Medicare Updates and What's Trending

MD AAHAM

November 22, 2019

INNOVATION IN ACTION

Disclaimer

- All Current Procedural Terminology (CPT) only are copyright 2018 American Medical Association (AMA). All rights reserved. CPT is a registered trademark of the American Medical Association. Applicable Federal Acquisition Regulation/ Defense Federal Acquisition Regulation (FARS/DFARS) Restrictions Apply to Government Use. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.
- The information enclosed was current at the time it was presented. Medicare policy changes frequently; links to the source documents have been provided within the document for your reference. This presentation was prepared as a tool to assist providers and is not intended to grant rights or impose obligations.
- Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services.
- Novitas Solutions' employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this guide.
- This presentation is a general summary that explains certain aspects of the Medicare program, but is not a legal document. The official Medicare program provisions are contained in the relevant laws, regulations, and rulings.
- Novitas Solutions does not permit videotaping or audio recording of training events.

INNOVATION IN ACTION

Subscribe to Novitas eNews!

- Receive current updates via email directly from Novitas Solutions:
  - Part A and Part B News
  - Issued every Tuesday and Friday
  - CMS MLN Connects issued Thursdays
- Subscribing is quick and easy:
  - Click the Join E-Mail List from our website tool bar

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

Acronym List

Acronym	Definition
ACH	Acute Care Hospital
CAH	Critical Access Hospital
CMS	Centers for Medicare & Medicaid Services
EDI	Electronic Data Interchange
FISS	Fiscal Intermediary Shared System
HIC	Health Insurance Claim
IPF	Inpatient Psychiatric Facility
IRF	Inpatient Rehab Facility
LTCH	Long Term Care Hospital
MBI	Medicare Beneficiary Identifier
MID	Medicare Identification Number
OIG	Office of Inspector General
OPPS	Outpatient Prospective Payment System

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

Today's Presentation

- Agenda:
  - Medicare Updates and Reminders
  - Overview of Hospital Off-Campus Outpatient Department Reporting Requirements
  - Part A East (PAE) QIC Demonstration
  - Credit Balance Reporting
  - Education and Training Events
- Objectives:
  - Identify and understand the current Medicare updates and reminders
  - Identify and utilize the educational resources and information
  - Explore the Medicare guidelines regarding outpatient services provided to an inpatient at another facility

Medicare Updates and Reminders

Update to Medicare Deductible, Coinsurance and Premium Rates for 2020

NOVITAS SOLUTIONS

- 2020 Part A – Hospital Insurance:
  - Deductible: $1408.00
  - Coinsurance:
    - ✓ $352.00 a day for 61st-90th day
    - ✓ $704.00 a day for 91st-150th day (lifetime reserve days)
    - ✓ 176.00 a day for 21st-100th day (Skilled Nursing Facility coinsurance)
- 2020 Part B –Medical Insurance:
  - Deductible: $198.00 a year
  - Coinsurance: 20 percent
- Reference:
  - 2020 Medicare Parts A & B Premiums and Deductibles Fact Sheet

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

Opioid Treatment Programs: Get Ready to Participate in the New Benefit

NOVITAS SOLUTIONS

- Starting January 1, 2020, under the CY 2020 Physician Fee Schedule proposed rule, CMS plans to pay Opioid Treatment Programs (OTPs) through bundled payments for opioid use disorder treatment services for people with Medicare Part B, including medication-assisted treatment medications, toxicology testing, and counseling
- Get ready to participate in the new benefit:
  - Obtain full OTP certification from the Substance Abuse and Mental Health Services Administration (SAMHSA)
  - Enroll in Medicare starting in early November
  - Subscribe to MLN Connects for the latest news and updates
- For More Information:
  - Fact Sheet
  - OTP webpage

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

Medicare Coverable Services for Integrative and Non-pharmacological Chronic Pain Management

