



Medicare Fee-for-Service Updates

AAHAM June 7, 2019



Today's Presenters

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Hot Topics



RuralServ Program



- Providers in rural areas face unique challenges in delivering quality care to Medicare beneficiaries and in the associated administrative functions
- Some providers face added challenges based on their specialty and the type of services they provide, particularly:
 - Critical Access Hospitals (CAHs)
 - Federally Qualified Health Centers (FQHCs)
 - Rural Health Clinics (RHCs)
 - Home Health and Hospice (HH+H) providers
 - Ambulance Suppliers
- To assist with and address these challenges, we have implemented the [NGS RuralServ](#) program



RuralServ Program



- Under the RuralServ program, NGS will:
 - Engage a core group of top providers in our rural and HPSA areas to gain deeper understanding of challenges they face
 - Develop new educational materials unique to this provider subset for our NGS Medicare website, listserv messages, webinars and teleconferences
 - Listen to recommendations for changes that we can make to ease provider burden
 - Communicate with CMS any concerns and recommendations for changes in regulations and program guidance
 - Create specialized information and education that can help rural providers increase self-service adoption, improve claim submission accuracy, reduce appeals and inquiries

RuralServ Program



■ Expectations of RuralServ participants:



Share with NGS concerns, input and ideas for improvement



Utilize self-service options when applicable



Take ownership in the provided data and disseminate information and education to their staff



Complete the website survey on a quarterly basis

340B-Acquired Drug Claim Appeal Requests

- 340B drug payment policy as of January 1, 2018
 - Applies to separately payable Part B drugs (assigned status indicator “K”) acquired through 340B program or 340B prime vendor program
 - Does not apply to vaccines (assigned status indicator “L” or “M”) and drugs on pass-through payment status (assigned status indicator “G”)
 - Hospitals paid under OPPS not excepted from this policy required to report modifier “JG” on same claim line as drug HCPCS code to identify 340B-acquired drug
 - Drug paid at the ASP minus 22.5 percent
- [For additional information, please refer to 340B-Acquired Drugs: Medicare Reimbursement and Appeals on our website](#)

340B-Acquired Drug Claim Appeal Requests

- Providers are reminded that when a service is reimbursed in accordance with Medicare's national payment policy for 340B-acquired drugs:
 - The amount paid is final
 - The method of reimbursement is not an appropriate reason for an appeal
- All appeals submitted to dispute CMS' 340B national payment policy will not be considered and will be automatically dismissed

Activation of System Validation Edits for OPPS Providers with Multiple Service Locations

- CMS will be implementing edits to ensure that service facility location on claims are exact match to address in PECOS
 - Full Production scheduled for July 2019
 - Refer to MLN Matters Special Edition Article [SE19007](#)
 - Note that this is not a change in Medicare policy but rather enforcement of current regulations
- Make sure you understand impacts and have all appropriate updates made prior to reactivation
- Reason codes related to this editing change:
 - 34977 – Claim service facility address doesn't match provider practice file address
 - 34978 – Off-campus provider claim line that contains a HCPCS must have a PN or PO Not currently activated

Provider Address Information

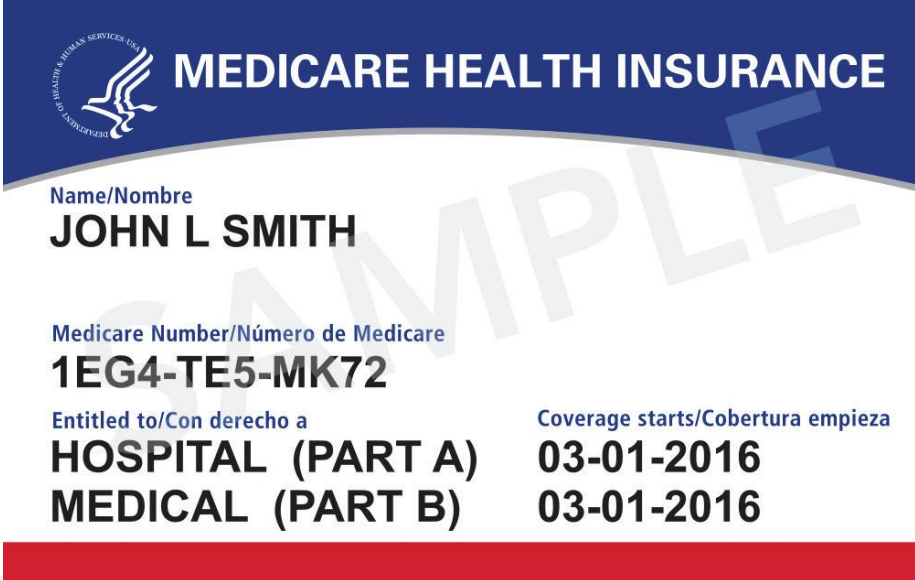
- Review your current addresses using the NEW FISS inquiry screen
 - Inquiry Menu (01) > Provider Practice Address Query screen (Option 1D)
 - Displays additional practice addresses for a facility, including off-campus, outpatient, or provider-based department of hospital
 - If addresses need to be updated, you may have to submit 855A Provider Enrollment Application (online or through Internet-Based PECOS)
- Ensure you correctly report the service facility location for off-campus, outpatient, provider-based department of hospital on your claims
 - Electronic submitters: 2310E loop of the 837 institutional claim transaction
 - DDE submitters: Must report the service facility location in MAP 171F
 - Paper Claim submitters: Report in Form Locator (FL) “01” claim form

