Medicare Updates and What's Trending for 2018

MD AAHAM

November 16, 2018

INNOVATION IN ACTION

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Acronyms

Acronym	Definition
CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology
E/M	Evaluation and Management
HCPCS	Healthcare Common Procedure Coding System
ICD-10	International Classification of Diseases 10th Revision
I/OCE	Integrated Outpatient Code Editor
MLN	Medicare Learning Network
NCCI	National Correct Coding Initiative
OPPS	Outpatient Prospective Payment System
PTP	Procedure To Procedure
SI	Status Indicator

Today's Presentation

- Agenda:
  - What is the National Correct Coding Initiative?
  - NCCI Edits W7020 and W7040
  - NCCI Self-Service Tools
  - NCCI Associated Modifiers
  - Medicare Updates and What's Trending
- Objectives:
  - Define the NCCI and explain edits W7020 and W7040
  - Explore NCCI self-service tools
  - Review NCCI associated modifiers
  - Share valuable resources

What is the National Correct Coding Initiative?

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National Correct Coding Edits

- Definition:
  - CMS developed NCCI to promote national correct coding methodologies and to control improper coding leading to inappropriate payment
- Purpose:
  - Applies prepayment edits when two services are performed:
    - ✓ By the same physician or provider
    - ✓ For the same beneficiary
    - ✓ On the same date of service
  - Edits are updated quarterly
  - Use modifiers to report special circumstances
- CMS created references to outline:
  - ✓ Column One/Column Two Correct Coding edit files:
    - ➢ Outpatient Hospital PTP edits
    - ➢ Practitioner PTP edits
- CMS has a step-by-step process on the Medicare National Correct Coding Initiative:
  - How to use NCCI Tools

NCCI Edits W7020 and W7040

Changes to Providers Who Are Now Subject to NCCI Edits

- Based on the implementation of the IOCE specifications from Change Request (CR) 10699 July 2018 Integrated Outpatient Code Editor (I/OCE) Specifications Version 19.2, for claims received on or after July 1, 2018, regardless of the date of service, the following provider types that previously were not subject to NCCI edits '20' (W7020) and '40' (W7040) are now subject to these edits:
  - Community Mental Health Centers (CMHCs)
  - Critical Access Hospitals (CAHs)
  - Indian Health Service (IHS) hospitals
  - End Stage Renal Disease (ESRD) facilities
  - Maryland (MD) Waiver hospitals
- For more information:
  - National Correct Coding Initiative (NCCI) Edits Apply to OPPS and Non-OPPS Claims (JH) (JL)

NCCI Edits W7020 and W7040

- Description of the edits:
  - W7020- Code 2 of a pair that is not allowed by NCCI even if appropriate modifier is present
  - W7040- Code 2 of a code pair that would be allowed by NCCI if appropriate modifier is present

Reminder on Billing Requirements Implemented for Non-OPPS Providers

- SE18012:
  - Key Points:
    - ✓ Conveys enforcement of correct coding editing requirements discussed in CR10504 National Correct Coding Initiative (NCCI) Add-on Codes for Non-Outpatient Prospective Payment System (OPPS) Institutional Providers Implementation and MLN Matters Article MM10699 July 2018 Integrated Outpatient Code Editor (I/OCE)
    - ✓ Provides a history of CCI Edits
    - ✓ Details the Outpatient Code Editor (OCE) history and the difference between Outpatient Prospective Payment System (OPPS) OCE and Non-OPPS OCE and I/OCE history
    - ✓ Outlines the addition of specific edit numbers and dispositions for non-OPPS hospitals effective with the July release

NCCI Edit Change Effects on Appeal Claim Adjustments

- Effective July 1, 2018, appeal decisions at all levels (Redetermination, Reconsideration, and Administrative Law Judge (ALJ)) resulting in a claim adjustment will now be subject to NCCI editing:
  - This may result in an unprocessed claim adjustment, which will Return to Provider (RTP) for correction:
    - ✓ Provider will need to make the necessary changes to address the NCCI editing to the RTP claim as appropriate by using the claims correction process outlined in the Fiscal Intermediary Standard System (FISS) Manual Chapter 4.2 Claims Correction (21, 23, 25) for payment consideration
    - ✓ Do not resubmit these claim corrections as a new claim

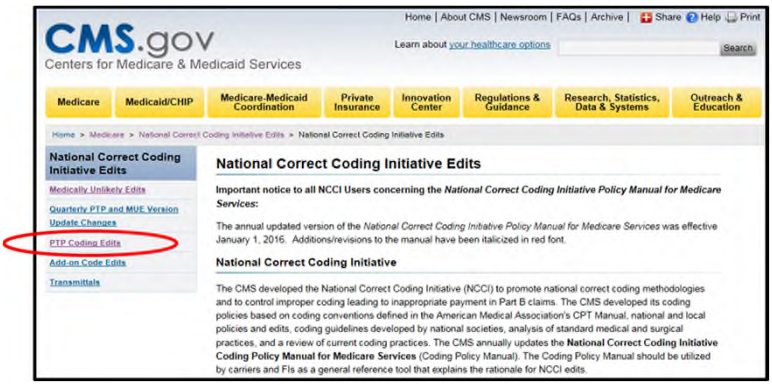
Temporary 90-day Moratorium for Suspending Edits W7020 and W7040 for Maryland Waiver Hospitals