- SE19008 Non-pharmacologic treatment options for pain:
  - National Coverage Determinations (NCDs):
    - ✓ Electrical nerve stimulation Electrical nerve stimulation (NCD 160.7)
    - ✓ Induced lesions of nerve tracts (NCD 160.1
    - ✓ Inpatient hospital pain rehabilitation (NCD 10.3)
    - ✓ Outpatient hospital pain rehabilitation (NCD 10.4)
    - ✓ Supervised exercise therapy for symptomatic peripheral artery disease (NCD 20.35)
    - ✓ Screening for depression (NCD 210.9)
  - Local Coverage Determinations (LCDs):
    - ✓ Epidural injections
    - ✓ Spinal cord stimulation
    - ✓ Peripheral nerve stimulation
    - ✓ Facet joint interventions
    - ✓ Therapy and rehabilitation services (PT, OT)
  - Additional National Policies:
    - ✓ Chronic care management
    - ✓ Behavioral health integration services
  - Preventive Services:
    - ✓ Initial Preventive Physical Exam (IPPE)
    - ✓ Annual Wellness Visits (AWV)

Influenza Vaccine Payment Allowances Annual Update for 2019-2020 Season

- MM11428:
  - Effective August 1, 2019
  - Implementation no later than October 1, 2019
- Key Points:
  - Updated payment allowances for influenza vaccines
  - 2019-2020 season
- Influenza resources:
  - SE19022 - 2019-2020 Influenza (Flu) Resources for Health Care Professionals

October 2019 Quarterly and Fiscal Year 2020 Updates

- MM11451 - October 2019 Hospital Outpatient Perspective Payment System Updates:
  - Reflects the HCPCS, Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in CR 11451
- MM11412 - October 2019 Integrated Outpatient Code Editor (I/OCE) Specifications Version 20.3:
  - Summarizes the modifications of the I/OCE for the October 2019 V20.3 release
  - Providers should review the entire CR 11412 document and note the highlighted sections, which also indicate changes from the prior release of the software
- MM11343 - October 2019 - Quarterly Average Sales Price (ASP):
  - Refers providers to review CR 11343 for new and revised Average Sales Price (ASP) and ASP Not Otherwise Classified (NOC) drug pricing files for Medicare Part B drugs
- MM11361 - Fiscal Year (FY) 2020 Inpatient Prospective Payment System (IPPS) and Long Term Care Hospital (LTCH) PPS Changes
  - Policy changes for FY 2020 were displayed in the Federal Register on August 2, 2019, with a publication date of August 16, 2019, and the corresponding correction document published on October 8, 2019 in the Federal Register
  - All items covered in this CR are effective for hospital discharges occurring on or after October 1, 2019, through September 30, 2020, unless otherwise noted
- Refer to the corresponding CRs and links within articles to determine coding and billing as it applies to MD Waiver

Inpatient Rehabilitation Facility (IRF) Services: Billing Requirements

- In a recent report, the OIG determined that payments for IRF services did not comply with Medicare billing requirements:
  - Medical record documentation did not support that IRF care was reasonable and necessary
  - CMS revised the Inpatient Rehabilitation Facilities (IRFs): Improving Documentation Positively Impacts CERT Web-Based Training (WBT) course and the IRF Prospective Payment System Booklet
- Additional resources:
  - MM11345 - Inpatient Rehabilitation Facility (IRF) Annual Update: Prospective Payment System (PPS) Pricer Changes for FY 2020
  - Many IRF Stays Did Not Meet Medicare Coverage and Documentation Requirements OIG Report
  - FY 2019 IRF PPS Final Rule
  - IRF Quality Reporting Program website
  - Medicare Benefit Policy Manual Chapter 1, Section 110

IRF Coverage Requirements

- A pre-admission screening, reviewed and approved by a rehabilitation physician before an IRF admission
- A post-admission physician evaluation verifying the patient's pre-admission screening information remains unchanged or documenting any changes
  - **NOTE:** Beginning October 1, 2018, the post-admission physician evaluation counts as one of the three required face-to-face rehabilitation physician visits in the first week of the IRF stay
- An individualized patient plan of care
- An interdisciplinary approach to IRF care with interdisciplinary team meetings held at least once per week throughout the IRF stay
  - **NOTE:** Beginning October 1, 2018, the rehabilitation physician may lead the interdisciplinary team meetings remotely without any additional documentation requirements
- Clarifies the IRF admission requirements by specifying a patient must:
  - Need the active and ongoing therapeutic intervention of multiple therapy disciplines (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics therapy):
    - ✓ One of the therapies must be physical therapy or occupational therapy
  - Generally, need an intensive rehabilitation therapy program uniquely provided in IRFs
  - Be reasonably expected to actively participate in and benefit from intensive IRF services
  - Need close medical supervision by a physician for managing medical conditions to support participation in an intensive rehabilitation therapy program
  - Need an intensive, coordinated interdisciplinary care approach

MBI is Here!

