Mississippi Rural Health Association

Jackson, MS

April 6, 2018

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Join Our Email List Today

- Stay current with Medicare by receiving emails twice a week
- Available email lists (not all-inclusive):
  - Jurisdiction H
  - Part B Electronic Billing
  - Novitasphere Portal
  - ABILITY| PC-ACE
  - Medicare Remit Easy Print (MREP) Users
- Join our Email

Today's Presentation

- Agenda:
  - 2018 Medicare Updates
    - ✓ RHC Reminders
    - ✓ RHC Top Claim Submission Errors
  - Getting Ready for New Medicare Cards
  - Utilizing the Novitasphere Portal
  - Reminders and Educational Resources
- Objectives:
  - Identify and understand the current 2018 Medicare updates
  - Prepare for New Medicare Cards
  - Understand the benefits of the Novitasphere Portal
  - Identify and utilize the educational resources and information

Acronym List 1

Acronym	Definition
AIR	All Inclusive Rate
BHI	General Behavioral Health Integration
CARC	Claim Adjustment Reason Code
CCM	Chronic Care Management
CMS	Centers for Medicare & Medicaid Services
CNM	Certified Nurse-Midwife
CoCM	Psychiatric Collaborative Care Model
CPT	Current Procedural Terminology
CWF	Common Working Files
EIDM	Enterprise Identity Management
EHR	Electronic Health Records
ERA	Electronic Remittance Advice

Acronym List 2

Acronym	Definition
ERA	Electronic Remittance Advice
FAQ	Frequently Asked Questions
HCPCS	Healthcare Common Procedure Coding System
HETS	HIPPA Eligibility Transaction System
HMO	Health Maintenance Organization
IPPE	Initial Preventive Physical Exam
IVR	Interactive Voice Response
NP	Nurse Practitioner
MBI	Medicare Beneficiary Identifier
MLN	Medicare Learning Network

Acronym List 3

Acronym	Definition
QMB	Qualified Medicare Beneficiary
PA	Physicians Assistant
PPS	Prospective Payment System
RA	Remittance Advice
RHC	Rural Health Clinic
RTP	Return to Provider
SSA	Social Security Administration
TCM	Transitional Care Management

2018 Medicare Updates

2018 MAC Satisfaction Indicator (MSI) Survey

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- This survey measures your satisfaction with our processes and service delivery so we can gain valuable insights and determine process improvements:
  - CFI Group is conducting the survey on behalf of CMS:
    - ✓ Evaluate our services in 10 minutes
    - ✓ Responses are kept confidential
    - ✓ Provide your name, telephone number and email address if you would like to be contacted about your survey responses
- Improvements based on 2017 MSI feedback:
  - Added a "Was this page helpful?" interaction to all content pages
  - Designed and debuted new information centers for Enrollment, Appeals and Claims
  - Enhanced and expanded data provided by many of our self-service lookup tools
- JH Provider MSI Survey

Update to the RHC PPS

- MM10333:
  - Effective: January 1, 2018
  - Implementation: January 2, 2018
- Key Points:
  - RHC PPS base payment rate is $83.45
    - ✓ 2018 base payment rate reflects a 1.4 percent increase

Care Coordination Services and Payment for Rural Health Clinics (RHCs)

- MM10175:
  - Effective: January 1, 2018
  - Implementation: January 2, 2018
- Key Points:
  - Payment for care coordination services in RHCs by establishing two new G codes for use by RHCs :
    - ✓ General Care Management HCPCS G0511:
      - ➢ This code could only be billed once per month per beneficiary, and could not be billed if other care management services are billed for the same time period
    - ✓ Psychiatric CoCM HCPCS G0512:
      - ➢ This code could only be billed once per month per beneficiary, and could not be billed if other care management services are billed for the same time period
  - RHC claims submitted using CPT 99490 for dates of service on or after January 1, 2018, will be denied

General Care Management Requirements (G0511)

- RHCs can bill new General Care Management when:
  - Practitioner furnishes a comprehensive E/M, AWV, or IPPE:
    - ✓ Prior to billing the CCM within one year
  - Beneficiary Consent:
    - ✓ Obtained during or after the initiating visit
    - ✓ Prior to care coordination services by RHC practitioner or clinical staff:
      - ➢ Written or verbal, must be documented in the medical record
- Eligible patients:
  - Option A:
    - ✓ Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient and place the patient at significant risk of death
  - Option B:
    - ✓ Any behavioral health or psychiatric condition treated by the RHC practitioner:
      - ➢ Including substance use disorders:
        - » Clinical judgment of the RHC practitioner, warrants BHI services

General Care Management Requirements (G0511) (cont.)

- Can only be billed once per month/per patient and by only one physician
- RHCs cannot bill for CCM services for a beneficiary during the same service period as billing any other care management (outside of the RHC AIR) for the same beneficiary
- Informing the patient that only one practitioner can furnish and be paid for the service during a calendar month
- Comprehensive care plan is established implemented revised or monitored
- Beneficiary must be able to receive notification and consent
- Patients must be given a written or electronic care plan

General Care Management Requirements (G0511) EHR

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- Care plan must be a structured recording using EHR technology:
  - Demographics
  - Problems
  - Medications/medication allergies
  - Creation of a structured clinical summary record
- Providers must use EHR
  - A full list of problems, medications and medication allergies in the EHR must inform the care plan, care coordination and ongoing clinical care
- Access to care management services 24/7 that provides the beneficiary with a means to make timely contact with health care practitioners
- Continuity of care with a designated practitioner or member of the care team with whom the beneficiary is able to get successive routine appointments
- RHCs would continue to be required to meet the RHC Conditions of Participation and any additional RHC payment requirements
- Coordinate with all health care providers:
  - Documentation of communication

