



# Wyoming Healthcare Financial Management Association (HFMA)

Part A/B Provider Outreach and Education

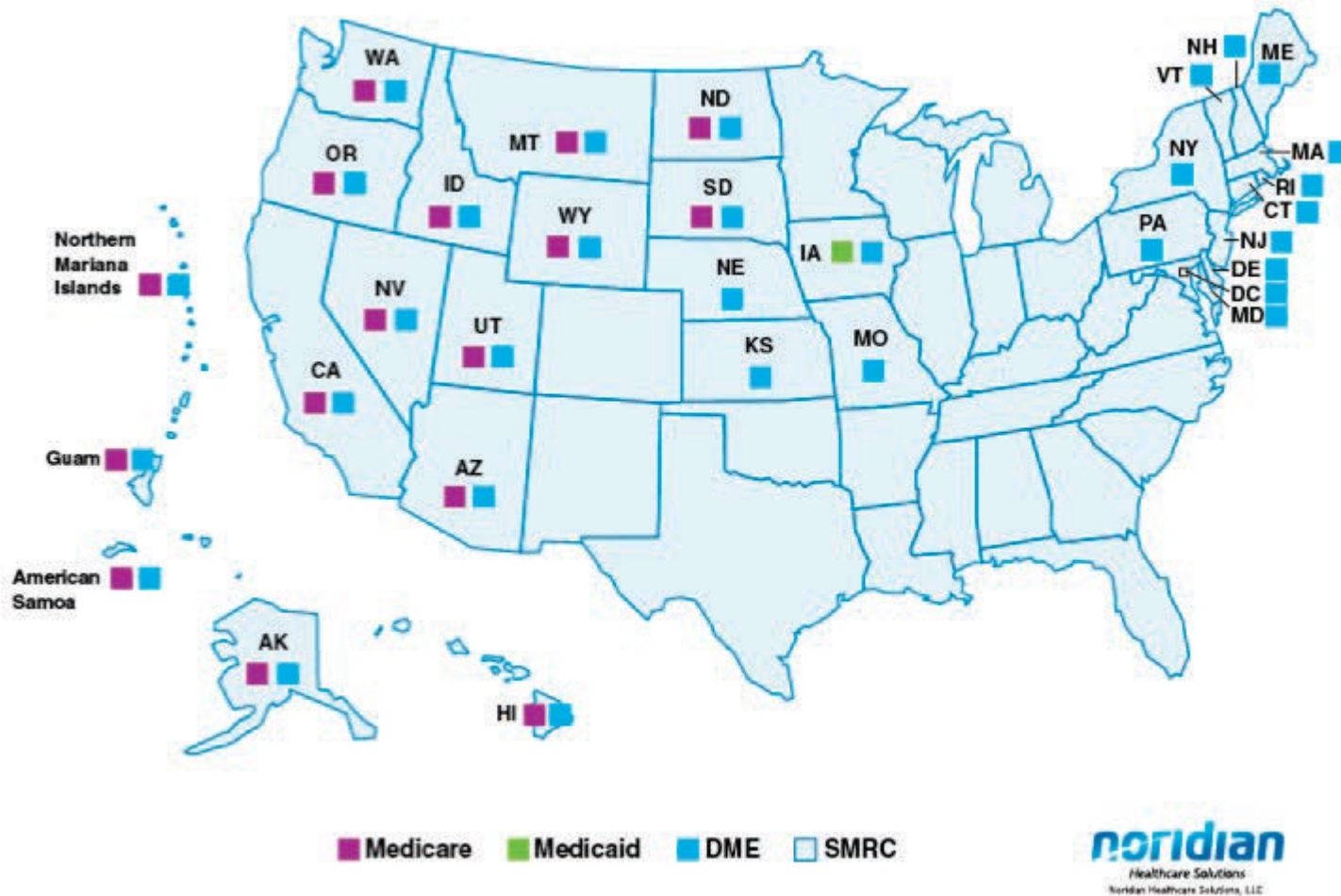
Fall 2019



# Agenda

- Noridian - Who Are We?
- Provider Based Enrollment/Billing
- CMS Updates
- Telehealth vs Telemedicine
- Review Contractors
- Noridian Medicare Portal (NMP)

# Noridian – Who Are We?



# Focused on Government Healthcare



Claims management



Call center services



Provider management



Medical review

# NHS Medicare Administrative Contractor (MAC) Online

<https://med.noridianmedicare.com>

Jurisdiction E	
<b>Medicare Part A</b>	<b>Medicare Part B</b>
Noridian Medicare Portal	Noridian Medicare Portal
Active LCDs	Active LCDs
Latest Updates	Latest Updates
Education & Outreach	Education & Outreach
Fee Schedules	Fee Schedules
Enrollment	Enrollment
Contact	Contact
Forms	Forms
EDI	EDI
New to Noridian	New to Noridian

Part A – Hospitals, clinics or providers/suppliers that bill electronically - CMS-1450 or UB04

Part B – Specialty providers, physicians or clinicians in private practice that bill electronically or paper – CMS-1500 form

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# **Provider Based Enrollment/Billing**

# What is Provider-Based?

- Provider-based clinics are owned and operated by single entities referred to as “main providers”
- Treated as departments of main provider for Medicare purposes
- May be located on-campus or off-campus
  - Clinics must meet location parameters for on-campus and off-campus designations

# Provider-Based Exceptions

- Provider types that do not meet provider-based status
  - Ambulatory Surgical Centers (ASC)
  - Comprehensive Outpatient Rehabilitation Facilities (CORF)
  - Home Health Agencies
  - Skilled Nursing Facilities (SNF)
  - Hospices
  - Inpatient Rehabilitation Units excluded from inpatient PPS for acute hospital services



# Provider-Based Exceptions<sub>2</sub>

- Independent Diagnostic Testing Facilities (IDTF) and laboratory tests paid only on fee schedule
- Facilities only furnishing
  - Physical therapy (PT)
  - Occupational therapy (OT) or
  - Speech pathology (SP) services
    - (unless at CAH)
- End Stage Renal Disease (ESRD) facilities

# Provider-Based Exceptions<sub>3</sub>

- Departments of providers that perform functions necessary for successful operation of provider but do not furnish services for which separate payment could be made under Medicare or Medicaid
- Ambulances
- Rural Health Clinics affiliated with hospitals having 50 or more beds

# Providers Affected

- Billing UB-04 or electronic equivalent 837I
- Outpatient departments
  - Location determines payment
    - On-campus located within 250 yards
    - Off-campus located within 35-mile
- PO modifier identifies off-campus non-expected
  - Validation edits affect off-campus

# Provider-Based Billing Practice Address Verification

- Activation of Systematic Validation Edits for OPPS Providers with Multiple Service Locations
  - These requirements not new
- What you can do
  - Verify claim submission
  - Verify PECOS enrollment
- Read more about provider-based facilities
  - <https://med.noridianmedicare.com/web/jea/provider-types/provider-based-facilities>

# Return to Provider Reason Code 34977



Implementation  
April 2020

- Provider practice location address does not match any practice location
- Complete verification
  - Full 9 digits of ZIP code (123456789)
  - DDE Page 3, F11 twice
    - MAP171F
  - Must match inquiries, option 1D

# DDE Loops and Segments

- 2010AA Billing Provider Loop
- 2310E Service Facility Loop
- N3 Segment – Facility Address
  - N301: Facility address; 1-55 alpha-numeric characters
    - Example: N3\*123 MAIN STREET~
  - N302: Facility address; 1-55 alpha-numeric characters (only if 2 address lines are needed)
- N4 Segment – Facility City, State, ZIP Code
  - N401: City Name; 2-30 alpha-numeric characters
  - N401: State: 2 alpha characters
  - N403: Postal ZIP Code; 3-15 numeric characters
    - Example: N4\*KANSAS CITY\*MO\*64108~

# Prov Practice Addr Quer – Option 1D

MAP1702

INQUIRY MENU

BENEFICIARY/CWF	10	ZIP CODE FILE	19
DRG (PRICER/GROUPER)	11	OSC REPOSITORY INQUIRY	1A
CLAIM SUMMARY	12	CLAIM COUNT SUMMARY	56
REVENUE CODES	13	HOME HEALTH PYMT TOTALS	67
HCPC CODES	14	ANSI REASON CODES	68
DX/PROC CODES ICD-9	15	CHECK HISTORY	FI
ADJUSTMENT REASON CODES	16	DX/PROC CODES ICD-10	1B
REASON CODES	17	CMHC PAYMENT TOTALS	1C
INVOICE NO/DCN TRANS	88	<b>PROV PRACTICE ADDR QUER 1D</b>	

ENTER MENU SELECTION: █

PLEASE ENTER DATA - OR PRESS PF3 TO EXIT

# Option 1D – MAP1AB1

MAP1AB1							
SC		PROVIDER PRACTICE ADDRESS QUERY SUMMARY					
SEL	NPI	OSCAR	PRAC EFF DT	PRAC TERM DT	ADDRESS	ZIP	
	NPI	OSCAR					

PLEASE ENTER DATA - OR PRESS PF3 TO EXIT



# Option 1D – MAP1AB1 Selection

MAP1AB1									
SC		PROVIDER		PRACTICE		ADDRESS		QUERY SUMMARY	
NPI	1234567890	OSCAR	051399						
<b>SEL</b>	NPI	OSCAR	PRAC	PRAC	ADDRESS	ZIP			
<b>S</b>			EFF DT	TERM DT					
				12319999					