- Effective January 1, 2020, claims submitted to Medicare will require the beneficiary's MBI number
- Is your office or facility prepared for the MBI transition?
- Use MBI now for all Medicare transactions
- 3 ways to get the MBI:
  - Ask your patient for their card
  - Use your Medicare Administrative Contractor's look up tool:
    - ✓ Sign up for the Portal to use the tool
  - Check the remittance advice:
    - ✓ MBI is returned on the remittance advice if a valid and active Health Insurance Claim Number is submitted
- Get Your New Medicare Card
- Beneficiaries who did not receive their card can:
  - Sign into MyMedicare.gov:
  - Call 1-800-MEDICARE (1-800-633-4227)
  - TTY users can call 1-877-486-2048

Is Your Vendor/Clearinghouse Submitting Your Claims With the MBI?

NOVITAS SOLUTIONS

- If you send the MBI to your vendor/clearinghouse on your Medicare claim for payment, but you see both the Health Insurance Claim Number and the MBI on your remittance advice:
  - Your vendor/clearinghouse is not using the MBI to submit your claims
  - Contact your vendor/clearinghouse today and ask about their process to submit Medicare claims
- Starting January 1, 2020, Medicare will reject claims with the Health insurance Claim Number, with a few exceptions
- For more information, see the MLN Matters Article

JL Claims Submitted With MBI October 2019

NOVITAS SOLUTIONS

- Part A

JL Region	Total % of Claims Submitted with MBI
Delaware	95.00%
Maryland	87.00%
New Jersey	79.70%
Pennsylvania	86.70%
Washington DC	82.20%
Monthly Average	86.12%

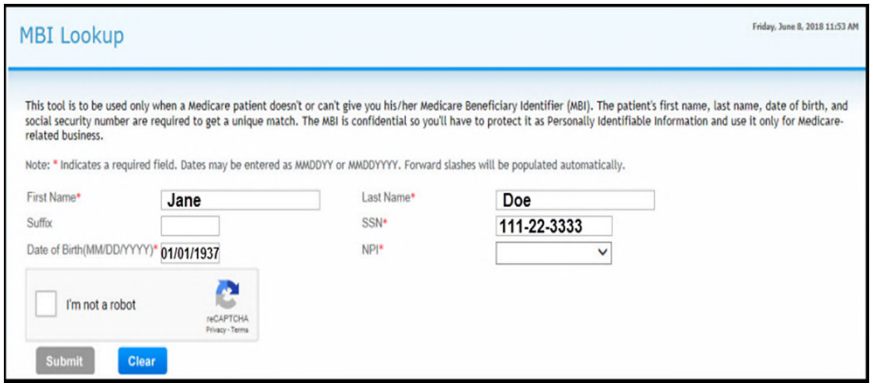
- Part B

JL Region	Total % of Claims Submitted with MBI
Delaware	89.40%
Maryland	86.10%
New Jersey	80.10%
Pennsylvania	86.10%
Washington DC	81.40%
Monthly Average	84.62%

