Medicare Updates and What's Trending

NJ, Keystone, and Philadelphia
AAHAMs Collaborative Webinar
April 29, 2020

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Acronym List

Acronym	Definition
CAH	Critical Access Hospital
CDLT	Clinical Diagnostic Laboratory Tests
CMS	Centers for Medicare and Medicaid Services
COVID-19	Coronavirus Disease 2019
CPT	Current Procedural Terminology
CTBS	Communication Technology Based Services
DOS	Date of Service
CTBS	Communication Technology Based Services
E&M	Evaluation and Management
ESRD	End Stage Renal Disease
FAQ	Frequently Asked Questions
FQHC	Federally Qualified Health Center
HCPCS	Healthcare Common Procedure Coding System
HHS	U.S. Department of Health & Human Services

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Acronym List Two

Acronym	Definition
ICD-10-CM	International Classification of Diseases, Tenth Revision, Clinical Modification
IPPS	Inpatient Prospective Payment System
IRF	Inpatient Rehabilitation Facility
LTCH	Long Term Care Hospital
MBI	Medicare Beneficiary Identifier
MLN	Medicare Learning Network
OIG	Office of Inspector General
OPPS	Outpatient Prospective Payment System
PECOS	Provider Enrollment, Chain and Operating System
PFS	Physician Fee Schedule
PHE	Public Health Emergency
POS	Place of Service
RHC	Rural Health Clinic
RTP	Return to Provider
SNF	Skilled Nursing Facility

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Today's Presentation

- Agenda:
  - Medicare Updates and Reminders
  - Coronavirus (COVID-19) – Stay Informed
  - Novitas Initiatives
  - Education and Training Events
- Objectives:
  - Identify and understand the current Medicare updates and reminders
  - Review COVID-19 information
  - Explore the educational resources and information

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Medicare Updates and Reminders

April 2020 Update of the Hospital Outpatient Prospective Payment System (OPPS)

- MM11691 :
  - Effective date: April 1, 2020
  - Implementation date: April 6, 2020
- Key Points:
  - CPT Proprietary Laboratory Analyses (PLA) Coding Changes
  - New Medicare National Coverage Determination for Acupuncture and Dry Needling Services
  - New Corona Virus Lab Test HCPCS Code
  - New CY 2020 HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals
    - ✓ Currently existing HCPCS codes for certain drugs, biologicals, and radiopharmaceuticals receiving pass-through status
    - ✓ Currently existing HCPCS codes for certain drugs, biologicals, and radiopharmaceuticals with pass-through status ending on March 31, 2010
  - Drugs and Biologicals with Payments Based on Average Sales Price (ASP)
  - Drugs and Biologicals Based on ASP Methodology with Restated Payment Rates
  - Drugs and Biologicals that Will Change Status Indicator

Quarterly Update to the MPFSDB - April 2020 Update

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- MM11661:
  - Effective date: January 1, 2020
  - Implementation date: April 6, 2020
- Key Points:
  - Amends payment files based upon the 2020 MPFS Final Rule, published in the Federal register on November 15, 2019
  - Revisions to relative value units (G0105, G0121, 45388, 45378, G2001-G2009, G2013) effective January 1, 2020
  - Revised HCPCS (20560-20561, 97810-97811, 97813-97814) effective January 21, 2020
  - New and deleted codes:
    - ✓ New codes G2168- G2169, effective January 1, 2020
    - ✓ New codes G1012- G1019, effective April 1, 2020
    - ✓ Deleted code G1000, effective April 1, 2020

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MBI is Here!

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- Effective January 1, 2020, claims submitted to Medicare will require the beneficiary's MBI number with few exceptions
- Use MBI now for all Medicare transactions for all dates of service
- 3 ways to get the MBI:
  - Ask your patient for their card
  - Use your Medicare Administrative Contractor's look up tool:
    - ✓ Sign up for the Portal to use the tool
  - Check the remittance advice prior to 2020:
    - ✓ MBI is returned on the remittance advice if a valid and active Health Insurance Claim Number is submitted (expired December 31, 2019)
- Get Your New Medicare Card
- Beneficiaries who did not receive their card can:
  - Sign into MyMedicare.gov:
  - Call 1-800-MEDICARE (1-800-633-4227)
  - TTY users can call 1-877-486-2048

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There Are Times When an MBI May Change

- Medicare beneficiaries or their authorized representatives can ask to change their MBIs:
  - Example, if the MBIs are compromised
- CMS can change MBIs
- CMS does NOT issue temporary MBIs
- CMS does NOT require a beneficiary to activate a new MBI
- It is possible for a beneficiary to seek and get care before getting a new card with the new MBI in the mail
- Eligibility transaction error code AAA 72 of "invalid member ID," indicates the beneficiary's MBI may have changed
- A historic eligibility search will indicate the termination date of the old MBI
- Get the new MBI from the secure MBI look-up tool