PLEASE MAKE A SELECTION, ENTER NEW KEY DATA, OR PRESS PF3 TO EXIT  
PRESS PF3-EXIT PF5-SCROLL BKWD PF6-SCROLL FWD

# Option 1D – MAP1AB2

```

MAP1AB2
SC █ PROVIDER PRACTICE ADDRESS QUERY INQUIRY
MNT: PECOS 20161219
NPI █ OSCAR █
PRAC EFF DT █ PRAC TERM DT 12319999
PRACTICE LOCATION KEY 20100403
OTHER PRACTICE Y
TYPE OF PRACTICE
ADDRESS 1 █ STREET
ADDRESS 2
CITY █ STATE CA ZIP █
NPI EFF DT █ NPI TERM DT 12319999

PRESS PF3-EXIT PF6-SCROLL FWD PF7-PREV
  
```

# Claim Entry – Page 3 – MAP1713

```

MAP1713    PAGE 03
SC          INST CLAIM ENTRY
MID        TOB 131  S/LOC S B0100  PROVIDER
NDC CD     OFFSITE ZIP 12345  ADJ MBI          IND
CD  ID     PAYER          OSCAR          RI AB          EST AMT DUE
A
B
C
DUE FROM PATIENT          0.00          SERV FAC NPI
MEDICAL RECORD NBR          COST RPT DAYS          NON COST RPT DAYS
DIAG CODES 01          02          03          04          05
06          07          08          09          END OF POA IND
ADMITTING DIAGNOSIS          E CODE          HOSPICE TERM ILL IND
IDE          GAF          PRV
PROCEDURE CODES AND DATES 01          02
03          04          05          06
ESRD HRS          ADJ REAS CD          REJ CD          NONPAY CD          ATT TAXO
ATT PHYS          NPI          L          F          M          SC
OPR PHYS          NPI          L          F          M          SC
OTH OPR          NPI          L          F          M          SC
REN PHYS          NPI          L          F          M          SC
REF PHYS          NPI          L          F          M          SC
PROCESS COMPLETED --- PLEASE CONTINUE
PRESS PF3-EXIT PF5-BKWD PF6-FWD PF7-PREV PF8-NEXT PF9-UPDT PF11-RIGHT
  
```

# Page 3 – F11 Twice – MAP171F

MAP171F	PAGE 03								
	SC			INST CLAIM ENTRY					
MID		TOB 131	S/LOC S B0100	PROVIDER					
	P R O V I D E R	P R A C T I C E	L O C A T I O N	A D D R E S S					
ADDRESS 1:	12345 1	STREET							
ADDRESS 2:									
CITY	:	█		STATE: CA		ZIP: 123456789			
PROCESS COMPLETED --- PLEASE CONTINUE									
PRESS PF3-EXIT PF7-PREV PF8-NEXT PF9-UPDT PF10-LEFT									

# PECOS Main Page

## Manage Medicare and Account Information

**MY ASSOCIATES** >>

- Enroll in Medicare for the first time
- View and update existing Medicare information
- Continue working on saved applications

**ACCOUNT MANAGEMENT** >>

- Update your user account information, request or remove access to organizations
- Manage access to Medicare enrollments

### Organizations

**REVALIDATION NOTIFICATION CENTER** >>

- View All Applications requiring revalidation
- Start or continue revalidation application

Records 1 - 5 of 5

Name: [REDACTED]	TIN: [REDACTED]	<b>VIEW ENROLLMENTS</b> >>
Name: [REDACTED]	TIN: [REDACTED]	<b>VIEW ENROLLMENTS</b> >>
Name: [REDACTED]	TIN: [REDACTED]	<b>VIEW ENROLLMENTS</b> >>
Name: [REDACTED]	TIN: [REDACTED]	<b>VIEW ENROLLMENTS</b> >>
Name: [REDACTED]	TIN: [REDACTED]	<b>VIEW ENROLLMENTS</b> >>



# Enrollment Record

## Medicare Enrollment for Providers and Suppliers

Close | Print

[Report Help \[PDF 1.15 MB\]](#)

### APPROVED MEDICARE ENROLLMENT RECORD

This is a report of your current Medicare enrollment in PECOS.

**Note:** This report is for your records only, please do not upload this report to your electronic submission or mail it to your Fee-For-Service Contractor.

[View Medicare ID Report](#)

Report Date: 06/04/2019

### Enrollment Record Summary

Enrollment ID: O [REDACTED]  
 Enrollment Status: APPROVED  
 Submitted By: [REDACTED]

### FROM SECTION 2: IDENTIFYING INFORMATION

#### ORGANIZATION INFORMATION

Organization Name [REDACTED]	Tax ID Number (TIN) (EIN) [REDACTED]	Year End Cost Report Date (MM/DD) [REDACTED]
Other Name	Type of Other Name	Organization Structure Corporation
IRS Proprietary/Non-Profit Status Non-Profit	Incorporation Date [REDACTED]	State Where Incorporated MT

# Enrollment Record<sub>2</sub>

FROM SECTION 4: PRACTICE LOCATION INFORMATION		
PHYSICAL LOCATION AND "SPECIAL PAYMENTS" ADDRESS		
<b># 1:</b> [REDACTED]		
Practice Location Information		
Location Name [REDACTED]	Location Type Practice Location	Practice Location Type
Address [REDACTED]	Effective Date [REDACTED]	
Telephone Number: [REDACTED] Fax Number: [REDACTED]		E-mail Address
CLIA Number [REDACTED]	FDA Certification Number	
Payment Address Information		
Effective Date: [REDACTED]	Payment Address [REDACTED]	
Claims Information		
• <b>Claims Detail</b>		
Medicare ID [REDACTED]	Primary Billing Information for Practice Location? [REDACTED]	Effective Date of Location [REDACTED]
NPI [REDACTED]	Tax ID Number(TIN) [REDACTED]	CP-575 Indicator? [REDACTED]



# More Options

**Existing Enrollments**

Contractor: NORIDIAN HEALTHCARE SOLUTIONS  
 State: MONTANA  
 Type/Specialty: CRITICAL ACCESS HOSPITAL

Enrollment Type: 855A  
 Medicare ID: [REDACTED] [View Medicare ID Report](#)   
 Status: APPROVED [View Approved Enrollment Record](#) 

Revalidation Due Date: [REDACTED]  
 Practice Location: [REDACTED]

Existing Reassignments: 0  
 Pending Reassignments Applications: 0  
[View/Manage Reassignments](#)

[VIEW](#)   
[REVALIDATE](#)   
[MORE OPTIONS](#) 

**Application Questionnaire**


(\*) Red asterisk indicates a required field.

**Approved Existing Provider Enrollment**

\* What type of action is the applicant trying to perform?

- Deactivate this Enrollment Record from the Medicare Program
- Create an Initial Enrollment Application
- Perform a Change of Information to Current Enrollment Information
- Revalidate the information in this Enrollment Record
- Perform a Change of Ownership

**Note:** All Electronic Funds Transfer (EFT) changes must be made through the Change of Information Scenario. Please select the "Perform a Change of Information to Current Enrollment Information" option above to make changes to your EFT Record.

[NEXT PAGE](#) 

# Application

## Confirm Reason for Application

### Medicare Part A Enrollment

Based on your responses, the following reason for application was identified.

- A Medicare Part B practitioner is currently enrolled in the Medicare program. The practitioner is adding, deleting or changing general Medicare enrollment information.

The application is for:

Legal Business Name	Tax Identification Number (TIN)	Provider Type	State
[REDACTED]	[REDACTED]	CRITICAL ACCESS HOSPITAL	MONTANA

Clicking on the 'Start Application' button will create a Medicare application using the above information.

**Please note:** After you click 'Start Application' a Web Tracking ID will be created. This does not mean that your application has been submitted.

At the conclusion of this process:

- The application is submitted to the appropriate Medicare fee-for-service contractor (s) for processing
- An Authorized Official or Delegated Official must sign a statement certifying the submitted information
- The certification statement, additional required signatures, and required attachments must be electronically signed or mailed to the identified fee-for-service contractor(s)
- The Medicare enrollment is finalized after the fee-for-service contractor processes this application and approves the information
- Any required and/or supporting documentation not uploaded must be mailed in to the fee-for-service contractor

**START APPLICATION** >>

[Home](#) > [My Associates](#) > [My Enrollments](#) > Change of Information

[Topic View](#)

[Fast Track View](#)

[Error/Warning Check](#) **4**

### Physical Location and "Special Payments" Address

Location Type: Practice Location

Practice Location Type: [REDACTED]

Physical Address: [REDACTED]

Payment Address: [REDACTED]

Effective Date of Information: [REDACTED]

Effective Date of Information: [REDACTED]

Physical Location Contact Information:

Claims Information:

Telephone Number: [REDACTED]

Medicare Identification Number: [REDACTED]

Fax Number: [REDACTED]

National Provider Identifier (NPI): [REDACTED]

E-mail address: [REDACTED]

Tax Identification Number (TIN)  
Type: [REDACTED]  
TIN: [REDACTED]  
CP-575 Indicator?: [REDACTED]  
Effective Date of this Practice Location: [REDACTED]

CLIA and FDA Certification Number (s):

CLIA Number: [REDACTED]

**GO TO TOPIC** >>

# Special Edition 19007

- Activation of Systematic Validation Edits for OPPS Providers with Multiple Service Locations
  - <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE19007.pdf>
- Continued efforts by CMS to enforce existing requirements for providers to properly document and report practice locations

