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Delivering solutions that put people first.

Noridian Healthcare Solutions, LLC

MEDICARE AB UPDATES AND HOT TOPICS HFMA - HAWAII

Part AB Provider Outreach and Education
April 7, 2022

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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- Noridian Medicare website
- CMS website

AGENDA

- AB Hot Topics and Updates
- Part B only
- Part A only
- Resources

HOT TOPICS AND UPDATES

Part A and B

ADDITIONAL DOCUMENT REQUEST (ADR)

- Requested documentation from Medical Review (MR) for both prepayment and post payment reviews
  - Claim submitted was coded correctly
  - Reasonable and necessary criteria met
- MR mails ADR request to provider's address
- Provider must respond with documentation needed to make claim determination
- Noridian Medicare JE Part B - Medical Review

ADR TIMELINE

- Respond within 45 days
  - Starts with ADR letter date
    - Consider postal mail transit time
- No documentation received
  - Claim denies provider-liable
- Noridian has 30 days for prepayment; attestation exception increased to 45 days
  - 60 days for post payment to review
- Courtesy calls made if timeline allows

COMMON ADR MISTAKES

- **Not** to be followed:
  - Using own FAX cover-sheet instead of ADR letter as cover sheet
  - Omitting requested information
  - Combining multiple ADR requests into single response
  - Sending original documents
  - Not sending response on ADR letter instructions
  - If sending CD, not following exact instructions
  - Sending USB flash drives

CLINICIAN'S CORNER HAS ARRIVED!

- Check out Noridian's newly created "Clinician's Corner" for JE
  - JEB Clinician's Corner Checklists
- Assist providers with appropriate documentation checklists:
  - Cataract Surgery
  - Chest X-ray
  - Controlled Substance Monitoring and Drugs of Abuse Testing
  - Hip Arthroplasty
  - Hyperbaric Oxygen (HBO) Therapy
- Watch website for future added checklists
- Read mission statement introduction
  - Collectively wrote by our Contractor Medical Directors (CMDs)

DUPLICATE CLAIMS AND CORRESPONDENCE REMINDERS

- Medicare contractors cannot override or bypass exact duplicate claim edits
  - Wait for remittance advice before correcting claim, rebilling or appealing
  - Ask clearinghouse or vendor to only auto-rebill after 30 days
  - Use repeat modifier (76, 77, or 91) for multiple procedures and labs
  - Utilize Noridian Medicare Portal (NMP) for claim status
- Noridian has 45 days to respond to correspondence and 60 days for claims
  - Do not keep sending inquiries or claims for same issue or question
  - Check claim status via NMP
- CMS Internet Only Manual (IOM) Publication 100-04 Chapter 1, Section 120 "Detection of Duplicate Claims"

