Medicare Updates

Jackson, Mississippi

November 2, 2018

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  - Jurisdiction H
  - Part B Electronic Billing
  - Novitasphere Portal
  - ABILITY| PC-ACE
  - Medicare Remit Easy Print (MREP) Users
- JH Providers join using:
  - http://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00007968

Today's Presentation

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

Acronym List 1

Acronym	Definition
AIR	All Inclusive Rate
BHI	General Behavioral Health Integration
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
EHR	Electronic Health Records
ERA	Electronic Remittance Advice
HCPCS	Healthcare Common Procedure Coding System
HETS	HIPPA Eligibility Transaction System

Acronym List 2

Acronym	Definition
HMO	Health Maintenance Organization
IPPE	Initial Preventive Physical Exam
IVR	Interactive Voice Response
NP	Nurse Practitioner
MBI	Medicare Beneficiary Identifier
MLN	Medicare Learning Network
PA	Physicians Assistant
PPS	Prospective Payment System
RA	Remittance Advice
RHC	Rural Health Clinic
RTP	Return to Provider
SSA	Social Security Administration

2018 Medicare Updates

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
- Reference:
  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10333.pdf

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
- Reference:
  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10175.pdf

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:
  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9234.pdf
    - ✓ 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

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- 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
- Reference:
  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10350.pdf

Suppression of the Standard Paper Remittance (SPR) Advice

- MM10151:
  - Effective: January 1, 2018
  - Implementation: January 2, 2018
- Key Points:
  - Beginning on February 14, 2018, Novitas will stop generating SPRs to providers who receive both SPRs *and* ERAs
  - ERA is generated 14 days from the date the file was submitted:
    - ✓ File is available for retrieval for 45 days
  - When you retrieve your ERA, save it to location on your system where you can easily locate it in the future if necessary
  - Those saved ERA files can be translated by your claim software, or by one of our free software products: Medicare Remit Easy Print (MREP) for Part B, PC Print for Part A, or ABILITY | PC-ACE for Part A or Part B:
  - Training modules are offered to help you retrieve and read your ERA files:
    - ✓ Part A: http://www.novitas-solutions.com/webcenter/content/conn/UCM_Repository/uuid/dDocName:00004760
    - ✓ Part B: http://www.novitas-solutions.com/webcenter/content/conn/UCM_Repository/uuid/dDocName:00004761
- Reference:
  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10151.pdf

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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
- Reference:
  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9269.pdf

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
- Reference:
  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1611.pdf

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
34538
U5210
U5200
5EXC1

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
- Research:
  - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf section 60
- Reason code action:
  - Bill Part B CMS 1500 claim form

Reason Codes 34538

- RTP error:
  - Claim submitted as Medicare primary positive MSP record exists at CWF
- Research:
  - Verify beneficiaries eligibility:
    - ✓ Novitasphere, Fiscal Intermediary Shared System (FISS), HETS or Interactive Voice Response (IVR)
- Reason code action:
  - MSP file has been terminated:
    - ✓ Submit adjustment stating ‘File is updated, Medicare is primary’
  - MSP file is valid and current:
    - ✓ Bill primary payer
    - ✓ Adjust claim to Medicare showing primary insurers payment

Reason Codes U5200/U5210

- Entitlement RTPs:
  - U5200: No Entitlement:
    - ✓ The beneficiary does not have Part B Entitlement
  - U5210: Services after benefits terminated:
    - ✓ The beneficiaries Part B Entitlement has been terminated
- Research:
  - Verify the beneficiaries entitlement:
    - ✓ Novitasphere, Fiscal Intermediary Shared System (FISS), HIPPA Eligibility Transaction System (HETS) or Interactive Voice Response (IVR)
- Reason code action:
  - If entitlement has been updated:
    - ✓ Resubmit, if date of service is within entitlement
  - Advise beneficiary to contact Social Security if discrepancies occur