Nationwide Testing

- Prior to implementation, CMS has been performing nationwide testing for these edits
 - At least one more round of testing will be performed in June 2019
- Common errors:
 - Providers not sending correct **exact** service facility locations on the claim
 - Must produce an *exact match* with the Medicare enrolled location based on the information entered into PECOS for the hospital's off-campus provider departments
 - Make sure all off-campus, outpatient, provider-based department locations are present in PECOS and if not submit the CMS 855A application to add the address(es)
 - PECOS has Road as part of address submitted with Rd or Rd.
 - PECOS has STE as part of address submitted with Suite
 - PECOS has Drive as part of address submitted with Dr. or DR

The New Medicare Number Project

- All Health Insurance Claim Numbers (HICNs) replaced with Medicare Beneficiary Identifiers (MBIs) as of April 2019



The image shows a sample Medicare Health Insurance card. At the top left is the Department of Health & Human Services logo. The title "MEDICARE HEALTH INSURANCE" is centered at the top. Below this, the cardholder's name "JOHN L SMITH" is listed. The Medicare Number is "1EG4-TE5-MK72". The cardholder is entitled to Hospital (Part A) and Medical (Part B) coverage, both starting on 03-01-2016. A large "SAMPLE" watermark is visible across the center of the card.

MEDICARE HEALTH INSURANCE	
Name/Nombre	JOHN L SMITH
Medicare Number/Número de Medicare	1EG4-TE5-MK72
Entitled to/Con derecho a	Coverage starts/Cobertura empieza
HOSPITAL (PART A)	03-01-2016
MEDICAL (PART B)	03-01-2016

The New Medicare Number Project

■ Implementation

- April 1, 2018 - December 31, 2019: Transition period, use either the HICN or the MBI to exchange data and information with Medicare
- January 1, 2020: Only the MBI will be accepted (limited exceptions)

■ Resources:

- www.NGS Medicare.com > [MBI Lookup Tool](#)
- <https://www.cms.gov/Medicare/New-Medicare-Card/index.html>
- <https://www.cms.gov/Medicare/New-Medicare-Card/Providers/Using-the-MBI.html>

Provider Contact Center - Jurisdiction K

- Connecticut, Maine, Massachusetts, New Hampshire, New York, Rhode Island, Vermont

Area	Phone Number	Hours Available (Eastern Time)
Live Representative (Toll-Free)	888-855-4356 TTY: 866-786-7155	<ul style="list-style-type: none">Monday - Friday: 8:00 a.m. - 4:00 p.m.Thursday (hours closed for training): 2:00 - 4:00 p.m.
Interactive Voice Response (IVR)	877-567-7205	<ul style="list-style-type: none">Monday - Friday: 6:00 a.m. - 7:00 p.m.Saturday: 7:00 a.m. - 3:00 p.m.

Provider Contact Center & IVR

- Be prepared to provide the following information:
 - NPI
 - PTAN
 - The last five digits of your TIN
- Required for claim-specific inquiries:
 - Patient's Medicare number
 - Patient's last name and first name or initial (date of birth may be needed)
 - The date(s) of service in question
 - Denial reason (if unknown please call IVR)

Provider Contact Center Reminder

- CMS mandates providers utilize the IVR instead of contacting a customer care representative to access beneficiary eligibility and general information
- Providers who call a customer care representative with a question that can be answered by the IVR will be referred back to the IVR

What is NGSConnex?

- <https://www.NGSConnex.com>
- Secure self-service online portal created and maintained by National Government Services
 - Registration and verification required
 - Local Security Officer (LSO)
 - Additional Users
- Options requiring system access limited to CWF's availability:
 - Monday – Friday: 7:00 a.m. – 6:00 p.m. ET
 - Saturday: 7:00 a.m. – 2:00 p.m. ET

What Does NGSConnex Do?

- **Allows provider to review:**
 - Claim status
 - Beneficiary eligibility
 - Financial data
 - Provider demographics
- **Allows provider to submit:**
 - Appeals requests for claim denials
 - Requests for remittance advice statements
 - Audit and reimbursement reports
 - Claim-specific inquiries online

Online Reason Code Look Up Tool

- Search for common claim error reason codes including denials, rejections, and RTPs
- Simply key the five-digit claim/line level reason code in the search box and press Submit
 - If reason code is part of our top claim errors, you will see:
 - Description of the reason code
 - Tips to correct the error and avoid this error in the future
 - Any related resources to assist you with avoiding the error, as applicable
- www.NGS Medicare.com
 - Provider Resources > Calculators and Tools > Reason Code Look Up Tool for Top Claim Errors