INNOVATION IN ACTION

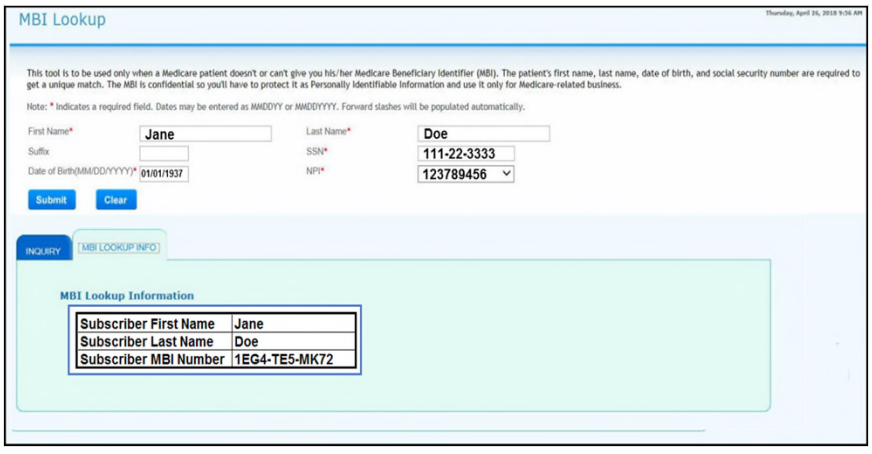
Novitasphere MBI Lookup

- Select the MBI Lookup from the left navigation bar



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

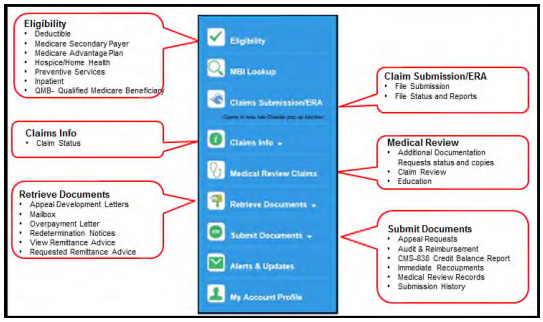
MBI Lookup Results



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

Part A Novitasphere

- New enhancements to Novitasphere for Part A
  - Appeal Status information
  - Remittance Advice copies
    - ✓ Copies similar to the Standard Paper Remittance (SPR)
- Novitasphere Portal Center
  - Enrollment information and reference materials
- Current features list:



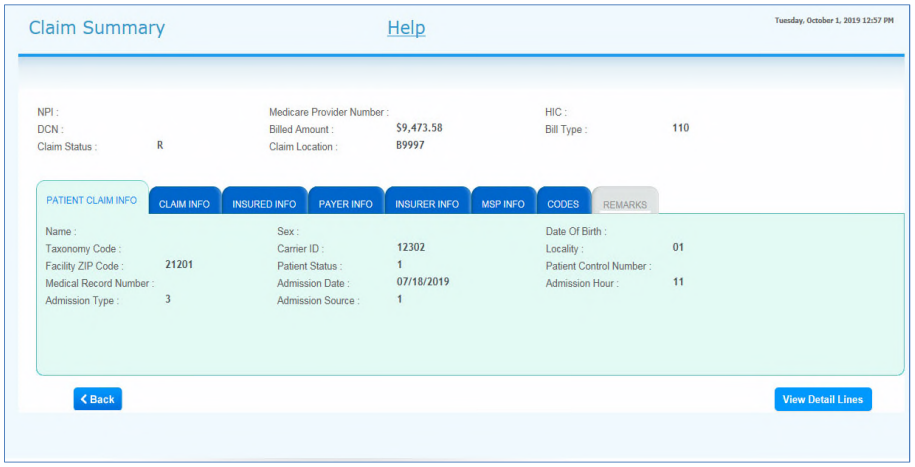
I N N O V A T I O N I N A C T I O N

New in Novitasphere: Part A Claim Status

- Part A Claim Status is now available in Novitasphere, our free, secure internet portal:
  - Status of claims going back over 2 years
  - Details such as:
    - ✓ Billed and paid amounts
    - ✓ Check number
    - ✓ Claim status and finalized date
    - ✓ Patient claim information
    - ✓ Line item details

