noridian
Healthcare Solutions

Wyoming Healthcare Financial Management Association (HFMA)

Part A/B Provider Outreach and Education

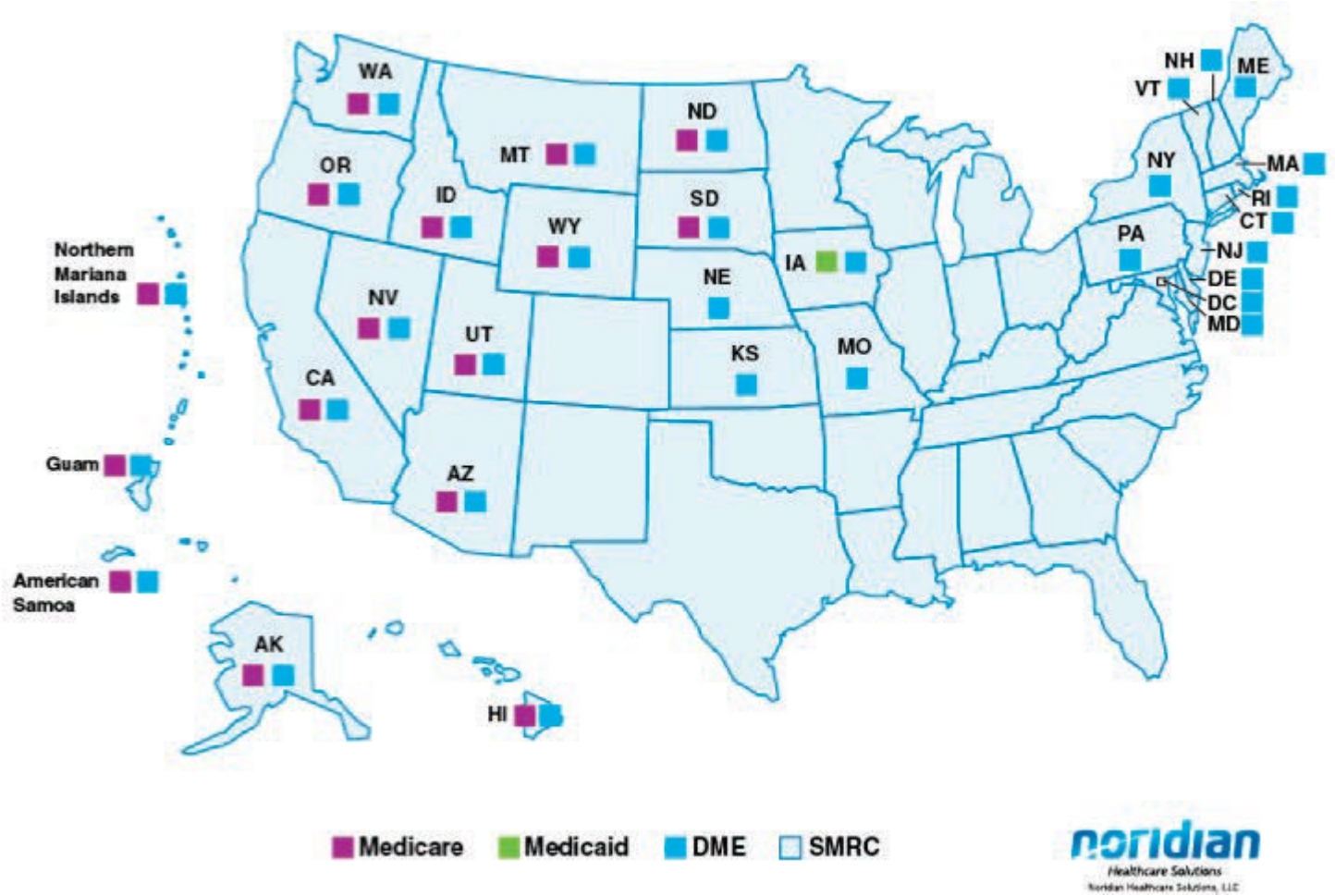
Fall 2019

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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