Top Claim Denials

- **Diagnosis coding/medical necessity**
 - 5WEXC (principal diagnosis or not specific enough)
 - 7C387 (principal diagnosis)
 - 52MUE (units exceed medically reasonable allowable)
 - 54NCD (diagnosis does not support medical necessity)
- **Missing/insufficient documentation**
 - 56900 (past 45 day window to submit)
 - 55B31 (missing/incomplete)
 - 55B15 (physician order missing)

Top Claim Rejections

■ Other payers

- U5233 (patient enrolled in MAO/HMO)
- 34538 (MSP – Working Aged)
- 34540 (MSP – Disabled)

■ Entitlement

- U5200 (type of services)
- U5210 (services after Medicare coverage end date)
- U5061 (HIC not found on CWF Crosswalk)

■ Hospice

- C7010 (dates overlap election period)

■ Duplicates/Overlaps

- 38200 (exact duplicate)
- 38032 (outpatient duplicate)
- 38031 (possible outpatient duplicate)

Avoid Timely Filing Rejections

- Provider has 12 calendar months from DOS to submit or resubmit a claim for processing
 - Not the date of RTP or rejection
 - Based on clean claim receipt date
 - Includes MSP claims
- Will result in timely filing rejections
 - Provider liable
- [Claim Timely Filing Job Aid](#)

Current Part A Production Alerts

- HCPCS Code 33249 Rejection Error Reason Code 31160
 - Implantable Cardiac Defibrillators (ICDs), Healthcare Common Procedure Coding System (HCPCS) Code 33249 rejecting in error
 - NGS initiated solution to stop claims from rejecting as of March 25, 2019
- No provider action necessary at this time

Current Part A Production Alerts

- **CPT code 84153 inappropriately denied**
 - CPT code 84153 which is included in the biomarker testing (prior to initial biopsy) for Prostate Cancer Diagnosis LCD (L37733) has been inappropriately denied as a result of a system issue for dates of service 12/1/2018 through 12/30/2018.
- **Update 2/11/2019**
 - Mass adjustments on denied claims initiated
 - Please continue to check Production Alerts section of our website and Email Updates for notice indicating adjustments have been completed

Current Part A Production Alerts

- **Negative reimbursement on inpatient claims**
 - 1/9/19 - Sporadic instances of negative reimbursement on inpatient claims with Demonstration 86, BPCI Advanced SNF Waiver
 - FISS system issue is causing the Value Code Y1-Y4 to be incorrectly added to these claims
- **We are working with CMS and the FISS maintainer to fix this system issue**
 - Until a fix is implemented, providers may adjust claims and remove the Y1-Y4 value codes
- **Please continue to monitor the website and email updates for additional updates**

Current Part A Production Alerts

- **Incorrect denials for codes in Transthoracic Echocardiography (TTE) LCD L33577**
 - We have identified persistent instances of incorrect denials for CPT and HCPCS codes 93306, 93307, 93308, C8923, C8924 and C8929 as part of an ongoing issue with the October ICD-10 code update
- **Update 1/10/2019**
 - Mass adjustments will be initiated once the issue is resolved
- **Please continue to monitor the website and email updates for additional updates**

Local Coverage Determination and Article Revisions: May–June 2019

- Intravenous Immune Globulin (IVIG) - Related to LCD L33394 (A52446)
 - Corrected product links in article
- Select Minimally Invasive GERD Procedures (L35080)
 - Based on a provider/practitioner request, the “Limitations” section has been revised to remove the following:
 - “any patient in which a staged procedure is being done, as described as a laparoscopic esophageal or paraesophageal diaphragmatic hernia/opening closure followed by a TIF endoscopically.”

Part A CMS April Quarterly Update

- Quarterly webinar by NGS regarding the latest change requests issued by CMS
- Last held on April 30, 2019
 - [Presentation](#)
 - [Summary](#)

FISS/CWF Resources

- FISS logon ID and password requests
 - <https://www.NGS Medicare.com>
 - Claims > Electronic Submissions (EDI)
- <https://www.NGS Medicare.com>
 - Part A > Publications > Manuals
 - FISS DDE Provider Online Guide
 - Health Insurance Query Access (HIQA) Manual
- Medicare University CBTs

Have You Heard of Automatic Immediate Recoupment?

- Interest accrues monthly rather than daily
 - Medicare calculates at current treasury rate
- Providers who activate “Automatic Immediate Recoupment” have recoupment begin prior to day 41 (or prior to day 16 for cost report settlements)
 - Payments considered on-time and avoid interest accrual
 - Optional one-time request to allow your organization to immediately begin saving money in interest on Medicare debts

Providers on Automatic Recoupments

- No longer have to submit checks or overpayment forms
 - Submitting receipts run risk of money being offset and check being applied to another open receivable
 - If you are set up for automatic recoupments and not submitting claims, then you may send checks to create an open account receivable
- Sign up today!
 - [Request an Immediate Recoupment](#)

Electronic Remittance Advice (ERA)

■ Benefits

- Providers create ERA files where Medicare automatically posts to accounts receivable system
- Fast, efficient, accurate payment, and claim reconciliation
- Free software such as PC Print available

