCDs)

MEDICAL POLICY CENTER

[View Draft Policies | View Future Policies]

Local Coverage Determinations (LCDs)

LCD	LCD #	Related CPT/HCPCS Codes
Air Ambulance Services *Related Terms: N/A*	L36749	A0430, A0431, A0435, A0436
Autonomic Function Testing *Related terms: tilt table, sudomotor*	L36236	95921, 95922, 95923, 95924, 95943
Botulinum Toxins *Related terms: Botox, Myobloc, Dysport,Xeomin, spasticity, chemodenervation*	L33646	43201, 43236, 46505, 52287, 53899, 64611, 64612, 64615, 64616, 64617, 64642, 64643, 64644, 64645, 64646, 64647, 64650, 64653, 67345, J0585, J0586, J0587, J0588
Breast Imaging Mammography/Breast Echography (Sonography)/Breast MRI/Ductography *Related terms: ultrasound, non-palpable masses, palpable masses*	L33585	19030, 76641, 76642, 77053, 77054, 77058, 77059, C8903, C8904, C8905, C8906, C8907, C8908
B-type Natriuretic Peptide (BNP) Testing *Related terms: congestive heart failure, acute dyspnea*	L33573	83880
Cardiac Catheterization and Coronary Angiography *Related terms: heart, circulatory*	L33557	36120, 36140, 36200, 36215, 36216, 36217, 36218, 36245, 36246, 36247, 36248, 36251, 36252, 36253, 36254, 75625, 75630, 75658, 75705, 75710, 75716, 92978, 92979, 93451, 93452, 93453, 93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461, 93462,

MEDICAL POLICY CENTER

Process - Medical Policy Article *Related Terms: N/A*		

Looking for ICD-9 LCDs and Supplemental Instructions/Medical Policy Articles?

All of the ICD-9 LCDs and Supplemental Instructions/Medical Policy Articles for Jurisdiction 6 and Jurisdiction K have been moved to the MCD Archive Site EXT and can be searched with the LCD identifier (L number) and/or article identifier (A number). **Note**: Providers must use the ICD-10 LCDs for all claims with DOS on or after 10/1/2015.

View Other Coverage-Related Information

Bottom of the Medical Policy Center page

- Active LCDs EXT
- Active Supplemental Instructions/Policy Articles EXT
- Draft LCDs and Supplemental Instructions/Policy Articles EXT
- Future LCDs and Supplemental Instructions/Policy Articles
- Investigational Device Exemption Request
- LCD Open Meeting Information
- LCD Reconsideration Process
- Medical Policy Contact Information
- National Coverage Determinations EXT
- Retired LCDs and Supplemental Instructions/Policy Articles EXT

Article for LCD Reconsideration Process A52842

- Requesting a revision to a final LCD
- Submit written request
- Identify language that requestor wants added/deleted from LCD
- Copies of published authoritative evidence
  - Scientific data or research studies published in peer-reviewed medical journals not previously reviewed or listed in sources of information
  - Consensus of expert medical opinion (recognized authorities in the field)
  - Medical opinion derived from consultations with medical associations or other healthcare experts

Reconsideration Process

- **Submission of electronic request is preferred**
  - NGS.lcd.reconsideration@anthem.com
  - Fax: 717-565-3592

- **Mail to:**
  - National Government Services, Inc.
    Medical Policy Unit
    Attention: Valerie Krushinsky

    LCD Reconsideration Request
    P.O. Box 7108
    Indianapolis, IN 46207-7108

Requesting Addition of ICD-10 Code

- Providers may request that an LCD be **revised** to **add coverage for additional diagnosis codes**
- Does not qualify as a reconsideration
- Can send a request to
  - ✓ NGS.lcd.reconsideration@anthem.com
- Include clinical rationale if no peer-reviewed literature is available
  - Remember no PHI or PII can be sent electronically

LCD Open Meetings

- Held when there are LCDs to present
- Notice of meeting is posted with location and time of meetings about one month in advance
- Medical Policy Section of the Web site
- Open to the public
- Teleconferences

Retired LCDs

- All Local Policy rules, requirements, and limitations within these policies will no longer be **applied** on a **pre-pay** basis, but as with any billed service, claims will be **subject to post-pay review**

- All CMS National Policy rules, requirements, and limitations remain in effect

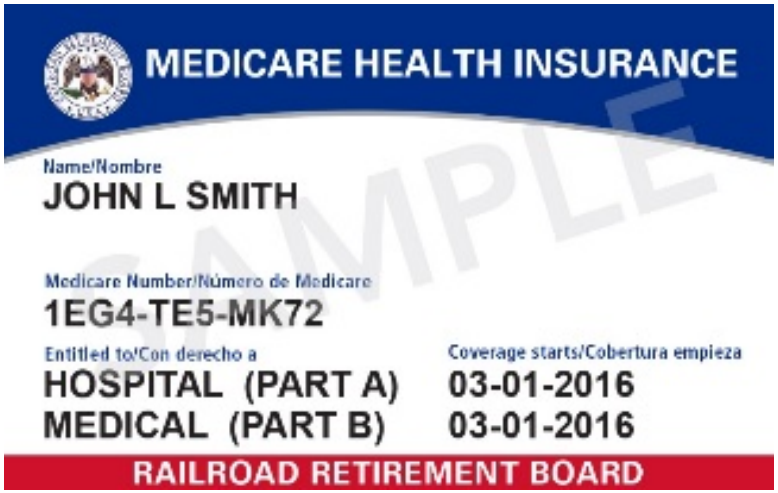
ICD-10 and Other Coding Revisions to National Coverage Determinations (NCDs) (MM10318)

- Maintenance update of the ICD-10 conversions and other coding updates specific to National Coverage Determinations (NCDs)
  - Changes include newly available codes, coding revisions to NCDs released separately, or coding feedback received

The New Medicare Number Project

The New Medicare Card Project

Railroad Retiree Example



What's Different?

- SSN is removed
- Signature line is removed
- Patient sex is removed
- 1-800-MEDICARE moved to the back
- No more suffix or prefix
- RRB identified at the bottom
- New card is paper
- English and Spanish descriptions of fields

New Medicare Card

- Medicare Beneficiary Identifier (MBI)
  - 11 numbers and uppercase letters
    - Numbers = 1 through 9
    - Letters = A to Z, except for S, L, O, I B, and Z
  - Numbers and letters are “nonintelligent”
  - Randomly generated
  - Each beneficiary is issued a unique MBI

Key	Example
SSA HICN	123-45-6789-A1
MBI	1EG4-TE5-MK73

New Medicare Card – Important Dates To Remember

Dates	Events
April 2018–December 2019	• Transition period where providers can use either the HICN or MBI in claims processing and eligibility transactions
April 2018	• CMS will begin to mail new cards • This will continue through April 2019
June 2018	• MBI look-up tool available in NGSConnex
October 2018	• RAs will display both the HICN and MBI when a valid HICN is submitted on a processed claim
January 2020	MBI in full effect • HICN no longer allowed on claims received on and after 1/1/2020 • Exceptions: appeals, claims status queries, span-date claims (Part A only), home health RAPs (Part A only) • HICN no longer allowed for entitlement queries

New Medicare Card – Important Dates To Remember

- April 2018 – CMS begins mailing the new cards
  - Continues through April 2019
  - 7 mailing waves based on geographic location and other factors
    - J6 = Wave 3
    - JK = Wave 4
      - Mailing scheduled to begin after June 2018
        - » Specific mailing dates will not be revealed at this time to ensure beneficiaries' private information is not shared, and to lessen attempted fraudulent activities
        - » Beneficiaries can use MyMedicare.gov for closer date range
    - Reminder for beneficiaries
      - Start using card as soon as it is received, and destroy the old card
      - Call 1-800-MEDICARE if card not received by April 2019

New Medicare Card – How Do I Get a Patient's MBI?

- Ask all patients for their new card at admission/registration
  - Use tools like posters and other signage created by CMS
- MBI Look-Up Tool in NGSConnex beginning June 2018
  - You will need your NGSConnex log-in information, the patient's first and last name, SSN and DOB
- Remittance Advice beginning October 2018
  - RAs will display both the HICN and MBI when a valid HICN is submitted on a processed claim

- **Note:** Once you have the MBI, it is necessary to verify entitlement. You should use NGSConnex Eligibility, IVR Eligibility, and/or HETs to always ensure accurate entitlement information.