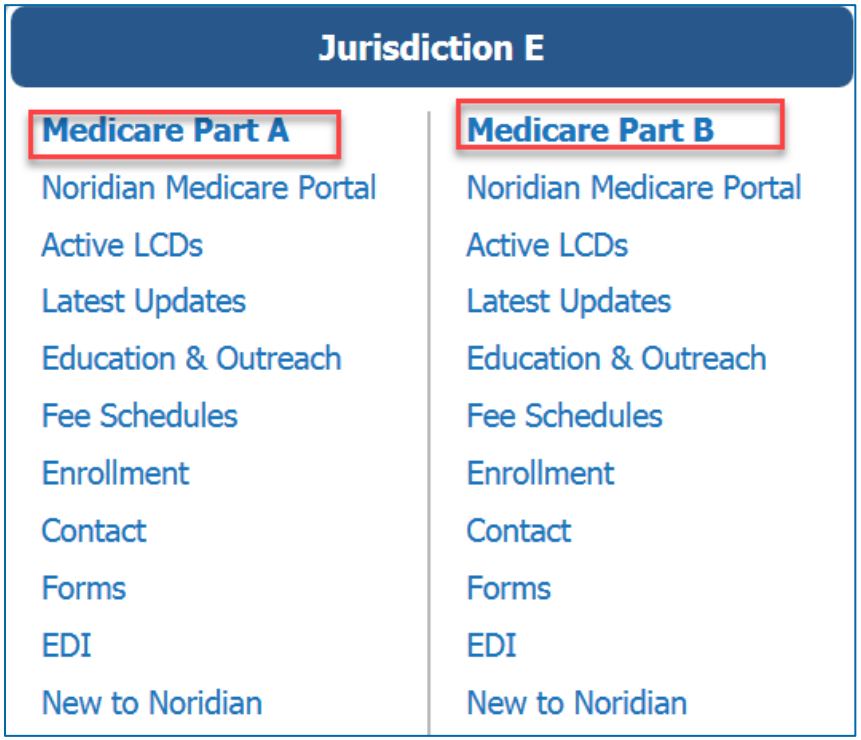
Call center services

Provider management

Medical review

NHS Medicare Administrative Contractor (MAC) Online

https://med.noridianmedicare.com



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

noridian
Healthcare Solutions

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[2]

- 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[3]

- 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

- 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

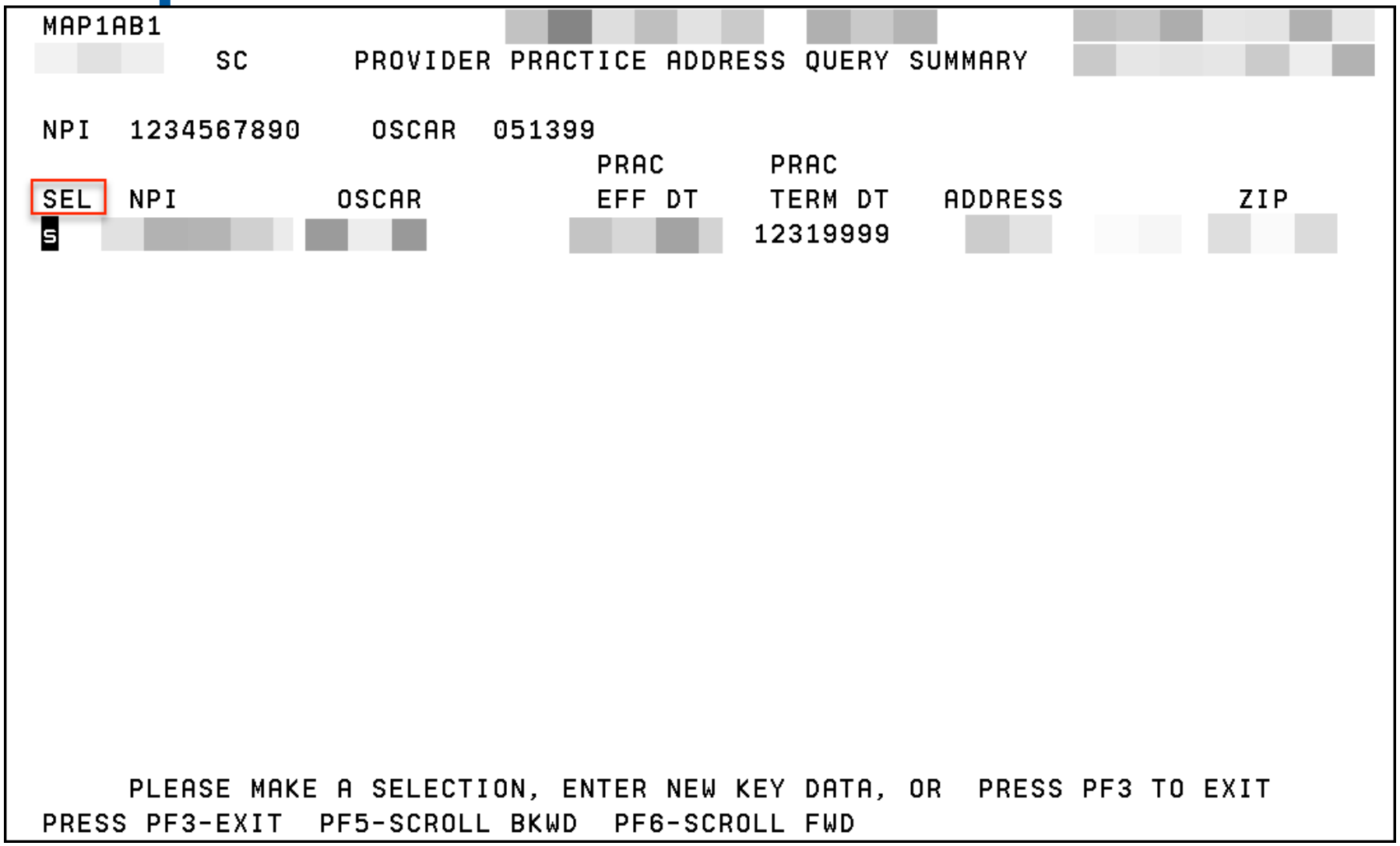
```
MAP1702
                              INQUIRY MENU

     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    PROV PRACTICE ADDR QUER  1D



   ENTER MENU SELECTION:

    PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
```