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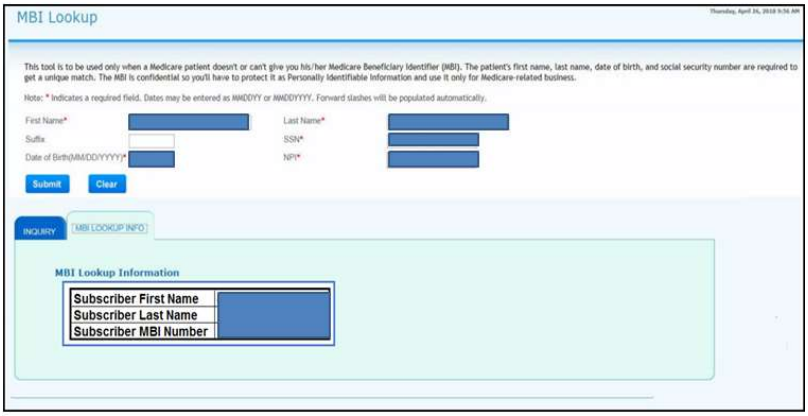
MBI Lookup



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Hospital Off-Campus Outpatient Department Reporting

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- On March 24, 2020, CMS announced **a delay until further notice to the activation of Systematic Validation Edits for OPPS Providers with Multiple Service Locations**:
  - Requirements for correct provider practice location reporting was effective back in 2017, however, systematic edits were not put in place at that time
- Changes to editing for appropriate reporting of off-campus outpatient department locations will impact all providers:
  - To ensure correct payment for services provided at a hospital off-campus provider-based departments, CMS will be enacting changes for OPPS providers that have multiple practice locations
  - Payment impacts only applies to those providers paid under OPPS
- Prepare by verifying that enrollment information is up to date and any claim submissions reflect the practice locations **EXACTLY** as it appears from the practice location address screen which is received from the Provider Enrollment, Chain and Operating System (PECOS)
- Ensure that the practice locations are linked to the National Provider Identifier (NPI) that is being reported on the claim submission
- References:
  - Hospital Off-Campus Outpatient Department Reporting Requirements (JH) (JL)
  - SE190007 - Activation of Systematic Validation Edits for OPPS Providers with Multiple Service Locations - Update

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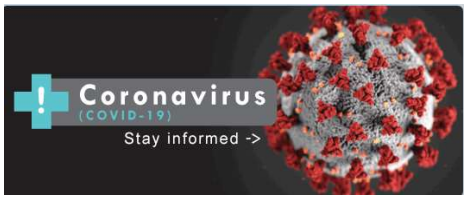

Coronavirus (COVID-19) – Stay Informed

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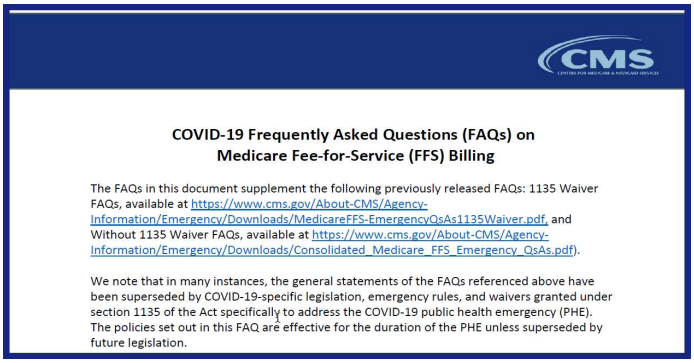
COVID-19 Frequently Asked Questions on Medicare Fee-for-Service Billing

- COVID-19 Frequently Asked Questions on Medicare Fee-for-Service Billing:
  - CMS has posted updated frequently asked questions



CMS

COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing

The FAQs in this document supplement the following previously released FAQs: 1135 Waiver FAQs, available at https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/MedicareFFS-EmergencyQsAs1135Waiver.pdf, and Without 1135 Waiver FAQs, available at https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Consolidated_Medicare_FFS_Emergency_QsAs.pdf).

We note that in many instances, the general statements of the FAQs referenced above have been superseded by COVID-19-specific legislation, emergency rules, and waivers granted under section 1135 of the Act specifically to address the COVID-19 public health emergency (PHE). The policies set out in this FAQ are effective for the duration of the PHE unless superseded by future legislation.

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Resources Relating to COVID-19

- Novitas Coronavirus COVID-19 information:
  - Dedicated page to encourage providers to stay current with all the updates related to COVID-19
- CMS Coronavirus (COVID-19) website:
  - Learn about CMS responses to Coronavirus and find the latest program guidance
- Medicare Coverage and Payment of Virtual Services video:
  - Video released providing answers to common questions about the Medicare telehealth services benefit
- SE20011 - Medicare Fee-for-Service (FFS) Response to the Public Health Emergency on the Coronavirus (COVID-19)
  - Summary of the blanket waivers including telehealth
- CMS Dear Clinician Letter:
  - CMS posted a letter to clinicians that outlines a summary of actions including information about telehealth and virtual visits, accelerated and advanced payments, and recent waiver information
- COVID-19@cms.hhs.gov
  - Questions related to COVID-19 can be directed to CMS