New Medicare Card – What Providers Need To Do To Prepare

- Talk with your vendors
  - Ensure their systems, and your internal systems, are prepared to accept and transmit the MBI
- Talk with your patients
  - Remind them to call SSA if they need to update their address
  - Remind them to bring their new Medicare cards to their appointments
- Visit the CMS new Medicare card website frequently for updates and schedules

New Medicare Card – Provider and Patient Resources

CMS.gov
Centers for Medicare & Medicaid Services

Learn about your health care options | type search term here | Search

Medicare | Medicaid/CHIP | Medicare-Medicaid Coordination | Private Insurance | Innovation Center | Regulations & Guidance | Research, Statistics, Data & Systems | Outreach & Education

Home > Medicare > New Medicare Card > Overview

Overview | Providers & office managers | Health & drug plans | Partners & employers | States | Outreach & education

New Medicare cards

We're removing Social Security Numbers (SSNs) from all Medicare cards. A new Medicare Beneficiary Identifier (MBI) will replace the SSN-based Health Insurance Claim Number (HICN) on the new Medicare cards for Medicare transactions like billing, eligibility status, and claim status. You can find more details in our frequently asked questions, 5/30/17 press release, and latest Open Door Forum slides. Also, you can see the new card.

We currently use an SSN-based HICN to identify people with Medicare and administer the program. We've used the HICN with our business partners:

New Medicare Card – Provider and Patient Resources

- New Medicare card web page
- Poster: New Card! New Number!
- MLN Fact Sheet: Transition to New Medicare Numbers and Cards
- New Medicare Card Mailing Strategy
- New Medicare Card Project Milestones
- Short Messaging Job Aid: New Medicare Cards Are Coming!
- New Medicare Card Open Door Forum web page

Who Is The Benefits Coordination and Recovery Center (BCRC)?

- The BCRC consolidates activities that support the collection, management, and reporting of other insurance coverage for Medicare beneficiaries
- All MSP claims investigations are initiated from and researched by the BCRC

When To Contact BCRC

- Report employment changes, or any other insurance coverage information
- Report a liability, auto/no-fault, or workers' compensation case
- Ask questions regarding a COB MSP claims investigation
- Ask general MSP questions
- To ask a question regarding the MSP letters and questionnaires (i.e. IEQ and Secondary Claim Development [SCD] questionnaires)

BCRC Contact Information

- **BCRC Customer Service:**
  - 1-855-798-2627
  - TTY/TDD: 1-855-797-2627
- **Written Inquiries:**

  Medicare – MSP General Correspondence

  P.O. Box 138897

  Oklahoma City, OK 73113-8897
- MSP information may be found on the CMS Website

Update to crossover/supplemental Eligibility Information

- Due to recent privacy updates with the Medicare Program, crossover/supplemental information for Medicare beneficiaries will only be available once a claim has been processed via your Medicare remittance
- You will not be able to access information on a preclaim basis using self-service technology (IVR or NGSConnex) via the Eligibility option or by speaking to a NGS customer service representative
  - Note: Providers still have access to MSP information on a preclaim basis using self-service technology

Update on QMB Medicare beneficiaries

- **People who are eligible to receive benefits from both the Medicare and Medicaid programs at the same time are known as “dual eligible beneficiaries.”**
- **CMS has two excellent resources to help our providers understand dual eligible beneficiaries under the Medicare and Medicaid programs.**

The Special Edition MLN Matters Article SE1128 Revised: Prohibition on Balance Billing Dually Eligible Individuals Enrolled in the Qualified Medicare Beneficiary (QMB) Program

Medicaid enrollment is not involved. The is a beneficiary protection and remains in place.

In effect from October 2, 2018 – December 8, 2017. This is a national issue. CMS is in the process of developing a revision to the process.

Impact varies by state.

Qualified Medicare Beneficiary (QMB) Program

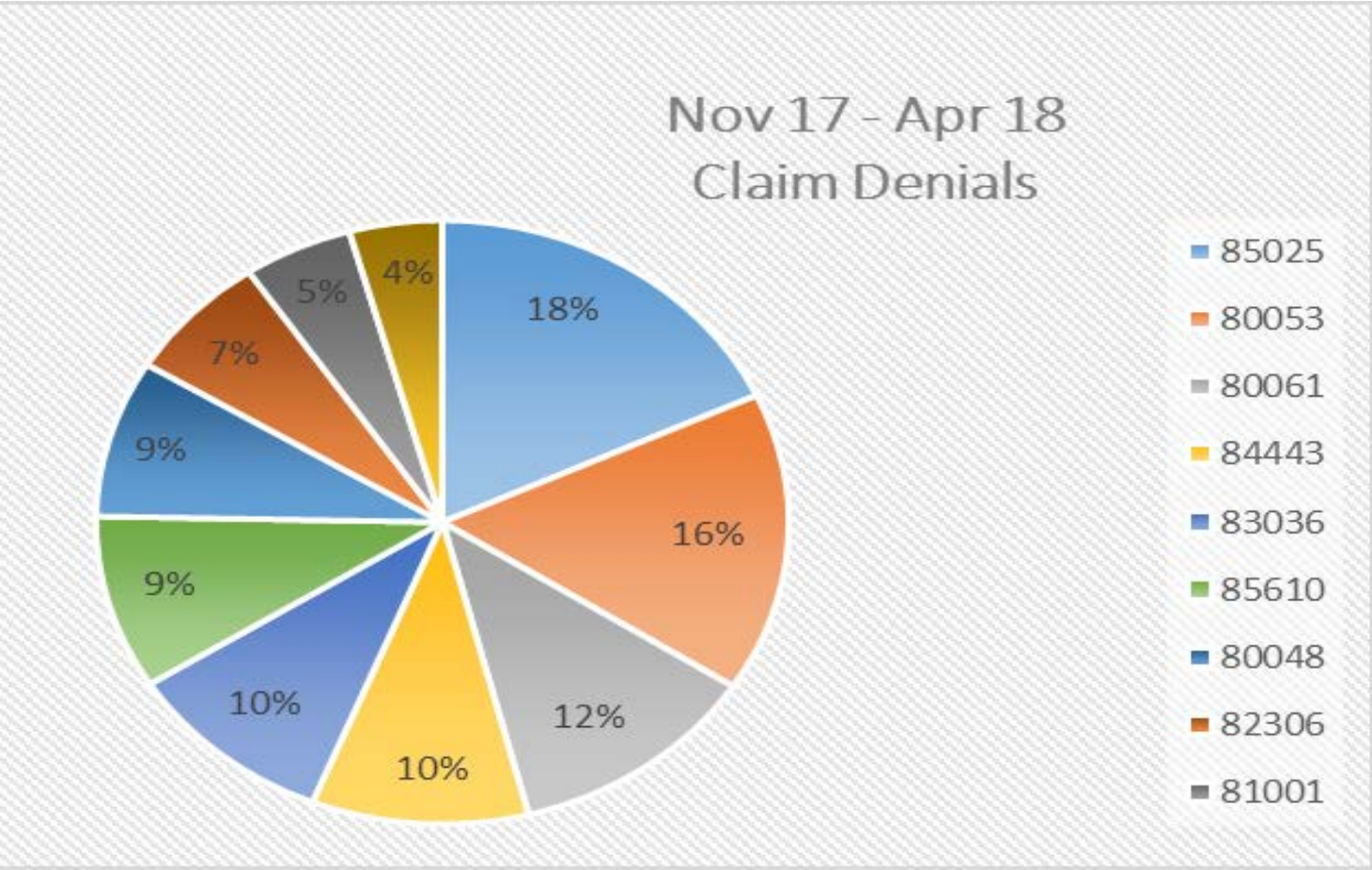
- Medicare beneficiaries enrolled in the QMB program have no legal obligation to pay Medicare Part A or B deductibles, coinsurance, or copays for any Medicare-covered items and services
- July 2015 study (Access to Care Issues Among QMBs) found that those in the QMB program are still being wrongly billed

Reinstating the Qualified Medicare Beneficiary (QMB) Indictor in the Medicare Fee –For –Service Claims Processing System From CR9911 (MM10433)

- Effective July 1, 2018
- CMS will reintroduce the QMB information on the Medicare Remittance Advice (RA) and Medicare Summary Notice (MSN)
  - The RA for QMB claims will retain the display of patient liability amounts needed by secondary payers to process QMB cost-sharing claims

A Look at Clinical Lab Claim Submission

Top 10 Denials November 2017 through April 2018



Most Common Denials

- Eligibility
  - Medicare Advantage
  - Hospice
  - Part A Covered SNF Stay
  - Beneficiary Name and HICN/MBI Mismatch
  - Medicare Secondary Payer
- Medical Necessity
  - Local Coverage Determinations (LCD)/ National Coverage Determinations (NCD)
- Duplicate Claim
- Referring Provider not Eligible

Eligibility

- Claim not covered by this payer/contractor; you must send the claim to the correct payer/contractor
  - OA 109
    - Medicare Advantage
    - N90 – Hospice related services
    - N538 – Skilled nursing facility consolidated billing

GSConnex: How to Check Beneficiary Eligibility

Medicare Advantage Plan

- OA 109: Claim not covered by this payer/contractor; you must send the claim to the correct payer/contractor

NATIONAL GOVERNMENT SERVICES connex

Interactive Voice Response (IVR) System

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Hospice Eligibility

N90 – Covered Only When Performed by the Attending Physician

- HCPCS modifier GW
  - Service not related to the hospice patient's terminal condition
- HCPCS modifier GV
  - Attending physician not employed or paid under agreement by the patient's hospice provider
  - Medicare Part B and the Hospice Patient