CUSTOMER SERVICE – PEAK CALL TIMES

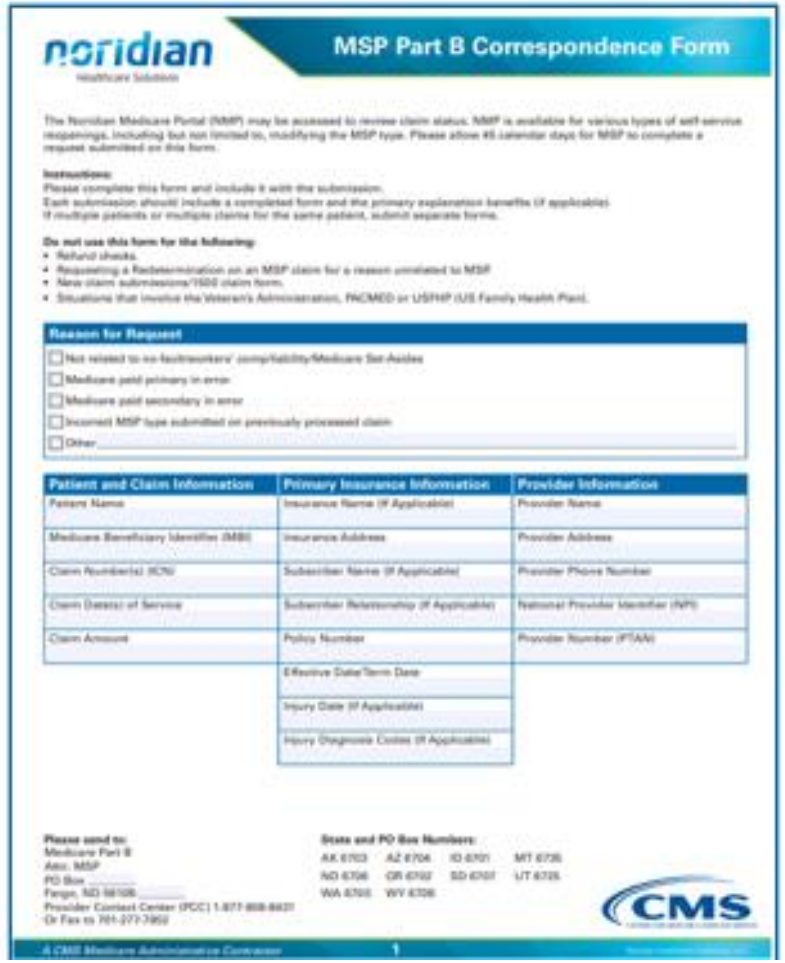
- Noridian committed to excellent provider customer service
- Part B provider contact center (PCC) seeing increased call wait times between **11am – 2pm** Central or **9am – Noon** Pacific
- PCC open to assist between 8am – 6pm Central
  - Consider calling outside of time span for faster service
- Utilize Noridian Medicare Portal (NMP) for patient eligibility and claim status or Interactive Voice Response (IVR)
- Outsourcing billing and/or revenue cycles?
  - Make them aware of checking NMP/IVR first
    - Out of U.S. outsourcing companies can not have access to NMP

BILLING HMO VS. NORIDIAN

- Health Maintenance Organizations (HMOs) and managed care must be billed instead of Noridian fee-for-service (FFS)
- Utilize Noridian's portal patient eligibility before billing or calling
  - Reduces claim rejections
  - Reduces thousands of customer service calls
- Link to register under Resources

MEDICARE SECONDARY PAYER (MSP) CORRESPONDENCE FORM

- Updated March 2022; ease of corresponding
- Request reason:
  - Claim not related-no fault, WC, liability, Medicare set-asides
  - Medicare paid primary or secondary in error
  - Incorrect MSP type with processed claim
  - Other_____
- Do not use for:
  - Appeal **not** MSP-related
  - New claim submission
  - VA, PACMED, USFHP, TRICARE involvement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MSP Part B Correspondence Form

Reason for Request

Patient and Claim Information | Primary Insurance Information | Provider Information

CMS

MSP CORRESPONDENCE DUPLICATION

- Avoid duplicate MSP inquiries
  - Noridian MSP has 45 calendar days to respond
- Mail only once to Noridian
  - Before resubmitting; wait full 45 calendar days for response
- Written Correspondence form not for MSP inquiries
- Use NMP to track MSP claims and appeals
- CMS IOM Publication 100-04 Chapter 1, Section 120

MSP SUMMARY

- Medicare primary to retirement plan and secondary to active plan
- Patient's financial responsibility based on Medicare's allowable or limiting charge amount; IF Medicare had allowed primary
  - Never pays more that if primary payer
- Replacement plans only (no MSP involvement)
  - VA, Health Maintenance Organizations (HMOs) or Managed Care
- Don't confuse with secondary to Medicare insurers (supplemental or coinsurance); where Medicare pays primary
- Must paper bill when Medicare Tertiary payer
- When needed, use correct MSP forms
  - Share clearinghouse letter if pertinent

ORDERED, REFERRED AND PRESCRIBED DENIALS

- Check that provider's specialty qualified to refer or order
- Claim Adjustment Reason Code (CARC) denial
  - Contractual Obligation (CO-183)
    - Provider's specialty not qualified to refer for this CPT
- CMS Medicare Provider Enrollment - MLN9658742 November 2021
  - Providers who Solely Order or Certify tab
- Missing or Invalid Order/Referring Provider Information
- YouTube tutorials - Ordered, Referred, and Prescribed Services