- CMS instituted a moratorium on the NCCI editing for MD Waiver hospitals from October 1, 2018, through December 31, 2018
- Novitas will bypass the W7020 and W7040 edits for claims received from October 1, 2018, through December 31, 2018, until the 90-day moratorium has expired:
  - Applies to any claims being resubmitted or appealed that were initially billed and processed from July 1, 2018 through September 30, 2018
- Effective January 1, 2019, claims will be subject to the edits

NCCI Self-Service Tools

Procedure-to-Procedure Edits

- To locate the proper PTP edit files:
  - NCCI Edits



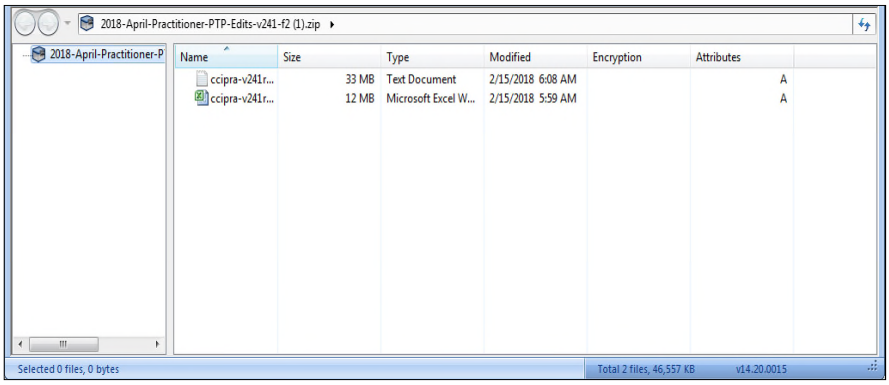
Locating Proper PTP File

- Select the proper column two code by clicking on the proper PTP Coding Edits

Hospital PTP Edits v24.2 effective July 1, 2018 (494,166 records) 0001M/80050 – 27894/G0471
Hospital PTP Edits v24.2 effective July 1, 2018 (491,954 records) 28001/0213T - 49999/49570
Hospital PTP Edits v24.2 effective July 1, 2018 (365,096 records) 50010/0213T - 79999/36000
Hospital PTP Edits v24.2 effective July 1, 2018 (142,271 records) 80003/80002 –R0075/R0070
Practitioner PTP Edits v24.2 effective July 1, 2018 (539,120 records) 0001M/36591 – 26992/G0471
Practitioner PTP Edits v24.2 effective July 1, 2018 (482,378 records) 27000/01995 – 37790/G0471
Practitioner PTP Edits v24.2 effective July 1, 2018 (523,129 records) 38100/0213T – 61888/G0471
Practitioner PTP Edits v24.2 effective July 1, 2018 (467,725 records) : 62000/0213T – R0075/R0070

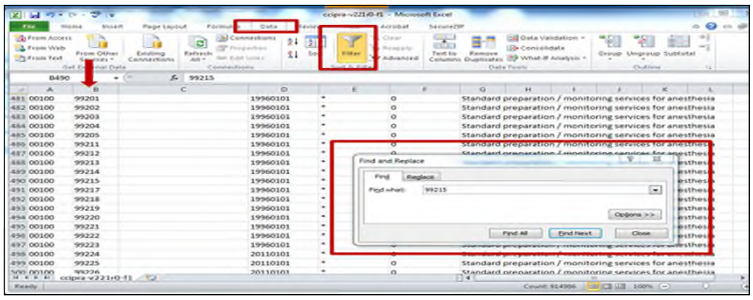
Filtering the PTP Data Tables

- Most efficient way to filter is to use Excel
- Locate the file you want to view and download



Filter Search

- Select the Data Tab
- Select the column you would like to search
- Use ‘Ctrl+F’
- Enter the code you want to look up and click Find All



NCCI PTP Example

Column 1 Code	Column 2 Code	Prior to 1996	Effective Date	Deletion Date * = no data	Modifier	Procedure to Procedure Edit Rationale
43280	51701	N/A	20071001	*	1	Standards of medical / surgical practice
43280	51702	N/A	20071001	*	1	Standards of medical / surgical practice
43280	51703	N/A	20071001	*	1	Standards of medical / surgical practice
43280	58660	N/A	20000605	20050701	0	CPT "separate procedure" definition
43280	61650	N/A	20160101	20160101	9	Misuse of column two code with column one code
43280	62310	N/A	20090401	20161231	0	Standards of medical / surgical practice

- Column 1 is the primary payable code
- Column 2 contains the secondary code:
  - May or may not be payable
  - Append modifier if applicable (reference column 6)
- Column 3 edit has been in existence prior to 1996
- Column 4 effective date of the edit
- Column 5 deletion date
- Column 6 modifier is permitted
- Column 7 underlying basis for each PTP edit