■ For more information and to sign up, visit <http://www.NGS Medicare.com>

- Claims & Appeals > Electronic Submissions (EDI) > Enroll to Submit Claims and/or Receive Electronic Remittance Advice
- Provider Resources > Forms > Electronic Data Interchange

Provider Outreach and Education



New www.NGSMedicare.com Personalized Provider Website

- New voluntary option for providers to use website more efficiently by creating free account
 - Options to save frequently-used bookmarks, forms, and job aids/manuals for easy access (up to 10 each)
 - Automatically saves recent searches
 - Customizes your news based on your provider type
- Easy to sign up!
 - NGSConnex users log in using NGSConnex User ID and password
 - Four-step process if not currently a NGSConnex user

Education Tab

- For a complete listing of our educational activities, visit the Education tab on our website!
 - <http://www.NGS Medicare.com>
- Our tab includes links to:
 - Webinars, Teleconferences, and Events
 - New Provider Center
 - POE Advisory Group
 - Medicare University Course List
 - Past Events
 - Job Aids and Manuals
- Easiest, fastest way to be aware of all POE information

NGS on Social Media

- YouTube channel
 - <https://www.youtube.com/user/NGSMedicare>
- Twitter
 - <https://www.twitter.com/ngsmedicare>



Medicare University

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

Email Updates

- Subscribe to receive the latest Medicare information

The screenshot shows the Medicare University website's 'Email Updates' page. At the top is a blue navigation bar with a home icon and links for ENROLLMENT, CLAIMS & APPEALS, MEDICAL POLICY & REVIEW, EDUCATION, Overpayment, Cost Reports, and Provider Resources. Below the navigation bar is the 'EMAIL UPDATES' section. It includes a welcome message, a list of password requirements, and links to 'Subscribe', 'Manage Account', and 'Unsubscribe'. At the bottom of the page are logos for 'Also from NGS', 'NGSCONNEX', 'MEDICARE UNIVERSITY', and 'CMS LINKS'. A footer bar contains copyright information and various utility links.

[Home](#) | [ENROLLMENT](#) | [CLAIMS & APPEALS](#) | [MEDICAL POLICY & REVIEW](#) | [EDUCATION](#) | [Overpayment](#) | [Cost Reports](#) | [Provider Resources](#)


EMAIL UPDATES


Welcome to the National Government Services email updates page! Here you can join electronic mail groups/lists and manage your subscriptions. To get started, join the desired electronic mail group(s) and create your profile so you can manage your subscriptions.


Email Updates Password Requirements

- Eight (8) character minimum length
- Must use at least three of the following:
 - uppercase letters
 - lowercase letters
 - numbers
 - special characters (with the exception of <, >, and |)

- [Subscribe](#)
- [Manage Account](#)
- [Unsubscribe](#)

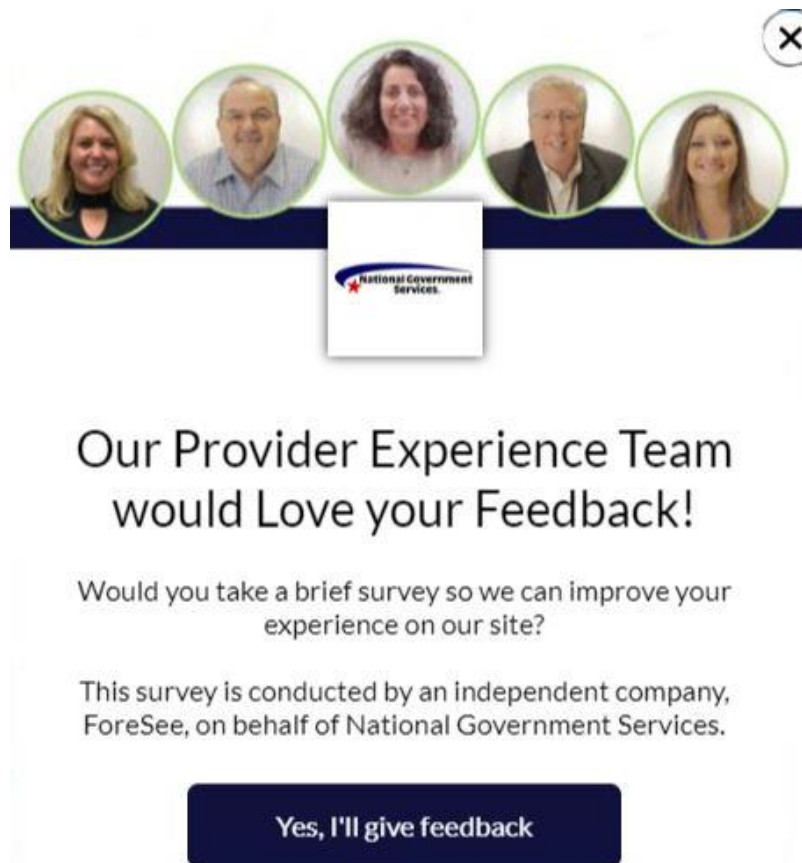
Also from  **NGSCONNEX**
Claims information & appeals

 **MEDICARE UNIVERSITY**
Online, self-paced learning

 **CMS LINKS**
Access to CMS.gov items

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Website and Portal Satisfaction – We Value Your Feedback



Our Provider Experience Team would Love your Feedback!