Hospice

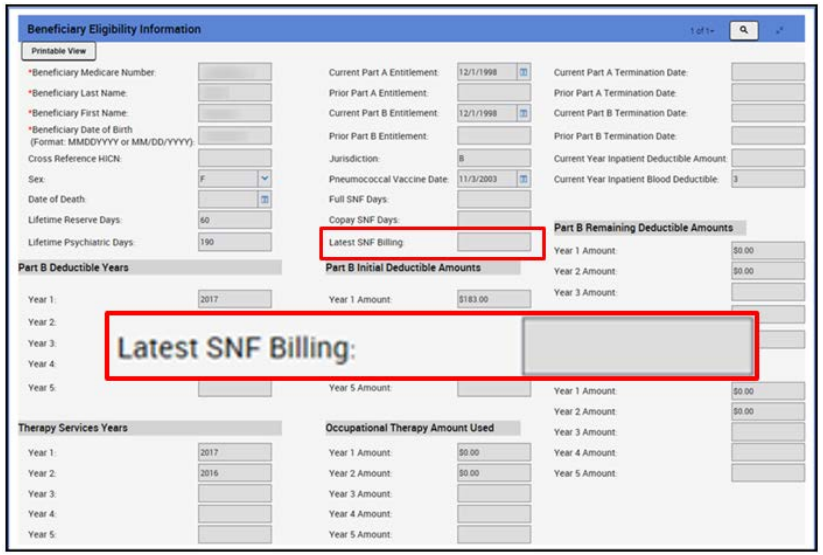
- N90 – Hospice related services

NATIONAL GOVERNMENT SERVICES connex

Interactive Voice Response (IVR) System

Skilled Nursing Facility Consolidated Billing

- N538 – A Facility is responsible for payment to outside providers who furnish these services/supplies/drugs to its patients/residents
- SNF Consolidated Billing

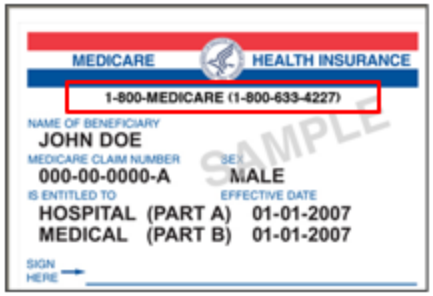


Patient Cannot Be Identified As Our Insured (PR 31)

- Incorrect or missing patient's name or Medicare number
- Patient does not have Medicare Part B entitlement

Railroad Medicare

- N105 – This is a misdirected claim/service for an RRB beneficiary
- Submit paper claims to the RRB carrier: Palmetto GBA, P.O. Box 10066, Augusta, GA 30999. Call 888-355-9165 for RRB EDI information for electronic claims processing



1-800-MEDICARE (1-800-633-4227) | RAILROAD RETIREMENT BOARD

New Medicare Card

- New Medicare cards
- How to talk to your Medicare patients about the new Medicare Card

Medicare Secondary Payer

OA 22 – This care may be covered by another payer per coordination of benefits
MA92 – Missing plan information for other insurance

- MLN Fact Sheet - Medicare Secondary Payer for Providers, Physicians, Other Suppliers, and Billing Staff
- Medicare Secondary Payer on NGSMedicare.com
- Prepare and Submit an MSP Claim

NATIONAL GOVERNMENT SERVICES connex

Interactive Voice Response (IVR) System

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CO 109 – Medicare beneficiary is enrolled in an MA plan

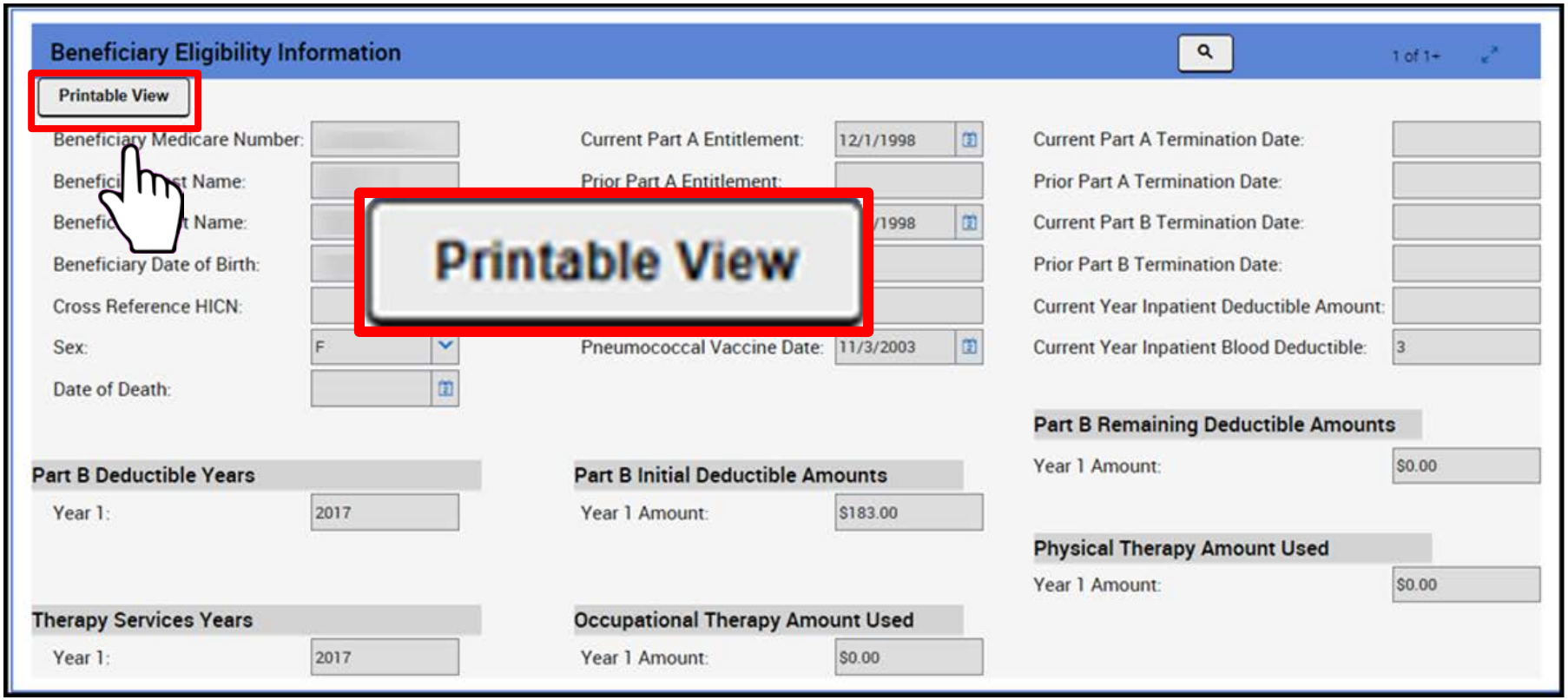
- Many times Medicare beneficiaries are enrolled in an MA plan, instead of “traditional fee-for-service” Medicare. Medicare Advantage plans; which are health plans offered by private companies approved by Medicare
- Suggestions to reduce or eliminate these kinds of claim denials
  - Patient screening during registration is very important to identify those patients that have joined an MA plan
  - Utilization of our self-service tools NGSConnex, IVR

Interactive Voice Response (IVR) Eligibility Checklist

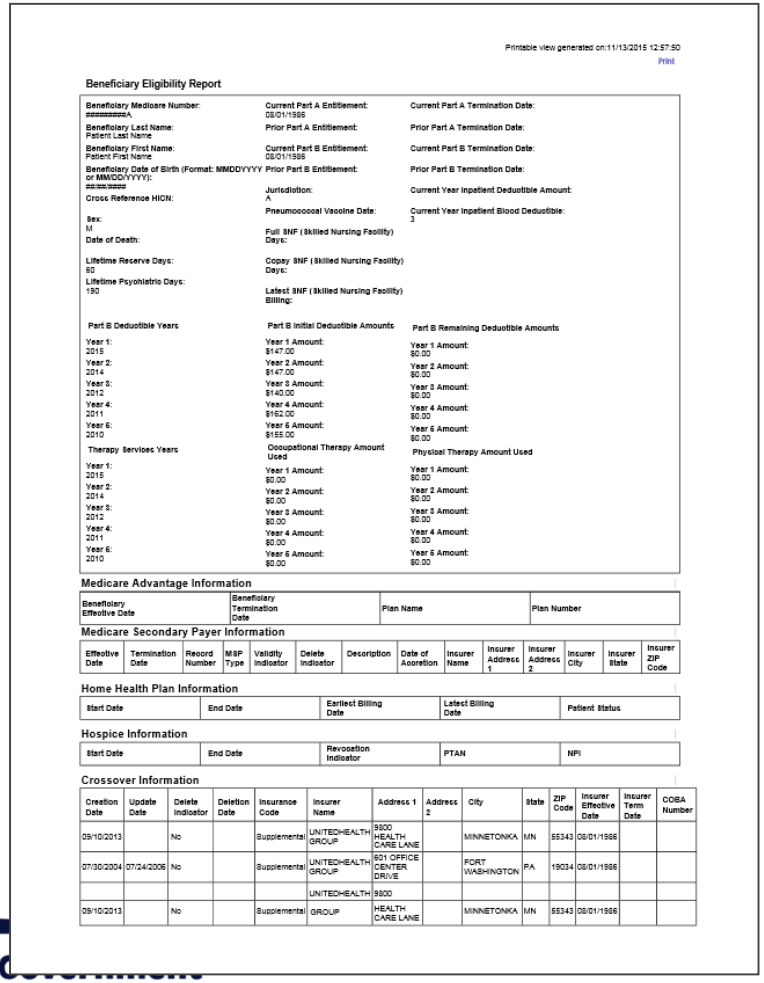
- Interactive Voice Response User Guide
- Part B IVR Navigation