General Care Management
Comprehensive Care Management

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- Eligibility requirements of Option B:
  - Initial assessment or follow-up monitoring:
    - ✓ Use of applicable validated rating scales
  - Behavioral health care planning:
    - ✓ Including revision for patients who are not progressing or whose status changes
  - Facilitating and coordinating treatment:
    - ✓ Psychotherapy, Pharmacotherapy, Counseling and/or Psychiatric consultation
  - Continuity of care with a member of the care team

Psychiatric CoCM (G0512)

- RHCs can bill Psychiatric CoCM when:
  - Practitioner furnishes a comprehensive E/M, AWV, or IPPE:
    - ✓ Prior to billing the CCM within one year
  - Beneficiary Consent:
    - ✓ Obtained during or after the initiating visit
    - ✓ Prior to care coordination services by RHC practitioner or clinical staff:
      - ➢ Written or verbal, must be documented in the medical record
  - First calendar month:
    - ✓ Minimum of 70 minutes:
      - ➢ Under direction of RHC practitioner
  - Subsequent calendar months:
    - ✓ Minimum of 60 minutes:
      - ➢ By RHC practitioner and/or Behavioral Heath Care Manager (under general supervision)
- Can only be billed once per month/per patient and by only one physician
- RHCs cannot bill for CCM services for a beneficiary during the same service period as billing any other care management (outside of the RHC AIR) for the same beneficiary

Psychiatric CoCM (G0512) Requirements

- Eligible patients:
  - Any behavioral health or psychiatric condition treated by the RHC practitioner:
    - ✓ Including substance use disorders
    - ✓ Clinical judgment of the RHC practitioner, warrants BHI services
- Requirement elements:
  - Psychiatric CoCM requires a team that includes the following:
    - ✓ RHC (physician, NP, PA, or CNM):
      - ➢ Directs the behavioral health care manager or clinical staff
    - ✓ Oversees the patients care:
      - ➢ Prescribing medications
      - ➢ Providing treatments for medical conditions
      - ➢ Referrals to specialty care when needed
- Continues to oversee ongoing oversight, management, collaboration and reassessment

Psychiatric CoCM (G0512) Behavioral Health Care Manager

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- Behavioral Health Care Manager:
  - Assessment and care management:
    - ✓ Including the administration of validated rating scales
    - ✓ Behavioral health care planning in relation to behavioral/psychiatric health problems:
      - ➢ Including revision for patients who are not progressing or whose status changes
      - ➢ Provision of brief psychosocial interventions ongoing collaboration with the RHC practitioner
      - ➢ Maintenance of the registry
- Acting in consultation with the psychiatric consultant
- Available to provide services face-to-face with the beneficiary
- Continuous relationship with the patient
- Collaborative, integrated relationship with the rest of the care team
- Available to contact the patient outside of regular RHC hours as necessary to conduct the behavioral health care manager's duties

Psychiatric CoCM (G0512)
Psychiatric Consultant

- Psychiatric Consultant:
  - Participates in regular reviews of the clinical status of patients receiving CoCM services
  - Advises the RHC practitioner regarding diagnosis:
    - ✓ Options for resolving issues with beneficiary adherence and tolerance of behavioral health treatment
  - Making adjustments to behavioral health treatment for beneficiaries who are not progressing
  - Managing any negative interactions between beneficiaries' behavioral health and medical treatments
  - Facilitate referral for direct provision of psychiatric care when clinically indicated

RHC Medicare Benefit Policy Manual Chapter 13 Updates

- MM10350:
  - Effective: February 15, 2018
  - Implementation: February 15, 2018
- Key Points:
  - Chapter 13 of the Medicare Benefit Policy Manual is being updated and revised for RHCs :
    - ✓ Care Management in RHCs as finalized in the Calendar Year (CY) 2018 Physician Fee Schedule Final Rule

Updated CMS RHC Fact Sheet

mln FACT SHEET

PRINT-FRIENDLY VERSION

KNOWLEDGE • RESOURCES • TRAINING

RURAL HEALTH CLINIC

The Hyperlink Table, at the end of this document, provides the complete URL for each hyperlink.

Learn about these Rural Health Clinic (RHC) topics:

- Background
- RHC services
- Medicare certification as an RHC
- RHC visits
- RHC payments
- Cost reports
- Annual reconciliation
- Resources
- Lists of helpful websites and Regional Office Rural Health Coordinators

BACKGROUND

[RHC Fact Sheet]

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RHC Reminders

Required Billing Updates for RHC

- MM9269:
  - Effective April 1, 2016
  - Implementation April 4, 2016
- Key Points:
  - RHCs are required to report the appropriate HCPCS code for each service line along with the revenue code and other codes as required
  - Payment for RHCs will continue to be made under the AIR when all of the program requirements are met

RHC HPCS Reporting Requirements and Updates

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- Special Edition Article SE1611
- Key Points:
  - When a preventative service is the primary service for the visit, RHC's should report modifier CG on the revenue code 052x with the preventative health service
  - Coinsurance and deductible are waived for the approved preventative health services
  - Medicare will pay 100 percent of the AIR service

Billing for Multiple Visits Same Day

- Multiple encounters on the same day constitute a single RHC visit, except for the following:
  - The patient suffers an illness or injury that requires additional diagnosis or treatment on the same day:
    - ✓ The subsequent medical service should be billed using a valid HCPCS code, revenue code 052X, and modifier 59:
      - ➢ Modifier 59 signifies that the conditions being treated are unrelated and services are provided at separate times of the day
  - The patient has a medical visit and a mental health visit on the same day
  - The patient has an IPPE and a separate medical and/or mental health visit on the same day:
    - ✓ IPPE is a once in a lifetime benefit and should be billed using HCPCS code G0402 and revenue code 052X.