Modifier Indicators

- Indicator 0:
  - Code pairs will not be reimbursed if submitted for the same date of service
  - Modifiers associated with NCCI are not allowed to be used with the PTP code pair
- Indicator 1:
  - Modifiers associated with NCCI are allowed with the PTP code pair when appropriate
- Indicator 9:
  - Not subject to NCCI edits for the PTP code pair
  - Edit for the code pair was deleted
- Documentation must be maintained in the medical record to support the use of NCCI modifier

NCCI Coding Manual

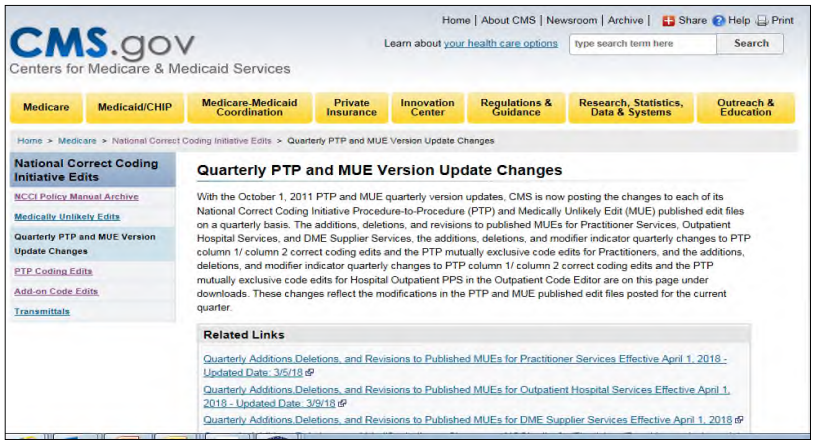
- The NCCI coding manual provides detailed information on the rationales related to proper billing and coding
- How to locate the NCCI Coding Manual

NCCI Edits Section Specific Examples

7. If a physician evacuates, aspirates, or drains an intracranial hematoma (e.g., CPT codes 61154, 61156, 61312-61315), the physician *shall* not separately report a code for drainage of a hematoma in the overlying skin to access the intracranial hematoma. Access through diseased tissue to perform a more extensive definitive procedure is not separately reportable.

Quarterly Updates

- How to locate Quarterly PTP Update Changes



NCCI Associated Modifiers

NCCI Modifiers

- Definition
  - Indicate that a service or procedure performed has been altered by some specific circumstance, but not changed in its definition or code
- Purpose
  - Used to add information or change the description of service in order to improve accuracy or specificity
- NCCI modifier categories:
  - Anatomical modifiers:
    - ✓ E1-E4, FA, F1-F9, TA, T1-T9, LT, RT, LC, LD, RC, LM, RI
  - Global surgery modifiers:
    - ✓ 24, 25, 57, 58, 78, 79
  - Other modifiers:
    - ✓ 27, 59, 91, XE, XS, XP, XU

Anatomical Modifiers

Modifier	Short Descriptor	Modifier	Short Descriptor
E1	Upper left eyelid	F8	Right hand fourth digit
E2	Lower left eyelid	F9	Right hand fifth digit
E3	Upper right eyelid	TA	Left foot great toe
E4	Lower right eyelid	T1	Left foot second digit
FA	Left hand thumb	T2	Left foot third digit
F1	Left hand second digit	T3	Left foot fourth digit
F2	Left hand third digit	T4	Left foot fifth digit
F3	Left hand fourth digit	T5	Right foot great toe
F4	Left hand fifth digit	T6	Right foot second digit
F5	Right hand thumb	T7	Right foot third digit
F6	Right hand second digit	T8	Right foot fourth digit
F7	Right hand third digit	T9	Right foot fifth digit

Additional Anatomical Modifiers

Modifier	Short Descriptor
LT	Left side (used to identify procedures performed on the left side of the body when another more specific modifier does not exist)
RT	Right side (used to identify procedures performed on the right side of the body when another more specific modifier does not exist)
LC	Left circumflex coronary artery
LD	Left anterior descending coronary
RC	Right coronary artery
LM	Left main coronary artery
RI	Ramus intermedius coronary artery

Anatomical Modifier Tips

- Anatomical modifiers designate the area or part of the body the procedure is performed:
  - Assist in prompt, accurate adjudication of claims
- Modifiers RT and LT define procedures performed on the side of the body:
  - Can be used with diagnostic and therapeutic services
- Anatomical modifiers, E1 – E4, identify the eyelid on which a procedure or service was performed at a single session:
  - Can be used with diagnostic and therapeutic services

Additional Anatomical Modifier Tips

- Coronary artery modifiers, LC, LD, LM, RC and RI, identify the coronary artery the procedure or service was performed on during a single session
- Anatomical modifiers, FA - F9, identify the finger the procedure or service was performed on during a single session during a single session:
  - Can be used with diagnostic and therapeutic services
- Anatomical modifiers, TA – T9, identify the toe the procedure or service was performed on during a single session:
  - Can be used with diagnostic and therapeutic services