# PN Modifier

- Effective January 1, 2017
- Non-excepted off-campus provider-based departments of hospital are required to report “PN” modifier on each claim line for non-excepted items and services including those for which payment will not be adjusted
- PN will trigger payment rate under Medicare Physician Fee Schedule

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# CMS Updates

# Health Professional Shortage Area (HPSA) Bonus Payments

- Mental Health Specialties
- Specialty 26 is currently set up to receive bonus payments
- April 2020 all psychiatric specialties eligible to receive mental health bonus
  - 27
  - 86

# Health Professional Shortage Area (HPSA) Bonus Payments

- HPSA Zip code used to pay claims
- AQ modifier - partially designated HPSA claims and HPSA geographic areas
- Physician bonus web page
  - <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HPSAPSAPhysicianBonuses/index.html>

# Provider Enrollment Processing Instructions to Manuals and Processing Guides

- Updates provider enrollment, including various processing alternatives
  - Forms CMS-855 application, CMS-20134 and CMS-588
  - Processing Independent Diagnostic Testing Facilities (IDTFs) in chapter 15 of Publication 100-08
  - CMS-855R processing guide



# Provider Enrollment Processing Instructions to Manuals and Processing Guides

- Receipt/review of internet-based PECOS applications
  - Receipt and review
- Updates to paper applications
- Receiving missing/clarifying data/documents
- Disposition of registration applications
- Returns
- Rejections

# Mammography Editing

- Modification to ensure correct payment for screening and diagnostic services
- PC/TC on CAH claims corrected
  - Pay or deny both
- FQHC/RHC provider-based billing instructions updated
  - Reimbursed on base provider payment method

# Emergency Medical Treatment and Labor Act (EMTALA)

- Newborn protected by Born-Alive Infant Act
  - Presumed presenting with emergency medical condition
  - Requires medical screening to provide stabilizing treatment
- Communication between healthcare professional and patients
  - Conditions of Participation: Patients rights are protected

# MBI Timelines

- Important Timelines
  - April 2018 - December 2019
    - MBI transition period
  - January 1, 2020
    - HICN no longer accepted by Noridian
    - All claims filed on/after January 1, 2020 regardless of date of service will require MBI



## HICN to MBI Transition Period

**53 days**

until providers/suppliers must  
submit all claims with MBIs only

Read More:

[JEA](#) | [JEB](#) | [JFA](#) | [JFB](#) | [JA](#) | [JD](#)

# Obtaining the MBI

- Ask beneficiary for new Medicare card
- MBI lookup tool through NMP
- MBI displays on remittance advice (RA)
- Learn more
  - <https://www.cms.gov/Medicare/New-Medicare-Card/Providers/Getting-MBIs.html>

# MBI Resources for Beneficiaries

## New Card Not Received

- New card won't be received if address is incorrect
  - Call Social Security
  - Log into online account at:  
<http://www.ssa.gov/myaccount>

### Don't Have Your Medicare Card?

To get your Medicare card or number:

- Sign in to your [MyMedicare.gov](http://MyMedicare.gov) account. If you don't have an account yet, visit [MyMedicare.gov](http://MyMedicare.gov) to create one. You can sign in to see your Medicare Number or print an official copy of your card.
- Call **1-800-MEDICARE** (1-800-633-4227). TTY users can call 1-877-486-2048. There might be a problem that needs to be corrected, like updating your mailing address.



Centers for Medicare & Medicaid Services (CMS)

CMS Product No. 12037  
March 2019

# Noridian's MBI Webpage

**noridian** Healthcare Solutions

Jurisdiction F - Medicare Part B  
Alaska, Arizona, Idaho, Montana, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming

Contact Us | Help | Tools  
| Noridian Medicare Portal (NMP) Login

Browse by Topic | Browse by Specialty | Fees and News | Policies | Medical Review | Education and Outreach | Enrollment | Forms

JF Part B / Browse by Topic / Medicare Beneficiary Identifier (MBI)

**BROWSE BY TOPIC**

- Advance Beneficiary Notice of Noncoverage (ABN)
- Appeals
- Claims
- Clinical Trials
- Compliance Program
- Documentation Requirements
- Drugs, Biologicals and Injections
- Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)
- Electronic Data Interchange (EDI)
- Emergencies and Disasters
- Fraud and Abuse
- Home Health and Hospice
- Incentive Programs
- Incident To
- Medicare Beneficiary Identifier (MBI)**
- Medicare Secondary Payer (MSP)
- Modifiers
- Non-Covered Services
- Noridian Medicare Portal (NMP)
- Observation
- Overpayment and Recoupment
- Preventive Services
- Remittance Advice (RA)
- Telehealth

**HICN to MBI Transition Period Ends 12/31/19**

Providers/Suppliers have **13 weeks** until all claims must be submitted with MBIs only

*If a beneficiary has not yet received his/her new Medicare card, he/she must contact 1-800-Medicare to update their home address to ensure another card can be mailed to the correct address.*

**Attend a Webinar**

- Using the Medicare Beneficiary Identifier (MBI) - 10/16/19

**Medicare Beneficiary Identifier (MBI)**

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS to remove Social Security Numbers (SSNs) from all Medicare cards by April 2019. A new randomly generated Medicare Beneficiary Identifier (MBI) will replace the SSN-based Health Insurance Claim Number on new Medicare cards for transactions like billing, eligibility status, and claim status. Prepare for this change by visiting the new overview and provider webpages, which include:

- Transition period
- Characteristics of the MBI
- How to obtain the MBI

It's time for provider to look at their practice management systems and business processes and determine what changes must be made to use the new MBI.

**Getting Started**

Moving to new Medicare Numbers and cards requires many changes to systems and how business is done.

Noridian has already started this work and we want to help you shift to the new MBIs. Beginning in April 2018, in phases by geographic location (see schedule below), CMS starts mailing the new Medicare cards, containing the MBI, to all people with Medicare.

**System Updates**

Providers may need to change their systems to accept the new MBI. If a vendor is used to bill claims to Medicare, be sure their systems are ready for the MBI. Providers should test system changes and work with their billing office staff to ensure all are prepared to use the new MBI format.

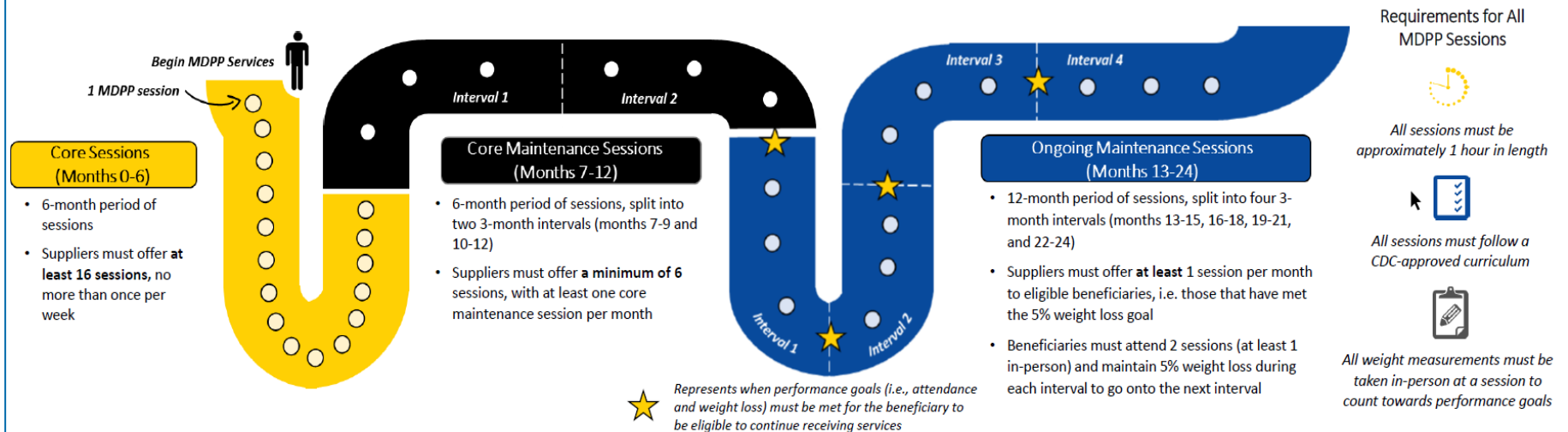
- Noridian website  
– <https://med.noridianmedicare.com>
- Jurisdiction E/F
- Medicare Part A/B
- Browse by Topic  
– Medicare Beneficiary Identifier (MBI)

# Medicare Diabetes Prevention Plan (MDPP)

## Medicare Diabetes Prevention Program (MDPP)

### Sessions Journey Map

MDPP services are **structured health behavior change sessions aimed at lowering the risk of type 2 diabetes in Medicare beneficiaries with prediabetes**. These sessions promote weight loss through healthy eating and physical activity. This journey map is intended to help MDPP suppliers understand the different session types, session sequencing, and important information to keep in mind when furnishing sessions.




<https://innovation.cms.gov/initiatives/medicare-diabetes-prevention-program/>



# Reducing Opioid Misuse

- CMS continues fight
- CMS roadmap updates
- Videos
- Learn more
  - <https://www.cms.gov/about-cms/story-page/reducing-opioid-misuse.html>




March 2019


## CMS Roadmap

### FIGHTING THE OPIOID CRISIS


**Opioids killed more than 47,000**  
in 2017, or 130 people per day.<sup>1</sup>





**36%** of all opioid overdose deaths involve a prescription opioid!




#### PRESCRIPTION OPIOID MISUSE


 When used correctly, prescription opioids are **helpful** for treating pain.