SELF SERVICE OPTIONS – REMINDERS

- Providers **required to use** self-service options for eligibility, claim status, and appeal status
  - Noridian Medicare Portal (NMP)
    - –Noridian Medicare Portal Inquiry Guide
  - Interactive Voice Response (IVR) Guide
    - –Quick navigation on each website page
      - Bottom left with conversion tool
      - Noridian Interactive Voice Response (IVR) Guide
- IOM Publication 100-09, Chapter 6, Section 50.1

SEQUESTRATION RETURNING

- Sequestration returning on Medicare Fee-For-Service (FFS) claims
- Implementing in stages
  - No payment adjustment through March 31, 2022
  - 1 percent payment adjustment April 1 – June 30, 2022
  - 2 percent payment adjustment beginning July 1, 2022

TELEHEALTH

- Public Health Emergency (PHE)
  - Temporary codes added will remain through December 1, 2023
    - List of Telehealth Services
  - Mental health disorders added
    - Purpose of diagnosis, evaluation, or treatment
    - Removed telehealth restrictions allowing rural areas only
    - Must have **in-person** visit every 12 months (amended during PHE from previous six months)

TELEHEALTH PLACE OF SERVICE CODES

- Change Request (CR) 12427 established new Place of Service (POS) code implemented April 4, 2022 (effective January 1, 2022)
- Duration of public health emergency (PHE), CMS waiving geographic and originating site restrictions
  - 10 – Provided in patient's home
  - 02 – Continues for traditional Telehealth
    - With distant and originating site requirements-not in patient's home
  - 11, 19, 22 – as if provider saw in person (during COVID PHE)

NEW TELEHEALTH MODIFIERS

- Effective January 1, 2022, implemented April 1, 2022, include:
  - **FQ** = telehealth service furnished using real-time **audio-only** communication technology
  - **FR** = A supervising practitioner was present through real-time two-way, **audio/video** communication technology
- Change Request 12549

HOT TOPICS AND UPDATES

Part B only

REPETITIVE, SCHEDULED NON-EMERGENT AMBULANCE TRANSPORT (RSNAT) – PRIOR AUTHORIZATION (PA)

- Nationwide expansion establishing process for prior authorization furnished to beneficiary, before claim submitted
- Medically necessary ambulance transport furnished
  - Three or more round trips during ten-day period
  - At least one round trip per week for at least three weeks
  - Usually, dialysis or cancer treatments involved
- Provider: Write, signs, dates Physician Certification Statement (PCS)
- Ambulance: Submits PA including PCS and supporting docs
- CMS Prior Authorization RSNAT Webpage
- Noridian Medicare Part A and B - YouTube

APPEALS – 2021 TOP HAWAII PART B PROCEDURES

CPT	DESCRIPTION	POSSIBLE SOLUTION
71045	Diagnostic Radiology Imaging of Chest	Diagnosis did not support
88305	Level IV - Surgical pathology, gross and microscopic exam	Check CCI/MUE Possible modifier needed
99213	E/M or established office visit	Either MDM level or time

PART B COGNITIVE ASSESSMENT AND CARE PLAN (CACP)

- During previous visit (AWV or E/M) assessing patient, need additional visit
- Improves detection, diagnosis, care planning and coordination for patients with Alzheimer's disease and related dementias (ADRD) and their caregivers
  - With signs of cognitive impairment
- Effective January 1, 2021
  - Reimburses for comprehensive clinical visit resulting in written care plan
  - May perform in-person or via Telehealth
  - May bill once every 180 days (six months)
    - Per single physician or qualified health professional (QHP)

CACP CPT

- 99483 – allows approximately $300
  - 50 minutes
- Detailed history and patient exam
- Must have independent historian present
- Noridian website: Browse by Specialty, under Mental Health, Behavioral Health Integration (BHI), CMS CACP
  - Noridian's CACP Webpage
- Cognitive Assessment and Care Plan Services
  - CMS Change Request (CR) 12247 Article