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Medicare Fee-for-Service (FFS) Response to the Public Health Emergency (PHE) on the Coronavirus (COVID-19)

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- SE20011:
  - Release Date: April 10, 2020 Revised
- Key Points:
  - On March 13, 2020, CMS issued blanket waivers as a result of the PHE under Section 1135 retroactive to March 1, 2020:
    - ✓ Prevents gap in access to car for beneficiaries impacted by the emergency
    - ✓ No need to apply when blanket waiver issued
  - Apply the following to claims:
    - ✓ DR condition code to inpatient and outpatient claims
    - ✓ CR modifier to professional claims
- References:
  - Current Emergence webpage
  - Waiver and Flexibilities webpage
  - Complete list of COVID-19 blanket waivers
  - COVID-19 FAQs

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Families First Coronavirus Response Act Waives Coinsurance and Deductibles for Additional COVID-19 Related Services

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- For services furnished on March 18, 2020, and through the end of the PHE cost sharing does not apply to COVID-19 related services:
  - Apply the CS modifier on applicable claim lines to identify the service as subject to the cost-sharing wavier for COVID-19 testing-related services
  - Do not charge patient deductible and coinsurance
  - Applies to medical visits for the E&M categories when an outpatient provider, physician, or other providers and suppliers bills Medicare for Part B services orders or administers COVID-19 lab test U0001, U0002, or 87635
- Note: the CS modifier does not apply to services unrelated to COVID-19
- **For telemedicine only report the CS modifier when the service provided is for an evaluation that results with the ordering or administration of COVID 19 testing:**
  - Adjust previously processed claims if submitted without the CS modifier

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Applying the CS Modifier

- Apply CS modifier to the following service categories for E&M and the order or administration of COVID-19 testing:
  - Office and other outpatient services
  - Hospital observation services
  - Emergency department services
  - Nursing facility services
  - Domiciliary, rest home, or custodial care services
  - Home services
  - Online digital evaluation and management services
- Cost-sharing (deductible and coinsurance) does not apply to the above medical visit services for which payment is made to:
  - Hospital Outpatient Departments paid under the OPPS
  - Physicians and other professionals under the PFS
  - CAHs
  - RHCs
  - FQHCs
- CS modifier does not apply to MD waiver hospitals and Indian Health Services (IHS)

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COVID-19: Expanded Use of Ambulance Origin/Destination Modifiers

- Coverage for medically necessary and non-emergency ground ambulance transportation from any point of origin to a destination equipped to treat the patient's condition
- Expanded list of destination include but not limited to:
  - Any location that is an alternative site determined to be part of a hospital, CAH, or SNF
  - Community mental health centers
  - FQHCs
  - RHCs
  - Physicians' offices
  - Urgent care facilities
  - ASCs
  - Any location furnishing dialysis services outside of an ESRD facility when an ESRD facility is not available
  - Beneficiary's home

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Expanded Origin and Destination Claim Modifiers for New Covered Locations

- Complete list of ambulance origin and destination modifiers:
  - Medicare Claims Processing Manual, Pub. 100-04, Chapter 15- Ambulance, Section 30 A. "Modifiers Specific to Ambulance Service Claims

Modifier	Description
D	Community mental health center, FQHC, RHC, urgent care facility, non-provider-based ASC or freestanding emergency center, location furnishing dialysis services and not affiliated with ESRD facility
E	Residential, domiciliary, custodial facility (other than 1819 facility) if the facility is the beneficiary's home
H	Alternative care site for hospital, including CAH, provider-based ASC, or freestanding emergency center
N	Alternative care site for SNF
P	Physician's office
R	Beneficiary's home

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New Specimen Collection Codes for Laboratories Billing for COVID-19 Testing

- Effective with line item DOS on or after March 1, 2020, report the following HCPCs codes to identify specimen for COVID-19 testing:
  - G2023 - Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), any specimen source
  - G2024 - Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), from an individual in a skilled nursing facility or by a laboratory on behalf of a home health agency, any specimen source
- Billable by clinical diagnostic laboratories
- Additional Reference:
  - COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing (pages 1-3)

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Beneficiary Notice Delivery Guidance in Light of COVID-19

- Be diligent and safe while issuing the following beneficiary notices if treating a patient with suspected or confirmed COVID-19:
  - Important Message from Medicare (IM)_CMS-10065
  - Detailed Notices of Discharge (DND)_CMS-10066
  - Notice of Medicare Non-Coverage (NOMNC)_CMS-10123
  - Detailed Explanation of Non-Coverage (DENC)_CMS-10124
  - Medicare Outpatient Observation Notice (MOON)_CMS-10611
  - Advance Beneficiary Notice of Non-Coverage (ABN)_CMS-R-131
  - Skilled Nursing Advance Beneficiary Notice of Non-Coverage SNFABN)_CMS-10055
  - Hospital Issued Notices of Non-Coverage (HINN)

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Delivery Notice Flexibilities