 The CDC issued **guidelines** for safe prescribing of opioids in primary care.


 An estimated **11.4 million** people misused prescription opioids<sup>2</sup>—putting them at risk for dependence and addiction.

 **3 out of 4** people who used heroin misused prescription opioids first.<sup>3</sup>

#### OPIOID USE DISORDER

 Over **two million** people have an opioid use disorder.

 Treatment **options** exist, including medication-assisted treatment (MAT).


 **Only 20%** of people with opioid use disorder receive treatment.<sup>4</sup>

Learn more about prescription opioid misuse


Learn more about opioid use disorder and treatment

### KEY AREAS OF CMS FOCUS


As one of the largest payers of healthcare services, CMS has a vital role in addressing the opioid epidemic and is focused on three key areas:

 **PREVENTION**

Manage pain using a safe and effective range of treatment options that rely less on prescription opioids

 **TREATMENT**

Expand access to treatment for opioid use disorder

 **DATA**

Use data to target prevention and treatment efforts and to identify fraud and abuse

November 2019

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# Reducing Opioid Misuse Letter

- CMS mailed letters to all fee-for-service providers addressing opioid crisis
- CMS committed to protect beneficiaries and communities affected
- Opioid Treatment Programs
  - January 1, 2020 bundled payments for opioid use disorder (OUD) treatment services
  - <https://www.cms.gov/Center/Provider-Type/Opioid-Treatment-Program-Center.html>

# Opioid Misuse Review

- While performing AWW; if beneficiary at risk:
  - CMS strongly encourages opioid-use review during medical/family history
  - Important to introduce prevention, education and treatment
- CMS Special Edition (SE)18004
  - <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE18004.pdf>
- CMS Reducing Opioid Misuse
  - <https://www.cms.gov/about-cms/story-page/reducing-opioid-misuse.html>

# MIPS Program

- Merit-Based Incentive Payment System (MIPS)
  - Medicare Access and CHIP Reauthorization Act (MACRA)
- Contact CMS or Quality Payment Program (QPP) contractor for questions, outreach, etc.
- Website: <https://qpp.cms.gov/about/help-and-support>
- Phone #: 866-288-8292

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# **Telehealth vs Telemedicine**

# Telehealth

- Eligibility criteria
  - Patient must be at originating site
  - Health Professional Shortage Area (HPSA)
  - Non-MSA geographic location
  - Originating site fee billed HCPCS Q3014
- Providers located at distant site
  - Must be enrolled as Medicare provider
  - Bill services to MAC where performed

# Telehealth Eligibility Search Analyzer

<https://data.hrsa.gov/tools/medicare/telehealth>

## Eligible



Home > Tools > Medicare Telehealth Payment Eligibility Analyzer

### Medicare Telehealth Payment Eligibility Analyzer

Check if an address is eligible for Medicare telehealth originating site payment.

Input address: 915 anderson drive, Seattle, WA, 98520  
Geocoded address: 915 Anderson Dr, Aberdeen, Washington, 98520

[Start Over](#)  
Data as of 1/1/2018

**Yes**

Yes, the geocoded address is eligible for Medicare telehealth payment.

## Not Eligible



Home > Tools > Medicare Telehealth Payment Eligibility Analyzer

### Medicare Telehealth Payment Eligibility Analyzer

Check if an address is eligible for Medicare telehealth originating site payment.

Input address: 550 17 AVE SW, Seattle, WA, 98122  
Geocoded address: 550 17th Ave E, Seattle, Washington, 98112

[Start Over](#)  
Data as of 1/1/2018

**No**

No, the geocoded address is not eligible for Medicare telehealth payment.



Home > Tools > Medicare Telehealth Payment Eligibility Analyzer

### Medicare Telehealth Payment Eligibility Analyzer

Check if an address is eligible for Medicare telehealth originating site payment.

**Search Criteria**  
Please provide a street address, city, and state or a street address and ZIP Code.

Street Address:

City:

State/Territory:

ZIP Code:

[Search](#) [Reset](#)

# Originating Billing Guidelines

Originating Site	Payment Methodology	Type of Bill	Revenue Code
Outpatient Hospital	Outside of OPPOS	12X	078X
Inpatient Hospital	Outside DRG	12X	078X
CAH	Separate from cost based (80% of originating site facility fee)	12X	078X
FQHC or RHC	Separate from Prospective Payment System (PPS) or All Inclusive Rate (AIR)	77X or 71X	078X
Hospital-Based or CAH-Based Renal Dialysis Center	In addition to ESRD PPS or Monthly Capitation payment	72X	078X
SNF	Outside of SNF PPS (not subject to consolidated billing)	22X or 23X	078X
CMHC	Not a partial hospitalization service (or used to determine payment for partial hospitalization). Not bundled in per diem.	76X	078X



# CY 2019 Medicare Telehealth Services

Service	HCPCS/CPT Service
Telehealth consultations, emergency department or initial inpatient	G0425-G0427
Office or other outpatient visits	99201-99233
ESRD related services for home dialysis per full month, patient younger than 2yrs	90963

- <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctsht.pdf>

# Telemedicine

- Clinical services provision by physicians and practitioners
  - From distant site using electronic communications to hospital or CAH patient either simultaneously or non-simultaneously
    - Example: Not face-to-face, analyzing reading or tele-ICU
- Enrollment > Telehealth/Telemedicine  
Noridian web page

# Part A Virtual Communication

- Patient receives medical discussion or remote evaluation
  - Not related to RHC and FQHC services
    - Previous 7-days or 24-hours
  - Bill HCPCS G0071\*
  - Paid average of HCPCS codes G2010 and G2012
- \*New code beginning 2019

# Part B Virtual Visits

- Performed by physicians
  - Established patient still image(s) and/or video is evaluated
    - Not related to in-person visit previous 7-days or 24-hours
  - Billed and reimbursed for G2010 and G2012 under MPFS

# Virtual Communication

HCPCS	Definition	Reimbursed
G0071	RHC/FQHC virtual communication services, minimum 5 minutes	\$13.60 - Average
G2010	Remote evaluation of patient-submitted recorded video and/or images	\$13.61 - PAR
G2012	Brief communication technology-based service, 5-10 minutes of medical discussion.	\$15.71 - PAR

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# **Technical/Professional Components (TC/PC)**

# Date of Service (DOS)

- Special Edition (SE) 17023 – Revised

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE17023.pdf>

- Radiology & Clinical Lab
- Surgical/Anatomical Pathology/Cardiovascular
- Care Plan Oversight (CPO)
- Home Health Certification/Recertification
- Physician End-Stage Renal Disease (ESRD)
- Transitional Care Management (TCM)
- Home Prothrombin Time (PT/INR) Monitoring
- Psychiatric Testing/Evaluation

# Radiology Services DOS

- Technical component (TC)
  - DOS is date patient had test performed
- Profession Component (PC)
  - DOS is date of review & interpretation completed
- Global Service
  - TC - DOS is date patient received service
  - PC – DOS is date when review and interpretation is completed, or date TC was performed



# Surgical & Anatomical Pathology DOS

- Technical component (TC)
  - DOS is date specimen collected
    - Surgery date
- Profession Component (PC)
  - DOS is when review and interpretation is completed
- Global Billing
  - Submit PC with DOS reflecting when review and interpretation is completed, or
  - Date TC was performed
- Collections span two calendar dates
  - Bill date collection ended

# Stored Specimens

- Specimen stored less than or equal to 30 calendar days from date collected, DOS of test must be date test performed only if all are met:
  - Test ordered by patient’s physician at least 14 days following date of discharge from hospital
  - Specimen collected while patient undergoing hospital surgical procedure
  - Medically inappropriate to have collected sample other than during hospital procedure for which patient was admitted
  - Results of test do not guide treatment provided during hospital stay;
  - Test reasonable and medically necessary for treatment of an illness
- Specimens over 30 day
  - Considered archived
  - DOS is date specimen obtained from storage

# Cardiovascular Monitoring Services

- TC/PC or combination
- Single point of time, 24 or 48 hours or 30-day periods
- DOS determined by CPT descriptor and time
- TC - DOS is monitoring conclusion
- PT - DOS is when physician completes review and interpretation
- Globally - DOS is physician review date

# Summary

- DOS is date test performed or completed
  - Some exceptions apply
- Check MPFSDB for PC/TC indicators
- Check CPT descriptions
  - Some codes include review and interpretations

# Date of Service Billing Guide

- <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017-Transmittals-Items/SE17023.html>
- FAQs - Change Request 7631
  - <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQs-CR7631-4-25-13.pdf>

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# **Review Entities**

# Review Contractor Learning Objectives

- Understand CMS contracted entities roles
- How to identify and respond to review requests
- Where to find helpful tools
- Apply instructions to your practice/facility
  - Compliance Officer, Case Managers

# Various Review Entities

- Noridian Medical Review
- Quality Improvement Organizations (QIO)
- Comprehensive Error Rate Testing (CERT)
- Recovery Audit Contractor (RAC)
- Supplemental Medical Review Contractor (SMRC)
- Unified Program Integrity Contractor (UPIIC)
- Office of Inspector General (OIG)



# The Goal of Any Review

- Process claims:
  - To legitimate providers
  - For covered services and items
  - Which are correctly coded, and correctly billed
  - Provided to an eligible beneficiary