COMPONENTS

- Observe cognition
- Record and review history
- Assess ADL's, including decision making
- Staging of dementia
  - FAST, CDR
- Review medication
- Evaluate for neuropsychiatric and behavioral conditions
- Safety evaluation – home and motor
- Identify social supports
- Address advanced care planning
- Create Written Plan of Care

PART B MEDICARE DIABETES PREVENTION PROGRAM (MDPP)

- MDPP service period changes from two years to one year
  - Only MDPP beneficiaries who started first service on or after January 1, 2022, per Change Request (CR) 12398
- Removes ongoing maintenance sessions phase of second year
  - Months 13 - 24 no longer needed
  - Relieves additional cost and burden to MDPP suppliers

PART B 2022 MDPP UPDATES 2

- Two-year MDPP still applies to beneficiaries whose first core session date of service (DOS) on or **before Dec. 31, 2021**
- HCPCS G9882 to G9885 no longer needed or allowed
- Application fee no longer required for MDPP
  - Per Change Request (CR) 12502
- IOM 100-08, Chapter 10, Section 10.6.14

2022 PHYSICIAN ASSISTANT (PA) UPDATES

- Program Integrity Manual (100-08): Chapter 10
  - Medicare Program Integrity Manual (cms.gov)
- Physician Assistants may
  - Individually enroll in Medicare
  - Receive direct payment for services
  - Establish Physician Assistant groups
  - Associate benefits to employer
- Changes effective January 1, 2022

PHYSICIAN ASSISTANT ENROLLMENT REFERENCES

- Home - Centers for Medicare & Medicaid Services | CMS
- Medicare Program Integrity Manual (cms.gov)
  - Chapter 10
    - 10.2.3.12 Physician Assistants
    - 10.3.1.1.5 Sections 5 and 6 Ownership Interest and/or Managing Control

PART B OUTPATIENT THERAPY ASSISTANT MODIFIERS

- Physical Therapy Assistant (PTA) and Occupational Therapy Assistant (OTA) services identified with payment reduced
  - Modifier **CQ** – outpatient physical therapy in whole or in part by PTA
  - Modifier **CO** – outpatient physical therapy in whole or in part by OTA
- CY 2022, CMS revised policy
  - Append modifier for therapy furnished in whole by PTA or OTA
  - When PTA or OTA furnishes eight minutes or more of 15-minute unit
    - Append modifier

HOT TOPICS AND UPDATES

Part A only

PRIOR AUTHORIZATION (PA) SERVICES ADDED

- CR 12214 New Services effective July 2021
  - Cervical Fusion with Disc Removal
    - CPT 22551, 22552
  - Implanted Spinal Neurostimulators
    - CPT 63650
- Documentation requirements found in OPD Operational Guide
  - CMS Prior Authorization for Certain Hospital Outpatient Department (OPD) Services

SKILLED NURSING FACILITY (SNF) CLAIMS PROCESSING UPDATES

- CR 12344 effective January 1, 2022
- Corrects hospital overlap edits when billing during interrupted stay with ancillary claim
  - Occurrence span code 74
  - ER claim with revenue code 45X falls within SNF Part A stay
  - Outpatient claims with revenue code 51X and E/M code
- Updates Pricer Input and Output to enhance return codes
  - Modify claims processing to adhere to current policy

CAPITAL RELATED ASSETS (CRA) ADJUSTMENT UNDER ESRD

- MACs will calculate annual allowance and pre-adjusted per-treatment for CRAs under End-Stage Renal Disease (ESRD)
  - Including home dialysis machines in home for single patient
  - Reduce per-adjusted per-treatment by estimated average per-treatment adjust to account for costs already paid through ESRD PPS base rate
  - Apply when HCPCS code on Transitional Add-on Payment for New and Innovative Equipment and Supplies (TPNIES) CRA list reported with AX modifier and revenue codes 0823, 0833, 0843, 0853, 0889
- Adjustment applies to maintenance treatments within three times per week paid, if deemed reasonable and necessary
- Does not apply to individuals on dialysis for acute kidney injury (AKI)