Global Modifiers

Modifier	Short Descriptor
24	Unrelated E/M services by the same physician or other qualified health care professional during a postoperative period
25	Significant separately identified E/M services by the same physician or other qualified health care professional on the same day of the procedure or other service
57	Decision for surgery
58	Staged or related procedure or service by the same physician or other qualified health care professional during the postoperative period
78	Unplanned return to the operating room by the same physician or other qualified health care professional following initial procedure for a related procedure during the postoperative period
79	Unrelated procedure or service by the same physician or other qualified health care professional during postoperative period

Other Modifiers

Modifier	Short Descriptor
27	Multiple outpatient hospital E/M encounters on the same day (Part A hospital outpatient departments only)
59	Distinct procedural service
91	Repeat clinical diagnostic laboratory test
XE	Separate encounter
XS	Separate structure
XP	Separate practitioner
XU	Unusual non-overlapping service

Modifier 25

- Definition:
  - A significant, separately identifiable E/M service by the same physician on the day of a procedure or other service
- Purpose:
  - Append to the E/M with the OPPS SI "V" (clinic or emergency department visit) when a separately identifiable, significant service and/or procedure is performed during the patient encounter:
    - ✓ Use to indicate the medical visit was unrelated to any procedure performed with SI " T" (procedure or service, multiple procedure reduction applies) or "S" (procedure or service, not discounted when multiple)
    - ✓ Does not require different or separate diagnosis based on CPT guidelines
  - Use only when the procedure or service requires additional work above and beyond preservice work for the procedure or service
  - Access the current OCE Quarterly Release file for the I/OCE CMS Specifications for OPPS medical visit processing
- Modifier 25 Fact Sheet (JH) (JL)

Modifier 59 versus the X Modifiers

- Definition:
  - Distinct procedural service for the same patient on the same day by the same provider
- Purpose:
  - Used to identify procedures or services that are not normally reported together, but are appropriate under the circumstances
  - Represents a different:
    - ✓ Session or patient encounter
    - ✓ Procedure or surgery
    - ✓ Site or organ system
    - ✓ Separate incision/excision
    - ✓ Separate lesion/injury
  - HCPCS modifiers to define specific subsets of the 59 modifier:
    - ✓ XE - Separate Encounter
    - ✓ XS - Separate Structure
    - ✓ XP - Separate Practitioner
    - ✓ XU - Unusual Non-Overlapping Service
- Modifier 59 Fact Sheet (JH) (JL)
- MLN Matters Special Edition Article SE1418 Proper Use of Modifier 59

Reminder: Use either modifier 59 or the X modifiers. Best practice use the X modifiers instead of 59.

Problematic Uses of Modifier 59

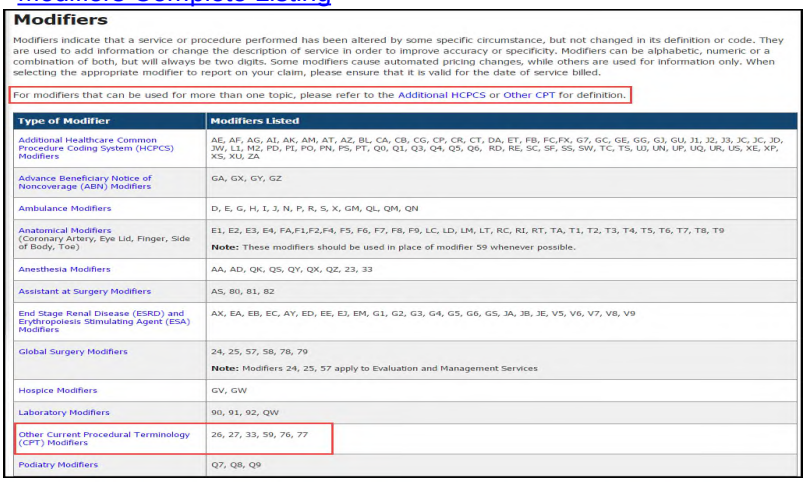
- Another established more descriptive modifier is available and more appropriate to identify the services
- Used with an Evaluation and Management (E/M) service:
  - If submitted on E/M codes 99201-99499
  - E/M codes are processed as though a modifier is not present (i.e., code pair subject to NCCI editing and indicator that does not allow bypass)
- Reporting a separate and distinct E/M service with a non-E/M service performed on the same date (refer to modifier 25)
- Documentation does not support the separate and distinct status

Modifier 59 Billing Tips

- Consult other NCCI modifiers prior to using modifier 59
- Bill all services performed on one day on the same claim
- Report each service on a separate line
- Append 59 modifier to the subsequent procedure
- Do not append modifier 59 to bypass an NCCI edit:
  - Documentation must substantiate the proper use of the modifier

Novitas Solutions' Website: Modifier Home Page

- Modifiers Complete Listing



Modifiers

Modifiers indicate that a service or procedure performed has been altered by some specific circumstance, but not changed in its definition or code. They are used to add information or change the description of service in order to improve accuracy or specificity. Modifiers can be alphabetic, numeric or a combination of both, but will always be two digits. Some modifiers cause automated pricing changes, while others are used for information only. When selecting the appropriate modifier to report on your claim, please ensure that it is valid for the date of service billed.

For modifiers that can be used for more than one topic, please refer to the Additional HCPCS or Other CPT for definition.