Reason Code 5EXC1

- Denial:
  - Exclusions from Medicare
- Research:
  - https://www.medicare.gov/what-medicare-covers/not-covered/item-and-services-not-covered-by-part-a-and-b.html
- Reason code action:
  - Not billable to Medicare

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Getting Ready for New Medicare Cards

Removal of Social Security Numbers

- Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS to remove Social Security Numbers (SSNs) from all Medicare cards by April 2019:
  - Medicare Beneficiary Identifier (MBI) will replace the SSN-based Health Insurance Claim Number on the new Medicare cards
- Initiative will help prevent fraud:
  - Fight identity theft
  - Protect private healthcare
  - Protect financial information

Inform Medicare Patients

- CMS will begin mailing the new MBI cards in April 2018
- Deadline for replacing all existing Medicare cards is April 2019
- Beneficiaries should destroy the traditional Medicare card
- Keep the new MBI confidential
- Issuance of the new number will not change Medicare benefits
- 2018 Medicare & You Handbook includes information on new card

CMS Products

- New Medicare Card Flyer
- New Medicare Card Poster:
  - Example of new card
- New Medicare Tear off pad:
  - You're getting a new Medicare card
- Still Waiting for Your New Card? Tear-off:
  - Published June 2018
  - Resources and options for online notification when card has been mailed
  - If patient doesn't get the new card and mailing has ended in their state:
    - ✓ Patient should contact 1-800-Medicare to resolve any issues
- CMS Product ordering

Get Ready for the New MBI

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- 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
    - ✓ www.ssa.gov/myaccount
  - Railroad Retirement Board:
    - ✓ 1-877-772-5772