- Hard copies of notices may be dropped off with a beneficiary by any hospital worker able to enter a room safely:
  - Provide a contact phone number for a beneficiary to ask questions about the notice if the individual delivering the notice is unable to do so
  - If a hard copy of the notice cannot be dropped off, notices to beneficiaries may also be delivered via email:
    - ✓ If a beneficiary has access in the isolation room
    - ✓ Annotate notice with the circumstances of the delivery,:
      - ➢ Including the person delivering the notice
      - ➢ When and to where the email was sent
- Notice delivery may be made via telephone or secure email to beneficiary representatives who are offsite
  - Annotate with the circumstances of the delivery"
    - ✓ Include the person delivering the notice via telephone
    - ✓ Time of the call, or when and to where the email was sent
- Specifics of notice delivery:
  - Medicare Claims Processing Manual, Pub. 100-04, Chapter30 – Financial Liability Protections

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Telemedicine Services Explained

- Urgency to expand the use of technology to help people who need routine care, and keep vulnerable beneficiaries and beneficiaries with mild symptoms in their homes while maintaining access to the care they need
- Limiting community spread of the virus, as well as limiting the exposure to other patients and staff members will slow viral spread
- Virtual services physicians and other health care professionals can provide:
  - Telehealth visits
  - Virtual check-in
  - E-visits
  - Telephone services
- References:
  - CMS Medicare Telemedicine Health Care Provider Fact Sheet
  - Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19
  - COVID-19 FAQs on Medicare Fee-for- Service (FFS) Billing (pages 20-26)
  - Coronavirus disease 2019 (COVID-19): Telehealth and telephone-only services during the emergency (JH) (JL)

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Telemedicine Services Defined

- Telehealth Visits:
  - A visit with a provider that uses telecommunication systems that has audio and video capabilities between a provider and a patient
- Virtual Check-Ins:
  - A brief CTBS (5-10 minutes) check in with your practitioner via telephone or other telecommunications device to decide whether an office visit or other service is needed. A remote evaluation of recorded video and/or images submitted by an new or established patient
- E-Visits:
  - A communication between a patient and their provider through an online patient portal
- Telephone Services:
  - Non-face-to-face E&M services provided using telephone audio

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Cost Sharing

- In general, with telemedicine services the out of pocket costs for beneficiaries has not changed
- Deductible and coinsurance still apply with some exceptions:
  - Waived when reporting the CS modifier for services provided is for an evaluation that results with the ordering or administration of COVID 19 testing
- HHS OIG is providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs
- Reference:
  - Medicare Telehealth Frequently Asked Questions (FAQs)

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Cost Sharing Examples

- Patient has a telehealth visit unrelated to COVID-19:
  - Do not report the CS modifier
  - Patient is responsible for applicable coinsurance and deductible
- Patient has telehealth visit related to COVID-19 and the provider orders COVID-19 testing:
  - Report the CS modifier
  - Patient is not responsible for any coinsurance or deductible

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Telehealth

- Use of audio and video capabilities
- Furnished in broader circumstances:
  - Includes office visits, emergency department visits, initial nursing facility and discharge visits, home visits, and therapy services, which must be provided by a clinician that is allowed to provide
- Considered the same as in-person visits and are paid at the same rate as in-person visits
- In all areas of the country in all settings
- Furnished to beneficiaries in any healthcare facility and in their home

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Billing for Professional Telehealth Services During PHE

- CMS will now allow for more than 80 additional services to be furnished via telehealth:
  - Covered Telehealth Services for PHE for the COVID-19 pandemic, effective March 1, 2020
- When billing professional claims for **all telehealth services** with **dates of services on or after March 1, 2020**, and for the duration of the PHE, bill with:
  - POS equal to what it would have been had the service been furnished in-person
  - **Modifier 95** indicating that the service rendered was actually performed via telehealth:
    - ✓ Modifier 95 is defined as synchronous telemedicine service rendered via real-time interactive audio and video telecommunications system

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Additional Billing for Professional Telehealth Services During PHE

- CR modifier and the DR condition code are not required on telehealth services
- Two scenarios where modifiers are required on telehealth professional claims:
  - Modifier GQ – Used when telehealth services are furnished via asynchronous (store and forward) technology as part of a federal telemedicine demonstration project in Alaska and Hawaii
  - Modifier G0 – Used for the diagnosis and treatment of an acute stroke
- No billing changes for institutional claims
- CAH method II claims bill with the GT modifier
- CMS video released with common telehealth service benefit

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Originating Site Facility Fee

- Definition:
  - Location of an eligible beneficiary at the time the service is furnished via a telecommunications system
- If the beneficiary is in a healthcare facility and receives services via telehealth the health care facility would only be eligible to bill for the originating site facility fee:
  - Report under HCPCS code Q3014
  - Revenue code 078x

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Eligible Providers

- The following health professionals can bill for telehealth services:
  - Physicians
  - Nurse practitioners (NPs)
  - Physician assistants (PAs)
  - Clinical nurse-midwives (CNM)
  - Clinical nurse specialists (CNS)
  - Certified registered nurse anesthetists (CRNAs)
  - Clinical psychologists (CPs) and Clinical social workers (CSWs)
  - Registered dietitians or nutrition professionals