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RHC Top Claim Submission Errors

Top Claim Submission Errors

JH Reason Codes
38200
U5233
C7010
32402
W7091

Reason Code 38200

- Duplicate rejection:
  - The newly submitted claim is a duplicate to a previously submitted outpatient claim
- Research:
  - Verify claims history to determine if another claim was submitted for this date of service:
- Reason code action:
  - If the posted claim is incorrect:
    - ✓ Submit an adjustment correcting the information

Reason Code U5233

- RTP error:
  - No Medicare payment can be made because the statement covered period falls within or overlaps an enrollment period in a risk HMO
- Research:
  - Verify the statement covered period
  - Verify the patients eligibility
- Reason code action:
  - Bill the claim to the beneficiaries HMO on file

Reason Code C7010

- RTP error:
  - The edited outpatient claim has a from/through date that overlap a hospice election period
- Research:
  - Verify the statement covered period:
    - ✓ Hospice election period verified through Novitasphere, Fiscal Intermediary Shared System (FISS), HETS or Interactive Voice Response (IVR)
- Reason code action:
  - Related to the terminal illness:
    - ✓ Bill the Hospice
  - Unrelated to the terminal illness:
    - ✓ Resubmit the claim to Medicare with the appropriate condition code 07

Reason Code 32402

- RTP error:
  - Invalid revenue code for a HCPCS code reported or HCPCS is not valid for the date on which services were provided
- Research:
  - Verify the revenue code billed
  - Verify the HCPCS code billed
  - Verify the “from” and “through” dates
- Reason code action:
  - Once revenue, HCPCS and/or from and through dates verified and corrected F9 claim for processing

Reason Code W7091

- RTP error:
  - Non RHC services
- Resolution:
  - Medicare Benefit Policy Manual, Pub. 100-02, Chapter 13- Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services, Section 60, “Non RHC/FQHC Services:
- Reason code action:
  - Bill Part B CMS 1500 claim form

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Getting Ready for The New Medicare Cards

Important Dates For The New Medicare Card

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- CMS to remove Social Security Numbers (SSNs) from all Medicare cards by **April 2019**
- The transition period will run from **April 2018 through December 31, 2019**
- **October 2018** through the end of the transition period, when a valid and active Medicare Number is submitted on Medicare fee-for-service claims both the Medicare Number and the MBI will be returned on the remittance advice
- CMS New Medicare card website
- Participate in CMS's Open Door Forums