**Prevent Improper Payment**

# Signature Requirements For Medical Review Purposes

*For medical review purposes, Medicare requires that services provided/ordered be authenticated by the author. The method used shall be a hand written or an electronic signature. Stamp signatures are not acceptable.*

*Note: Refer to exceptions for stamped signatures*

# Noridian Medical Review Targeted Probe & Educate (TPE)

- Services selected based on data analysis
  - If provider selected, MR conducts reviews
    - Provides one-on-one education
    - 1-3 rounds of prepayment probe review
      - Learn from education/improve results in next "round"
- Goal to lower provider error rates

# TPE Review Results

## Ambulance Example: Denial Reasons

- Beneficiary could have been safely transported by other means of transportation
- Documentation not received within 45 days
- Documentation did not support level of service billed
- Documentation not legible
- No PCS (non-emergent, scheduled, repetitive)
- Incomplete/invalid/illegible PCS (non-emergent, scheduled)

# Medical Review (MR) Reopening

- Request Reopening
  - If denial related to missing or insufficient documentation
- Contact MR
  - Contact clinical reviewer to discuss
  - MR will evaluate if reopening requirements met
  - Reopening form sent to provider within 3 business days

# Medical Review (MR) Reopening<sub>2</sub>

- Provider submits documentation
  - Fax reopening form and documentation within required time frame
  - Failure to submit form/documentation timely revokes reopening rights
  - If revoked, submit redetermination request

# TPE Provider Noncompliance


- If not responding to Additional Development Requests (ADRs), Noridian refers provider to ZPIC/UPIC, RAC, etc.
- If high denial rates continue after 3 rounds, MACs will refer to CMS for additional action, which may include
  - 100% prepayment review
  - Extrapolation
  - Referral to ZPIC/UPIC, RAC, etc.

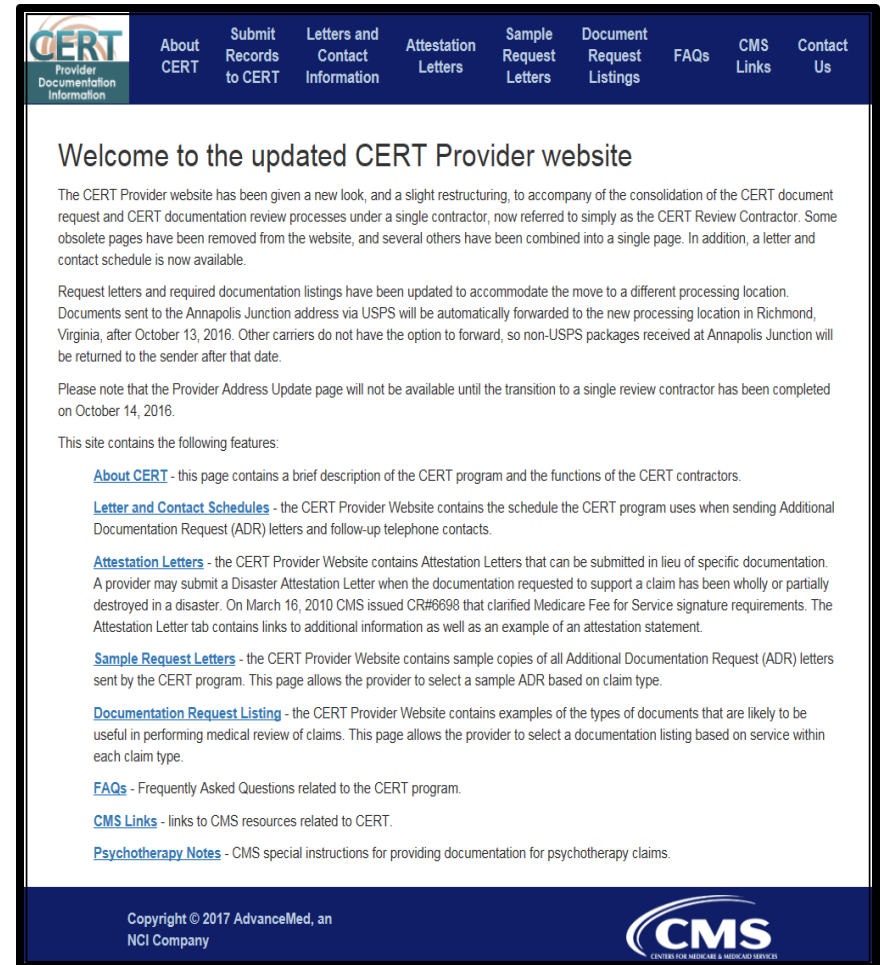
# Comprehensive Error Rate Testing Program (CERT)

- Measures Medicare fee-for-service improper payments
- Randomly select claims, documents are requested
- CERT reviews make payment determination to complying with Improper Payment Elimination and Recovery Act of 2010



# CERT Review Contractor

- AdvanceMed
  - Attn: CID#  
1510 E. Parham Road  
Henrico, Virginia 23228
- Phone: 888-779-7477
- Fax: 804-261-8100
  - Medical documentation with bar coded sheet
- Website 
  - <https://certprovider.admedcorp.com/>

The screenshot shows the CERT Provider website interface. At the top is a navigation menu with links: About CERT, Submit Records to CERT, Letters and Contact Information, Attestation Letters, Sample Request Letters, Document Request Listings, FAQs, CMS Links, and Contact Us. The main content area features a welcome message and several informational paragraphs. A red arrow points from the 'Website' bullet point in the main text to the 'Website' link in the screenshot.

**CERT**  
Provider Documentation Information

About CERT   Submit Records to CERT   Letters and Contact Information   Attestation Letters   Sample Request Letters   Document Request Listings   FAQs   CMS Links   Contact Us

Welcome to the updated CERT Provider website

The CERT Provider website has been given a new look, and a slight restructuring, to accompany the consolidation of the CERT document request and CERT documentation review processes under a single contractor, now referred to simply as the CERT Review Contractor. Some obsolete pages have been removed from the website, and several others have been combined into a single page. In addition, a letter and contact schedule is now available.


Request letters and required documentation listings have been updated to accommodate the move to a different processing location. Documents sent to the Annapolis Junction address via USPS will be automatically forwarded to the new processing location in Richmond, Virginia, after October 13, 2016. Other carriers do not have the option to forward, so non-USPS packages received at Annapolis Junction will be returned to the sender after that date.

Please note that the Provider Address Update page will not be available until the transition to a single review contractor has been completed on October 14, 2016.

This site contains the following features:

- [About CERT](#) - this page contains a brief description of the CERT program and the functions of the CERT contractors.
- [Letter and Contact Schedules](#) - the CERT Provider Website contains the schedule the CERT program uses when sending Additional Documentation Request (ADR) letters and follow-up telephone contacts.
- [Attestation Letters](#) - the CERT Provider Website contains Attestation Letters that can be submitted in lieu of specific documentation. A provider may submit a Disaster Attestation Letter when the documentation requested to support a claim has been wholly or partially destroyed in a disaster. On March 16, 2010 CMS issued CR#6698 that clarified Medicare Fee for Service signature requirements. The Attestation Letter tab contains links to additional information as well as an example of an attestation statement.
- [Sample Request Letters](#) - the CERT Provider Website contains sample copies of all Additional Documentation Request (ADR) letters sent by the CERT program. This page allows the provider to select a sample ADR based on claim type.
- [Documentation Request Listing](#) - the CERT Provider Website contains examples of the types of documents that are likely to be useful in performing medical review of claims. This page allows the provider to select a documentation listing based on service within each claim type.
- [FAQs](#) - Frequently Asked Questions related to the CERT program.
- [CMS Links](#) - links to CMS resources related to CERT.
- [Psychotherapy Notes](#) - CMS special instructions for providing documentation for psychotherapy claims.