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Telehealth Eligible Provider Clarification

- Question:
  - Can a PT, OT, and SLP perform telehealth services?
- Answer:
  - Currently PTs, OTs, and SLPs are not on the list of eligible providers to provide PT, OT, or SLP services
  - CMS did advise CMS did advise PTs, OTs and SLPs can bill for the following services:
    - ✓ Virtual Check in Codes: G2010 and G2012
    - ✓ E- Visits: G2061-G2063
    - ✓ Telephone assessment codes 98966 – 98968
- Reference:
  - Physicians and Other Clinicians: CMS Flexibilities to Fight COVID 19
  - COVID-19 Public Health Emergency Interim Final Rule

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Distant Site Practitioner Clarification #1

- Question:
  - Can the distant site practitioner furnish Medicare telehealth services from their home? Or do they have to be in a medical facility?
- Answer:
  - No payment restrictions on distant site practitioners furnishing Medicare telehealth services from their home during the PHE
  - Practitioner should report the POS code that would have been reported had the service been furnished in person:
    - ✓ Allow systems to make appropriate payment for services furnished via Medicare telehealth which, if not for the PHE for the COVID-19 pandemic, would have been furnished in person, at the same rate they would have been paid if the services were furnished in person
- Reference:
  - COVID-19 FAQs on Medicare Fee-for- Service (FFS) Billing

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Distant Site Practitioner Clarification #2

- Question:
  - Should on-site visits conducted via video or through a window in the clinic suite be reported as telehealth services? How could a physician or practitioner bill if this were telehealth?
- Answer:
  - Services should only be reported as telehealth services when the individual physician or practitioner furnishing the service is not at the same location as the beneficiary:
    - ✓ If the physician or practitioner furnished the service from a place other than where the beneficiary is located (a “distant site”), they should report those services as telehealth services
  - If the beneficiary and the physician or practitioner furnishing the service are in the same institutional setting but are utilizing telecommunications technology to furnish the service due to exposure risks:
    - ✓ The practitioner would not need to report this service as telehealth and should instead report whatever code described the in-person service furnished.

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FAQ: Claim Correction

- Question:
  - How do I correct a previously submitted claim when submitted:
    - ✓ With POS 02;
    - ✓ Without the 95 modifier; or
    - ✓ Omitted the CS modifier
- Answer:
  - Part A :
    - ✓ Submit correction through FISS/DDE
      - ➢ FISS Manual – Chapter 4 Claims Correction/Adjustment/Cancel
    - ✓ Clerical Error Reopening (CER) (JH) (JL)
  - Part B - Submit a correction (JH) (JL) through one of the following:
    - ✓ Novitasphere (JH) (JL)
    - ✓ Gateway Reopening (JH) (JL)
    - ✓ Automated IVR (JH) (JL)
    - ✓ Fax: 1-888-541-3829
    - ✓ Mail (JH) (JL)

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Virtual Check-Ins

- Service is not limited to only rural settings
- Patient must agree to the virtual service
- Use HCPCS code G2012 or HCPCS code G2010:
  - May only be reported when they do not result in an in-person or telehealth visit
- Can be conducted with a broader range of communication methods
- Virtual check in services can be provided for new and established patients
- Bill the appropriate code with the POS where the service would normally take place

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E-Visits

- Not limited to only rural settings
- No geographic or location restrictions for these visits
- Initiated by the patient
- Practitioners may educate
- Applies to new or established patient
- Bill using the following HCPCS/CPT codes:
  - 99421-99423 (online digital E&M services)
  - G2061-G2063 (qualified non-physician qualified health care)
- Bill the appropriate code with the POS where the service would normally take place

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Telephone Services

- Virtual patient communication codes will be used to report telephone E&M for beneficiaries who need routine, uncomplicated follow-up for chronic disease or routine primary care
- Reported for new and established patient for non-face-to-face patient-initiated communications with their doctor using a telephone
- Telephone service codes include:
  - 98966-98968 (Non-face-to-face non-physician telephone services)
  - 99441-99443 (Non-face-to-face physician telephone services)
- Bill the appropriate code with the POS where the service would normally take place
- Coronavirus Waivers & Flexibilities:
  - Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19

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Claim Denials for Telephone Services (Part B)

- Expansion of telehealth services caused invalid denials for telephone services
- System edits have been updated:
  - Retroactive to January 1, 2020
  - Updated April 1, 2020
- Two denials received:
  - Prior to April 1, 2020, claims were denying as non-covered:
    - ✓ These claims can be resubmitted
  - After April 1, 2020, claims were denying for Medically Unlikely Edits (MUE):
    - ✓ Novitas will automatically adjust these claims

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RTP Claims for Telemedicine Claims (Part A)