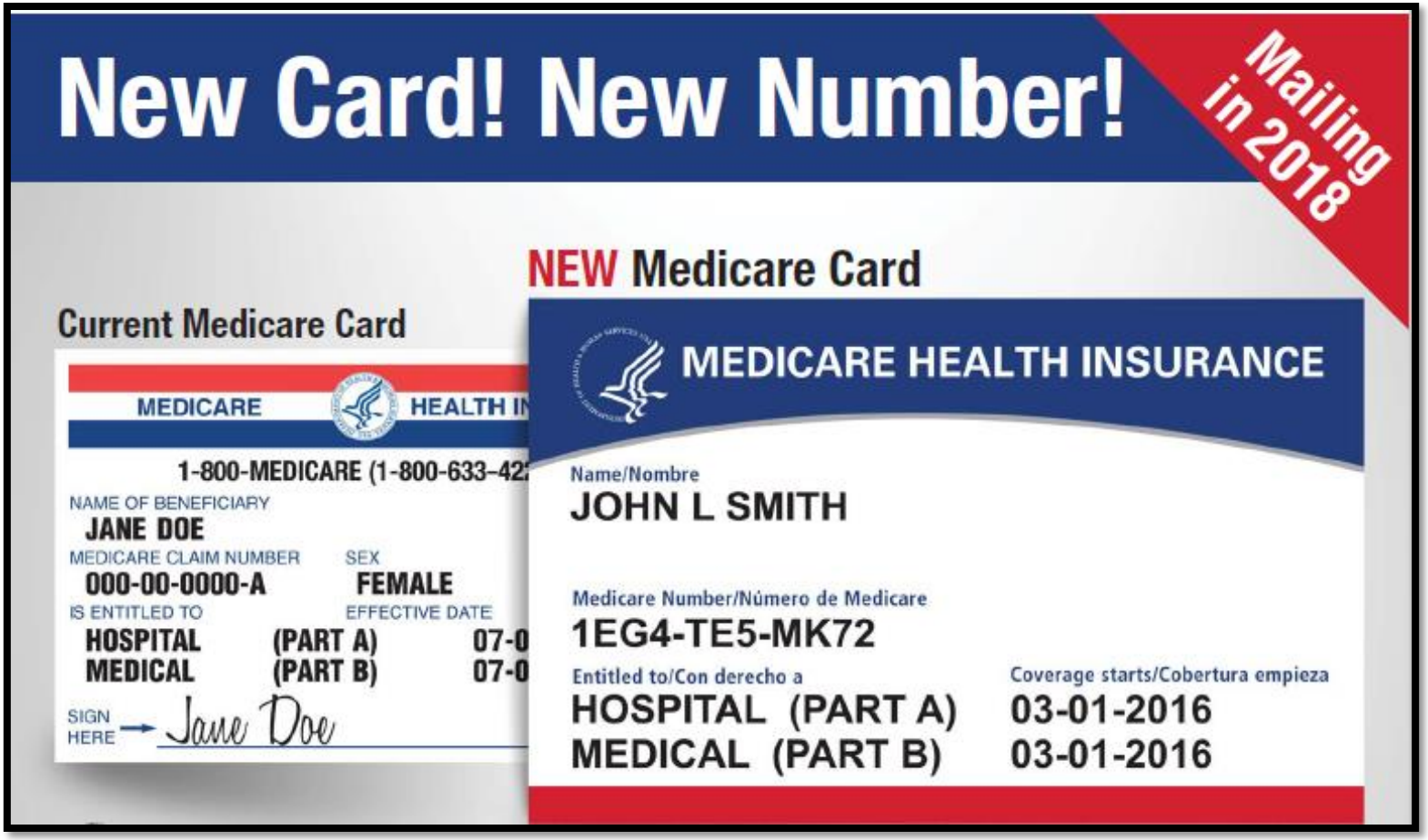
Get Ready for the New MBI

- Participate in CMS quarterly open door forums
- Sign up for weekly MLN Connects® newsletter
- Obtain technical information from your regular communication channels
- Test your systems
- Work with your billing office staff to be sure you are ready for the new MBI format
- Check CMS' new Medicare card website for updated information
- Patient may not get a new card if their address with SSA is not correct
- Verify your patients addresses:
  - If the address you have on file is different than the address you get in electronic eligibility transaction responses, ask your patients to contact Social Security and update their Medicare records
  - This may require to verify and correct address
- Beneficiaries contact:
  - Social Security:
    - ✓ 1-800-772-1213
  - Railroad Retirement Board:
    - ✓ 1-877-772-5772

New Medicare Card

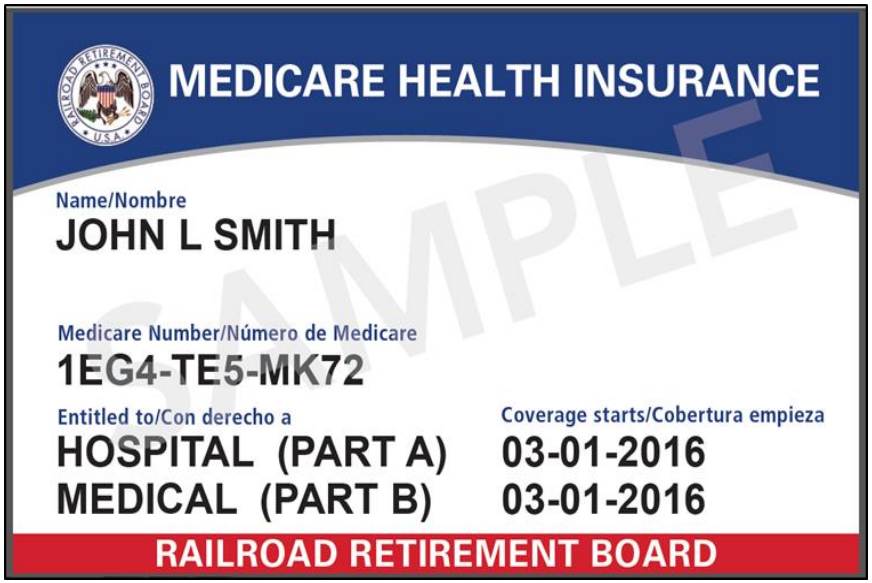
- MBI characteristics:
  - Same number of characters as the current Medicare Number (11)
  - Contains uppercase alphabetic and numeric characters
  - Occupies the same field as the Medicare Number on transactions
  - Unique to each beneficiary (e.g. husband and wife will have their own MBI)
  - Easy to read:
    - ✓ Alphabetic characters upper case only and will exclude S, L, O, I, B, Z
  - Contains no embedded intelligence or special characters
  - Contains no inappropriate combinations of numbers or strings that may be offensive
- Position 1, 4, 7, 10, and 11 will always be a number (0-9)
- Position 2, 5, 8, and 9 will always be a letter (A-Z):
  - Exclusions:
    - ✓ S, L, O, I, B, Z
- Position 3 and 6 will be a letter or a number:
  - Exclusions:
    - ✓ S, L, O, I, B, Z

Newly Designed Medicare Card



Railroad Retirement Beneficiaries

- Railroad Retirement MBI card:
  - Railroad Retirement Board logo will be the key identifier
  - Mailing will begin June 2018



During Transition Period

- Beginning October 2018 through transition period:
  - When submitting claim using the Medicare Number:
    - ✓ Both Medicare Number and MBI will be returned on remittance advice
  - MBI will be in same place you currently get the changed Medicare Number :
    - ✓ 835 Loop 2100, Segment NM1 (corrected Patient/Insured Name)
    - ✓ Field NM109 (Identification Code)
  - Message field on eligibility transaction responses will indicate when new Medicare card has been mailed to each person

After Transition Period

- January 1, 2020 use MBIs on all your claims
- Exceptions for Fee-for-Service claims:
  - For appeals:
    - ✓ Either Medicare Number or MBI for related forms
  - For claim status query:
    - ✓ Either the Medicare Number or MBI if the earliest date of service is before January 1, 2020
    - ✓ Status of dates of service after January 1, 2020 you have to use the MBI

Novitasphere MBI Lookup Coming June 2018

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- New MBI crosswalk tool in Novitasphere June 2018
- Enroll now!
  - Part B:
    - ✓ Claim corrections, eligibility, claim status, electronic claim submission, electronic remittance advice, comparative billing reports, medical review record submission, and more
  - Part A:
    - ✓ Eligibility, electronic claim submission, electronic remittance advice, medical review record submission, cost report submission, and more