Would you take a brief survey so we can improve your experience on our site?

This survey is conducted by an independent company, ForeSee, on behalf of National Government Services.

Yes, I'll give feedback

No thanks



Powered by ForeSee [Privacy Policy](#)

Jurisdiction K – Part A



Targeted Probe and Education Medical Review Process



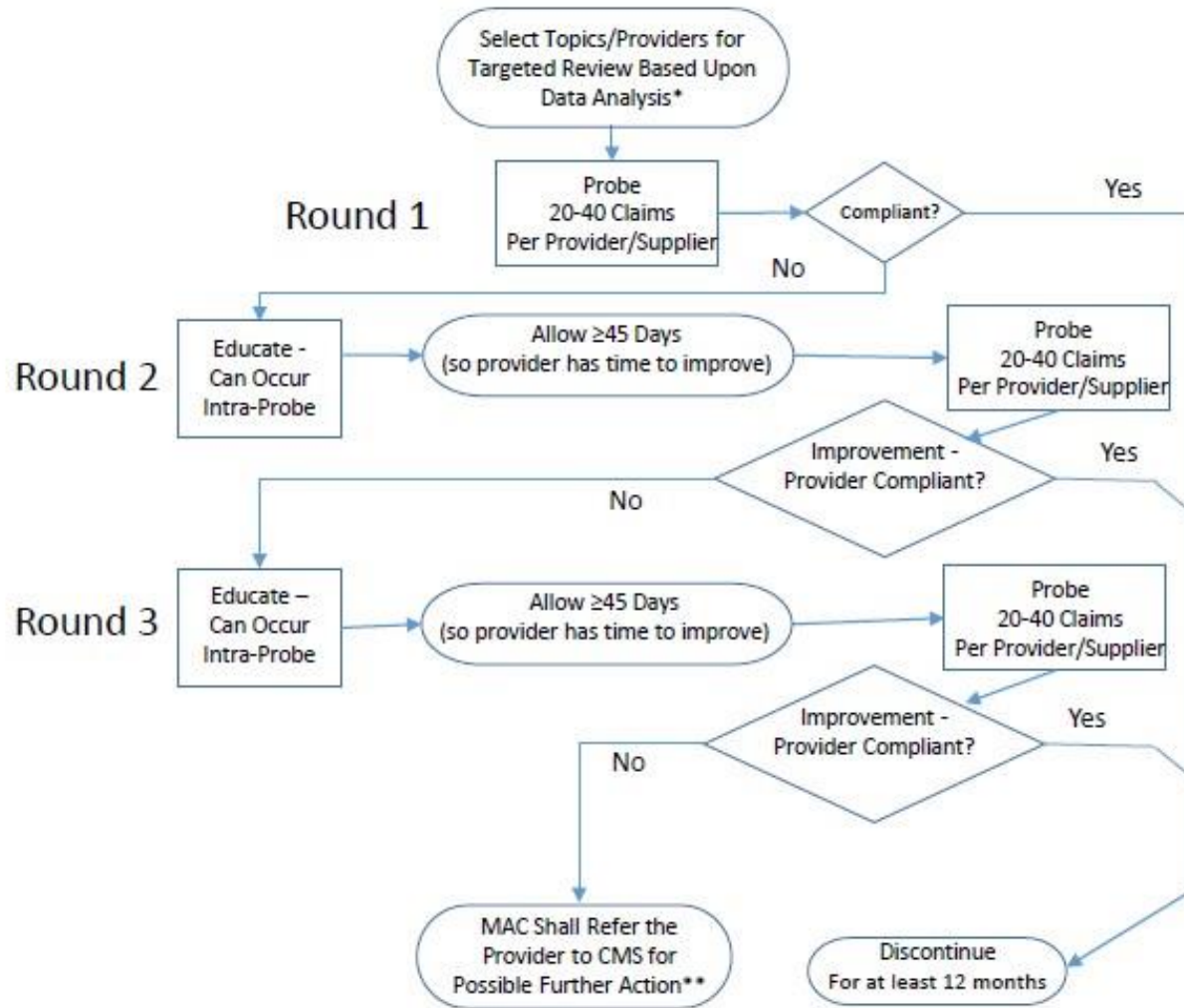
Objective for Medical Review Activities

- Objectives of a medical review is to
 - Identify and prevent inappropriate payment
 - Identify potential risk to the Medicare trust fund
 - Educate providers
 - Appropriately pay for covered services