- Prior to the April release, the telemedicine services below had status indicator B:
  - Virtual Check-Ins (G2010 and G0212):
    - ✓ RTP reason code W7050
  - Telephone Services (98966, 98967, and 98968):
    - ✓ RTP reason code W7072
- CMS changed the status indicator form B to A with the April release:
  - Claims processing systems can accept these codes starting April 1, 2020 for DOS on or after March 1, 2020, however the I/OCE software will update July 2020:
    - ✓ Claims after the April release may have RTP'd with reason code W7062
    - ✓ Currently claims are set to suspend to bypass the edit
- Claims that RTP'd with either W7050, W7072, or W7062 can be F9'd to send back for processing

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Clinical Diagnostic Laboratory Tests (CDLTs)

- Clinical diagnostic lab tests pay at 100% of allowed amount:
  - Not subject to deductible and coinsurance
- Billable HCPCS and CPT codes:
  - U0001 - CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel
  - U0002 - 2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC
  - 87635 - Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique
- Payable for DOS on or after March 13, 2020
- Reference:
  - COVID-19 FAQs on Medicare Fee-for- Service (FFS) Billing (pages 4-5)

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CDLTs – Use of High Throughput Technologies

- Medicare will pay labs $100 effective April 14, 2020, and after for the CDLTs for the high throughput lab tests:
  - Payment for all other CDLTs remains at the current level
- HCPCS codes:
  - U0003 - Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique, making use of high throughput technologies as described by CMS-2020-01-R:
  - U0004 - 2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC, making use of high throughput technologies as described by CMS-2020-01-R
  - Reference:
    - ✓ Press Release - CMS Increases Medicare Payment for High-Production Coronavirus Lab Tests (4/15/2020)

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Hospital Services

- CMS is allowing hospitals to provide hospital outpatient services in temporary expansion sites, which may include ASCs, gymnasiums or other sites:
  - If a hospital meets the conditions of participation CoPs in effect during the COVID-19 PHE while operating one or more temporary expansion sites:
    - ✓ Medicare will pay for covered Medicare outpatient services provided at those sites as if they were provided at the permanent outpatient locations of the hospital
    - ✓ Expected to be operating in a manner not inconsistent with its state's emergency preparedness or pandemic plan
- *CMS Hospital Without Walls* initiative, for the duration of the COVID-19 PHE:
  - Hospitals can repurpose existing clinical (e.g., outpatient beds) and non-clinical space (e.g., cafeterias) for use as acute inpatient patient care areas to help address the urgent need to increase capacity
- Follow existing rules to bill under the applicable Medicare payment system depending on whether they provided outpatient care or inpatient care:
  - DR condition code to inpatient and outpatient
  - CR modifier on profession claims
- Reference:
  - COVID-19 FAQs on Medicare Fee-for- Service (FFS) Billing (pages 5-11)

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The CARES Act Provider Relief Fund

- Effective April 26, 2020, CMS reevaluated the accelerated and advanced payment program and suspended the program to Part B suppliers
- Funding will continue to be available to hospitals and other health care providers on the front lines of the coronavirus response primarily from the CARES Act Provider Relief Fund:
  - Administered through HHS
  - Payments do not have to be repaid
  - Congress appropriated $100 billion in the Coronavirus Aid, Relief, and Economic Security (CARES) Act (PL 116-136) and $75 billion through the Paycheck Protection Program and Health Care Enhancement Act (PL 116-139)
- For more information:
  - CARES Act Provider Relief Fund and how to apply
  - Press release 4/27/2020: CMS Reevaluates Accelerated Payment Program and Suspends Advance Payment Program
  - Fact Sheet: Expansion Of The Accelerated And Advance Payments Program For Providers And Suppliers During Covid-19 Emergency

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Credit Balance Submission Delay

- CMS is currently authorizing a 60-day delay for the submission of the quarter ending March 31, 2020 Credit Balance Reports from April 30, 2020, to June 30, 2020
- Extending the due date will delay the mailing of delinquency letters to July 15, 2020, and 100% withholding to August 3, 2020
- Credit Balance Reporting Extension Information for Quarter Ending 03/31/2020 - (JH) (JL)

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New Waivers for Inpatient Prospective Payment System (IPPS) Hospitals, Long-Term Care Hospitals (LTCHs), and Inpatient Rehabilitation Facilities (IRFs) due to Provisions of the CARES Act

- SE20015:
  - Release Date: April 15, 2020
- Key Points:
  - Payment increases for IPPS and LTCHs:
    - ✓ Claims received prior to April 20, 2020 – Medicare will reprocess
    - ✓ Claims received April 21, 2020, and after – Process in accordance to the CARES Act
  - IPPS Hospitals:
    - ✓ Section 3710 of the CARES Act -increase the weighting factor of the assigned DRG by 20 percent for an individual diagnosed with COVID-19 discharged during the COVID-19 PHE period
    - ✓ Discharges of an individual diagnosed with COVID-19 will be identified by the presence of the following ICD-10-CM diagnosis codes:
      - ➢ B97.29 (Other coronavirus as the cause of diseases classified elsewhere) for discharges occurring on or after January 27, 2020, and on or before March 31, 2020
      - ➢ U07.1 (COVID-19) for discharges occurring on or after April 1, 2020, through the duration of the COVID-19 PHE period

