NOVITAS SOLUTIONS

Medicare Updates and What's Trending for 2019

MD AAHAM

February 15, 2019

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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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:
    - NCCI Edits W7020 and W7040 Reminders
    - Medicare Updates and What's Trending
    - Novitas Initiatives
- Objectives:
    - Provide the latest news and updates
    - Stay updated on Medicare changes
    - Take advantage of the various self-service options available to the provider community
    - Explore the Medicare guidelines regarding outpatient services provided to an inpatient at another facility

NCCI Edits W7020 and W7040 Reminders

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

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 Moratorium Extended for Suspending Edits W7020 and W7040 for Maryland Waiver Hospital

- CMS issued an extension to the moratorium on the NCCI editing for MD Waiver hospitals from October 1, 2018, through June 30, 2019:
  - This is an extension of the previous 90-day moratorium from October 1, 2018, through December 31, 2018
- Novitas will bypass the W7020 and W7040 edits for claims received from October 1, 2018, through June 30, 2019, until the 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 July 1, 2019, claims will be subject to the edits

Add-On Code Edits – Reason Code W7106

- W7106 Add-on code reported without required primary procedure code:
  - Add-on code editing went into effect April 1, 2018, and includes non-OPPS providers
- Due to the moratorium in effect, this edit was applying incorrectly on a limited number of MD waiver hospital claims when there truly was a primary procedure code reported on the claim
  - Example – both the primary code (95939) and add-on code (95940) are present and showing as covered:
    - ✓ If the moratorium was not in place the primary code (95939) would have rejected for W7040 (pairs with code 22554 on the claim)
    - ✓ Due to the moratorium, an override applied to the claim allowing the primary code to pay, however, subsequently the add-on code line is denying
      - ➢ This is happening because the system is reading the primary code as non-covered, therefore denying the add-on code as missing the primary code
  - System issue has been resolved and providers are instructed to adjustment claims rejected in error:
    - ✓ Delete and rekey the line into covered

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Medicare Updates and What’s Trending

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

Annual Update to the Per-Beneficiary Therapy Amounts

- MM11055:
  - Effective: January 1, 2019
  - Implementation: January 7, 2019
- Key Points:
  - Outpatient therapy limits (KX modifier threshold) for:
    - ✓ Physical Therapy (PT) and Speech-Language Pathology (SLP) combined is $2,040
    - ✓ Occupational Therapy (OT) is $2,040
  - Medical Review (MR) threshold amount :
    - ✓ PT and SLP services combined is $3,000
    - ✓ OT services is $3,000
- Provider Specialty: Therapy (JH) (JL)

Removal of Functional Reporting Requirements for Therapy

- MM11120:
  - Effective: January 1, 2019
  - Implementation: February 26, 2019
- Key Points:
  - HCPCS G-codes and severity modifiers for functional reporting are no longer required on claims for therapy services
  - The retention of the therapy cap amounts as thresholds of incurred expenses above which claims must include a modifier to confirm services are medically necessary as shown by medical record documentation
- Functional reporting requirements were effective for dates of service, January 1, 2013 through December 31, 2018
  - Functional Reporting

Changes to Amount in Controversy (AIC) for Appeals in 2019

- The AIC for appeals filed on or after January 1, 2019:
  - Administrative Law Judge (ALJ) hearing will remain at $160
  - Federal District Court will increase from $1,600 to $1,630
- The amount in controversy is calculated in the following manner:
  - Amount Charged minus Medicare payments already made or awarded = Subtotal Balance
  - Subtotal Balance minus any applicable Deductible/Coinsurance = Amount in Controversy

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"

January 2019 Integrated Outpatient Code Editor (I/OCE) Specifications Version 20.0