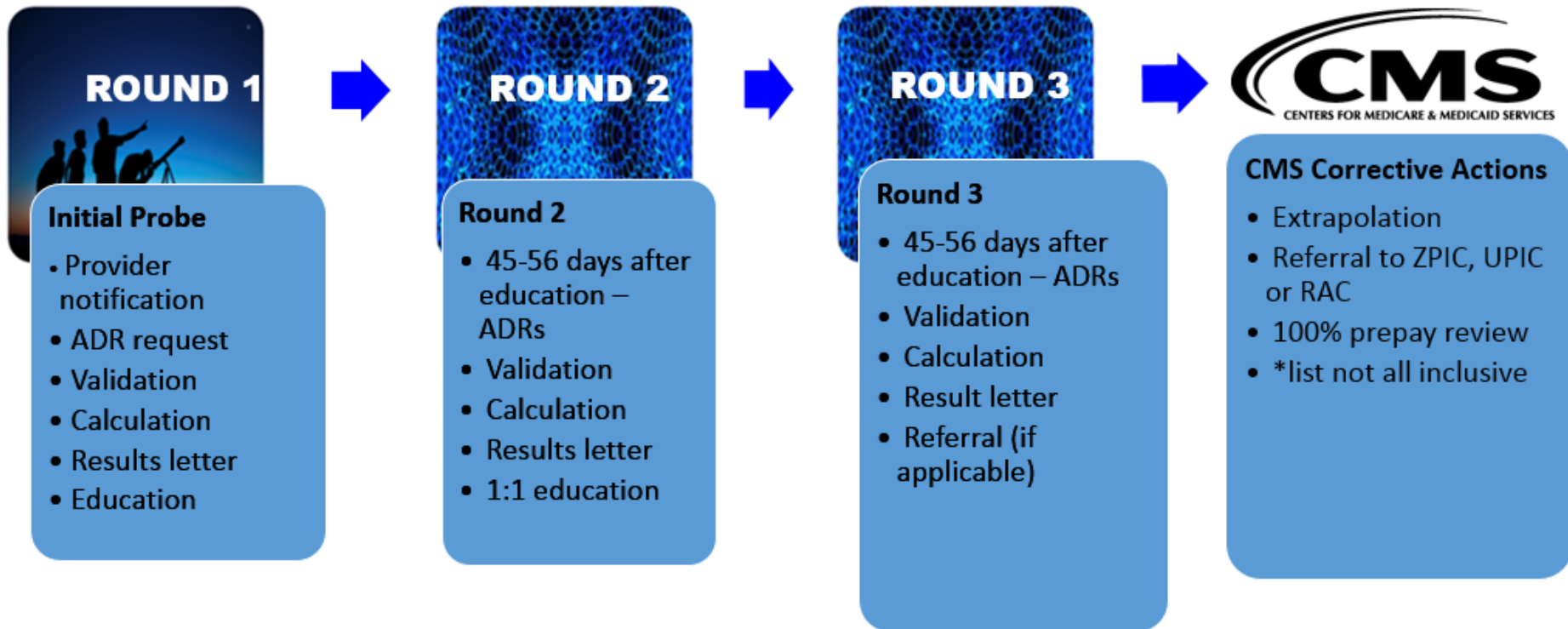
Medical Review History

- The medical review process moved from a PCA process to TPE 10/1/2017
 - All lines of business
- TPE History
 - Demonstration projects for inpatient services and home health
 - Proved successful in lowering providers payment error rates
 - This new model will change some of the process but not affect policy and procedures

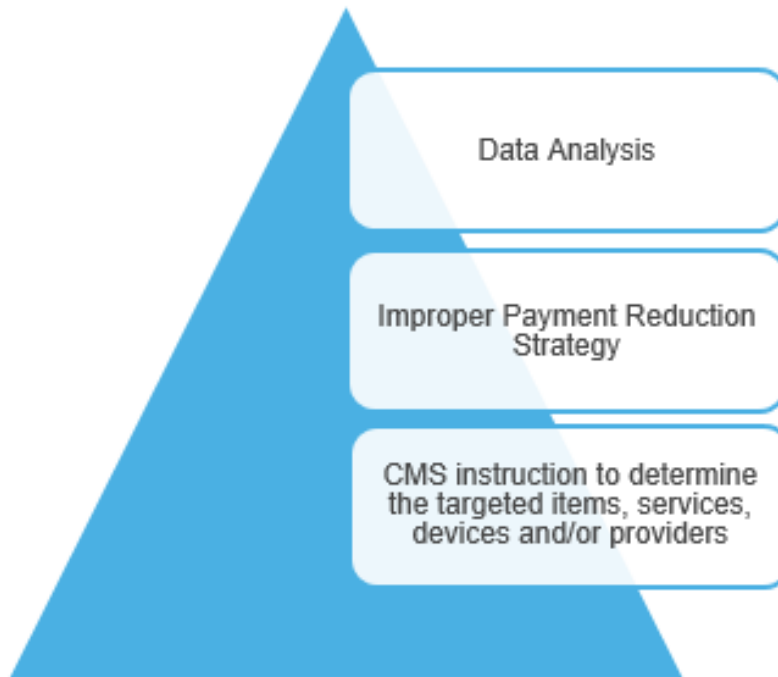
Targeted Probe & Educate



TPE Process



How are Reviews Selected?