Type of Modifier	Modifiers Listed
Additional Healthcare Common Procedure Coding System (HCPCS) Modifiers	AE, AF, AG, AI, AK, AM, AT, AZ, BL, CA, CB, CG, CP, CR, CT, DA, ET, FB, FC,FX, G7, GC, GE, GG, GJ, GU, J1, J2, J3, JC, JD, JW, L1, M2, PD, PI, PO, PN, P5, PT, Q0, Q1, Q3, Q4, Q5, Q6, RD, RE, SC, SF, SS, SW, TC, TS, UJ, UN, UP, UQ, UR, US, XE, XP, XS, XU, ZA
Advance Beneficiary Notice of Noncoverage (ABN) Modifiers	GA, GX, GY, GZ
Ambulance Modifiers	D, E, G, H, I, J, N, P, R, S, X, GM, QL, QM, QN
Anatomical Modifiers (Coronary Artery, Eye Lid, Finger, Side of Body, Toe)	E1, E2, E3, E4, FA,F1,F2,F4, F5, F6, F7, F8, F9, LC, LD, LM, LT, RC, RI, RT, TA, T1, T2, T3, T4, T5, T6, T7, T8, T9 **Note:** These modifiers should be used in place of modifier 59 whenever possible.
Anesthesia Modifiers	AA, AD, QK, QS, QY, QX, QZ, 23, 33
Assistant at Surgery Modifiers	AS, 80, 81, 82
End Stage Renal Disease (ESRD) and Erythropoiesis Stimulating Agent (ESA) Modifiers	AX, EA, EB, EC, AY, ED, EE, EJ, EM, G1, G2, G3, G4, G5, G6, G5, JA, JB, JE, V5, V6, V7, V8, V9
Global Surgery Modifiers	24, 25, 57, 58, 78, 79 **Note:** Modifiers 24, 25, 57 apply to Evaluation and Management Services
Hospice Modifiers	GV, GW
Laboratory Modifiers	90, 91, 92, QW
Other Current Procedural Terminology (CPT) Modifiers	26, 27, 33, 59, 76, 77
Podiatry Modifiers	Q7, Q8, Q9

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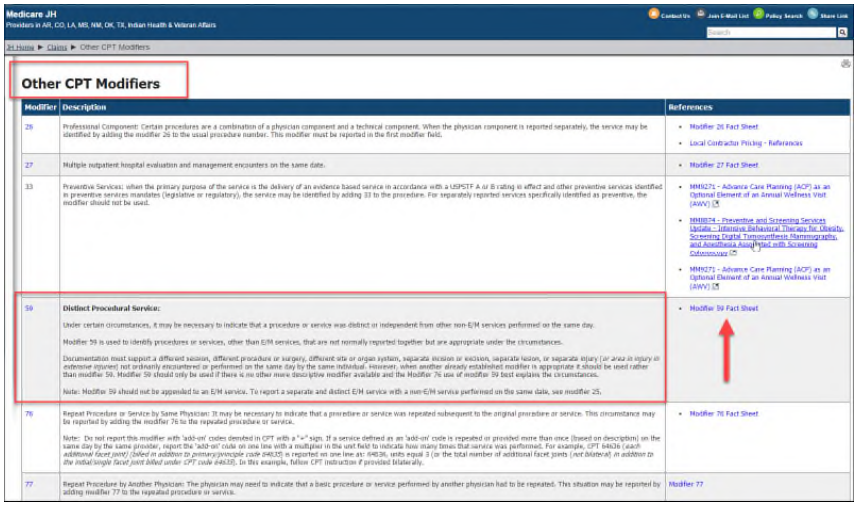
Definition and Fact Sheet



Inquiries Regarding NCCI

National Correct Coding Initiative

Correct Coding Solutions, LLC

Attention: Niles R. Rosen, M.D., Medical Director and Linda S. Dietz, RHIA, CCS, CCS-P, Coding Specialist

P.O. Box 907

Carmel, IN 46082-0907

Fax #: 317-571-1745

Email: NCCIPTPMUE@cms.hhs.gov

NCCI Reminder

- NCCI modifiers should NOT be used to inappropriately bypass an NCCI edit
- Documentation in the medical record must satisfy the criteria required by any NCCI associated modifier used
- Additional Resources:
  - Medicare Claims Processing Manual, Pub. 100-04, Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPPS)
  - MLN Matters Article MM3200 Clarification of Payments and Billing Procedures for Hospitals Subject to the Maryland Waiver
  - National Correct Coding Initiative/ Medically Unlikely Edits: The Nuts and Bolts of Correct Coding Edits