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New Waivers IPPS Hospitals, LTCHs, and IRFs due to Provisions of the CARES Act Continued

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- LTCHs:
  - Section 3711 of the CARES Act waives certain site neutral payment rate provisions:
    - ✓ Waives payment adjustment for LTCHs that do not have a Discharge Payment Percentage (DPP) for the period that is at least 50 percent during the COVID 19 PHE period:
      - ➢ All admissions during the COVID-19 PHE period will be counted in the numerator of the calculation (counted as discharges paid the LTCH PPS standard Federal payment rate
    - ✓ Waiver of the application of the site neutral payment rate for LTCH admissions that are in response to the PHE and occur during the COVID-19 PHE period:
      - ➢ The claims processing systems will be updated to pay all LTCH cases admitted during the COVID-19 PHE period the LTCH PPS standard Federal rate, effective for claims with an admission date occurring on or after January 27, 2020
- IRFs -Intensity of Therapy Requirement ("3-Hour Rule"):
  - Section 3711(a) of the CARES Act, during the COVID-19 PHE:
    - ✓ Waiving criterion that Medicare Part A fee-for-service patients treated in IRFs receive at least 15 hours of therapy per week
    - ✓ Waiver supersedes the clarification provided in the interim final rule with comment titled, Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 PHE (CMS-1744-IFC)

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Novitas Initiatives

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What is Novitasphere?

- Free, secured web-based portal
- Dedicated Help Desk- 1-855-880-8424
- For demonstrations and more information:
  - Novitasphere Portal

Novitasphere
Your link to the world of on-line Medicare claims data.

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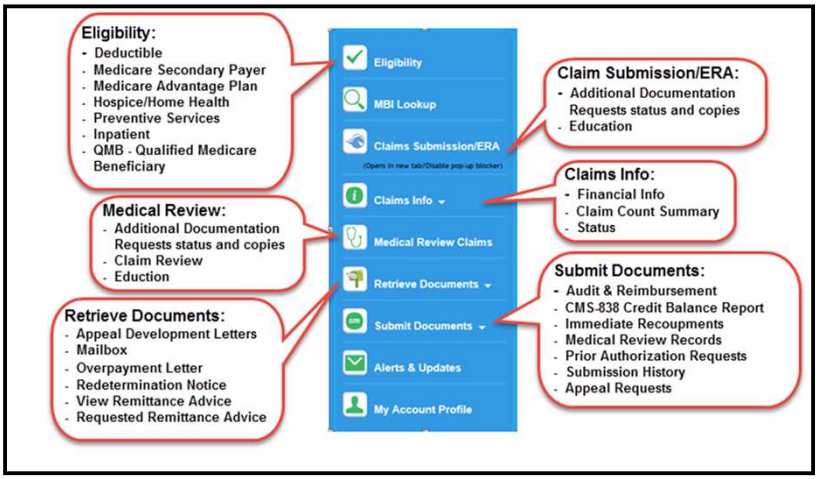
Novitasphere Part A Navigation Bar



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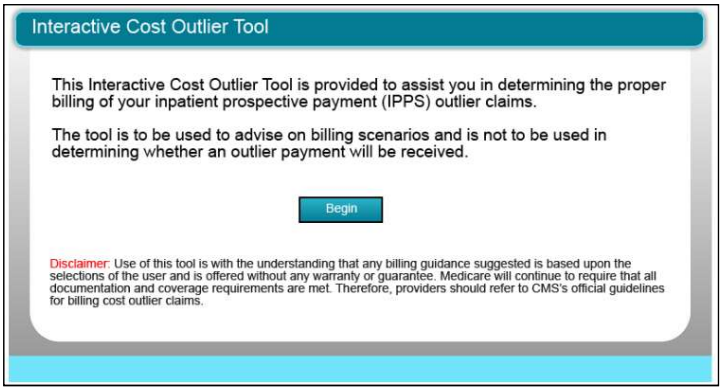
Interactive Cost Outlier Tool

- The Interactive Cost Outlier Tool (JH) (JL) is a new Self-Service Tool (JH) (JL) provided to assist in determining the proper billing of inpatient prospective payment system (IPPS) outlier claims



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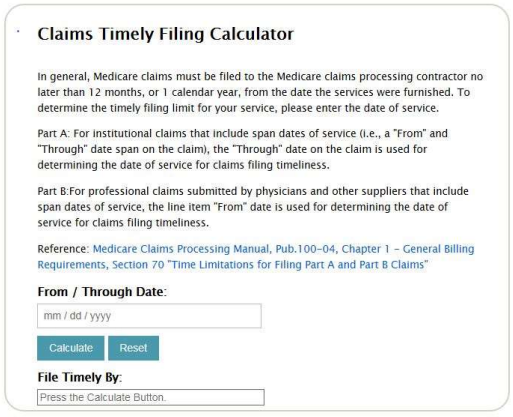
Claims Timely Filing Calculator