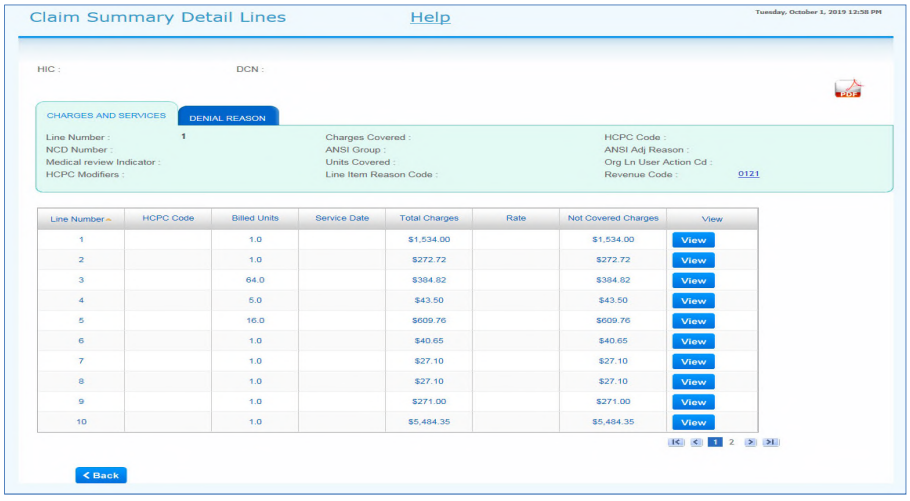
I N N O V A T I O N I N A C T I O N

Claim Status – Header Level



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

Claim Status – Detail Lines



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

Submitting a Redetermination in Novitasphere

- Enter the following data elements to locate a claim:
  - DCN
  - File to upload:
    - ✓ Use browse button
    - ✓ Documents must be in PDF or TIF format and less than 1500 pages
    - ✓ **Do not** submit a copy of Redetermination and Clerical Error Reopening Form with records:
      - ➢ Will cause duplication and will impact submission
    - ✓ Note: Add More Documentation creates another line entry

CMS HETS Production: Returns Wrong MSP Info

- Recent change resulted in HETS not receiving new and updated MSP data:
  - Could cause incorrect MSP information to be returned by the system
  - Issue is only impacting a limited number of beneficiaries' records
  - Resolution has been identified and CMS expects this issue to be resolved by late November

Conditional Payment Claim Reminder

- Definition:
  - A conditional payment is a payment made by Medicare when there is evidence that payment has not been made or cannot reasonably be expected to be made promptly
- Purpose:
  - For auto/no-fault, liability, or WC:
    - ✓ When the primary insurer does not pay promptly (within 120 days) or the case is in litigation payment is made "on condition" that Medicare will be refunded if primary insurer pays
    - ✓ When the primary insurer denies/rejects a claim because benefits exhausted or there is personal liability, or a policy exclusion bill a conditional claim
  - For WA, disability, and ESRD:
    - ✓ Although it is not a conditional payment, you must follow the conditional payment billing guidelines in order for the claim to process correctly when the primary insurance denied the claim in full or applied the full amount to either deductible or coinsurance.
- Conditional Payment

Conditional Billing

- The following requirements must be met in order to consider processing as a conditional payment:
  - Occurrence codes 01, 02, 03, 04 or 33 (whichever is applicable) with corresponding date;
  - Occurrence code 24 with the date primary insurance denied/date billed to primary insurer (120 day elapsed date);
  - Medicare Secondary Payer (MSP) value code 12, 13, 14, 15, 16, 41, 42, 43, or 47 must be present;
  - Associated MSP value code amount must contain all zeros;
  - Payer Name, "C" along with primary insurer name
  - Remarks must state why the primary payer has not paid on this claim.
    - ✓ The information for Remarks can be pulled directly from the primary payer Explanation of Benefits
- Increase of claim being RTP'd with Reason Code 31102 and 31361

Open Claim Issues

- The "Open Claim Issues for Medicare Part A" JL is a list of known errors that Novitas has implemented actions for correction
- Providers are encouraged to review this listing to confirm their issue is not already being researched/addressed before contacting the Customer Contact Center for assistance

Open Claim Issues for Medicare Part A

Looking for past Claims Issues archives?			
2019 Resolved Claims Issues	2018 Resolved Claims Issues	2017 Resolved Claims Issues	2016 Resolved Claims Issues