New Medicare Card Mailing Waves

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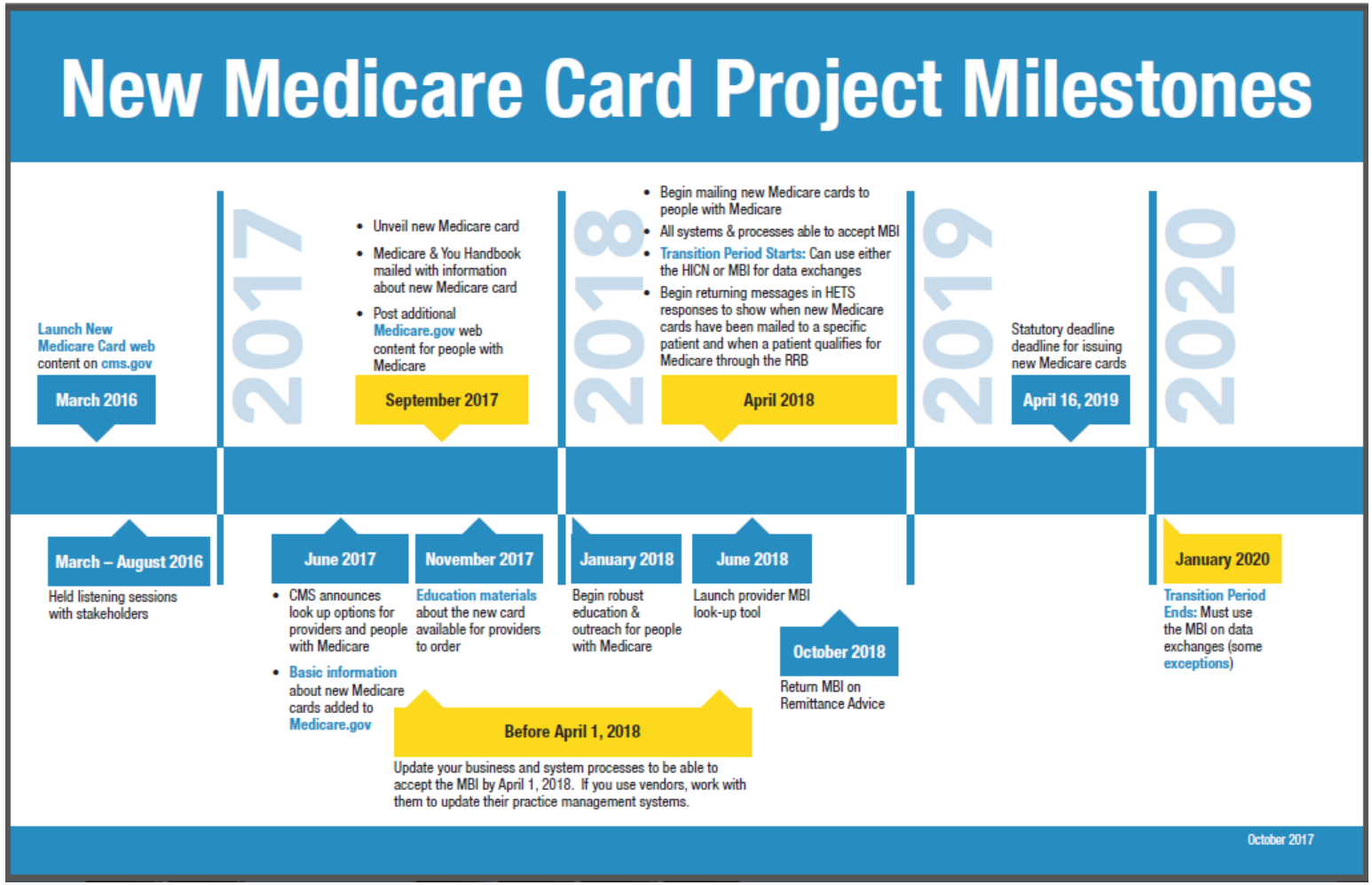
Wave	States Included	Cards Mailing
1	Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia	April – June 2018
2	Alaska, American Samoa, California, Guam, Hawaii, Northern Mariana Islands, Oregon	April – June 2018
3	Arkansas, Illinois, Indiana, Iowa, Kansas, Minnesota, Nebraska, North Dakota, Oklahoma, South Dakota, Wisconsin	After June 2018
4	Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Rhode Island, Vermont	After June 2018
5	Alabama, Florida, Georgia, North Carolina, South Carolina	After June 2018
6	Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Texas, Utah, Washington, Wyoming	After June 2018
7	Kentucky, Louisiana, Michigan, Mississippi, Missouri, Ohio, Puerto Rico, Tennessee, Virgin Islands	After June 2018

MBI Implementation



More CMS Products

- New Medicare Card Poster
- New Medicare Tear off pad
- CMS Product ordering
- New-Medicare-Card-flyer