Patient's Can Receive Email Notification of New Card Mailing

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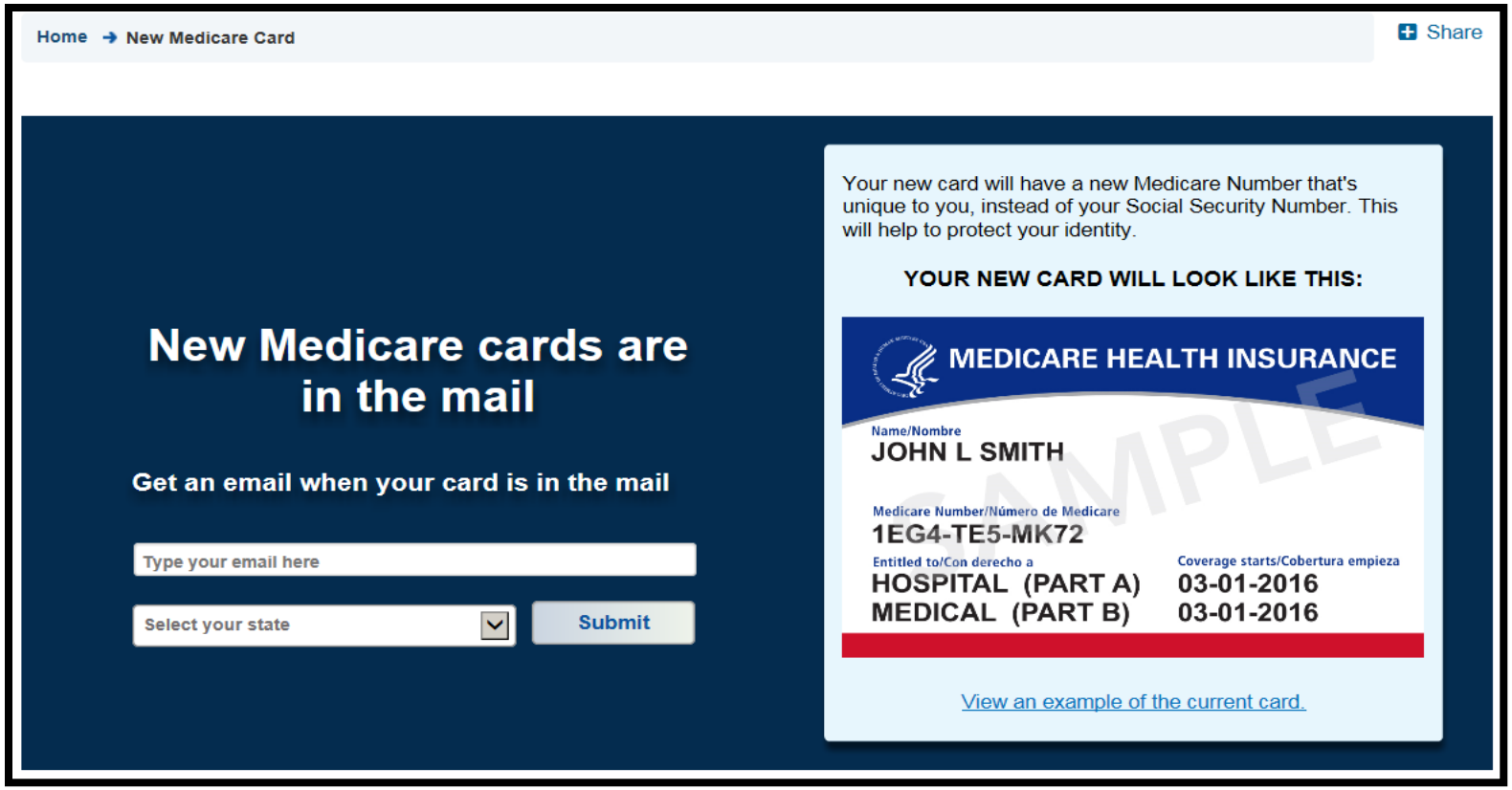
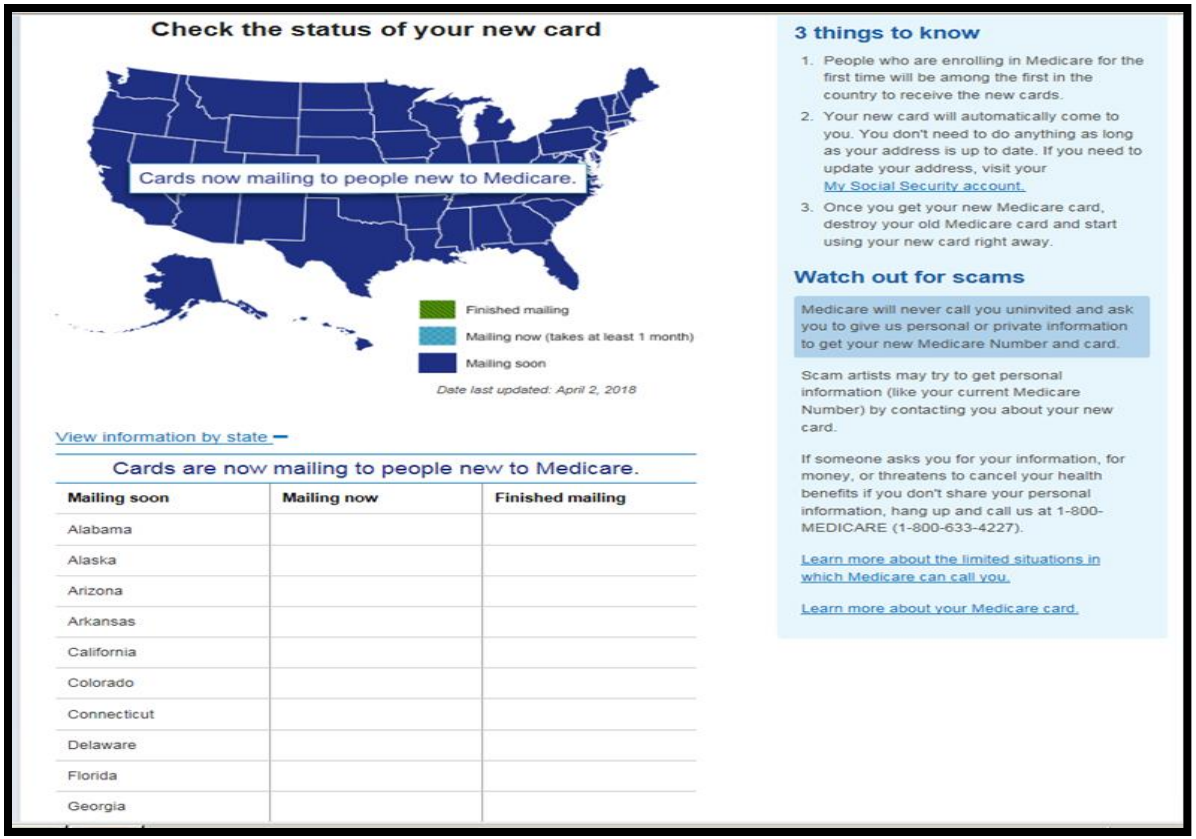
- Medicare.gov