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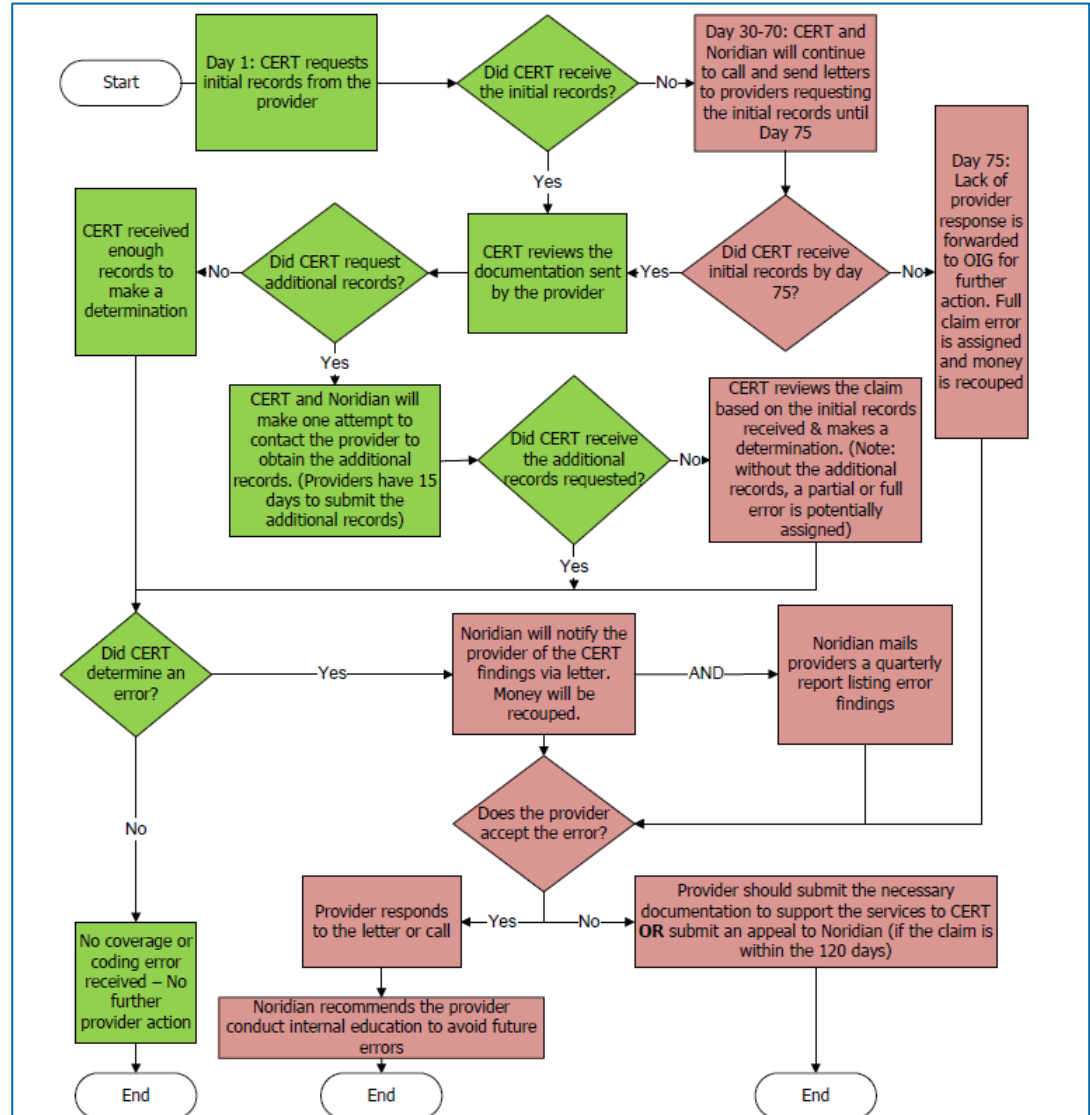
# MAC Contact Information

- Part A/B Provider Contact Center
  - 1-877-908-8431 (JF)
  - 1-855-609-9960 (JE)
- Noridian Part A, send an email to [CERTPartAQuestion@noridian.com](mailto:CERTPartAQuestion@noridian.com)
- Noridian Part B, send an email to [CERTQuestions@noridian.com](mailto:CERTQuestions@noridian.com)
- PHI should **not** be included in emails

# CERT Reviews

## Call and Letter Timelines

<https://med.noridianmedicare.com/documents/10546/12345760/CERT+Call+and+Letter+Timeline>



# Recovery Auditor (RAC) Issues

- Clinical Laboratory Add-on Codes (primary code denied)
- Clinical Social Worker (CSW) during Inpatient
- Drugs& Biologicals Excessive/Insufficient Drug Units
- Evaluation and Management (E/M) Same Day Dialysis
- Excessive Units of Critical Care
- Facility vs. Non-Facility Reimbursement
- Inappropriate Home Visit E/M During Inpatient
- Monthly Capitation Payment (MCP) for ESRD (4>month)
- Ophthalmology - Not a New Patient
- Observation Same Day as Inpatient Admission
- Physician Services During Hospice Period

# Recovery Auditor Provider Options

<https://med.noridianmedicare.com/web/jfb/cert-reviews/rac/recovery-auditor-determination-decision-tree>

JE Part B / Medical Review / Other Review Contractors / Recovery Auditor / Recovery Auditor Determination Decision Tree Share

## Recovery Auditor Determination Decision Tree

Providers may use the below decision tree to determine the correct action to take when the Recovery Auditor has reviewed a claim.

Did the Recovery Auditor Request Records?

Yes  No

Providers have 45 calendar days from the date of the request to submit medical records.

Were medical records submitted within 45 days?

Yes  No

Recovery Auditor will issue the Review Results Letter to the provider. The letter will not communicate the improper payment amount or the claim appeal rights. The Review Result Letter will start the discussion period timeframe for complex reviews.

Did the findings result in a claim adjustment?

Yes  No

The Recovery Auditor will submit the claim for adjustment through the Medicare Data Center. The MAC will process the claim to completion and issue a demand letter.

Provider agrees with the Recovery Auditor findings?

Yes  No

Providers have three options.

1. Providers may submit additional information to the Recovery Auditor during the discussion period. The discussion period is 40 days from receipt of the demand Letter for automated reviews and 40 days from receipt of the Review Results Letter for complex reviews.
2. Providers may submit a rebuttal to Noridian documenting why the overpayment will cause financial hardship within 15 days of the date of the demand letter.
3. Providers may submit a redetermination within 120 days of the demand letter.

# CERT vs. RAC

- CERT reviews take precedence over RAC audits
  - CERT may sample claim that has been reviewed by RAC
  - RAC may not sample claim that has been selected for review by CERT

# CERT vs. RAC<sub>2</sub>

- If RAC reviews claim that has been first selected by CERT, email Noridian CERT coordinators
- Noridian will request closure file from RAC
  - Negates RAC's decision
- Corrective adjustment keyed upon receipt of closure file
- CERT review will stand and is subject to change only via CERT's decision or appeal determination

# Livanta BFCC-QIO

- Patients may appeal hospital discharge decisions, file complaints and get help from Livanta website
- Provider must have a Memorandum of Agreement (MOA) agreement
  - Medicare requirement, complete for compliance
  - Form and instructions on website
- <https://www.livantaqio.com/en>



# QIO Short Stay Reviews

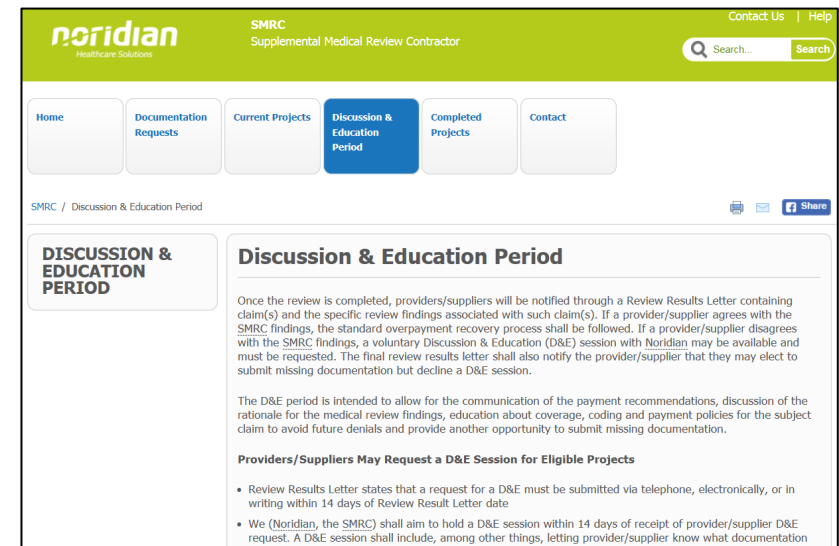
- CMS provides Livanta monthly universe of eligible paid provider claims with less than two midnight
  - May be picked once within 6-month round
  - High or increasing number of short stay claims per area
  - 25 cases sampled

# Supplemental Medical Review Contractor (SMRC)

- Review claims to lower improper payment rates and claim errors
  - Conduct nationwide medical review
    - Part A
    - Part B
    - Durable Medical Equipment (DME)
  - Notify CMS of improper payments and noncompliance of documentation requests
  - May result in claim adjustments completed by MACs

# Supplemental Medical Review Contractor (SMRC)

- Website  
<https://www.noridiansmrc.com>
- Conduct nationwide Part A/B medical review
  - Documentation requests
  - Current and completed projects
  - Discussion & education period



# UPIC

- Purpose is to detect, prevent, deter, reduce and make referrals to recover fraud, waste and abuse
- Integrate program integrity functions for audits and investigations across Medicare and Medicaid
- May refer providers to State Boards
- Medical Review pre and post-pay reviews based on Data Analysis
  - Provider
  - Time-frame
  - Beneficiary
  - Demographic
  - Scheme
  - Benefit/Utilization

# Office of Inspector General (OIG)

- OIG website at <https://oig.hhs.gov/>
- Active workplans
  - <https://oig.hhs.gov/reports-and-publications/workplan/updates.asp>
- Newly published reports



# OIG Report

- Medicare Inappropriately Paid Acute-Care Hospitals for Outpatient Services They Provided to Beneficiaries Who Were Inpatients of Other Facilities
- Noridian article:
  - <https://med.noridianmedicare.com/web/jfa/article-detail/-/view/10538/oig-report-medicare-inappropriately-paid-acute-care-hospitals-for-outpatient-services-they-provided-to-beneficiaries-who-were-inpatients-of-other-faci>

# OIG Report


## Medicare Paid Twice While Patient in SNF

- Medicare made Part B payments to ambulance suppliers for transportation services that were also included in Medicare Part A payments to SNFs as part of consolidated billing requirements
- <https://oig.hhs.gov/oas/reports/region1/11700506.asp>



# CMS Ambulance Booklet

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Medicare-Ambulance-Transports-Booklet-ICN903194.pdf>