Option 1D – MAP1AB1

```
MAP1AB1
        SC      PROVIDER PRACTICE ADDRESS QUERY SUMMARY

NPI                 OSCAR
                                  PRAC        PRAC
SEL   NPI           OSCAR         EFF DT      TERM DT     ADDRESS          ZIP
```

PLEASE ENTER DATA - OR PRESS PF3 TO EXIT

Option 1D – MAP1AB1 Selection



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
```

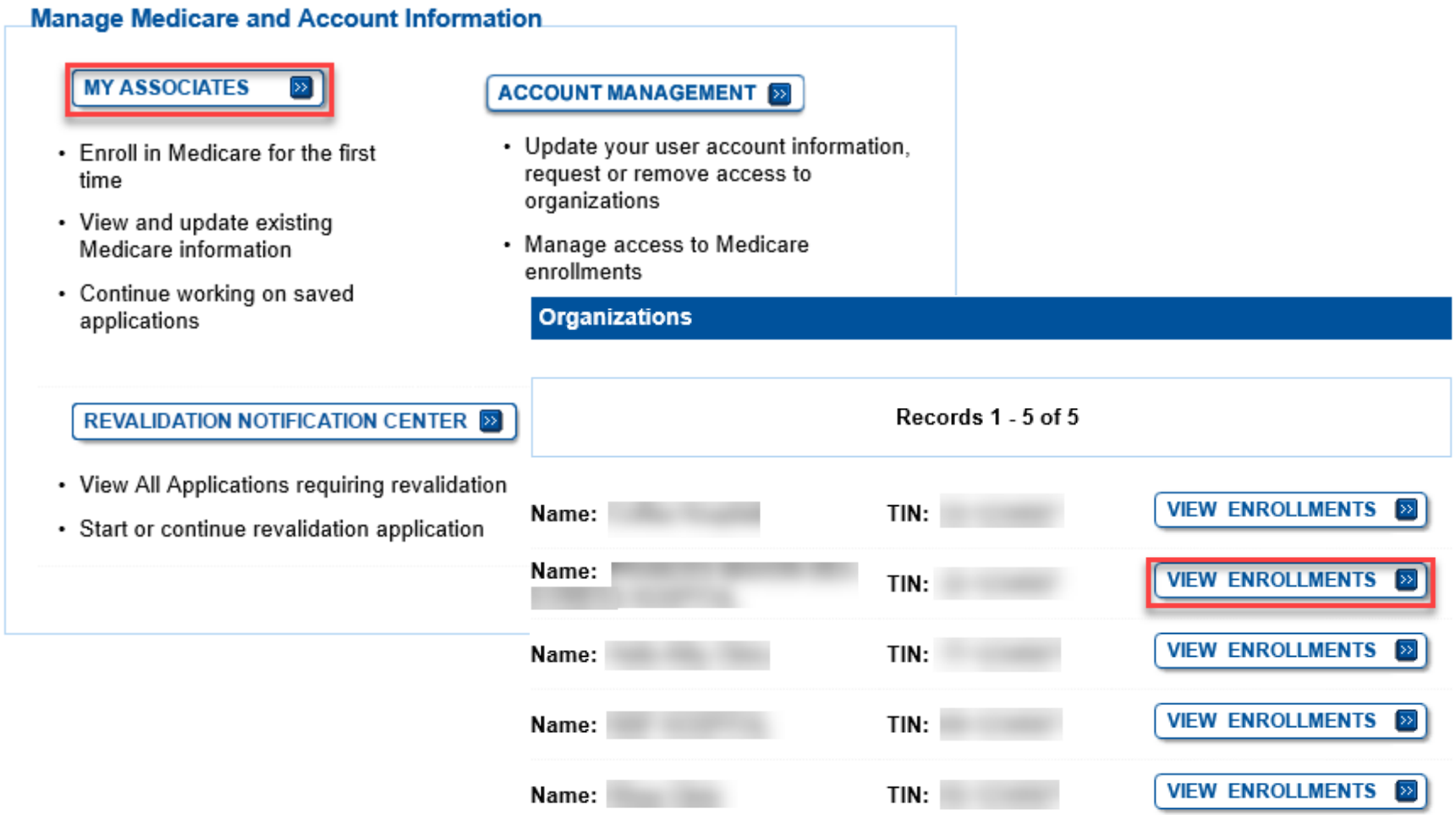
Claim Entry – Page 3 – MAP1713