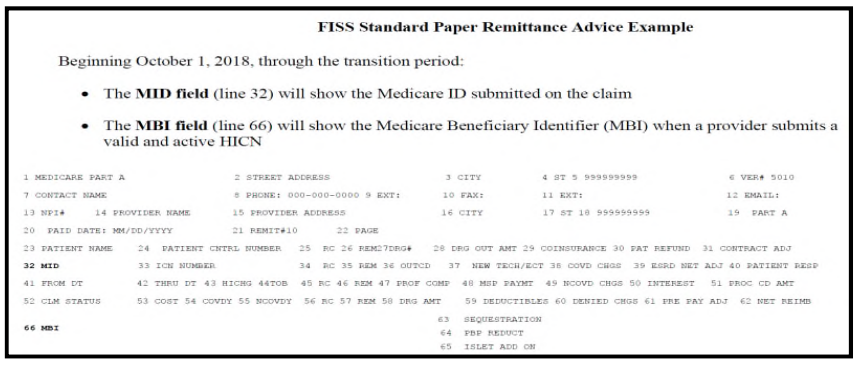
Medicare Updates and What's Trending

Important Dates For The New Medicare Card

- CMS to remove Social Security Numbers (SSNs) from all Medicare cards by **April 2019**
- The transition period will run from **April 2018 through December 31, 2019**
- Effective October 1, 2018, updates were 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)
- Find more information on the New Medicare Card on the CMS website on the New Medicare Card home page and the Providers page

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

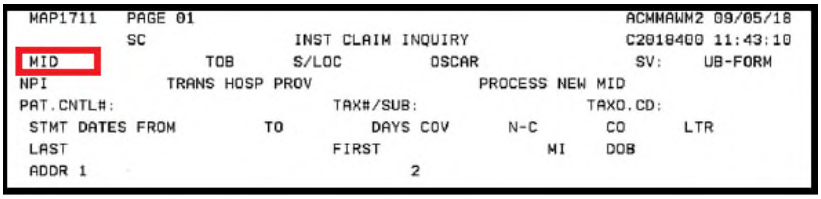
Beginning October 1, 2018, through the transition period:

- 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 | 19 PART A
20 PAID DATE: MM/DD/YYYY | 21 REMIT#10 | 22 PAGE
23 PATIENT NAME | 24 PATIENT CNTRL NUMBER | 25 RC 26 REM27DRG# | 28 DRG OUT AMT 29 COINSURANCE 30 PAT REFUND | 31 CONTRACT ADJ
32 MID | 33 ICN NUMBER | 34 RC 35 REM 36 OUTCD | 37 NEW TECH/ECT 38 COVD CHGS | 39 ESRD NET ADJ 40 PATIENT RESP
41 FROM DT | 42 THRU DT 43 HICHG 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 DNG AMT | 59 DEDUCTIBLES 60 DENIED CHGS 61 PRE PAY ADJ | 62 NET REIMB
66 MBI | 63 SEQUESTRATION | 64 PBP REDUCT | 65 ISLET ADD ON

FISS Health Insurance Claim (HIC) Field Changed to MID

- FISS Manual updated to reflect Direct Data Entry (DDE) screen changes as part of the Social Security Initiative
- Effective October 1, 2018, all fields currently named 'HIC' in FISS to be renamed to 'MID' (Medicare Identification Number)

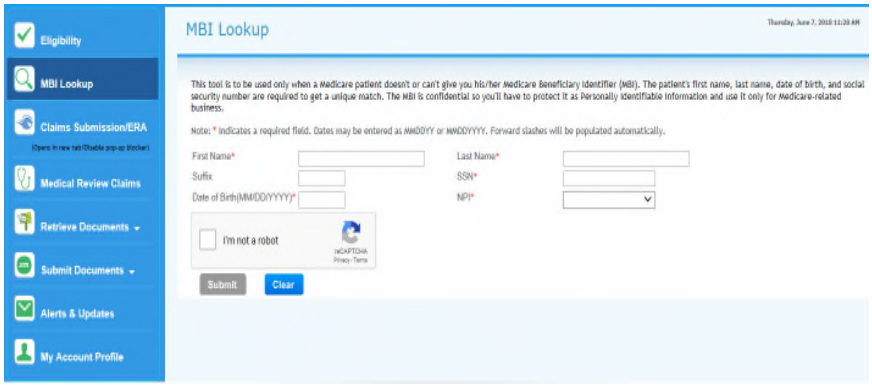


New Medicare Card

- 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

Novitasphere MBI Lookup

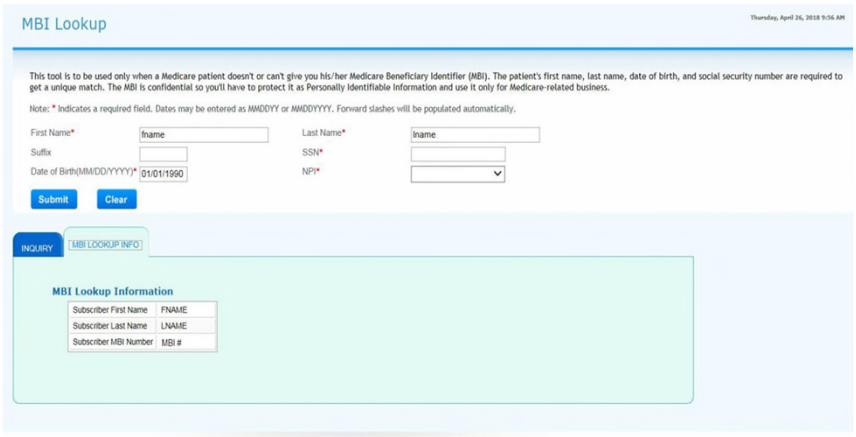
- MBI crosswalk tool in Novitasphere now available