GV MODIFIER FOR RHCs/FQHCs

- CR 12357 effective January 1, 2022
- Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) can bill and receive payment when attending physician provides services during patient's hospice election.
- RHCs report GV modifier on claim line each day
  - Include CG modifier when applicable
  - Coinsurance and deductible apply
- FQHCs report GV modifier with qualifying visit code G0466-G0470
  - Only coinsurance applies
- Also applies to Nurse Practitioner (NP) and Physician Assistant (PA)

UPDATE TO 2022 RHC AIR PAYMENT/FQHC PPS PAYMENT LIMIT

- CR 12489 effective January 1, 2022
- RHC payment limit $113.00
- RHCs with April 1, 2021, established payment limit will either receive payment with percentage increase 2.1 percent or $113.00
- CR 12490 effective January 1, 2022
- 2022 FQHC PPS base payment $180.16
- FQHC PPS GAFs also updated

END-STAGE RENAL DISEASE (ESRD) CHANGES

- CR 12499 implements ESRD Prospective Payment System (PPS) and dialysis for Acute Kidney Injury (AKI) in ESRD facilities
- ESRD PPS base rate and AKI dialysis payment rate = $257.90
  - ($253.13 X 0.99985 (wage index)) X 1.019 (market basket increase) = $257.90
- Labor-related share = 52.3 percent
- Wage index floor = 0.5000
- Consolidated billing remains same in CY 2022