Date Reported	Provider Type Impacted	Workload Impacted	Reason Code	Description/Claim Coding Impact	Proposed Resolution / Fix /Action Required	Status
11/13/2019	Maryland Outpatient Skilled Nursing Facilities (SNF) and Outpatient Therapy Facilities	Type of Bill (TOB) 22x, 23x, and 74x	39910	Claims for Maryland SNFs and outpatient therapy facilities, provider numbers starting with 215xxx or 216xxx, are not receiving reimbursement on various services, primarily services that are paid at the Medicare Physician Fee Schedule, such as therapy.	The Centers for Medicare and Medicaid Services (CMS) is actively researching this issue. The majority of the claims are suspended in status location SMQ218 with reason code 39910. Some claims have finalized without payment. Once a correction is scheduled and implemented, we will release all held claims. We will also identify all claims that incorrectly finalized without reimbursement and reprocess them.	Open
10/16/19	Outpatient	Ambulance services	C7275	It has come to the attention of the Centers for Medicare & Medicaid Services (CMS) that CWF-SNF CB edit 7275 is denying Part B ambulance claims inappropriately with date of service on/after, April 1, 2019. This is occurring when the beneficiary is in a covered Part A SNF stay but requires a Part B covered transport for emergency services and when the transport claim is billed with Healthcare Common Procedure Coding System (HCPCS) code A0427, A0429, or A0433.	A correction is tentatively scheduled for January 1, 2020. Claims will be suspended and the error 7275 will be manually overridden until the correction is installed. Any claims with HCPCS A0427, A0429, or A0433, with dates of service on/after April 1, 2019, that have rejected with reason code C7275, can be resubmitted or can be brought to our attention to be reprocessed.	Open

INNOVATION IN ACTION

Overview of Hospital Off-Campus Outpatient Department Reporting Requirements

INNOVATION IN ACTION

Hospital Off-Campus Outpatient Department Reporting

- Changes to editing for appropriate reporting of off-campus outpatient department locations will impact all providers:
  - To ensure correct payment for services provided at a hospital off-campus provider-based departments, CMS will be enacting changes for OPPS providers that have multiple practice locations
  - Payment impacts only applies to those providers paid under OPPS
- System related editing set to activated with the April 2020 Quarterly Release:
  - Requirements for correct provider practice location reporting was effective back in 2017, however, systematic edits were not put in place at that time
- Prepare by verifying that enrollment information is up to date and any claim submissions reflect the practice locations **EXACTLY** as it appears from the practice location address screen which is received from the PECOS
  - Must match, word for word, including abbreviations and punctuation
- Ensure that the practice locations are linked to the NPI that is being reported on the claim submission:
  - Providers who need to add a new or correct an existing practice location address will need to submit a new CMS-855A enrollment application in PECOS
- References:
  - Hospital Off-Campus Outpatient Department Reporting Requirements
  - SE190007 - Activation of Systematic Validation Edits for OPPS Providers with Multiple Service Locations

Affect on Non-OPPS Providers

- Non-OPPS providers include Maryland (MD) waiver and Indian Health Service (IHS) providers
- Hospital providers are required to include all practice locations in PECOS or on the CMS-855A enrollment form
  - Claim will RTP with reason code 34977 if:
    - ✓ Hospital claim is submitted with a service facility location that was not included in PECOS or on the CMS-855A enrollment form; or
    - ✓ Location reported does not **exactly match** the information from the CMS - 855A
  - Applies to TOBs 13x and 14x
- Non-OPPS providers are exempt from reporting the modifiers PN, PO, or ER as payments will not change due to off-campus practice locations
- Non-OPPS providers only have to ensure the off-campus location is reported correctly

FISS Claim Page 3 Provider Practice Location Address

- To access Claim Page 03 MAP171F press F11 from Claim Page 03 MAP1719
- 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
```

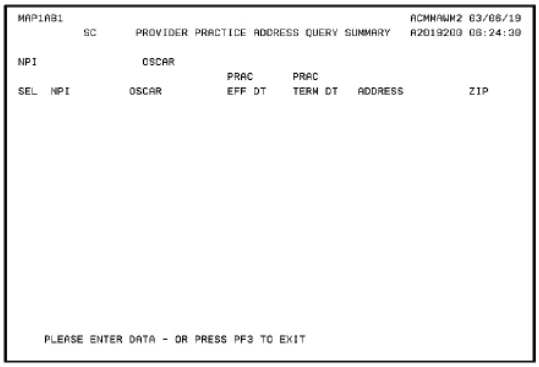

Provider Practice Address Query Screen

- Practice location screen received from the PECOS is available in DDE:
  - Compare this file to ensure claims submitted for the practice location is an **exact** match
  - Select the Provider Practice Address Query menu selection 1D from the Inquiry Menu