Interactive Voice Response (IVR) System

Get a Personalized Beneficiary Eligibility Report in NGSConnex



Get a Personalized Beneficiary Eligibility Report in NGSConnex



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Beneficiary Eligibility Report

Beneficiary Medicare Number: ##########A	**Current Part A Entitlement:** 08/01/1998	**Current Part A Termination Date:**
Beneficiary Last Name: Patient Last Name	**Prior Part A Entitlement:**	**Prior Part A Termination Date:**
Beneficiary First Name: Patient First Name	**Current Part B Entitlement:** 08/01/1998	**Current Part B Termination Date:**
Beneficiary Date of Birth (Format: MMDDYYYY or MM/DD/YYYY): ##/##/####	**Prior Part B Entitlement:**	**Prior Part B Termination Date:**
Cross Reference HICN:	**Jurisdiction:** A	**Current Year Inpatient Deductible Amount:**
Sex: M	**Pneumococcal Vaccine Date:**	**Current Year Inpatient Blood Deductible:** 3
Date of Death:	**Full SNF (Skilled Nursing Facility) Days:**	
Lifetime Reserve Days: 60	**Copay SNF (Skilled Nursing Facility) Days:**	
Lifetime Psychiatric Days: 190	**Latest SNF (Skilled Nursing Facility) Billing:**	

Part B Deductible Years	Part B Initial Deductible Amounts	Part B Remaining Deductible Amounts
Year 1: 2015	Year 1 Amount: $147.00	Year 1 Amount: $0.00
Year 2: 2014	Year 2 Amount: $147.00	Year 2 Amount: $0.00
Year 3: 2012	Year 3 Amount: $140.00	Year 3 Amount: $0.00
Year 4: 2011	Year 4 Amount: $162.00	Year 4 Amount: $0.00
Year 5: 2010	Year 5 Amount: $155.00	Year 5 Amount: $0.00

Therapy Services Years	Occupational Therapy Amount Used	Physical Therapy Amount Used
Year 1: 2015	Year 1 Amount: $0.00	Year 1 Amount: $0.00
Year 2: 2014	Year 2 Amount: $0.00	Year 2 Amount: $0.00
Year 3: 2012	Year 3 Amount: $0.00	Year 3 Amount: $0.00
Year 4: 2011	Year 4 Amount: $0.00	Year 4 Amount: $0.00
Year 5: 2010	Year 5 Amount: $0.00	Year 5 Amount: $0.00

Medicare Advantage Information

Beneficiary Effective Date	Beneficiary Termination Date	Plan Name	Plan Number

Medicare Secondary Payer Information

Effective Date	Termination Date	Record Number	MSP Type	Validity Indicator	Delete Indicator	Description	Date of Accretion	Insurer Name	Insurer Address 1	Insurer Address 2	Insurer City	Insurer State	Insurer ZIP Code

Home Health Plan Information

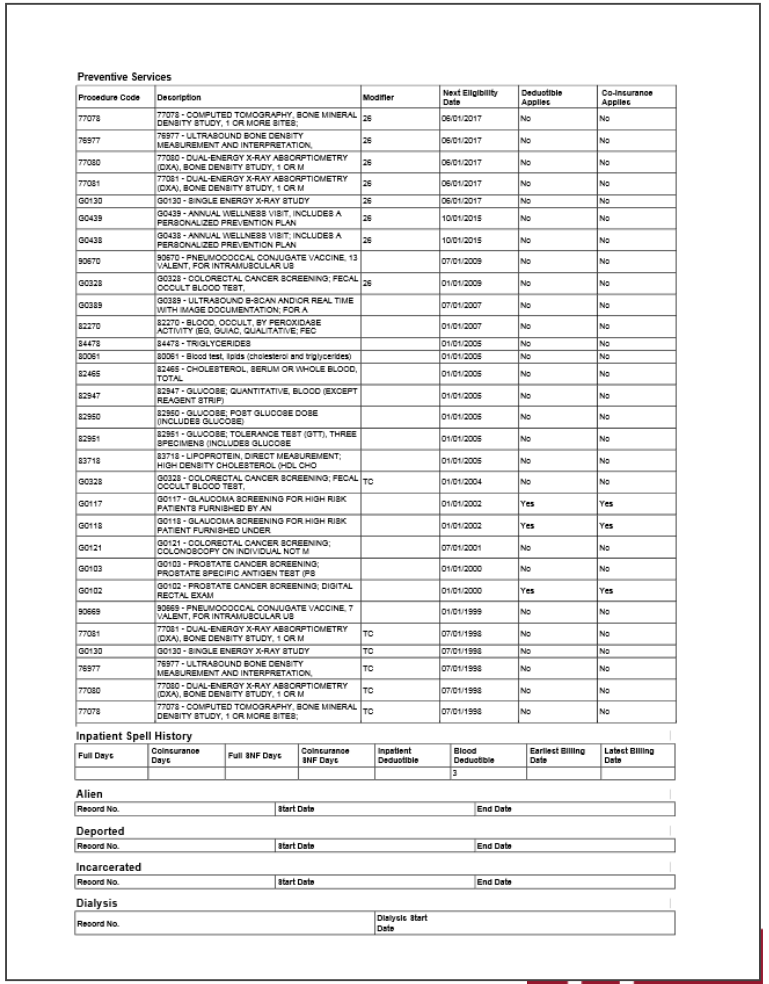
Start Date	End Date	Earliest Billing Date	Latest Billing Date	Patient Status

Hospice Information

Start Date	End Date	Revocation Indicator	PTAN	NPI

Crossover Information

Creation Date	Update Date	Delete Indicator	Deletion Date	Insurance Code	Insurer Name	Address 1	Address 2	City	State	ZIP Code	Insurer Effective Date	Insurer Term Date	COBA Number
09/10/2013		No		Supplemental	UNITEDHEALTH GROUP	9800 HEALTH CARE LANE		MINNETONKA	MN	55343	08/01/1998		
07/30/2004	07/24/2006	No		Supplemental	UNITEDHEALTH GROUP	501 OFFICE CENTER DRIVE		FORT WASHINGTON	PA	19034	08/01/1998		
					UNITEDHEALTH	9800							
09/10/2013		No		Supplemental	GROUP	HEALTH CARE LANE		MINNETONKA	MN	55343	08/01/1998		