**mln**  
BOOKLET

KNOWLEDGE • RESOURCES • TRAINING

PRINT-FRIENDLY VERSION

## AMBULANCE FEE SCHEDULE AND MEDICARE TRANSPORTS





**TARGET AUDIENCE**

Medicare Fee-For-Service Providers

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

**CPT Disclaimer-American Medical Association (AMA) Notice**  
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Ambulance Fee Schedule and Medicare Transports		MLN Booklet
<p><b>Acute Care Hospitals</b></p> <p>An acute care hospital provides acute hospital inpatient care to the beneficiary. A hospital inpatient is defined as a beneficiary who has been formally admitted to a hospital. It does not include a beneficiary who is in the process of being transferred from one hospital to another hospital.</p> <p><b>Coverage and Billing Guidelines – Acute Care Hospitals</b></p>		
COVERED TRANSPORTS	BILLING GUIDELINES	
<p>A beneficiary is transported by ground ambulance to the nearest hospital equipped to provide needed hospital or skilled nursing care on admission or discharge date or within occurrence span code 74 "From" and "Through" dates plus 1 day.</p>	<p>The ambulance provider or supplier bills the MAC separately under Part B.</p>	
<p>A beneficiary who is an inpatient of a hospital is transported by ground ambulance to or from the nearest appropriate Long-Term Care Facility (LTCH), Inpatient Psychiatric Facility (IPF), or Inpatient Rehabilitation Facility (IRF) for specialized services not available at the first hospital. Inpatient status is maintained at the first hospital.</p>	<p>The first hospital bills the MAC under Part A.</p>	
<p>A beneficiary who is an inpatient of a hospital or freestanding facility (such as an LTCH, IPF, or IRF) is transported by ground ambulance to or from the nearest appropriate hospital to receive specialized services not available at the first hospital. Inpatient status is maintained at the first hospital.</p>	<p>The first hospital, LTCH, IPF, or IRF bills the MAC under the appropriate Prospective Payment System.</p>	
<p>A beneficiary who is an inpatient of a hospital is transported by ground ambulance to transfer him or her to the nearest appropriate hospital equipped to provide needed hospital or skilled nursing services not available at the first hospital. The beneficiary is admitted as an inpatient to the second hospital after the ambulance transport</p>	<p>The ambulance provider or supplier bills the MAC separately under Part B.</p>	
<p>A beneficiary under a home health plan of care (POC) is transported by ground ambulance to or from home to the nearest appropriate hospital to obtain needed medical services not otherwise available. Place of origin requirements must be met.</p>	<p>The ambulance provider or supplier bills the MAC separately under Part B.</p>	
<p>A beneficiary under a hospice POC is transported by ground ambulance to or from home to the nearest appropriate hospital for services related to terminal illness and/or related conditions.</p>	<p>Ambulance transports are included in the hospice per diem payment. Ambulance transports related to the terminal illness or related conditions should be arranged by the hospice. Payment to the ambulance supplier is the responsibility of the hospice.</p>	



# Medical Necessity Defined

- Nature of ambulance's response (whether emergency or not) does not independently establish or support medical necessity for ambulance transport
- Beneficiary's condition at time of transport determines whether service is medically necessary

# Medical Records

Document clear picture of patient's condition  
at time of transport

## **42 CFR 424.5 (A) (6)**

**Sufficient information. The provider, supplier, or beneficiary, as appropriate, must furnish to the intermediary or carrier sufficient information to determine whether payment is due and amount of payment.**

# Claims Overlap

- Medicare providers are expected to verify
  - Eligibility prior to or at the time of service
- Avoids billing disputes, denial, rejections
  - Overlapping dates of service
  - Patient discharge status
  - Long Term Care Facility (LTCH) services
  - Skilled Nursing Facility (SNF) services
  - Ambulance services

# Hospital/Ambulance Claims

- Hospital bills inpatient claim and receives payment
- Independent ambulance supplier bills services using date of hospital discharge
  - Denial results; line items falls within admission and discharge dates IPPS claim
  - Ambulance supplier looks to hospital for payment

# Hospital/Ambulance Claims<sub>2</sub>

- Internet Only Manual (IOM) 100-04, Chapter 3, Section 5
- Independent ambulance bills and receive payment
- Inpatient hospital claim processes
  - Recoupment results; line item falls within admission and discharge date
  - Ambulance supplier looks to hospital for payment

# Reminder

- Your documentation:
  - Affects your payments
  - Can affect your ability to appeal
  - Can be reviewed post-pay by CERT and Recovery Auditor
  - Can be reviewed pre-pay by Noridian Medical Review (MR)
- Affects recipients of your referrals and orders
  - Can affect their ability to appeal
  - Their claims also reviewed pre and post-pay

# Responding to Additional Documentation Requests (ADR)

- Gather information quickly and neatly
- Make sure signatures are present and legible
- Verify documentation supports
  - Medical necessity
  - Meets requirements of LCD
- Submit all requested documentation
- Ensure information sent as instructed

# TOB Quick Reference

If your TOB equals:	Responsible Contractors:
XX1-8 or XXI	NHS Medical Review, UPIC or OIG
XXH	CERT or RAC
XXP	QIO



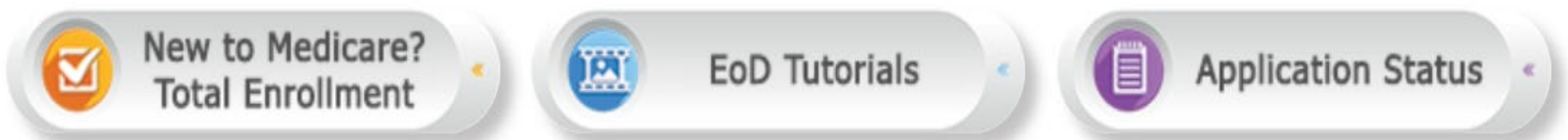


# Noridian Medicare Portal (NMP)



# Provider Enrollment

- Enroll in Medicare – lists application steps
- Enrollment on Demand (EoD) – self-paced video tutorials
- Follow application progress – view status



# Provider Enrollment on Demand

- New web content and webinar courses
  - Medicare Diabetes Prevention Program (MDPP)
  - Submitting Your Enrollment Online
    - Part 1 (I&A)
    - Part 2 (PECOS)
  - Telehealth/Telemedicine Enrollment only

# Provider Enrollment Application and Correspondence

- New details available in NMP
  - Application status
  - View/download correspondence
  - Upload documentation for applications currently being processed
  - Download notification letters (once application is complete)
- Access granted to provider admin or dual users
  - Part A organizations can only view their organizational applications
  - Part B providers can view Group and Rendering applications

# Provider Enrollment Revalidation

- Resubmission of documentation is not required
  - Necessary information was included in previous submission or
  - Development request will be mailed for supporting documentation
- You can submit applications 7 months in advance of the revalidation due date

# NMP Remittance Advice

- Get full remittance advices for hospitals/clinics that receive paper remits
  - Download or print PDF format
  - View last 30 days
  - Search by date range, check amount or check number
- Learn more: Education on demand tutorial or NMP user manual

# NMP Eligibility Inquiry Responses

- MSP - Displays pertinent MSP diagnosis codes
- MDPP - Includes MDPP Preventive Service Codes, etc.
- HMO or MCO - Displays HMO/MCO plan benefit number and name

# NMP Expanded Denial Details

- Alien, Incarcerated - Lists dates
- SNF and ESRD Facility - Overlapping dates and NPI shared

**SNF/INPT Overlap**

This patient has QMB for part of the date span chosen. The patient may or may not be responsible for the deductible depending on QMB status. Please contact the patient's Medicaid agency.

CMS mailed a Medicare card with a new Medicare Beneficiary Identifier (MBI) to this beneficiary. Medicare providers, please get this in your system(s).

**Inpatient SNF Hospital Summary**

This data will be fetched real time and on-demand from Noridian information systems.

[Please click here to load this data.](#)

**Related Inquiries**

- Submit Appeal
- View Financials
- View Full Remittance
- Claim Specific Remittance
- ESRD/Dialysis Denial Details**

**Claim Denial Details**

The services have not paid due to an open End-Stage Renal Disease (ESRD) file.

From Date	Thru Date	Provider NPI

◀ Previous | Next ▶

**Resources:**

1. For details on the facility, search the NPI Registry for the contact information. The NPI Registry can be found through the link: <https://www.cms.gov/npr/>
2. To learn more about ESRD and which services may pay separately refer to the ESRD Consolidated Billing Chart: [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/Consolidated\\_Billing.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/Consolidated_Billing.html)



# Qualified Medicare Beneficiary (QMB)

Dual-eligible Medicare/Medicaid beneficiaries

**Eligibility Benefits Response** 
[New Inquiry](#) [Print Page](#)

<b>Beneficiary:</b> Gender: M DOB: Date of Death: HICN: Transaction ID: 100002016	<b>Provider/Supplier:</b> NPI: PTAN: TIN or SSN: From Date of Service: 01/30/2017 To Date of Service: 08/21/2017	<b>Related Inquiries</b> <a href="#">View Claim Status</a>
--	---	---

View All Eligibility HMO/MCO MSP HHEH Hospice Hospital SNF ESRD Preventive

**Eligibility**

Our records indicate this beneficiary is a Qualified Medicare Beneficiary Enrollee.