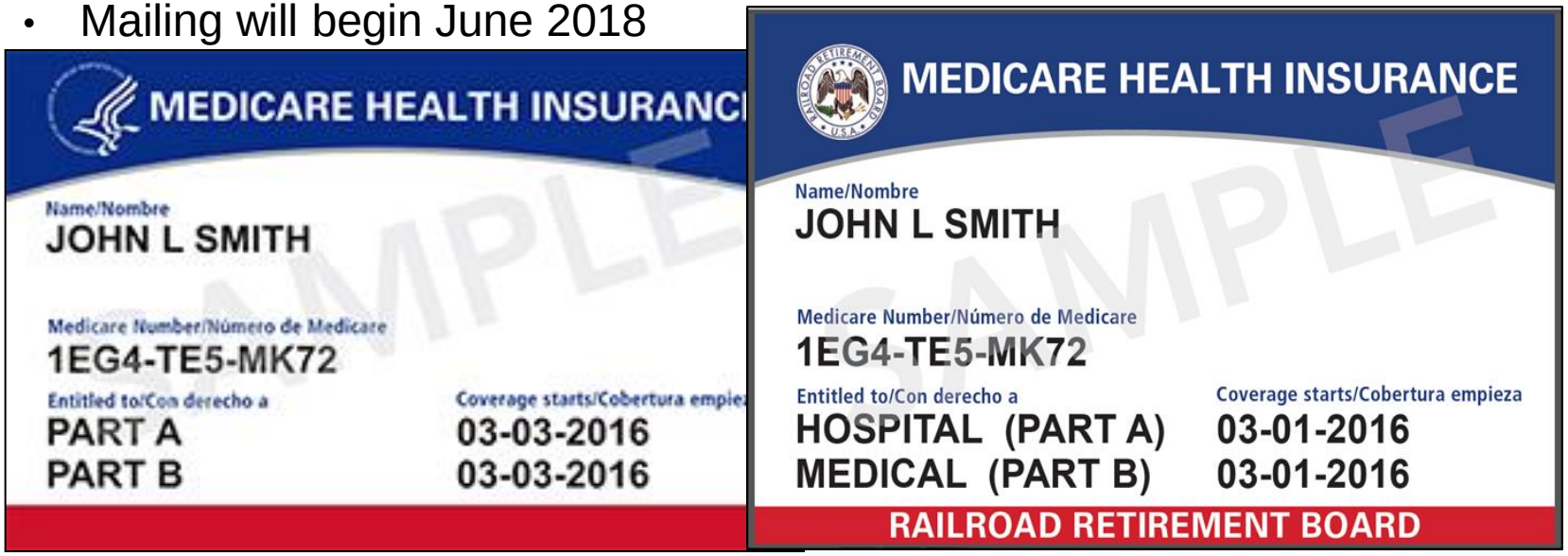
Patient's Can Check Status of Mailing by State