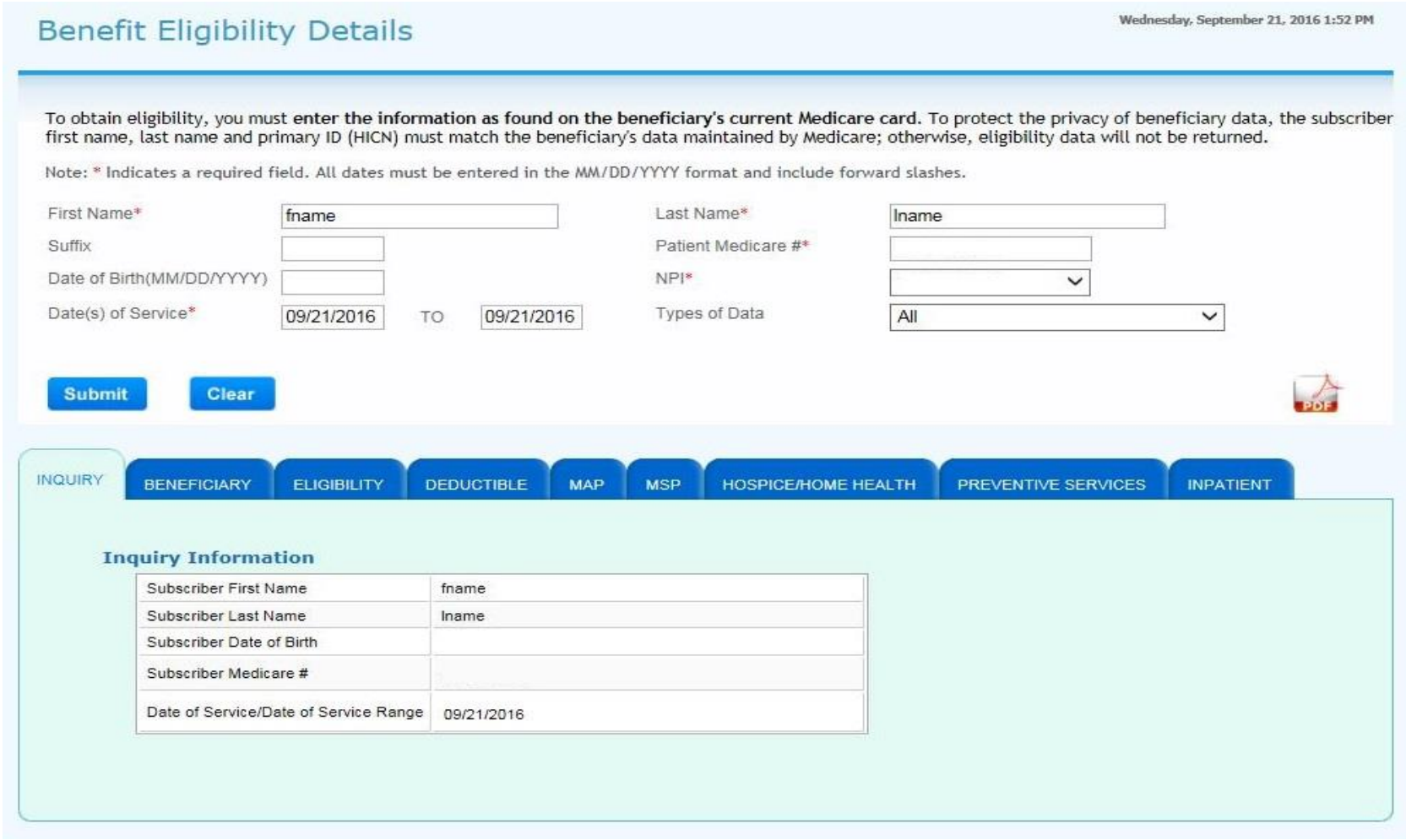
NOVITAS SOLUTIONS

Utilizing the Novitasphere Portal

What is Novitasphere?

- Free, secure web-based portal
- Part A – Access to Eligibility, Claim Submission with File Status, ERA, Medical Review Record Submission, and Audit and Reimbursement Cost Reports Submission
- Part B - Access to Eligibility, Claim Information and Remittance Advice, Claim Submission with File Status, ERA, Claim Correction, Secure Messaging and a Mailbox
- Live Chat feature
- Dedicated Help Desk- 1-855-880-8424
- For demonstrations and more information:
  - JH Providers

Benefits & Eligibility Results



Benefit Eligibility Details

Wednesday, September 21, 2016 1:52 PM

To obtain eligibility, you must **enter the information as found on the beneficiary's current Medicare card.** To protect the privacy of beneficiary data, the subscriber first name, last name and primary ID (HICN) must match the beneficiary's data maintained by Medicare; otherwise, eligibility data will not be returned.

Note: * Indicates a required field. All dates must be entered in the MM/DD/YYYY format and include forward slashes.

First Name*	fname	Last Name*	lname
Suffix		Patient Medicare #*	
Date of Birth(MM/DD/YYYY)		NPI*	
Date(s) of Service*	09/21/2016 TO 09/21/2016	Types of Data	All

Submit Clear

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

Inquiry Information

Subscriber First Name	fname
Subscriber Last Name	lname
Subscriber Date of Birth	
Subscriber Medicare #	
Date of Service/Date of Service Range	09/21/2016

Eligibility Information

- Eligibility:
  - Part A Eligibility Effective and Termination Dates
  - Part B Eligibility Effective and Termination Dates
  - Inactive Periods
  - End Stage Renal Disease (ESRD) dates and information
- Deductible:
  - Part B Total Deductible Remaining for Calendar year
  - Occupational, Physical and Speech Therapy amounts applied to the capitation limits
  - Rehabilitation Session counts
- Medicare Advantage Plan (MAP):
  - Contract Name and Number
  - Type of Medicare Advantage Plan
  - The Bill Option code of the Plan type
  - Effective and Termination Dates
  - Plan Address and Telephone Number
- Medicare Secondary Payer (MSP):
  - The reason Medicare is secondary
  - Effective and Termination Dates
  - Name of Insurance Company and Address
- Hospice/Home Health:
  - Certification codes and dates
  - Home Health Eligibility History
  - Insurer Name and Address
  - Home Health Episode Start and End Dates
  - Home Health Episode termination date
  - Provider NPI Number of the Home Health Facility
- Preventive Services:
  - Number of Smoking Sessions remaining for the beneficiary
  - Next Available Smoking Cessation Date
  - Preventive Service Procedure Code
  - Preventive Technical and Professional Dates
  - Calendar Year
  - Deductible Applied for the Calendar Year
  - Deductible Remaining for the Calendar Year
  - Coinsurance Remaining for the Calendar Year
- Inpatient:
  - Date of earliest and latest billing activity for the spell of illness
  - Hospital Information
  - Skilled Nursing Facility Information