**Part A - Beneficiary Details**  
 Effective Date: 05/01/2001      Termination Date:

**Part B - Beneficiary Details**  
 Effective Date: 08/01/2011      Termination Date:



# MSP Claims Corrections in NMP

## Payer Type

- Incorrect payer type/provision?
- Use NMP to reopen MSP claims for reject/denial for payer type/provision

**ICN:** Receipt Date: 02/03/2017  
**Status:** APPROVED AND PAID **MSP Ind:** Y  
**Billed Amount:** \$200.00 **MSP Type:**   
**Finalized Date:** 02/22/2017 **Crossover Ind:** N  
**Provider Paid Amount:** \$0.00 **Last Worked Date:** 02/22/2017  
**Referring NPI:** **Check/EFT #:**  
**Rendering NPI:** **Specialty:** 11  
**Rendering PTAN:** **Total Deductible:** \$96.80  
**Place of Service:** 11

**Claim Diagnosis Code and Pointer Details**

Diagnosis Pointer	Diagnosis Code	Diagnosis Pointer	Diagnosis Code	Diagnosis Pointer	Diagnosis Code
A	E1010	E		I	
B		F		J	
C		G		K	
D		H		L	

Line	From DOS	To DOS	Procedure Code	Modifier	Units	Diagnosis Pointer	Billed Amount	Allowed Amount	Provider Paid
1	09/06/2016	09/06/2016	99212		1.0	A	\$75.00	\$48.40	\$0.00
2	09/10/2016	09/10/2016	99212		1.0	A	\$75.00	\$48.40	\$0.00
3	09/10/2016	09/10/2016	20550		1.0	A	\$50.00	\$0.00	\$0.00

**Instructions:**

- In the space provided, input the two-digit numeric value

12	Working Aged
13	ESRD
14	Auto/No Fault
15	Worker's Compensation
16	Federal
19	Worker's Compensation Set-aside
41	Black Lung
43	Disability
44	Liability Insurance Medicare Set-aside
45	No-Fault Insurance Medicare Set-aside
47	Liability

**Note:** MSP Type applies to all lines where applicable

**Adjustment Type:** MSP Type

# Send Questions via Portal Message

- If receive documentation request from **CERT** or **Noridian Medical Review** teams only
- Send Noridian secure messaging
- <https://med.noridianmedicare.com/web/jeb/topics/nmp/end-user-manual/send-us-a-message>

The screenshot displays the Noridian Medicare Portal interface. At the top right, the navigation bar includes links for 'Welcome', 'Manage Account', 'Send Us A Message' (highlighted with a red box), and 'Sign Out'. Below this, the main header features the Noridian logo and 'Noridian Medicare Portal' text, along with the user's last login information: 'Last Login on 4/20/2018 08:30 AM CDT | Failed attempts: 0'. A secondary navigation bar contains icons for 'Home', 'Contact Us', and 'Help'. Below the header is a horizontal menu with categories: 'Eligibility', 'Claim Status', 'Appeals', 'Remittance Advices', 'Financials', 'Same or Similar DME', 'Prior Authorizations', and 'Provider Audit'. The main content area is divided into two sections: 'Availability' on the left, which shows a green progress bar indicating 'System Normal' and a link for 'Hours of Availability', and 'Notifications & Updates' on the right, which includes a 'See All >' link.

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# **Education Team**

# Sign Up - Medicare News!

- Receive most recent Noridian/CMS news
  - MLNs posted under What's New Articles
  - Tuesday/Friday
  - Simple/quick signup



# Social Media

- Facebook
  - Give us a 'Like'
  - 'Follow' us to stay connected
- YouTube
  - <https://www.youtube.com/channel/UCcmjLoqW4RyRVjOYDxQCNTA>

**noridian** **Noridian Jurisdiction F**  
January 2 at 9:35am · 🌐

Welcome to the Noridian JF Facebook page!

The Noridian Facebook page will pass along updates from Noridian and Medicare through articles and links previously published to our website. Upcoming educational events and self-paced tutorials will also be available here for you to stay connected.

Inquiries may be submitted and answered during regular business hours, but remember PHI or PII is not accepted. Your inquiry may need to be re-directed to the appropriate department for further research.

Noridian News

**noridian**  
Healthcare Solutions

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Healthcare Solutions

med.noridianmedicare.com

Noridian Medicare Part A & B Subscribe 117

Home Videos Playlists Channels Discussion About

Created playlists

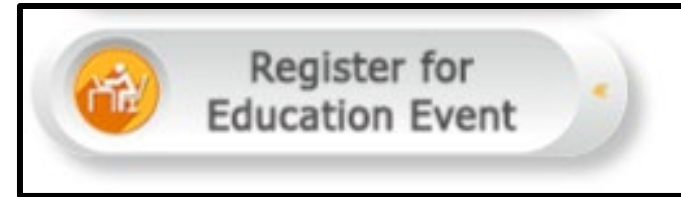
- Claim Status
- Appeals
- Part A General Medicare Coding and Billing
- Critical Access Hospital
- Preventive Services

Popular channels

- BuzzFeedVideo
- The ACE Family
- Dude Perfect

# Upcoming Webinars

- Earn CEUs
- Part A



- JE: <https://med.noridianmedicare.com/web/jea/education/training-events>
- Part B
  - JE: <https://med.noridianmedicare.com/web/jeb/education/training-events>
- After Hours webinars



# Online Provider Education

- Education on demand
  - View self-paced tutorials at your convenience
- Certificate emailed upon completion
- Learn More
  - Education & Outreach

The screenshot displays the Noridian Healthcare Solutions website interface. At the top, the Noridian logo is on the left, and the text 'Jurisdiction F - Medicare Part B' followed by a list of states (Alaska, Arizona, Idaho, Montana, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming) is on the right. There are links for 'Contact Us | Help' and 'Noridian Medicare Portal (NMP) Login'. A search bar is also present.

The main navigation bar includes buttons for 'Browse by Topic', 'Browse by Specialty', 'Fees & News', 'Policies', 'Medical Review', 'Education & Outreach' (which is highlighted), 'Enrollment', and 'Forms'.

The breadcrumb trail reads: 'JF Part B / Education & Outreach / Education on Demand Tutorials'. There are social media share icons for print, email, and Facebook.

The 'EDUCATION & OUTREACH' sidebar lists various resources: Ask the Contractor Teleconference (ACT), CMS Medicare Learning Network (MLN), Collaboration with Associations, Education on Demand Tutorials, Educational Forms, Event Materials, New Provider New Biller, Provider Outreach and Education Advisory Group (POE AG), Schedule of Events, Small and Rural Providers, and Tools.

The main content area is titled 'Education on Demand Tutorials'. It includes a paragraph explaining that the Noridian Provider Outreach and Education (POE) team offers educational material to assist providers. Below this is a search bar with the text 'Search for Tutorials' and a clear button (X).

The 'Education on Demand Tutorials - Get the Most Out of Them' section contains a table:

Topic	Self-Paced Training / Tutorial
Advance Beneficiary Notice of Noncoverage (ABN)	<ul style="list-style-type: none"> <li>• <a href="#">ABN</a> ⌚ Jan 2018 - 21:56 minutes</li> <li>• <a href="#">Tutorial</a></li> </ul>
Anesthesia Services	<ul style="list-style-type: none"> <li>• <a href="#">New Clinical Social Worker (CSW) Reassigning Benefits</a> ⌚ May 2016 - 6:28 minutes</li> <li>• <a href="#">Completing the CMS-855R</a> ⌚ May 2016 - 4:50 minutes</li> </ul>
Claim Submission	<ul style="list-style-type: none"> <li>• <a href="#">CMS-1500 Claim Form Tutorial - Version 02/12</a></li> <li>• <a href="#">CMS-1500 Claim Form Instructions</a></li> <li>• <a href="#">CMS-1500 Claim Form Submission Items 1-16</a> ⌚ Feb 2016 - 18:36 minutes</li> <li>• <a href="#">PECOS Ordering/Referring Edits</a> ⌚ Dec 2013, 7 minutes</li> <li>• <a href="#">Claim Submission Guidelines</a> ⌚ Feb 2016 - 12:11 minutes</li> </ul>



# Provider Outreach & Education Request Form

- Complete and send to:  
[mac@noridian.com](mailto:mac@noridian.com)
  - Subject line: Education request
- Contact Provider Contact Center for claim specific information



**JF Provider Outreach & Education Request Form**

Noridian offers the opportunity for education targeted to the particular needs of each health care provider. Complete this form to only request specific education trainings. For questions specific to individual provider situations, call the Provider Contact Center at 1-877-908-8431.

**Provider Contact Information**

Provider Facility Name: \_\_\_\_\_  
 PTAN/NPI Number: \_\_\_\_\_ Date Submitted: \_\_\_\_\_  
 Contact Person: \_\_\_\_\_ E-mail: \_\_\_\_\_  
 Provider Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_  
 Number of Attendees: \_\_\_\_\_

Check appropriate box:  Web-based Training  Teleconference  In Person  
 Select the appropriate form used to bill Medicare claims:  UB04 for Part A  1500 Claim for Part B  
 Requested date(s) and time (Onsite education is based on availability): \_\_\_\_\_

Location of Event: City: \_\_\_\_\_ State: \_\_\_\_\_

Select the state you bill claims for: \_\_\_\_\_

Enter specialty type that best fits your facility: \_\_\_\_\_

Provide Detailed Reason for Education (Provide additional detailed information for the type of education being requested. Example: billing, coverage, speaker for meeting/conference): \_\_\_\_\_

*Your request will be processed and a Noridian Education Representative will be in contact with your organization within 10 business days.*

After completion of this form, click the "Save" button at the top and save to your desktop. Next, open a new email message, attach this form to the message and send to mac@noridian.com.

2019101 • 2-17

A CMS Medicare Administrative Contractor  
Noridian Healthcare Solutions, LLC



Questions?

Thank you!