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

MBI Lookup Results

- MBI lookup results



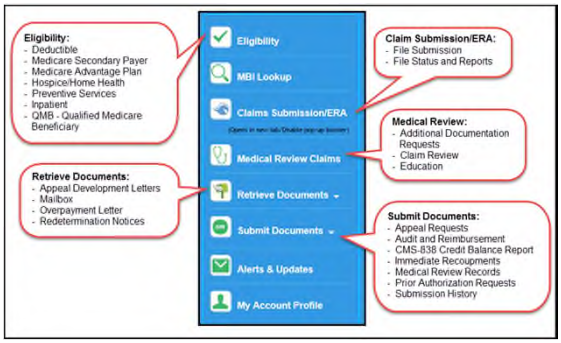
I N N O V A T I O N I N A C T I O N

Trending Inquiries Received in the Customer Contact Center

- Trouble using IVR to obtain beneficiary eligibility or claim status using an MBI?
  - When speaking an MBI in the IVR be sure to speak naturally, including normal pauses ever few characters
  - Convert a MBI to a number that can be keyed into the IVR using the IVR Alphanumeric Conversion Tool (JH) (JL):
    - ✓ Example:
      - ➢ MBI number EG-4TE-5MK-72 converted 1*32*414*81*325*61*5272
- Consider using the Novitasphere (JH) (JL) for most self service inquiries

Novitasphere

- Novitasphere is a FREE, secure internet portal for the provider community to use to easily connect directly to Novitas Solutions
- Novitasphere User Guides and Instructions
- Live Chat feature
- Dedicated Help Desk: 1-855-880-8424
  - Available from 8:00AM-5:00 PM ET



Important: Novitasphere Log In Requirement Changes

- CMS will be implementing a system security change that affects the Novitasphere log in requirements for maintaining access.
- **Effective September 1, 2018**, registered Novitasphere users must log into Novitasphere at https://www.novitasphere.com **at least once every 30 days** to be considered active.
- Upcoming Changes to Novitasphere Log In Requirements – Action Required

Update to Medicare Deductible, Coinsurance and Premium Rates for 2019

- MM11025:
  - Effective Date: January 1, 2019
  - Implementation Date: January 7, 2019
- Key Points:
  - 2019 Part A – Hospital Insurance:
    - ✓ Deductible: $1,364.00
    - ✓ Coinsurance:
      - ➢ $341.00 a day for 61st-90th day
      - ➢ $682.00 a day for 91st-150th day (lifetime reserve days)
      - ➢ $170.50 a day for 21st-100th day (Skilled Nursing Facility coinsurance)
  - 2019 Part B –Medical Insurance:
    - ✓ Deductible: $185.00 a year
    - ✓ Coinsurance: 20 percent
- Additional Reference:
  - 2019 Medicare Parts A & B Premiums and Deductibles Fact Sheet

Updating Language to Clarify for Providers Chapter 3, Section 20 and Chapter 5, Section 70 of the Medicare Secondary Payer Manual

- MM10863:
  - Effective: November 20, 2018
  - Implementation: November 20, 2018
- Key Points:
  - Clarification regarding when and where to obtain information from Medicare beneficiaries, or authorized representatives, for inpatient admissions or outpatient encounters
  - Medicare Secondary Payer (MSP) Manual, Pub. 100-05, Chapter 3 - MSP Provider, Physician, and Other Supplier Billing Requirements, Section 20.2.1 "Model Admission Questions to Ask Medicare Beneficiaries" provides a model questionnaire listing the type of questions hospitals may use to determine the correct primary payer
  - Providers may access CWF or HETS 270-271 transaction to verify if any insurance information it contains has changed:
    - ✓ No changes, no need to ask MSP questions, but notate for auditing purposes:
      - ➢ CWF or 270/271 screen print
    - ✓ Insurance information changed, must ask the MSP questions
  - Affiliated hospital-based service provider, such as a transfer ambulance service, does not need to ask MSP questions if already verified by hospital admissions staff:
    - ✓ Admissions staff bills for the service
    - ✓ Non-affiliated providers are responsible for verifying correct information prior to billing services

Outpatient Services Payment: Beneficiaries Who Are Inpatients of Other Facilities - Reminder

- Recent OIG report determined that Medicare inappropriately paid ACHs for outpatient services provided to beneficiaries who were inpatients of other facilities, including LTCH, IRF, IPF, and CAH:
  - As a result, beneficiaries were unnecessarily charged outpatient deductibles and coinsurance payments
- All items and non-physician services provided during a Medicare Part A inpatient stay must be provided directly by the inpatient hospital or under arrangements with the inpatient hospital and another provider
- References:
  - Medicare Inappropriately Paid Acute-Care Hospitals for Outpatient Services They Provided To Beneficiaries Who Were Inpatients of Other Facilities OIG Report, September 2017.
  - MLN Matters Special Edition Article SE170133 Medicare Does Not Pay Acute-Care Hospitals for Outpatient Services They Provide to Beneficiaries in a Covered Part A Inpatient Stay at Other Facilities
  - Provider Compliance Tips for Ordering Hospital Outpatient Services Fact Sheet
  - Acute Care Hospital Inpatient Prospective Payment System Fact Sheet Page 3
  - Items and Services Not Covered Under Medicare Booklet Page 12
  - Medicare Claims Processing Manual, Pub. 100-04, Chapter 3 – Inpatient Hospital Billing , Section 10.4 " Payment of Nonphysician Services for Inpatients"