```
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
```

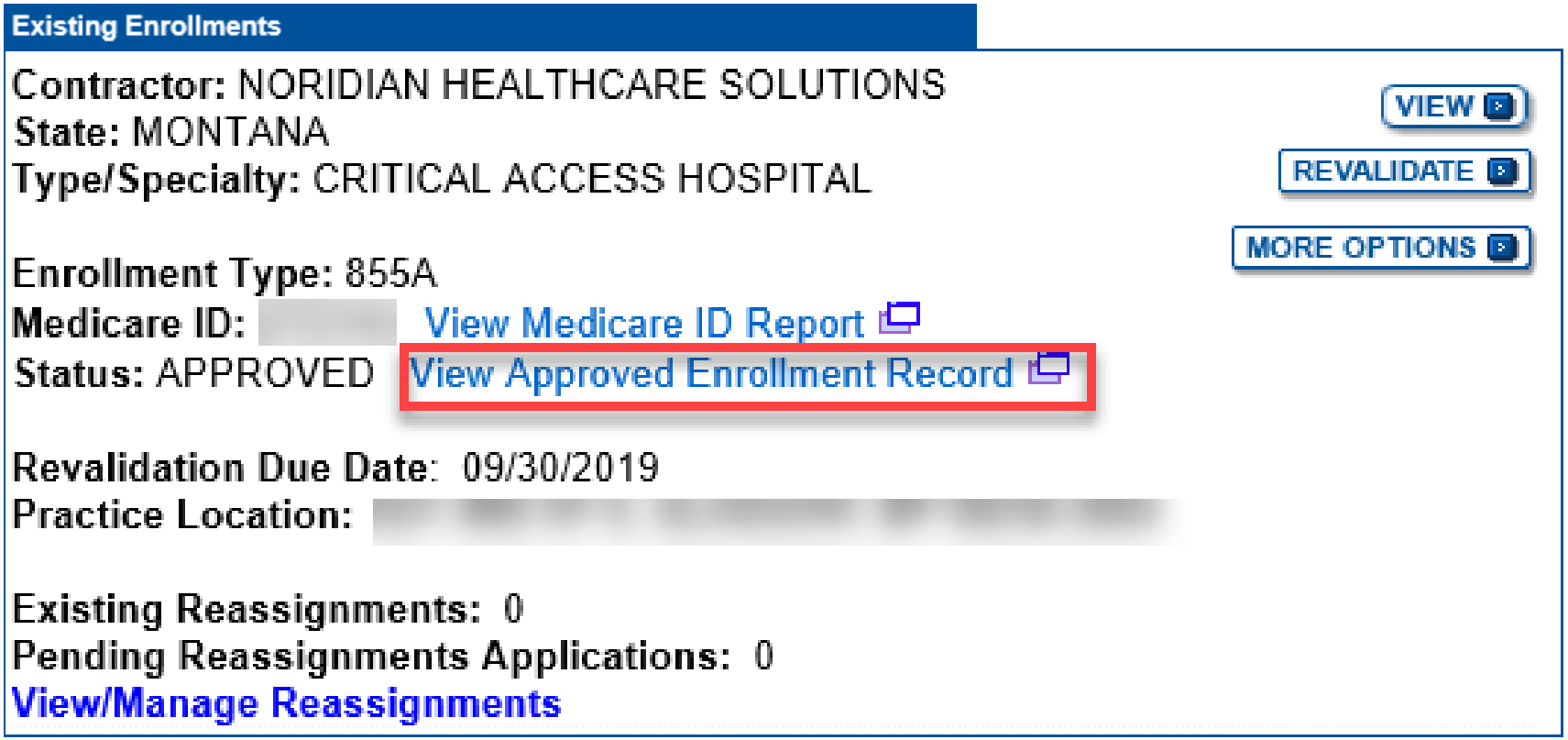
Page 3 – F11 Twice – MAP171F