- MM11068:
  - Effective: January 1, 2019
  - Implementation: January 7, 2019
- Key Points:
  - Instructions and specification for the I/OCE under OPPS and non-OPPS outpatient departments, CMHCs, and all non-OPPS providers
  - Summary of modifications:
    - ✓ New payment adjustment flags for radiological procedures on the coinsurance deductible not applicable list and subject to a payment reduction due to presence of either the FX (flag 23) or FY modifier (flag 24)
    - ✓ New payment method for claims for off-campus provider-based outpatient department with clinic code G0463 with modifier PO:
      - ➢ Bill type 13x with or without condition code (CC) 41
    - ✓ Edit 102 updated to not allow any conflicting modifiers to be reported together on the same HCPCS line;
      - ➢ See Modifier Pairs table for conflicting modifiers
    - ✓ Edit 109 implemented when a code first diagnosis is submitted on a PHP claim (Bill type 76x or 13x with CC41) without a mental health diagnosis in the secondary position
    - ✓ Edit 110 implemented for service provided prior to initial marketing date

Additonal January 2019 I/OCE Specifications

- Edit 22 added new valid modifiers:
  - ER - Items and services furnished by a provider-based off-campus emergency department
  - CO - Outpatient occupational therapy service provided by occupational therapy assistant
  - CQ - Outpatient physical therapy service provided by physical therapy assistant
  - G0 – Telestroke
- Update Comprehensive APC Assignment Rules and Criteria section"
  - Any procedure assigned a New Tech APC is excluded from packaging under Comprehensive APC processing effective 1/1/19
- Update Radiological Processing sections to include the modifier conflict conditions as well as conditions needed to obtain new payment adjust flags 23 and 24
- New section under Section 603 processing logic for new conditions related to hospital off-campus provider-based outpatient departments submitting claims with modifier PO
- Update FQHC processing section:
  - Line items submitted with bill type 770 are submitted to I/OCE with line item action flag 5
- Make all HCPCS/APC/SI changes as specified by CMS (quarterly data files)
- Implement version 25.0 of the NCCI (as modified for applicable outpatient institutional providers)

I/OCE Lists Updated With January 2019 Release

- Add on Type I (edit 106)
- Comprehensive APC list (Updated list and Rank)
- C-APC Exclusions list
- Comprehensive APC code pairs
- Device and Device-Procedure lists (edit 92)
- Terminated Device Procedures for offset APC
- Pass-through device offset amounts
- Pass-through radiopharmaceutical for offset APC (edit 99)
- Pass-through skin substitute product for offset APC (edit 99)
- Pass-through contrast for offset APC (edit 99)
- Pass-through stress agent for offset APC (edit 99)
- Radiological HCPCS reported with FX or FY modifier
- Skin Substitute Hi and Low-Cost lists (edit 87)
- Non-covered service (edit 9)
- Service not paid by Medicare (edit 13)
- Not recognized by Medicare (edit 28)
- Not recognized by OPPS (edit 62)
- Contrast HCPCS
- Male only procedure list (edit 8)
- Code first diagnoses list (edit 109)
- Mental health diagnosis list (edit 29)
- Daily mental health services list
- Mental health not approved for PHP (edit 80)
- PHP Primary Services list (list B)
- Rural Health Clinic (RHC) CG modifier non-payable list
- FQHC non-covered list
- FQHC flu ppv list
- FQHC Chronic Care Management procedure list
- Modifier pairs (new table for conflicting modifiers)
- Edit 99 Exclusions list
- Inherently bilateral procedure list
- Conditionally bilateral procedure list

Total Knee Arthroplasty (TKA) Removal fro the Medicare Inpatient-Only (IPO) List and Application of the 2- Midnight Rule

- SE19002:
  - Effective January 1, 2018, TKA procedures have been removed from the IPO list
  - TKA procedures can be performed on **an inpatient or an outpatient basis** assuming all other criteria is met
  - CMS contracted the Beneficiary and Family-Centered Care Quality Improvement Organizations (BFCC-QIOs) to review a sample of Medicare fee-for-service (FFS) short-stay inpatient for compliance with the 2-Midnight Rule looking at documentation in the medical record to support:
    - ✓ The admitting physician/practitioner's reasonable expectation that the beneficiary will require medically necessary hospital services spanning 2 midnights or longer and admits the patient to the hospital based on that expectation; or
    - ✓ The admitting physician/practitioner's judgment that the beneficiary required hospital care on an inpatient basis despite lack of a 2-midnight expectation based on complex medical factors including but not limited to:
      - ➢ Patient's history, co-morbidities and current medical needs
      - ➢ Severity of signs and/or symptoms
      - ➢ Risk of adverse events