Documentation Submission

- Cost Report Reopening:
  - Used for Submission of reopening Requests for a cost report after it has been settled
- Cost Report Appeals:
  - Used for the submission of supporting documents for cost reposts that are under appeal
- SSI Realignment Request (DSH):
  - Used to request an update to a provider's disproportionate share statistics
- Provider-Based Determination:
  - Used to request initial setup or change in a unit's provider-based status
- Wage Index/Occupational Mix Submissions:
  - Used to upload documentation for the yearly wage index and occupational mix audits
- Desk Review/Audit Additional Documentation:
  - Used to upload documentation requested by the Novitas audit staff during the time of a desk review and/or audit
- Submit FOIA Request:
  - Used to submit a Freedom of Information Act request for Medicare cost reports
- Submit PS&R Request:
  - Used to submit a Provider Statistical & Reimbursement report request for fiscal years not covered on the CMS PS&R online system. Providers may utilize this selection if they are currently experiencing PS&R access issues as well
- General Correspondence:
  - Used to submit documentation for items not covered in the above-mentioned table selections; such items include:
    - ✓ Request for Interim Rate Change
    - ✓ Request for Tentative Settlement Change
    - ✓ TEFRA Exception Request
    - ✓ SCH Low Volume Request
    - ✓ Request for Change in Statistical Basis
    - ✓ CMS Tie-In-Notice
    - ✓ Bankruptcy
    - ✓ Other Supporting Documentation
    - ✓ 50%Reduction Request

Novitasphere References

- Novitasphere Provider Portal Enrollment Overview Training Module
- EIDM Registration Instructions
- Portal Enrollment Forms