Preventive Services

Procedure Code	Description	Modifier	Next Eligibility Date	Deductible Applies	Co-insurance Applies
77078	77078 - COMPUTED TOMOGRAPHY, BONE MINERAL DENSITY STUDY, 1 OR MORE SITES;	26	06/01/2017	No	No
76977	76977 - ULTRASOUND BONE DENSITY MEASUREMENT AND INTERPRETATION,	26	06/01/2017	No	No
77080	77080 - DUAL-ENERGY X-RAY ABSORPTIOMETRY (DXA), BONE DENSITY STUDY, 1 OR M	26	06/01/2017	No	No
77081	77081 - DUAL-ENERGY X-RAY ABSORPTIOMETRY (DXA), BONE DENSITY STUDY, 1 OR M	26	06/01/2017	No	No
G0130	G0130 - SINGLE ENERGY X-RAY STUDY	26	06/01/2017	No	No
G0439	G0439 - ANNUAL WELLNESS VISIT, INCLUDES A PERSONALIZED PREVENTION PLAN	26	10/01/2015	No	No
G0438	G0438 - ANNUAL WELLNESS VISIT; INCLUDES A PERSONALIZED PREVENTION PLAN	26	10/01/2015	No	No
90670	90670 - PNEUMOCOCCAL CONJUGATE VACCINE, 13 VALENT, FOR INTRAMUSCULAR US		07/01/2009	No	No
G0328	G0328 - COLORECTAL CANCER SCREENING; FECAL OCCULT BLOOD TEST,	26	01/01/2009	No	No
G0389	G0389 - ULTRASOUND B-SCAN AND/OR REAL TIME WITH IMAGE DOCUMENTATION; FOR A		07/01/2007	No	No
82270	82270 - BLOOD, OCCULT, BY PEROXIDASE ACTIVITY (EG, GUAC, QUALITATIVE; FEC		01/01/2007	No	No
84478	84478 - TRIGLYCERIDES		01/01/2005	No	No
80061	80061 - Blood test, lipids (cholesterol and triglycerides)		01/01/2005	No	No
82465	82465 - CHOLESTEROL, SERUM OR WHOLE BLOOD, TOTAL		01/01/2005	No	No
82947	82947 - GLUCOSE; QUANTITATIVE, BLOOD (EXCEPT REAGENT STRIP)		01/01/2005	No	No
82950	82950 - GLUCOSE; POST GLUCOSE DOSE (INCLUDES GLUCOSE)		01/01/2005	No	No
82951	82951 - GLUCOSE; TOLERANCE TEST (GTT), THREE SPECIMENS (INCLUDES GLUCOSE		01/01/2005	No	No
83718	83718 - LIPOPROTEIN, DIRECT MEASUREMENT; HIGH DENSITY CHOLESTEROL (HDL CHO		01/01/2005	No	No
G0328	G0328 - COLORECTAL CANCER SCREENING; FECAL OCCULT BLOOD TEST,	TC	01/01/2004	No	No
G0117	G0117 - GLAUCOMA SCREENING FOR HIGH RISK PATIENTS FURNISHED BY AN		01/01/2002	Yes	Yes
G0118	G0118 - GLAUCOMA SCREENING FOR HIGH RISK PATIENT FURNISHED UNDER		01/01/2002	Yes	Yes
G0121	G0121 - COLORECTAL CANCER SCREENING; COLONOSCOPY ON INDIVIDUAL NOT M		07/01/2001	No	No
G0103	G0103 - PROSTATE CANCER SCREENING; PROSTATE SPECIFIC ANTIGEN TEST (PS		01/01/2000	No	No
G0102	G0102 - PROSTATE CANCER SCREENING; DIGITAL RECTAL EXAM		01/01/2000	Yes	Yes
90669	90669 - PNEUMOCOCCAL CONJUGATE VACCINE, 7 VALENT, FOR INTRAMUSCULAR US		01/01/1999	No	No
77081	77081 - DUAL-ENERGY X-RAY ABSORPTIOMETRY (DXA), BONE DENSITY STUDY, 1 OR M	TC	07/01/1998	No	No
G0130	G0130 - SINGLE ENERGY X-RAY STUDY	TC	07/01/1998	No	No
76977	76977 - ULTRASOUND BONE DENSITY MEASUREMENT AND INTERPRETATION,	TC	07/01/1998	No	No
77080	77080 - DUAL-ENERGY X-RAY ABSORPTIOMETRY (DXA), BONE DENSITY STUDY, 1 OR M	TC	07/01/1998	No	No
77078	77078 - COMPUTED TOMOGRAPHY, BONE MINERAL DENSITY STUDY, 1 OR MORE SITES;	TC	07/01/1998	No	No

Inpatient Spell History

Full Days	Coinsurance Days	Full SNF Days	Coinsurance SNF Days	Inpatient Deductible	Blood Deductible	Earliest Billing Date	Latest Billing Date
					3		

Alien

Record No.	Start Date	End Date

Deported

Record No.	Start Date	End Date

Incarcerated

Record No.	Start Date	End Date

Dialysis

Record No.	Dialysis Start Date

Medical necessity

- “Medical necessity” assures services are reasonable and necessary for the diagnosis or treatment of illness/injury
- The procedure code is billed with an incompatible diagnosis, for payment purposes and the ICD-10 code(s) submitted is not covered under a LCD/NCD

Medical necessity

- PR 50 – These are noncovered services because this is not
  deemed a ‘medical necessity’ by the payer
  N180 – This item or service does not meet the criteria for the category under which it was billed

Medical Necessity

National Coverage Determinations (NCD)

- 85025 (NCD 190.15)
- 80061 (NCD 190.23)
- 84443 (NCD 190.22)
- 85610 (NCD 190.17)
- 87086 (NCD 190.12)

Duplicate Claims

Duplicate Claims

- May delay payment
- Increases administrative costs to the Medicare Program
- Could be identified as an abusive biller; or
- May result in an investigation for fraud if a pattern of duplicate billing is identified

Duplicate Claims

- OA -18 Duplicate claim/service
  - Definition of duplicate claim submission
    - When provider resubmits claim either on paper or electronically for single encounter and service is provided by same provider to
      - same beneficiary, for
      - same item(s) or service(s), for
      - same date(s) of service

NATIONAL GOVERNMENT SERVICES connex

Interactive Voice Response (IVR) System

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Tip to Avoiding Denials

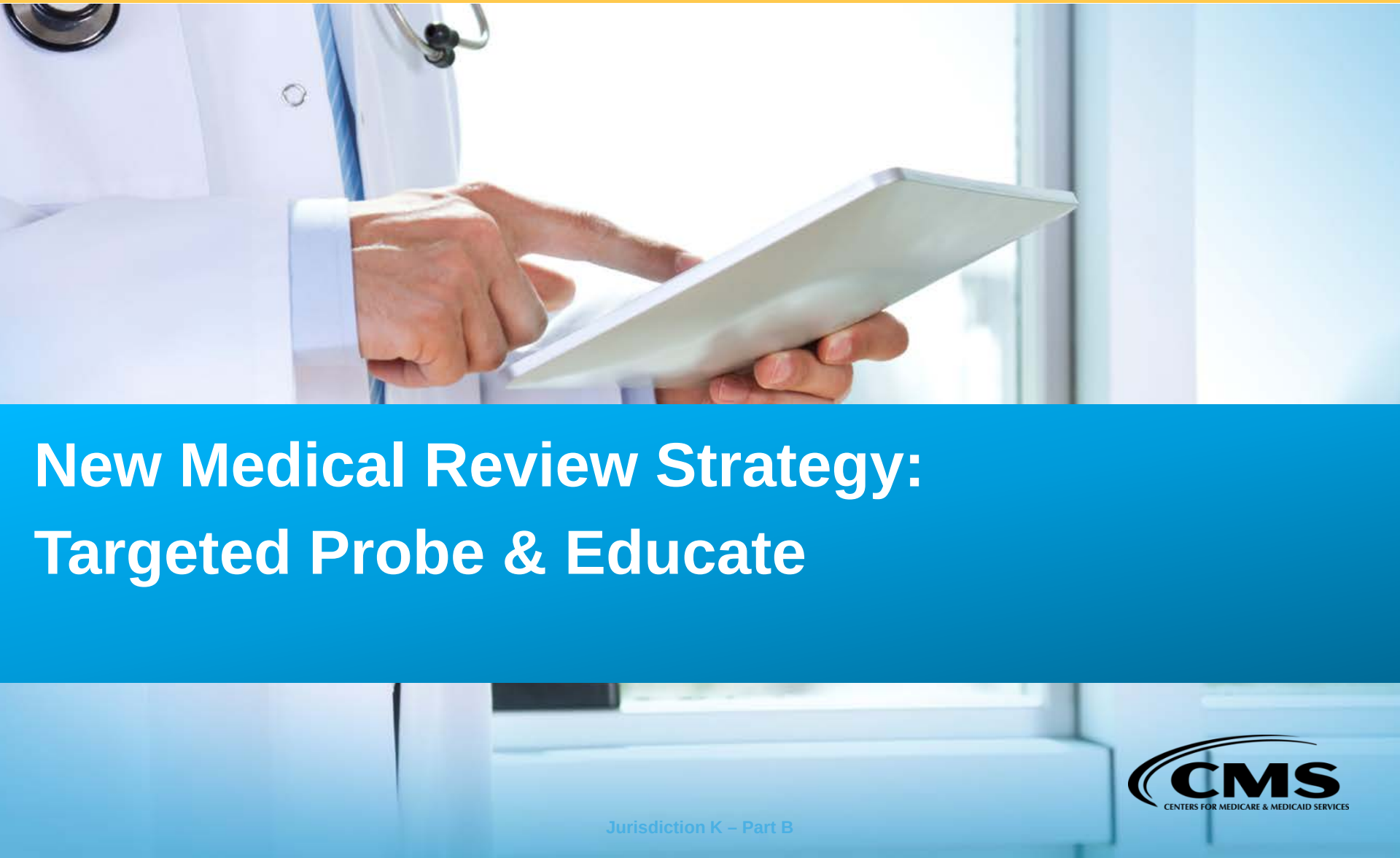
- Check your remittance advice for previously posted claim
- Verify reason initial claim was denied
- Don’t just resubmit to correct a denial
- Use the IVR or NGSConnex to check on current claim status
- Allow 30 days from the receipt date
- Make sure your billing service/clearing house is waiting the appropriate time frame

Duplicate Claim Resources

- Medicare Learning Network (MLN) SE0415 “Reminder to Stop Duplicate Billings”
  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se0415.pdf
- CMS Provider Minute: Duplicate Professional Claims Video