Revision of Definition of the Physician Supervision of Diagnostic Procedures, Clarification of DSMT Telehealth Services, and Establishing a Modifier for Expanding the Use of Telehealth for Individuals with Stroke

- MM11043 :
  - Effective: January 1, 2019
  - Implementation: January 2, 2019
- Key Points:
  - Revises the definition of "Personal Supervision" of the Physician Supervision of Diagnostic Procedures indicator to specify that procedures performed by a Registered Radiologist Assistant (RRA) or a Radiology Practitioner Assistant (RPA) may be performed under direct supervision
  - Adds instructions to use modifier G0 (G zero) to identify Telehealth services furnished for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke
  - Clarifies requirements for when Diabetes Self-Management Training (DSMT) services may be paid as a telehealth service

New Instructions for Local Coverage Determinations (LCDs)

- MM10901:
  - Implementation: January 8, 2019
- Key Points:
  - New LCDs:
    - ✓ Informal meetings are optional for customers to request information on how to submit valid new LCD request:
      - ➢ Will be conducted via teleconference
    - ✓ New LCD requests have specific requirements to be valid
    - ✓ Comment period and notice period will not change for new LCDs
  - Contractor Advisory Committee (CAC):
    - ✓ Will now be open to interested parties to observe:
      - ➢ Locations and times will be posted to our website
    - ✓ CAC members will also include non-physician healthcare professionals such as Dentist, Certified Registered Nurse Anesthetist (CRNA), Physical Therapist (PT) and Licensed Clinical Social Worker (LCSW)

New LCD Process

- LCD reconsideration request:
  - ✓ Coding updates only, such as adding diagnosis code, will be handled through revision to companion local coverage article:
    - ➢ No longer appropriate to include CPT or ICD-10 codes in LCDs instead they will be placed in billing and coding articles linked to LCD (process could take up to 1 year to complete)
  - ✓ Change in coverage will require a comment and notice period:
    - ➢ This change may delay LCD revisions for a reconsideration request

Revised LCDs and Articles

- The list of revised LCDs and Articles are on our website under December 28:
  - The revised LCDs and Articles will be published to the Medicare Coverage Database and on our Website in February

Hospital Price Transparency

- Effective in 2019 CMS updated its guidelines to 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
- References:
  - CMS Finalizes Changes to Empower Patients and Reduce Administrative Burden
  - 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)
  - Frequently Asked Questions Regarding Requirements for Hospitals To Make Public a List of Their Standard Charges via the Internet

FISS Provider Practice Location Address

- FISS Claim Page 3 Provider Practice Location:
  - New claim page must include your practice location address when services billed are rendered in an off-campus, outpatient, or provider-based department of a hospital facility
    - ✓ Report the address **exactly** as it appears in PECOS
    - ✓ Upon implementation of the April 2019 quarterly release, claims that do not match exactly will RTP
    - ✓ Ensure that an accurate address for each hospital department practice location is present in PECOS
      - ➢ Providers who need to add a new or correct an existing practice location address will need to submit a new 855A enrollment application in PECOS
  - Refer to MLN Special Edition Article SE18002 Billing Requirements for OPPS Providers with Multiple Service Locations and SE18023 Activation of Systemic Validation Edits for OPPS Providers with Multiple Service Locations

FISS Claim Page 3 Provider Practice Location Address

- To access Claim Page 03, (MAP171F), from Claim Page 03 (MAP1719) press F11
- Enter the provider practice location address in the fields provided on this page

```
MAP171F    PAGE 03             NOVITAS SOLUTIONS              ACPMAWP2 08/22/18
           SC                INST CLAIM INQUIRY               C201833P 15:13:05

HIC                  TOB      S/LOC          PROVIDER
      P R O V I D E R   P R A C T I C E   L O C A T I O N   A D D R E S S

ADDRESS 1:

ADDRESS 2:

CITY     :                                    STATE:      ZIP:

                                                                <== REASON CODES
PRESS PF3-EXIT PF7-PREV PF8-NEXT PF10-LEFT
```

Reporting the Service Facility Location for an Off-Campus, Provider-Based Department of a Hospital