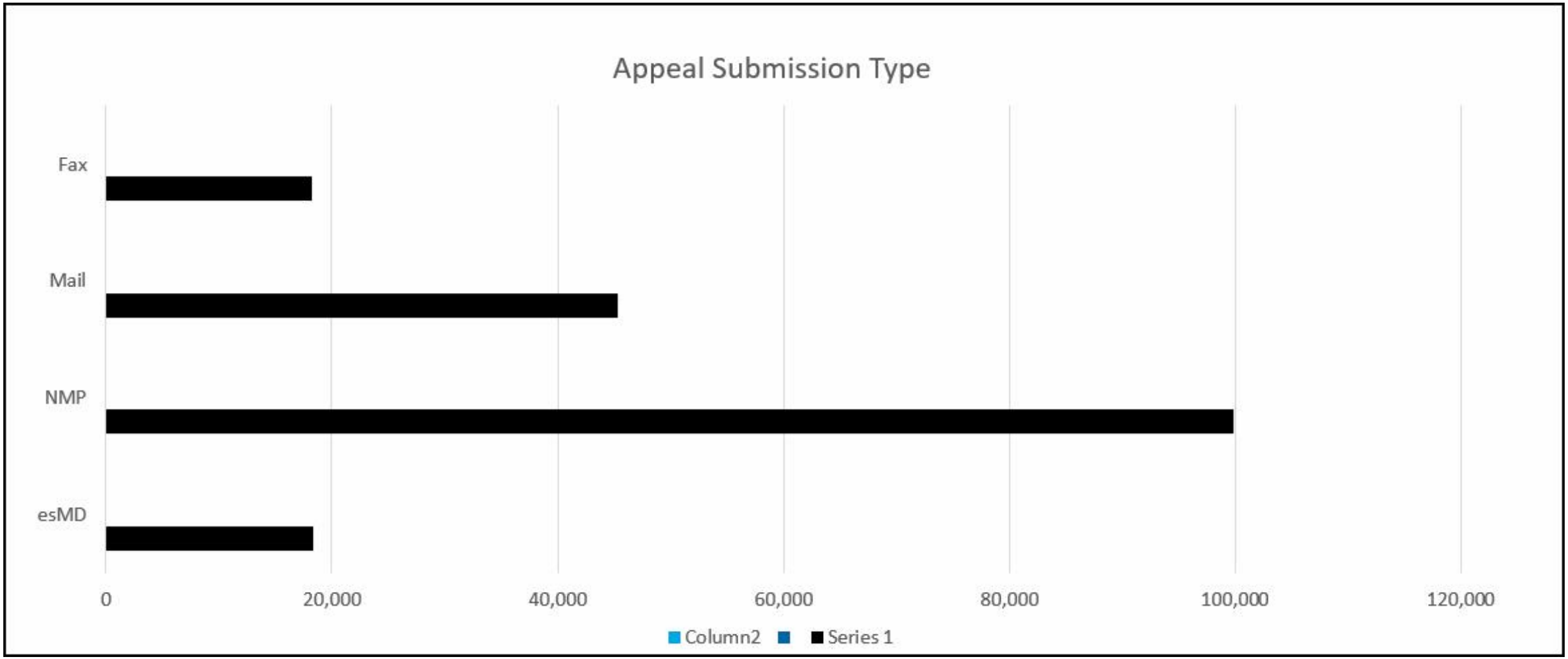
END-STAGE RENAL DISEASE (ESRD) CHANGES 2

- Outlier policy
  - Medicare Allowable Payment (MAP) amount - $42.75 adult, $27.15 pediatric
  - Fixed Dollar Loss (FDL) amount - $75.39 adult, $26.02 pediatric
- Prices for renal dialysis drugs update
- Mean dispensing fee of National Drug Code (NDC) for outlier consideration
  - $0.58 per NDC per month

APPEALS-2021 TOP HAWAII PART A PROCEDURES

CPT	Claims	Top Reason Code/Solution
71045 -Radiologic exam, chest; single view	5798	5LPDN- Medicare doesn't pay for service with diagnosis shown Redetermination may be submitted, if additional documentation will support need. DDE
J3010- Injection, fentanyl citrate, 0.1mg	3587	W7047- Service not separately payable (line-item rejection) Reference status indicator which identifies if HCPCS is paid under OPPS before submitting claim/Appeal
71046- Radiologic exam, chest; 2 views	3151	Same as 71045
J3490- Unclassified drugs	2902	Same as J3010
J0690- Injection, cefazolin sodium, 500mgN1	2880	Same as J3010

PART A APPEAL SUBMISSION TYPE 2021



REMINDERS AND RESOURCES

JE/JF ASK THE CONTRACTOR TELECONFERENCE (ACT)

- 2022 ACT – ask questions on Medicare topics
  - Multiple Noridian staff available to answer or follow up
  - One-hour meeting
  - General ACT A – September 28, 2022
  - General ACT B – April 20 and October 19, 2022
- Free registration at GO TO WEBINAR
  - Part A ACT – JE
  - Part B ACT - JE

CMS RESOURCES

- Medicare Learning Network (MLN) Home Page | CMS
  - Sign up for Medicare updates with MLN Connects newsletter
  - Publications, Webcasts, Web-based trainings, Articles, etc..
- CMS COVID-19 web page
  - CMS Released this Toolkit for Providers
    - Help the health care system quickly administer vaccines as they're available
    - Increase the number of providers who can administer the vaccine
    - Ensure adequate Medicare payment for administering the vaccine
    - Ensure private insurers and Medicaid programs understand their responsibility to cover the vaccine at no cost to patients

PUBLIC HEALTH EMERGENCY (PHE)

- PHE Pages
- Renewal of Determination That A Public Health Emergency Exists
- CMS Current PHE Emergency Page

CMS ENROLLMENT REFERENCES

- Enrollment Quick Reference Guides
  - I&A Quick Reference Guide (hhs.gov)
  - I&A Frequently Asked Questions (FAQs) (hhs.gov)
- PECOS Login
  - Medicare Provider Enrollment, Chain, and Ownership System (PECOS) (hhs.gov)

ALL MAC CUSTOMER EXPERIENCE (MCE) SURVEY

- Must have surveys for all Medicare Administrative Contractors (MACs)
  - Today's Individual Education
    - https://cmsmacfedramp.gov1.qualtrics.com/jfe/form/SV_8qNdI3xK0fNo5Lf?EventType=&Title=Association&Topic=&Date=01/00/1900&Presenter=Lori%2520Weber&Location=&Channel=&LOB=B&
  - Webinars (3 Chances!)
    - Via CHAT after Resources presented
    - Via Automated Email 1 Hour After Event
    - Via Email with CEU within 1 Business Day of Event
  - POE Webpages
    - Schedule of Event, ACT
  - YouTube
    - Education on Demand

THANK YOU!

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