Resources

- National Correct Coding Initiative Edits
  - https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html
- National Government Services
  - https://www.NGSMedicare.com
  - Medical Policy Center
  - CMS-1500 Claim Form Completion Instructions
  - Policy Education Topics
  - Top Claim Errors
  - Fee Schedule Lookup Tool
  - Job Aids & Manuals
- Washington Publishing Company
  - http://www.wpc-edi.com/



New Medical Review Strategy: Targeted Probe & Educate

Jurisdiction K – Part B

October 1, 2017 - New Approach to Targeted Probe and Educate

The objective of a Medicare medical review is to identify and prevent inappropriate payments

Identify potential risk to the Medicare trust fund

Educate providers

Appropriately pay for covered services

National Medical Review Change Process

The medical review process will move from a progressive corrective action (PCA) process to Targeted Probe and Educate (TPE)

Effective date of change is 10/1/2017

- **Trial projects for inpatient services and home health**
- **Proved successful in lowering providers payment error rates**
- **This new model will change some of the process but not affect policy and procedures**

Basics of the new process

- NGS will select the area of review based on existing data analysis procedures CMS selected the area of review during the demonstration projects
- NGS can target the providers based on data rather than perform a100% review of all providers. All providers were subject to review during the demonstration project
- NGS will perform prepay reviews
- NGS will request between 20 -40 claims for probes and each

Education between each round of review will be a primary focus

Changes in the process of selecting claims

- Set number of claims to be reviewed during each round of medical review with decision analysis and results notification at conclusion of each round.
- The previous PCA process allowed advancement of review activities to progress to percentages of all claims submitted. Education will occur prior to the 2nd and 3rdround of the review.
- Opportunity for intra-round education if the nurse reviewer identifies a common theme that can easily be corrected during the review phase
- Providers will have 45-56 days after the education before the next round of records will be requested

Providers will receive a notice of review

- **Notice includes a reason for the review**
- **It will involve 20-40 claims: prior review had no limit**

Tip: Do not send any documentation in response to this letter

- **The provider will be notified via ADR letter on each claim selected for review ADRs will be generated per the usual process**
- **Non-responders could be referred to the RAC, ZPIC, or UPIC**
- **Medical review will review documentation within 30 days of receipt offering.**

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Documentation Request

Round/Probe

- ADR between 20-40 claims from the provider
  - Provider notification letter will advise your agency of how many claims will be requested
- Provider has 45 days to respond to the contractor with medical records
  - This includes mail time and contractor processing time to a medical review location
  - Highly recommend as an internal best practice of sending documentation **within 30 days**
- No response counts as an error

Medical Record Review

Medical review of records for:

- Technical components
  - Physician Certifications
  - Physician orders
  - Beneficiary election statements
- Eligibility
  - Medicare coverage guidelines
  - Medical necessity
  - Documentation supports the services billed

Detailed Provider Results Letter

Detailed results letter at the conclusion of each round will include:

- Outline the targeted probe & educate process
- Reason for denials including the Medicare regulations
- Denial rates (PER)
- Release or retention from medical review
  - PER of less than 15% in order to be released from additional rounds of review
- 1:1 education information

Read the letter in its entirety for important information regarding additional rounds of review

Appealing the determination

- With the implementation of targeted probe and educate, the process for appeal has not changed
  - First level of appeal is the redetermination level
  - 120 days from date of receipt of the initial determination notice
  - May file an appeal via:
    - NGSConnex
    - Mail
- Reminder: To ensure a timely request for an appeal, do not wait for the results letter to submit the appeal request!

Part B Medical Review Focus Areas

PART B PRIORITY	PROBLEM AREA
#1 Problem	Evaluation and Management
#2 Problem	Diagnostic Services
#3 Problem	Specific Procedures/Specialties
#4 Problem	Rehabilitation Services
#5 Problem	Ambulance Services
#6 Problem	Psychiatric Services
#7 Problem	Other Services
#8 Problem	Drugs and Biologicals

Medical Review: Part B Services

Reviews started:

Evaluation and Management Services

Prolonged care with Subsequent Hospital Visits: 20 Providers

Physical Therapy Services : 100 Providers

Office Visit: 40 Providers

Medical Review Targeted Probe and Educate

Intra-Probe Education: what/when and how????

- Occurs during the probe
- Nurse reviewer contacts the provider to discuss easily correctible errors or concerns noted during the review.
- The intent of intra-probe education is to correct the problem before the entire claim sample is denied.

Requesting additional Records

- Occurs during the probe
- Contacting providers requesting missing information
- Trying to pay claims on first review and avoid appeals

Medical Review Targeted Probe and Educate

End of Round Education:

This is provided at the conclusion of the Round, after the provider has received their Results Letter.

- 1:1 education with nurse reviewer and provider; it is in depth and detailed; not an Appeal forum.
- Provider will be transitioned into next Round about 45 days after 1:1 education has been provided.

Questions…..

CMS Referral

After three rounds of review and continued high denial rates CMS may instruct the MAC for additional action which might include:

- **Extrapolation**
- **Referral to the Zone Program Integrity Contractor (ZPIC) or Unified Program Integrity Contractor (UPIC)**
- **Referral to the Recovery Audit Contractor (RAC)**
- **100 % pre-pay review**

You Tube Video Share with staff

NGS YouTube Video: *Targeted Probe and Educate (TPE) Medical Review Strategy*

- Six-minute YouTube video to learn about the new Targeted Probe and Educate (TPE) Medical Review Strategy

Did you know that NGS has created many helpful videos on a variety of topics?

- NGS YouTube home page
- NGS You Tube video list

References

NGS Website

Part A Medical Review article: "Important Information and Instructions for Responding to Additional Development Requests"

Part B NGSConnex User Guide: "View/Search for MR ADR Submission Documents"

NGSMedicare.com > choose contract > Medical Policy & Review tab > Medical Review > Targeted Probe and Educate

Change Request 10249, "Targeted Probe and Educate," effective 10/1/2017

CMS website:

- Targeted Probe and Educate (TPE)
- "Reducing Provider Burden"
- CMS TPE Flow Chart

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Thank you!

Thank you!

The remaining slides are for your reference

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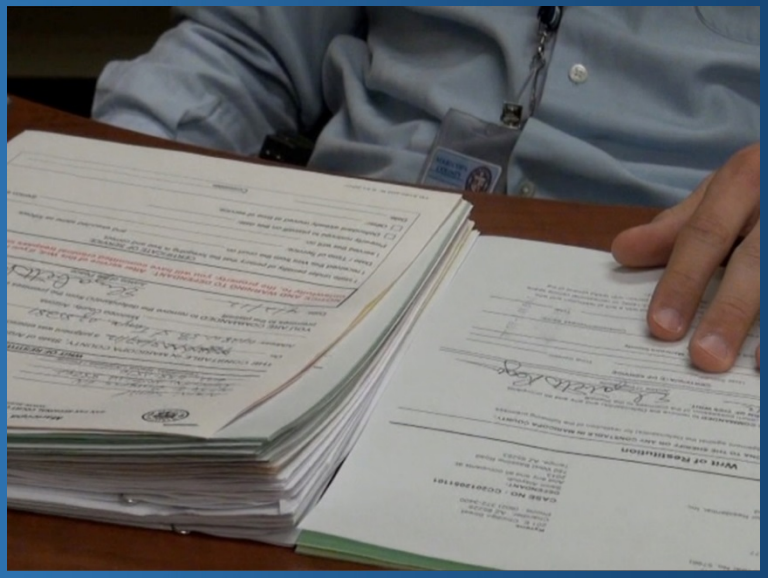
Advance Beneficiary Notice

Advance Beneficiary Notice

- Effective June 21, 2017
  - No changes to the form itself
  - New expiration date (3/2020)
  - Revised to include language informing beneficiaries of their rights to CMS nondiscrimination practices and how to request the ABN in an alternative format if needed
- Medicare Claims Processing Manual, Chapter 30, Section 50
- Questions
  - BNImailbox@cms.hhs.gov



Appeals

Appeals


ENROLLMENT
CLAIMS & APPEALS
MEDICAL POLICY & REVIEW
EDUCATION
Overpayment
Provider Resources
APPEALS
About Appeals
Who May File an Appeal?
Levels of Appeals and Time Limits for Filing
Reopenings for Minor Errors and Omissions
What Documents are Needed?
Submit an Appeal Electronically with NGSConnex
Submit an Appeal Electronically via esMD
ABOUT APPEALS
Providers, suppliers and beneficiaries have the right to appeal claim determinations made by National Government Services. The purpose of the appeals process is to ensure the correct adjudication of claims. Appeals activities conducted by National Government Services are governed by the CMS.
First Level of Appeal (Redetermination) Processing Timeline
Per the Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual (IOM) Publication, Medicare Claims Processing Manual, Chapter 29 – Appeals of Claims Decisions, Section 310.5 PDF:
LOG IN TO NGSCONNEX
Appeals Timeline Calculator
Appeals Forms