- Claim level information:
  - When all the services rendered on the claim are from the billing provider address:
    - ✓ Report the billing provider address only in the billing provider loop 2010AA and not to report any service facility location in loop 2310E (or in DDE MAP 171F screen for DDE submitters)
  - When all the services rendered on the claim are from one campus of a multi-campus provider that report a billing provider address:
    - ✓ Report the campus address where the services were rendered in the service facility location in loop 2310E if the service facility address is different from the billing provider address loop 2010AA (or in DDE MAP 171F screen for DDE submitters)
  - When all the services rendered on the claim are from the same off-campus, outpatient, provider-based department of a hospital:
    - ✓ Report the off-campus, outpatient, provider-based department service facility address in the service facility provider loop 2310E (or in DDE MAP 171F screen for DDE submitters)
  - When there are services rendered on the claim from multiple locations:
    - ✓ If any services on the claim were rendered at the billing provider address:
      - Report the billing provider address only in the billing provider loop 2010AA and do not report the service facility location in loop 2310E (or in DDE MAP 171F screen for DDE submitters)
    - ✓ If no services on the claim were rendered at the billing provider address:
      - Report the service facility address in loop 2310E (or in DDE MAP 171F screen for DDE submitters) from the first registered encounter of the “From” date on the claim
- Line level information:
  - Report modifier PO (Services, procedures and/or surgeries provided at off-campus provider-based outpatient departments) for all excepted items for services reported with a HCPCS furnished
  - Report modifier PN (Non-excepted service provided at an off-campus, outpatient, provider-based department of a hospital) for all non-excepted items and services
    - ✓ Triggers payment under the MPFS

User CR: FISS to Add Additional Search Features to Provider Direct Data Entry (DDE) Screen

- MM10542:
  - Effective: January 1, 2019
  - Implementation: January 7, 2019
- Key Points:
  - New feature will allow providers to find the claim associated with the AR and reconcile it back to their patient accounts:
    - ✓ Use the invoice number on the AR to find the DCN
    - ✓ Use the DCN to look up the claims
    - ✓ New screen will be "Invoice Number/DCN Translator"

FISS Invoice Number/DCN Translator

- Menu option 88 on the Inquiry Menu in FISS
- Enter up to 5 DCNs on the left or 5 DCNs on the right

```
MAPHDCN                                                  ACMMAWM2 12/10/18
                          MEDICARE PART A                C2019100 09:22:52
                   INVOICE NUMBER/DCN TRANSLATOR

PLEASE ENTER UP TO 5 DCNS ON THE LEFT OR 5 DCNS ON THE RIGHT. PRESS PF9.
THE EQUIVALENT DCNS WILL BE DISPLAYED IN THE OPPOSITE FIELD.

    F I S S   D C N                          INVOICE NUMBER

    _______________________                  __________________

    _______________________                  __________________

    _______________________                  __________________

    _______________________                  __________________

    _______________________                  __________________

MSG:      PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
PF1=         PF2=         PF3=END      PF4=         PF5=         PF6=
PF7=         PF8=         PF9=PROCESS  PF10=        PF11=        PF12=
```

Annual FISS Recertification

- CMS requires annual recertification of every user who has access to FISS
- Users must be recertified by the authorized official (AO) or delegated official (DO) on file within 30 days of the date of the letter:
  - Letter mailed to the AO/DO listed on the provider's CMS-855A
  - User's access will be removed if letter is:
    - ✓ Incomplete
    - ✓ Inaccurate
    - ✓ Not returned by the due date
  - Completed recertification letters must be return to EDI via fax at 1-877-439-5479
- For more information:
  - Novitas Solutions Annual Recertification of Part A FISS Users

CMS New Cost Reporting Portal

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

MSP Diagnosis Codes Available in HETS and Novitasphere

- HETS and Novitasphere will return MSP diagnosis codes when applicable:
  - MSP diagnosis codes primarily relate to treatment from an injury or illness resulting from and auto or other accident which:
    - ✓ Liability or no-fault insurance may pay
    - ✓ Another party is responsible for payment
    - ✓ Workers' compensation benefits for a given condition
  - Helps you determine primary and secondary billing for patient services
  - These are ICD-10 diagnosis codes that are listed on the beneficiaries' MSP file:
    - ✓ If the MSP file was set up with ICD-9 codes, these will not populate
- References:
  - MLN Connects December 6, 2018
  - Novitasphere Portal Part A User Manual