Notification Letter

- During the initial probe providers can expect
 - Provider Notice of Review – Targeted Probe and Education includes
 - Reason for review
 - Request of between 20–40 claims
 - Do not send any documentation in response to this notification
 - Facility will be notified via ADR letter on each claim selected for review
 - Nonresponders could be referred to the RAC, ZPIC or UPIC
 - Medical review will review documentation within 30 days of receipt
 - Medical review will make contact for one-on-one education upon completion of review
 - Automated reviews and prior authorizations are not part of the TPE program

Documentation Request - ADR

■ Probe

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

ADRs

- Providers receive ADRs in the same manner
 - Part A via
 - DDE access
 - U. S. Mail – Bright pink envelope
 - NGSConnex
 - Part B via
 - U.S. Mail – Bright pink envelope
 - NGSConnex

Validation Phase

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

Calculations



Payment Error Rate

- Payment/payment denied
- $1,000/500 = 50\%$ PER



Claims Error Rate

- # of claims/claims in error
- $10 \text{ claims}/5 \text{ claims denied} = 50\%$ CER



Service Error Rate

- # of services/services in error
- $10 \text{ services}/5 \text{ services denied} = 50\%$ SER

Calculations

- Medical review will calculate the providers payment error rate based on the payment determination made in medical review
- Payment error rates will not be adjusted based on the outcomes of the appeals process
 - Additional documentation is often received at the time of appeal that was not available at the initial medical review level
 - This is not a change from current medical review process

Detailed Provider Results Letter

- Detailed results letter at the conclusion of each round will include
 - Outline the targeted probe and educate process
 - Reason for denials including the Medicare regulations
 - Denial rates (PER)
 - Release or retention from medical review
 - PER of less than 15% in order to be released from additional rounds of review
 - One-on-one education information
- Read the letter in its entirety for important information regarding additional rounds of review

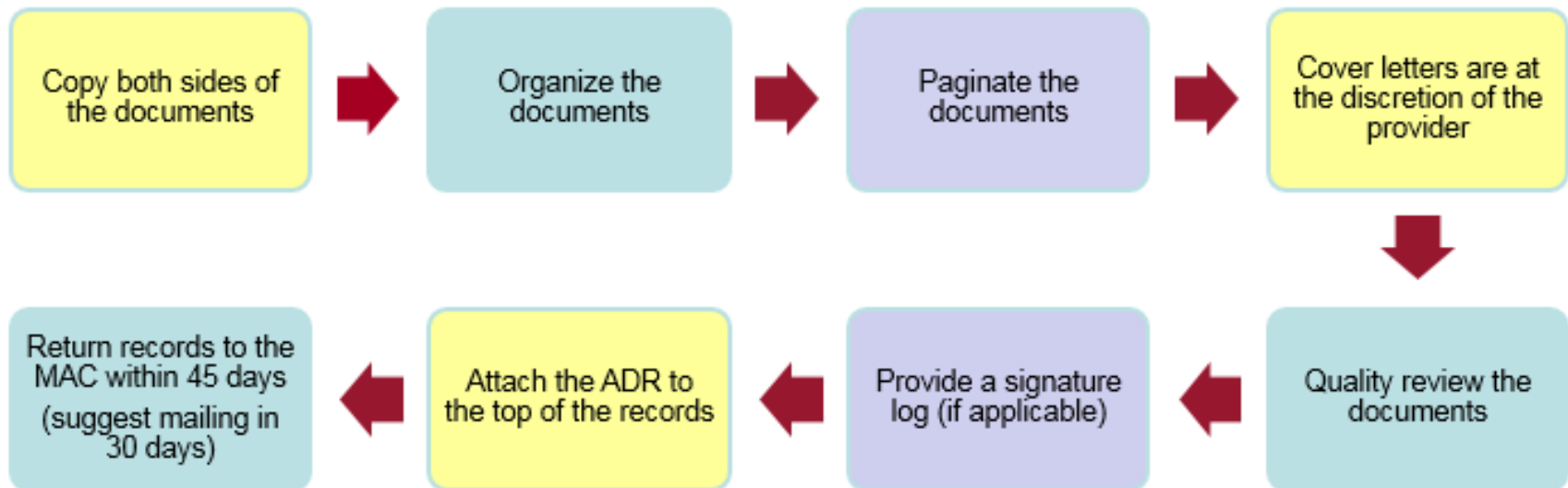
CMS Referral

- After three rounds of review and continued high denial rates CMS may instruct the MAC for additional action which could include
 - Extrapolation
 - Referral to the ZPIC or Unified Program Integrity Contractor (UPIC)
 - Referral to the RAC
 - 100% prepay review