Five Levels of Appeal

	LEVEL ONE	LEVEL TWO	LEVEL THREE	LEVEL FOUR	LEVEL FIVE
Type of Appeal	Redetermination	Reconsideration (QIC)	ALJ - Administrative Law Judge Hearing	MAC - Medicare Appeals Council	Federal Court Review
Time Limit for Filing Appeal	120 days from date of receipt of the initial determination notice	180 days from date of receipt of the redetermination decision	60 days from the date of receipt of the reconsideration (QIC decision)	60 days from date of receipt of the ALJ decision	60 days from date of receipt of the MAC decision
Amount in Controversy (monetary threshold to be met)	No minimum (none)	No minimum (none)	The amount that must remain in controversy for ALJ hearing requests filed on or after 1/1/2018 is $160 for ALJ hearing requests	No minimum (none)	For requests filed on or after 01/01/2018, at least $1,600 remains in controversy

Redetermination Examples

- Limitation of Liability Issues
  - Frequency, diagnosis, and/or medical necessity
- LCDs and NCDs
- Medical necessity denials for ambulance transports
- Analysis of documents
  - Operative reports, progress notes, consultation notes and/or radiology notes
- Request disputing recoupment

Redetermination Examples

- Addition of Modifiers
  - AQ, AR, 22, 23, 52, 53, 62, 66, GA, GY, and GZ
- Requests for Additional Allowance
- Modifier 22
- Services that deny as routine
- Screening Procedures
- Cosmetic Surgery
- Procedures not deemed to be proven effective

What Is a Reopening

- Allows providers and suppliers to Correct Clerical Errors or Omissions without having to request a formal appeal

- A reopening can be initiated via Telephone, in Writing or via NGSConnex

What Can Be Requested as a Reopening on the TRU Line?

- **What issues are handled by the TRU?**
  - Adding/changing a modifier (excludes modifiers AQ, AR, 22, 23, 52, 53, 55, 62, 66, GA, GY, and GZ)
  - Adding/changing a diagnosis code
  - Changing a submitted charge
  - Changing a place of service

What Can Be Requested as a Reopening?

- Changing the Number of Services
- Changing the Date of Service as long as it is within the same calendar year
- Changing a Procedure Code
- Contractor Error-excludes unprocessable claims

Claims that Cannot Be Reopened

- **Adding a line** of service (not on the original claim)
- Any claim that **requires additional documentation**
- Ambulance inquiries regarding the modifier GY
- Dispute of an entitlement denial
- Unprocessable/returned/rejected claims
  - RA identified as message MA130
- A previously **appealed claim**
  - redetermination or reconsideration
- **Pending claim** status or check status

Reopening Claims for Minor Errors Telephone Reopening Line (TRU)

- When calling TRU, 888-812-8905, Press 1 (NY) 2 (CT) please provide:
- Beneficiary's name
- Medicare HICN
- Your name and phone number
- Provider's full name
- PTAN
- Item or service in question
- Date(s) of service in question
- Reason for request

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Changes to Diagnosis Codes That Will Not Change the Determination

- Increase in telephone inquiries where the provider wishes to change the ICD-10 diagnosis code on a previously paid Medicare claim
- Important to note: TRU will not reopen a claim to change a diagnosis if the correction will not change the initial determination of a claim
- If you need to change a diagnosis code due to a CMS initiative, please submit your request in writing and state that your change is due to a CMS initiative
- Posted 4/14/2017

Overpayment

OVERPAYMENT

- Overpayment: How Should I Respond?
- Respond to a Demand Letter (Solicited Refund)
- Request an Immediate Recoupment
- Complete a Voluntary Refund
- Overpayment Request
- Set Up an Extended Repayment Schedule
- MSP Post-Pay Overpayments

OVERPAYMENT: HOW SHOULD I RESPOND?

An overpayment may be identified and self-reported by a provider, or it may be discovered by Medicare contractors as part of the claim and reimbursement review process. **The key to reporting and repaying overpayments in compliance with Medicare policies** is selecting the appropriate form and submitting it to the correct address for processing.

What Action Should I Take?

The left navigation tasks represent each of the overpayment scenarios. **Choose the task that applies to your overpayment** for full instructions on:

Financial Contact Submissions

Revised Overpayment Request Form Allows Immediate Offset Request!

- Overpayment request is when you have identified you have been overpaid and you would like Medicare to issue you a demand letter
- Immediate Offset
  - Save on Check Printing/Postage Costs
  - Avoid Interest Charges on collections received at NGS in full or by the 30th day
  - Receive Offset Claim Detail on Provider Remittance
  - Request Overpayment/Immediate Offset on One Easy Form

Request an Immediate Recoupment

- This is considered a voluntary repayment. The request may be for the following:
  - A one-time request for all current overpayment(s) addressed in the reference demand letter and all future overpayments
  - A request for all current overpayment(s) addressed in the referenced demand letter only
  - A request to terminate a previously established immediate recoupment agreement
- You can submit your request by fax, or by using the Immediate Recoupment Request - Electronic/Email Form

NGSConnex – Immediate Recoupment

- Streamlined Process
  - Using Connex to fullest capacity by submit all of your Non-Medicare Secondary Payer (MSP) Provider-Initiated Overpayments via Connex portal as a one-stop-shop for re-openings and reporting overpayments
  - Providers can elect to request ***"Automatic Immediate Recoupment"*** of demanded overpayments to avoid making payment by check or avoid assessment of interest
- Request an immediate recoupment for all and future

Providers on Automatic Immediate Recoupments

- Refrain from submitting:
  - Checks
  - Overpayment forms
- Submitting receipts run risk of money being offset and check being applied to another open receivable
  - Note: If you are set up for automatic immediate recoupments and not submitting claims, then we can accept checks and apply to an open account receivable

NGSConnex

What Is NGSConnex

- Only need:
  - Internet access and email
  - Free program!
- Provides:
  - Beneficiary eligibility/therapy caps/preventive services
  - Claim status-duplicate claim status
  - Financial data/provider demographics
  - Ability to order/download duplicate remittances
  - Rederminations/reopenings/Inquiries
  - Submission of medical records (ADR request)
  - Print and view Appeals Letters
  - Claims submission
  - https://www.NGSConnex.com

NGSConnex Feature Electronic Claims Submission

- Allows Part B providers to submit claims on our secure http://www.NGSConnex.com portal
- It is faster than paper - **14-day** turnaround!
- It is **free** to submit a claim
- You can **edit errors** immediately
- Receive e-mail **confirmation** of claim submission

NGSConnex: Revamped, Expanded, Streamlined

- User Guide
  - More detail provided on the transactions
  - Images to visually guide you on how to perform transactions
  - Easier navigation and search
- Daily MFA security code
  - Option to receive your MFA security code via text
- Streamlined the NGSConnex registration process
  - Process is now completed in one step
  - LSO will receive instant access to provider account information
  - Standard users will no longer need to request a code from their LSO to request access
- NGSConnex User Guide

NGSConnex Redetermination/Reopening Requests

- **Redeterminations /Reopenings** can be accepted via Connex
- Rules for reopenings has not changed
- Only claims that have **processed** through our system are eligible
- Claims rejected **MA-130 must be corrected** and resubmitted

Hours of Availability

- **NGSConnex is available 24/7**
- **Information obtained from the local system is only available:**
  - **Monday–Friday: 7:00 a.m.– 6:00 p.m. ET**
  - **Saturday: 7:00 a.m.–3:00 p.m. ET**
- **Not available during system upgrades or maintenance**

NGSConnex Support

- **Provider Contact Center**
  - Visit http://www.NGSMedicare.com and click on the contact us link for your jurisdiction

Contacting IVR
877-869-6504

- Providers must use the interactive voice response (IVR) system or NGSConnex to obtain information regarding:
  - Claim status
  - Appeal (redetermination/reopening) status
  - Duplicate claims
  - Provider eligibility
  - Check/payment information
  - Financial control number (FCN) information
  - Automated development request (ADR) status

How Do I Get an Issue Resolved?