```
MAP1702                                                  ACMMAWM2 03/08/19
                              INQUIRY MENU               A2019200 08:20:31

     BENEFICIARY/CWF          10   ZIP CODE FILE          19
     DRG (PRICER/GROUPER)     11   DSC REPOSITORY INQUIRY 1A
     CLAIM SUMMARY            12   CLAIM COUNT SUMMARY    59
     REVENUE CODES            13   HOME HEALTH PYMT TOTALS 67
     HCPC CODES               14   ANSI REASON CODES      68
     DX/PROC CODES ICD-9      15   CHECK HISTORY          F1
     ADJUSTMENT REASON CODES  16   DX/PROC CODES ICD-10   1B
     REASON CODES             17   DMHC PAYMENT TOTALS    1C
     INVOICE NO/DCN TRANS     88   PROV PRACTICE ADDR QUER 1D




 ENTER MENU SELECTION:

  PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
```

Provider Practice Address Query Summary

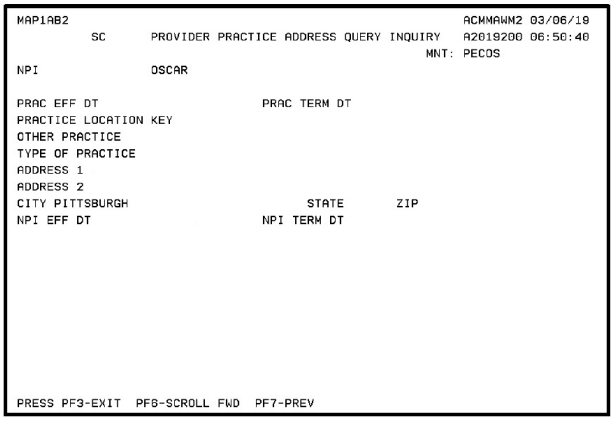
- Provider Practice Address Query Summary MAP1AB1:
  - Type 'S' in the SEL field and press enter to go to the Provider Practice Address Query Inquiry Screen



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

Provider Practice Address Query Inquiry

- Provider Practice Address Query Inquiry MAP1AB2



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

Part A East (PAE) QIC Demonstration

Demonstration Background

- In 2015, CMS authorized the QIC (C2C) to conduct the Telephone Discussion Demonstration:
  - Selected DME suppliers had the opportunity to participate in a formal recorded telephone discussion to offer verbal testimony
- In 2019, CMS authorized C2C to conduct the Telephone Discussion Demonstration for Part A East:
  - The Phone Discussion and Reopening Process will be conducted the same as DME
  - Providers will receive a letter requesting phone discussion with C2C:
    - ✓ Phone discussions are voluntary
    - ✓ Reviews can take 120 days instead of traditional 60 day time frame
- Participation in demonstration will not impact subsequent appeal rights

Benefits of Demonstration

- Selected provider who elect to participate in the demonstration will have the opportunity for direct interaction with the reconsideration decision maker to:
  - Provide verbal testimony
  - Submit any missing/critical documentation needed to further support a favorable decision
  - Receive feedback/education on CMS policies and requirements
  - Improve proper claim submission
- C2C will conduct an analysis on completed unfavorable claims currently pending a decision at the ALJ:
  - ✓ For potential claim reopening
- References:
  - Part A East Appeals Demonstration (JH) (JL)
  - C2C Website for PAE Appeals Demonstration

Provider Discussion Request

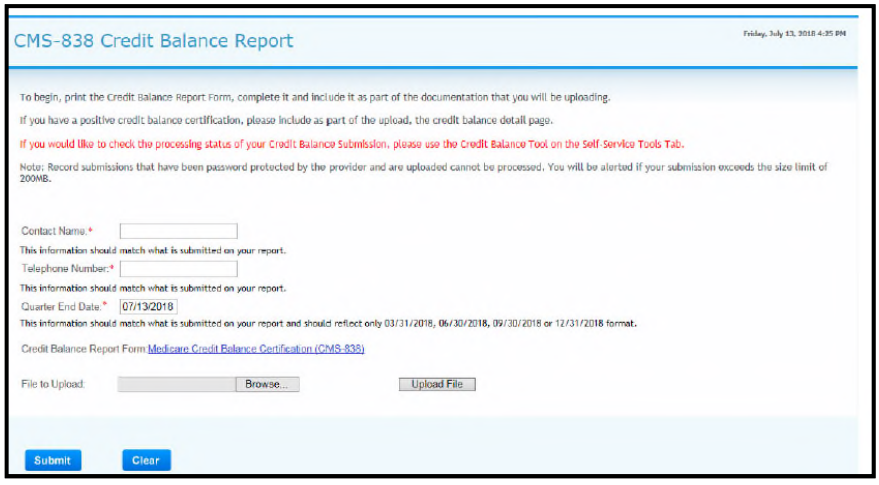
- Indicate in writing at the top of reconsideration form requesting a phone discussion
- If reconsideration request has already been submitted contact via fax or email:
  - ADemoFeedback@c2cinc.com
  - Fax: 904-224-2732
- Not all requests can be granted a phone discussion:
  - C2C will determine eligibility
  - Notification will be sent if appeal criteria is not met

NOVITAS SOLUTIONS

Credit Balance Reporting

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