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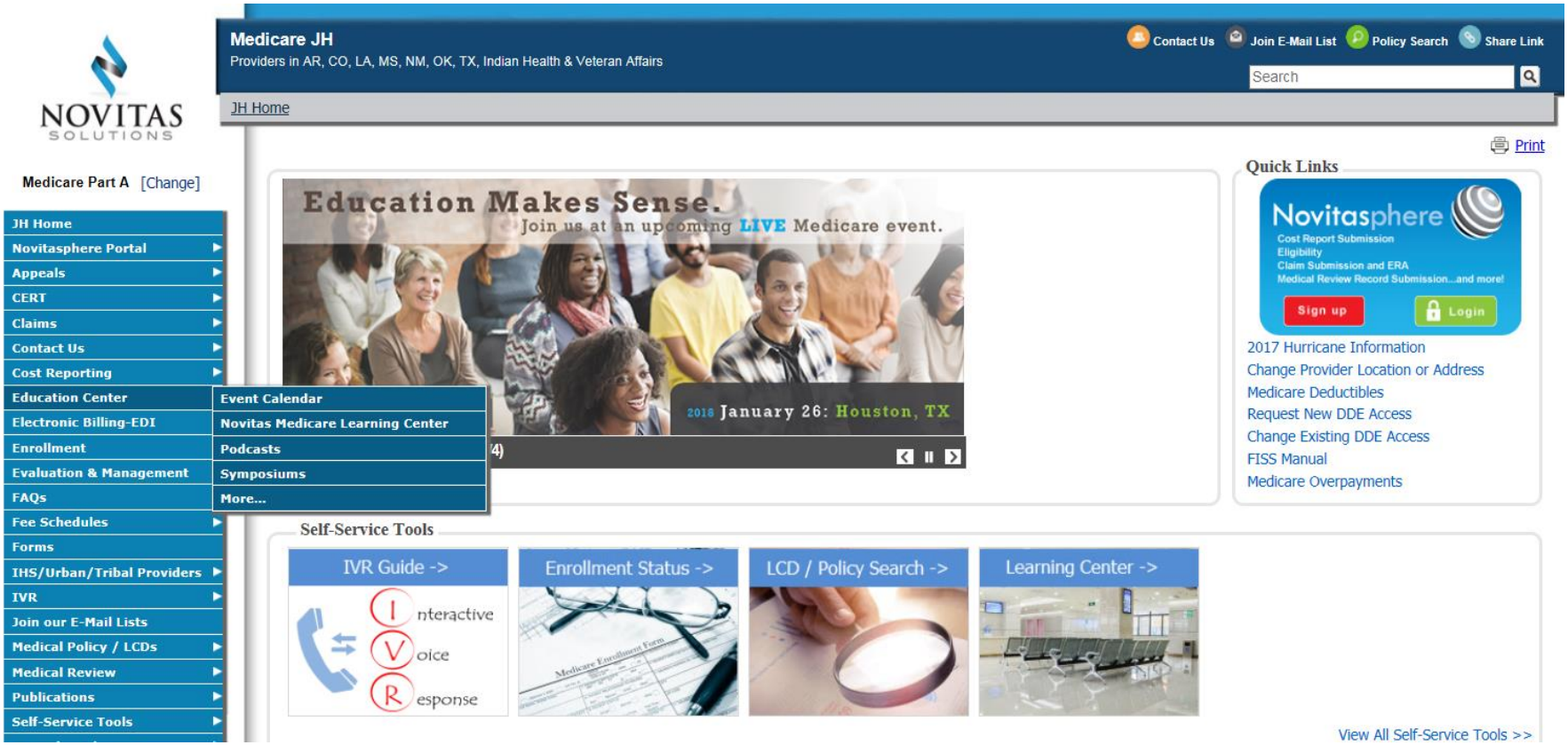
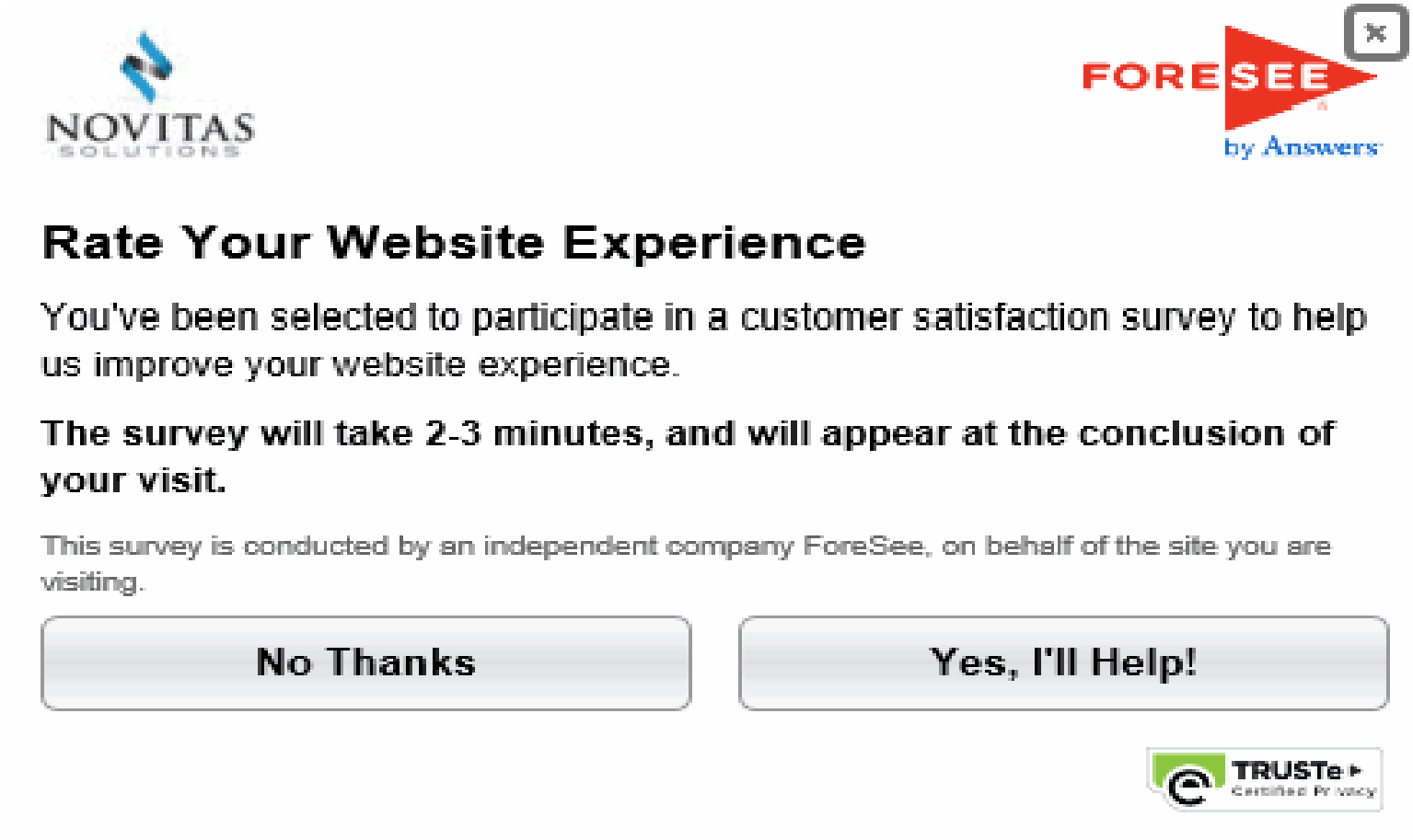
Reminders and Educational Resources

Novitas Website

- [JH Novitas website]



Website Satisfaction Surveys



Novitas Solutions eNews Mailing Schedule

- In response to your feedback, we are implementing a new delivery schedule for our “Novitas Solutions eNews” email
- Our emails will arrive in your inbox just twice a week:
  - Every Tuesday and Thursday
- These emails will still contain all the important Medicare news and updates you need
- We will continue to send any urgent Medicare news or alerts to your inbox instantly
- Website

Customer Contact Information

- Providers are required to use the IVR unit to obtain:
  - Claim Status
  - Patient Eligibility
  - Check/Earning
  - Remittance inquiries
- Jurisdiction H:
  - Customer Contact Center- 1-855-252-8782
  - Provider Teletypewriter- 1-855-498-2447
- Patient / Medicare Beneficiary:
  - 1-800-MEDICARE (1-800-633-4227)

Summary

- Provided the latest news, updates, reminders and top claim submission errors
- Discussed the importance of the new Medicare cards
- Demonstrated the user-friendly functionality of the Novitasphere Portal
- Reviewed helpful Medicare reminders and education resources

Thank You

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