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 CPT codes 77014, 77280, 77285, 77290, 77295, 77306-77321, 77331, 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
  - Novitas Solutions will begin adjusting claims for outpatient IMRT that did not comply with Medicare billing requirements and were overpaid as a result of a recent audit by the OIG
- For more information:
  - Proper Billing for Intensity-Modulated Radiation Therapy (IMRT) Planning Services
  - MLN Matters Special Edition Article SE18013 - Intensity-Modulated Radiation Therapy (IMRT) Planning Services Editing

Claims for Beneficiaries Eligible as a Qualified Medicare Beneficiary (QMB)

- Based on MM10433, the QMB information was reintroduced on the Medicare remittance with revised coding from what was implemented with CR9911:
  - Claim Adjustment Group Code “Patient Responsibility” (PR)
  - Remittance Advice Remark Codes (RARC):
    - ✓ 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.
- Claims that processed with the QMB information between October 2, 2017, and December 8, 2017 are being reprocessed per instruction from MM10494

2019 Payment Updates Overview

- Fiscal Year (FY) 2019 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long-Term Acute Care Hospital (LTCH) Prospective Payment System Final Rule (CMS-1694-F) Fact Sheet:
  - Hospital Transparency:
    - ✓ Guidelines specifically require hospitals to make public a list of their standard charges
    - ✓ Encourage price transparency by improving public accessibility of charge information:
      - ➢ Post via the Internet in a machine readable format
      - ➢ Update this information at least annually, or more often as appropriate
    - ✓ Frequently Asked Questions Regarding Requirements for Hospitals To Make Public a List of Their Standard Charges via the Internet
  - Two Midnight Policy:
    - ✓ No longer a requirement that written inpatient admission orders be present in the medical record as a specific condition of Medicare Part A payment
  - Updates Medicare payment policies and rates under IPPS and LTCH PPS
- MLN Connects email newsletter:
  - Weekly email newsletter includes recently released MLN Matter Articles
  - Recent letter to clinicians outlining how the agency is reducing burden through reform of documentation and coding requirements

Medicare and Opioids

- CMS Opioids Roadmap:
  - CMS is exploring all of our options to address this national crisis:
    - ✓ Focus on **prevention** of new cases of opioid use disorder (OUD), the **treatment** of patients who have already become dependent on or addicted to opioids, and the utilization of **data** from across the country to target prevention and treatment activities
- MLN Matters Special Edition Article SE18004 Review of Opioid Use during the Initial Preventive Physical Examination (IPPE) and Annual Wellness Visit (AWV):
  - Review the patient's medical and family history:
    - ✓ Medicare would like to emphasize that review of opioid use is a routine component of this element, including OUD
    - ✓ If a patient is using opioids, assess the benefit from other, non-opioid pain therapies instead, even if the patient does not have OUD but is possibly at risk
- MLN Matters Special Edition Article SE18016 A Prescriber's Guide to the New Medicare Part D Opioid Overutilization Policies for 2019:
  - New policies for Medicare drug plans to follow starting on January 1, 2019:
    - ✓ Involve further partnership with providers and prescription drug plans:
      - ➢ Providers are in the best position to identify and manage potential opioid overutilization in the Medicare Part D population
      - ➢ Medicare prescription drug plans can assist providers by alerting them about unusual utilization patterns in prescription claims
    - ✓ Improved safety alerts when opioid prescriptions are dispensed at the pharmacy, and drug management programs to better coordinate care when chronic high-risk opioid use is present

Part A Upcoming Events

- Novitas Medicare Part A Educational Event Calendar

Date	Time	Title
November 20	2:00 PM	Credit Balance Overview
November 27	11:00 AM	Novitasphere Hot Topics
November 29 and November 30	8:00 AM to 4:45 PM	Virtual Symposiums
December 4	2:00 PM	Novitasphere Overview
December 6	10:00	NCCI Edits W7020 and W7040

- Part A Request for Education

Customer Contact Information

- Providers are required to use the IVR unit to obtain:
  - Claim Status
  - Patient Eligibility
  - Check/Earning
  - Remittance inquiries
- Customer Contact Center- 1-877-235-8073
- Provider Teletypewriter- 1-877-235-8051
- Self-Service Tools:
- Patient / Medicare Beneficiary:
  - 1-800-MEDICARE (1-800-633-4227)
  - Medicare.gov

Summary

- Defined National Correct Coding Initiative (NCCI) and edits W7020 and W7040
- Explored NCCI self-service tools and NCCI associated modifiers
- Gave key points and references to the latest Medicare updates and trending issues
- Take advantage of the various self service options available to the provider community

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Thank you