- Medicare.gov



MBI New Design

- New Medicare card:
  - Health and Human Services (HHS) logo
  - Gender and signature line removed
- Railroad Retirement MBI card:
  - Railroad Retirement Board logo will be the key identifier
  - Mailing will begin June 2018



Transition Period

- Transition period April 2018 through December 31, 2019
  - Submit either Medicare number or MBI
- 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
- Medicare number and MBI for the same patient in same batch of claims:
  - During the transition period:
    - All claims with either Medicare number and MBI can be in the same batch

FISS Standard Paper Remittance Advice Example with MBI

- Beginning October 1, 2018 through transition period:
  - MID field will reflect the Medicare identification submitted
  - MBI field will reflect the MBI when a valid and active Medicare number is submitted

FISS Standard Paper Remittance Advice Example

Beginning October 1, 2018, through the transition period:

- The **MID field** (line 32) will show the Medicare ID submitted on the claim
- The **MBI field** (line 66) will show the Medicare Beneficiary Identifier (MBI) when a provider submits a valid and active HICN

1 MEDICARE PART A 2 STREET ADDRESS 3 CITY 4 ST 5 999999999 6 VER# 5010

7 CONTACT NAME 8 PHONE: 000-000-0000 9 EXT: 10 FAX: 11 EXT: 12 EMAIL:

13 NPI# 14 PROVIDER NAME 15 PROVIDER ADDRESS 16 CITY 17 ST 18 999999999 19 PART A

20 PAID DATE: MM/DD/YYYY 21 REMIT#10 22 PAGE

23 PATIENT NAME 24 PATIENT CNTRL NUMBER 25 RC 26 REM27DRG# 28 DRG OUT AMT 29 COINSURANCE 30 PAT REFUND 31 CONTRACT ADJ

32 MID 33 ICN NUMBER 34 RC 35 REM 36 OUTCD 37 NEW TECH/ECT 38 COVD CHGS 39 ESRD NET ADJ 40 PATIENT RESP

41 FROM DT 42 THRU DT 43 HICHG 44TOB 45 RC 46 REM 47 PROF COMP 48 MSP PAYMT 49 NCOVD CHGS 50 INTEREST 51 PROC CD AMT

52 CLM STATUS 53 COST 54 COVDY 55 NCOVDY 56 RC 57 REM 58 DRG AMT 59 DEDUCTIBLES 60 DENIED CHGS 61 PRE PAY ADJ 62 NET REIMB

66 MBI

63 SEQUESTRATION

64 PBP REDUCT

65 ISLET ADD ON

New Medicare Card Mailing Waves

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

After Transition Period

- January 1, 2020 use MBIs on your claims
- Exceptions for Fee-for-Service claims:
  - For audits:
    - ✓ You can use either the Medicare number or the MBI for audit purposes
  - For appeals:
    - ✓ Either Medicare number or MBI for appeals and 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

Medicaid and Supplemental Insurers

- CMS will provide State Medicaid Agencies and supplemental insurers MBIs for Medicaid eligible people who also have Medicare
- Crossover claims:
  - During transition period either Medicare number or MBI is accepted
- Supplemental insurer:
  - During transition period:
    - ✓ Continue using your unique numbers
  - After transition period:
    - ✓ Use MBI where the Medicare number would have been used