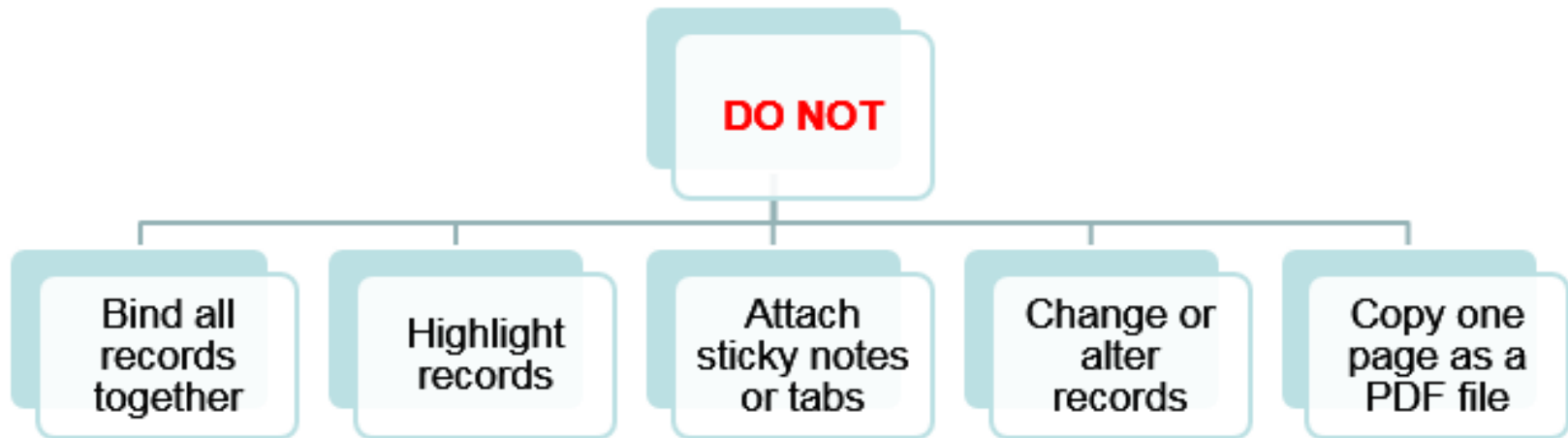
Record Preparation



Preparing your Documentation



Preparing Your Documentation



Helpful Tips

- Speak to whomever handles your mail to watch for and act quickly upon receipt of the pink envelope
- Set up someone at your facility to handle these requests
- Ask a clinician to check the records to be sure the correct documentation is being submitted
- Please be sure reach out for education within two weeks of receiving your results letter

How to Submit Your Records to JK NGS



National Government
Services Inc. P.O. Box
7108 Indianapolis, IN
46207-7108



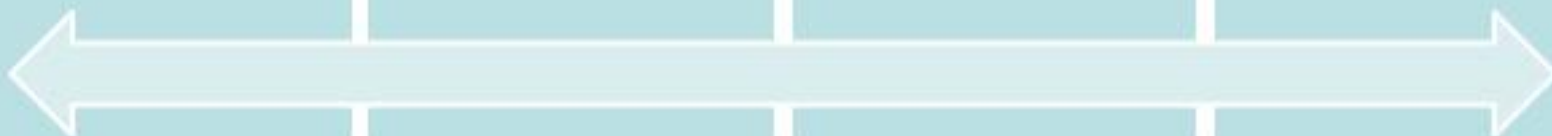
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Road Indianapolis, IN
46250
ATT: Mail and Distribution
*Add insert for operational
area to be scanned



NGSConnex



FAX #:
315-442-4231



Appealing a Medical Review Decision

- With the implementation of targeted probe and educate, the process for appeal has not changed
 - First level of appeal is the redetermination
 - 120 days from date of receipt of the initial determination notice
 - May file an appeal via
 - NGSConnex
 - Mail

Common Questions



Common Questions

- Why were the TPE sample sizes generally set at 20–40 claims?
 - The sample size is intended to allow MACs to review enough claims to represent how accurately providers have the necessary documentation to meet Medicare rules and requirements.

Common Questions

- What can providers expect during a one-on-one education session?
 - During a one-on-one education session (usually held via teleconference), the MAC will walk through errors in the claims. The provider will have the opportunity to ask questions regarding their claims and the policies that apply to the service reviewed.

Common Questions

- Is education furnished each round provider-specific or general education given to all providers?
 - The education session in each round is developed based on the review findings and is not the same unless errors found in the reviewed claims are the same.

Common Questions

- Can providers be included in multiple TPE probes at the same time?
 - Yes, if a provider has multiple National Provider Identifiers (NPIs), each NPI could be subject to TPE review. Additionally, if a provider submits claims to Medicare for more than one service, each service could be subject to a separate probe.

References



References

- [Internet Only Manual \(IOM\) 100-02, Chapter 1, Section 10.2](#)
- [Internet Only Manual \(IOM\) 100-01, Chapter 4, Section 10](#)
- [Medicare Learning Network ICN 006400 August 2017, Critical Access Hospitals](#)

Resources

- [Part B NGSConnex User Guide: “View/Search for MR ADR Submission Documents”](#)
- [CMS Change Request 10249](#)
- YouTube video: [Targeted Probe and Educate](#)
- [Targeted Probe and Educate](#)
- [CMS website: Targeted Probe and Educate \(TPE\)](#)
- [CMS TPE Flow Chart](#)
- [CMS website: Reducing Provider Burden](#)

Thank You!

- Questions?