- The Claims Timely Filing Calculator (JH) (JL) is a new Self-Service Tool (JH) (JL) provided to assist in determining the timely filing limit for your service



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2020 Medicare Participation Physicians/Suppliers Directory

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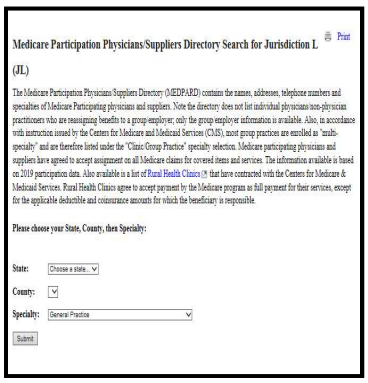
- 2020 MEDPARD is available (JH) (JL)


Medicare Participation Physicians/Suppliers Directory Search for Jurisdiction L

Print

(JL)

The Medicare Participation Physicians/Suppliers Directory (MEDPARD) contains the names, addresses, telephone numbers and specialties of Medicare Participating physicians and suppliers. Note the directory does not list individual physicians/non-physician practitioners who are reassigning benefits to a group employer; only the group employer information is available. Also, in accordance with instruction issued by the Centers for Medicare and Medicaid Services (CMS), most group practices are enrolled as "multi-specialty" and are therefore listed under the "Clinic/Group Practice" specialty selection. Medicare participating physicians and suppliers have agreed to accept assignment on all Medicare claims for covered items and services. The information available is based on 2019 participation data. Also available is a list of Rural Health Clinics that have contracted with the Centers for Medicare & Medicaid Services. Rural Health Clinics agree to accept payment by the Medicare program as full payment for their services, except for the applicable deductible and coinsurance amounts for which the beneficiary is responsible.

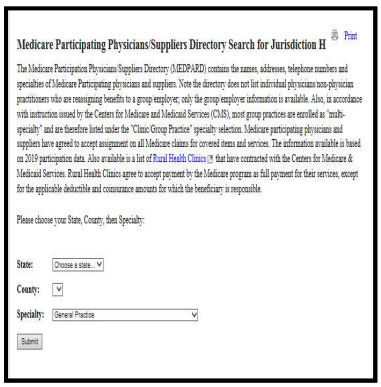
Please choose your State, County, then Specialty:

State: Choose a state...

County:

Specialty: General Practice

Submit


Medicare Participating Physicians/Suppliers Directory Search for Jurisdiction H

Print

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Please choose your State, County, then Specialty:

State: Choose a state...

County:

Specialty: General Practice

Submit

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Education and Training Events

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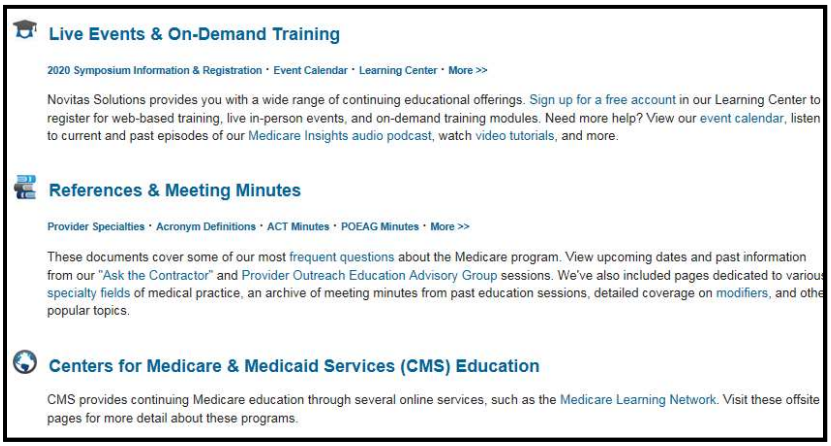
Novitas Education Center

- Education Center



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Part A Education and Training Events

- Novitas Medicare Part A Educational Event Calendar

Date	Time	Event	Event Details
May 1	11 am	Webinar	FQHC Update for Telehealth and Virtual Technology During COVID-19 PHE
May 5	11 am	Webinar	Understanding Critical Access Hospital Billing Webinar
May 5	2 pm	Webinar	RHC for Telehealth and Virtual Technology During COVID-19 PHE
May 6 and 7	9 am – 5 pm	Webinar	Virtual Symposiums
May 12	11 am	Webinar	Credit Balance Submission Errors
May 13	10 am	Webinar	Part A Ask the Contractor Webinar
May 13	1 pm	Webinar	Novitasphere Overview Part A

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Learning Center Online Course Catalog

- Learning Center Web-Based Training Course Catalog
- Self-paced, free online courses
- Part A Courses:
  - Drugs and Biologicals
  - Medicare Coverage
  - NCCI Program Overview
  - Skilled Nursing Facility Consolidated Billing
- Check back often for an updated list

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Summary

- Identified and understand the current Medicare updates and reminders
- Reviewed COVID-19 information
- Explored the educational resources and information

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Thank You for Attending

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

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