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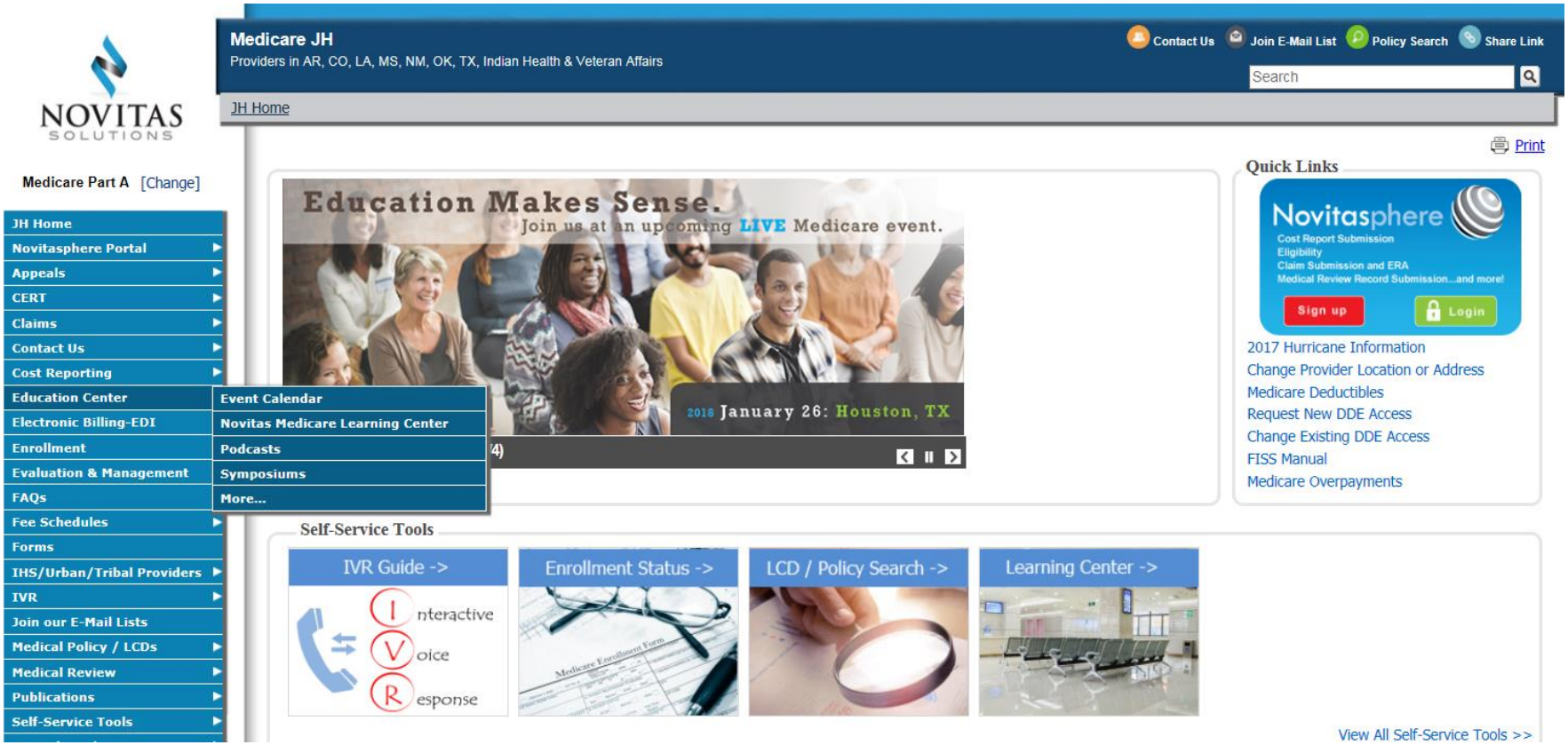
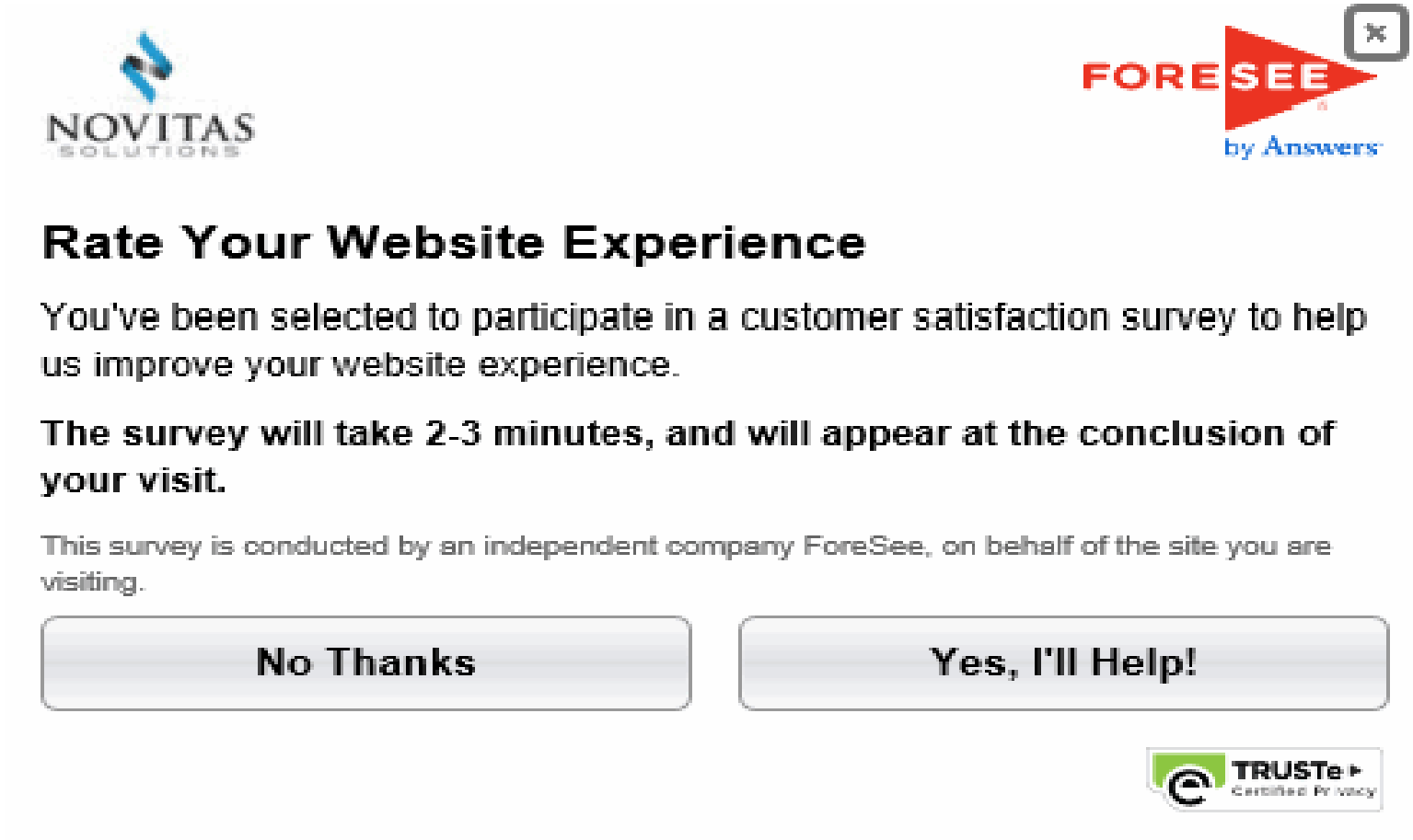
Reminders and Educational Resources

Novitas Website

- http://www.novitas-solutions.com/webcenter/portal/MedicareJH/Medicare+JH+Home



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
- Join:
  - JH Providers:
    - ✓ http://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00007968

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)
  - http://www.medicare.gov

Summary

- Provided the latest news, updates, reminders and top claim submission errors
- Discussed the importance of the new Medicare cards
- Reviewed helpful Medicare reminders and education resources

Thank You

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