- Provider Contact Center
  - Be prepared
    - NPI
    - PIN
    - Last five digits of your TIN
- Provider Contact Center
  - Part A
    - **877-567-7205**
  - Part B
    - **866-837-0241**

JK Contact Information

- Fax on Demand: **866-709-1905**
- EDI Helpdesk: **888-379-9132**
- Correspondence

  National Government Services
  Part B Provider General Written Inquiries
  P.O. Box 6189
  Indianapolis, IN 46207-6189
- New Direct Telephone line for Provider Enrollment (JK): **888-379-3807**

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Use Dedicated Medicare Contact Information for People with Medicare

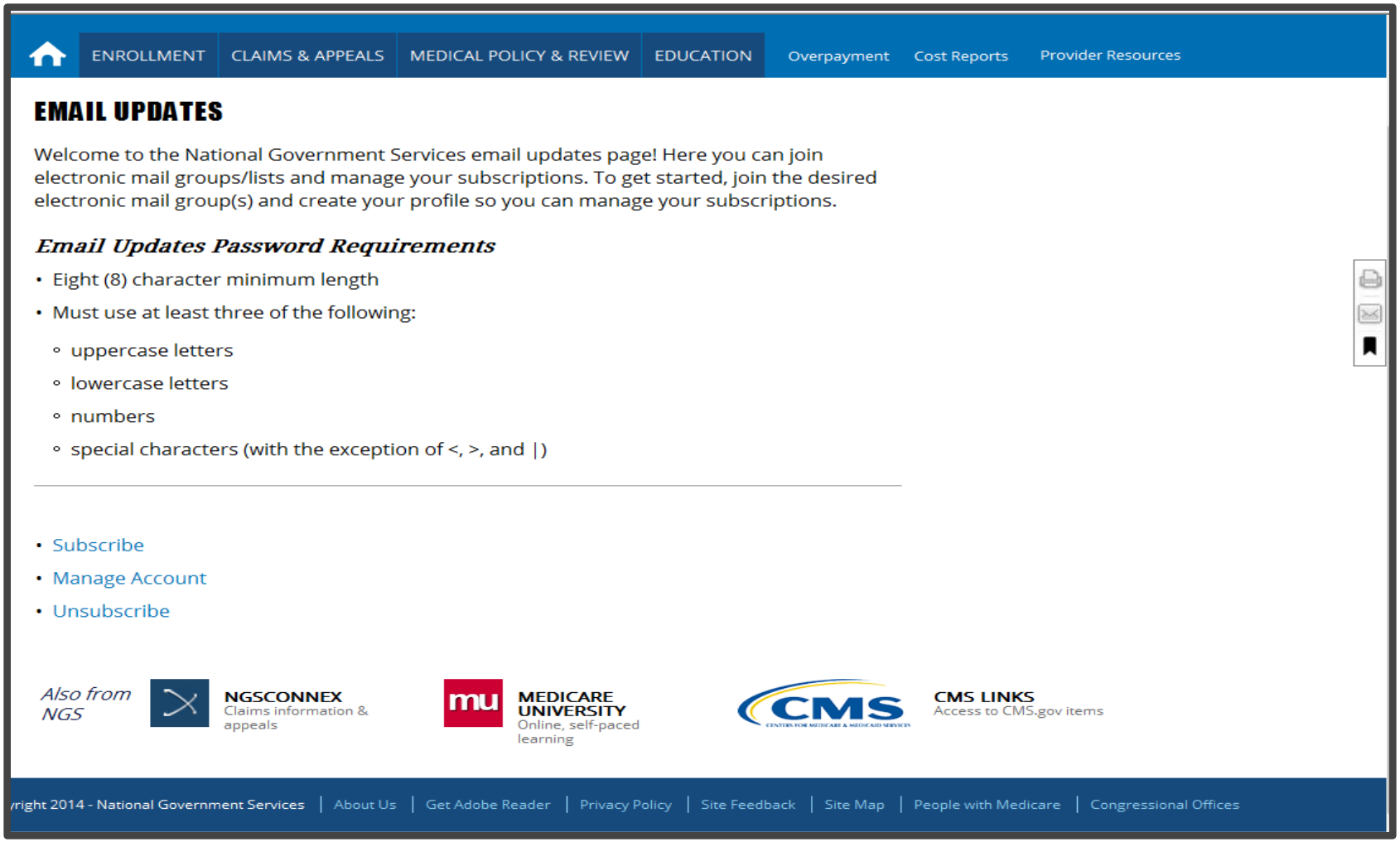
- National Government Services has observed an increase in Medicare beneficiary calls to our Provider Contact Center. As a reminder, People with Medicare have a single Medicare point-of-contact at:
  - **1-800-MEDICARE**
    1-800-633-4227
    TTY/TDD: 1-877-486-2048
- Written inquiries can be mailed to:
  - **Medicare Beneficiary Contact Center**
    P.O. Box 39
    Lawrence, Kansas 66044

Help Encourage Your Medicare Patients to Sign-up for Electronic Medicare Summary Notices

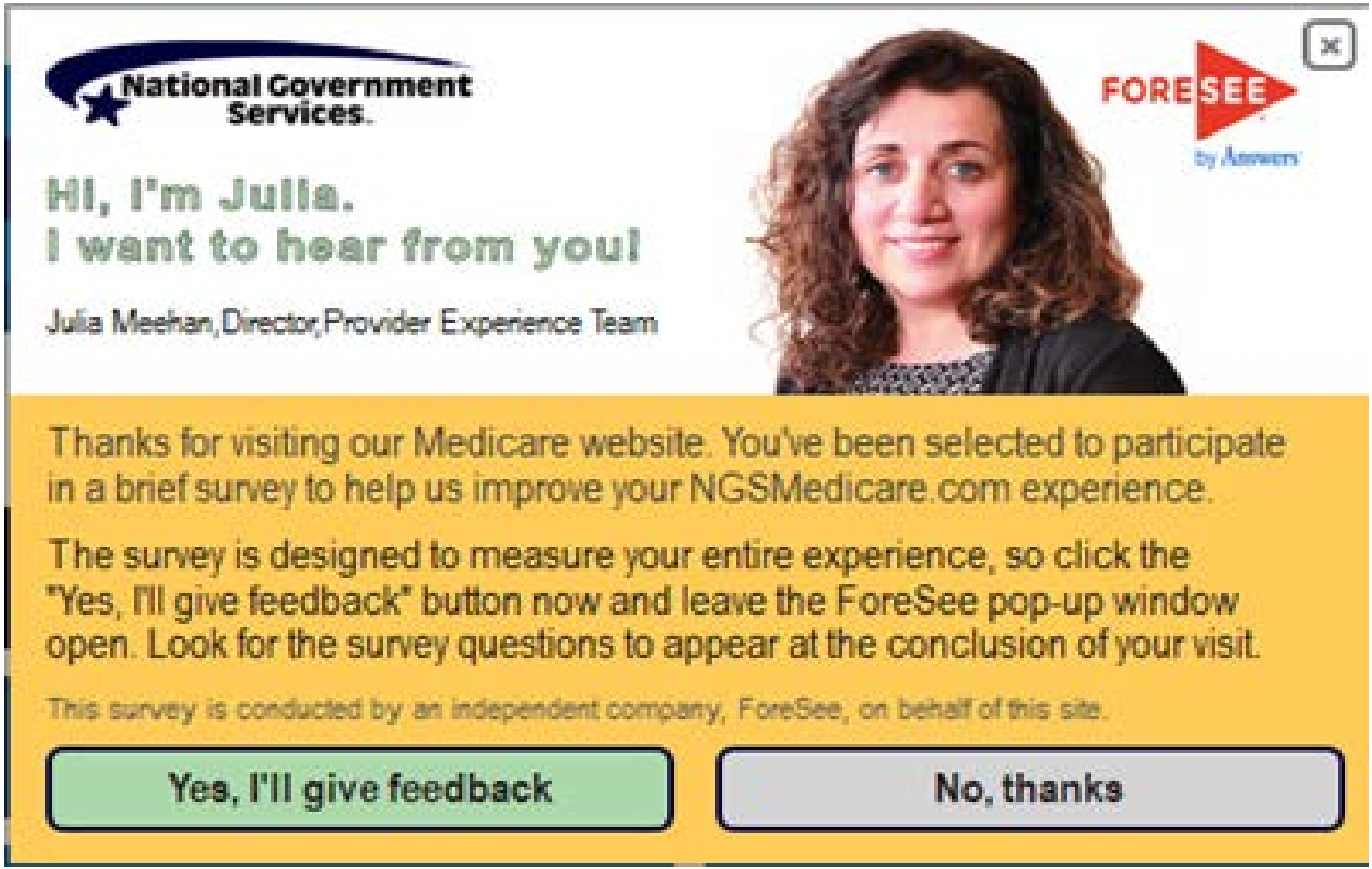
- CMS Go Paperless, Go Green
  - Electronic Medicare Summary Notice (eMSN)
    - Email every month through a secure email
    - Eliminates the three month wait for the paper mailed MSN
  - eMSN poster available to post in your lobby, bulletin boards, behind patient waiting room doors, or in the patient's discharge papers
    - 8.5"×11" version of eMSN poster

Email Updates

- Subscribe to receive the latest Medicare information.



Website Survey!



Medicare University

- Interactive online system available 24/7
- Educational opportunities available
  - Computer-based training courses
  - Teleconferences, webinars, live seminars/face-to-face training
- Self-report attendance
- Website
  - http://www.MedicareUniversity.com

Medicare University Self-Reporting Instructions

- Log on to National Government Services' Medicare University
  - http://www.MedicareUniversity.com
    - Topic = **2018 Medicare Update**
    - Medicare University Credits (MUCs) = **2**
    - Catalog Number = **AA-C-04367**
    - Course Code = **18115SBPAM1**
    - Date: **04/25/2018**
    - Visit our website for step-by-step self-reporting instructions.
    - Click on the **Education** tab, then the **Medicare University Course List** tab, click on the **Get Credit** link. This will open the **Get Credit for Completed Courses** web page.

Thank you!