CMS-838 Credit Balance Report



NOVITAS SOLUTIONS

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

Important Medicare Credit Balance Report Dates

- Due each quarter ending
- Medicare Credit Balance Report must be submitted within 30 days after the close of each calendar quarter

Quarter End	Medicare Credit Balance Report Due	Warning Letter Mailed	Placed on 100% Payment Withhold
March 31	April 30	May 15	June 03
June 30	July 30	August 15	September 03
September 30	October 30	November 15	December 03
December 31	January 30	February 15	March 03

INNOVATION IN ACTION

Helpful Hints for Successful Credit Balance Reporting

- Providers must first attempt to make their own claim adjustments:
  - Submit adjustments as soon as you identify the credit balance once that particular quarter begins
- Submit the correct version of the CMS-838 form:
  - Use of the electronic version is preferred, however paper copies are still acceptable
- Complete the entire CMS-838 detail page when reporting credit balances
- Ensure the provider number (PTAN) on the certification page matches the detail page
- One refund check per Credit Balance Report
- Review your Credit Balance Report to verify all data is correct and matching before you submit it
- Visit our website for more details on Credit Balance Reporting

INNOVATION IN ACTION

Contact Person

- Contact person should be a person who has knowledge of Credit Balance Report and should also know how to process claims:
  - Listed at the top of the Detail Page
- Ensure the telephone number is correct
- Only one attempt will be made to contact the provider regarding questions on the submitted report:
  - If the provider does not return the telephone call then Novitas will offset the amount reported on the credit balance report
  - The claim will not show an adjustment in FISS

Education and Training Events

Novitas Learning Center

- New Novitas Learning Center (NLC)!
  - Improved look and feel and streamlined navigation
  - More sophisticated design:
    - ✓ Intuitive dashboard provides quick view of learning customized for the learner
    - ✓ Learn anywhere, anytime on any device
    - ✓ Improved content library
  - Take the lead in your own professional development when seeking and accessing Medicare training opportunities

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

2019 Novitas Symposiums

- 2019 Novitas Explore Medicare Education Symposiums

Date	Location	Venue Information
12/4/2019-12/5/2019	Virtual	Virtual Symposium

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

Summary

- Identified the current Medicare updates and reminders
- Provided educational resources and information
- Explored the Medicare guidelines regarding outpatient services provided to an inpatient at another facility

Thank You for Attending

- Contact Information:
  - Diane Hess
    Education Specialist
    Diane.Hess@novitas-solutions.com
    Phone: (717) 526-6520
  - Stephanie Portzline
    Manager, Provider Engagement
    Stephanie.Portzline@novitas-solutions.com
    Phone: (717) 526-6317
  - Janice Mumma
    Supervisor Provider Outreach and Education
    janice.mumma@novitas-solutions.com
    717-526-6406