Novitasphere MSP Information

INQUIRY | BENEFICIARY | ELIGIBILITY | DEDUCTIBLE | MAP | MSP | HOSPICE/HOME HEALTH | PREVENTIVE | INPATIENT | QMB

Medicare Secondary Payer Information

Type Code	Eff Date	Term Date	MSP Diagnosis Code	Policy Number	Insurer Name	Address
14	01/01/2017	07/31/2017	S8002XA,S40012A,S93609A,G5622	12345	ABC HEALTH PLAN	123 MAIN ST ANY TOWN, MD 21204
14	12/01/2017		M545,M542,M25512,M25412,S40012A,G5622	54321	XYZ HEALTH PLAN	987 BROAD WAY ANYTOWN, HI 999999999
15	07/28/2016		B20,M1612,M25552,M879	WCP101725801GIC	GUARANTEE INSURANCE COMPANY, INC	401 E LAS OLAS BLVD STE 1650 FT LAUDERDALE, FL 333014252
13	06/01/2011	06/01/2013		POLICYNUMBER	ORGNAME	ADDRESSLINE1 ADDRESSLINE2 CITY, ST ZIPCODE
47	01/23/2016		S0100XA	AOH0217727	STATE AUTOMOBILE MUTUAL INSURANC	518 E BROAD ST COLUMBUS, OH 432153901
14	01/23/2016	02/18/2016	S0100XA	AOH0217727	STATE AUTOMOBILE MUTUAL INSURANC	518 E BROAD ST COLUMBUS, OH 432153901

HETS and Novitasphere Include Medicare Diabetes Prevention Program Information

- HETS and Novitasphere will return MDPP information:
  - Use this information to determine the next available (MDPP) services for you patients
  - MDPP usage information will not be available if a beneficiary is ineligible for MDPP
- Reference:
  - MLN Connects December 13
  - Provider Specialty: Preventive Services Part A

Novitasphere – Preventive Services

INQUIRY | BENEFICIARY | ELIGIBILITY | DEDUCTIBLE | MAP | MSP | HOSPICE/HOME HEALTH | PREVENTIVE | INPATIENT | QMB

Smoking Cessation

Remaining Sessions	Next Session Date
8	

MDPP With No Prior Usage

HCPCS Code	Description
G9873	Initiating Payment

MDPP With Prior Usage

HCPCS Code	Date of Service	NPI
G9873	06/05/2018	1234567893
G9891	08/27/2018	1234567893
G9891	07/20/2018	1111111113
G9874	09/23/2018	1234567893

Preventative Services

* Deductible and Coinsurance will not be displayed if it is waived

Service Code	Next Technical Date	Next Professional Date	Calendar Year	Deductible Applied	Deductible Remaining to be met	Coinsurance %
80061	01/05/2013	01/05/2013	01/05/2013	$0.00		0
G0117	01/07/2012	01/07/2012	01/07/2012	$147.00	$0.00	.2

2019 Medicare Part D Opioid Policies: Information for Prescribers

- CMS implemented new opioid policies for Medicare drug plans on January 1, 2019, that include:
  - Improved safety alerts when patients fill opioid prescriptions at the pharmacy
  - Drug management programs for patients at-risk for misuse or abuse of opioids or other drugs
  - Posted new training materials, including slide decks and tip sheets for:
    - ✓ Prescribers
    - ✓ Pharmacists
    - ✓ Patients
- MLN Matters Special Edition Article SE18016 A Prescriber's Guide to the New Medicare Part D Opioid Overutilization Policies for 2019
- Visit the Reducing Opioid Misuse webpage for more information on CMS' overall strategy:
  - Prevention
  - Treatment
  - Data
- Review of opioid use during the IPPE and is helpful in diagnosing and then treating as appropriate opioid disorders:
  - MLN Matters Special Edition Article SE18004 - Review of Opioid Use During the IPPE and AWV

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