```
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



Existing Enrollments



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
Enrollment Status:	APPROVED
Submitted By:	

FROM SECTION 2: IDENTIFYING INFORMATION

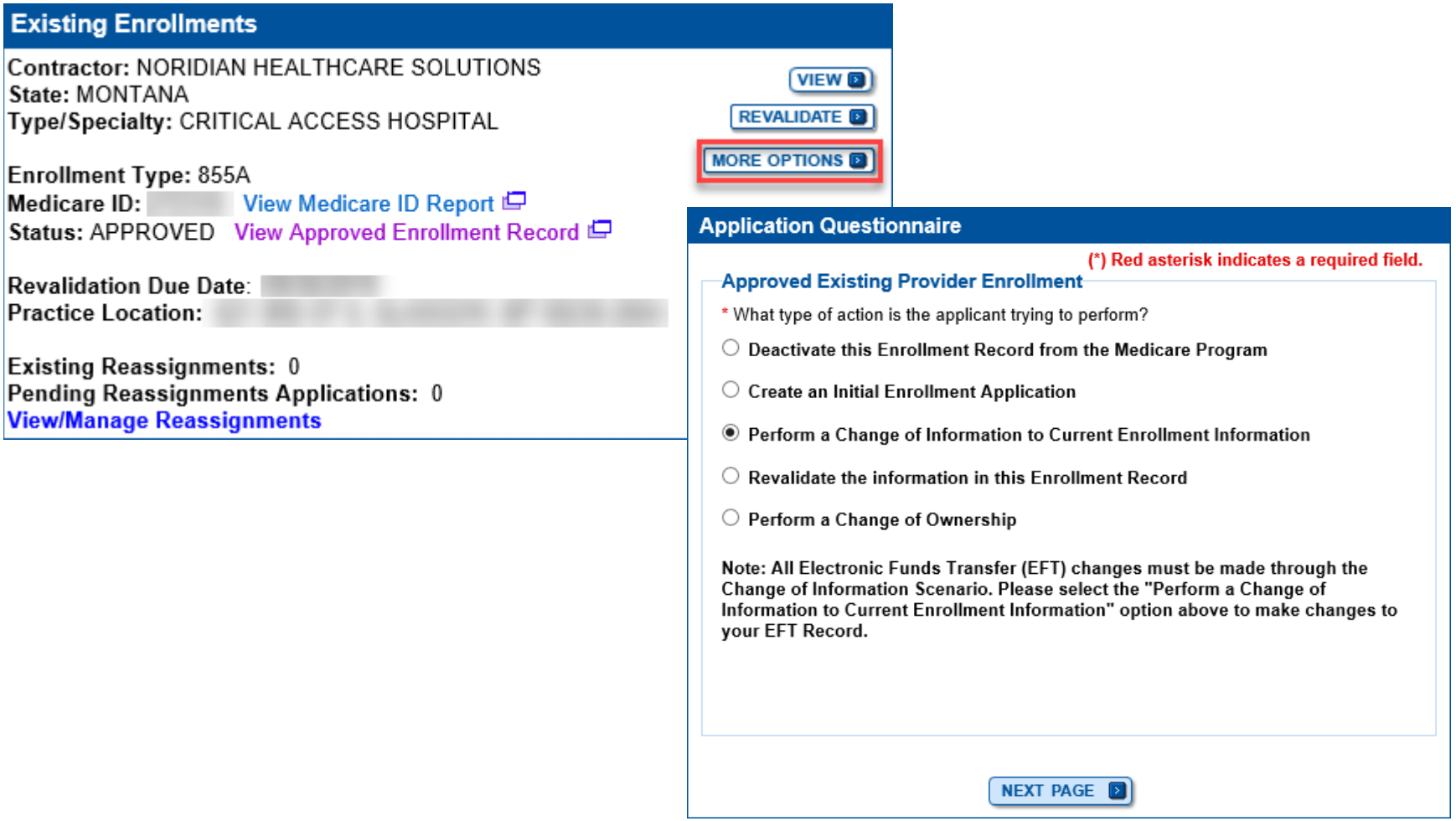
ORGANIZATION INFORMATION

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

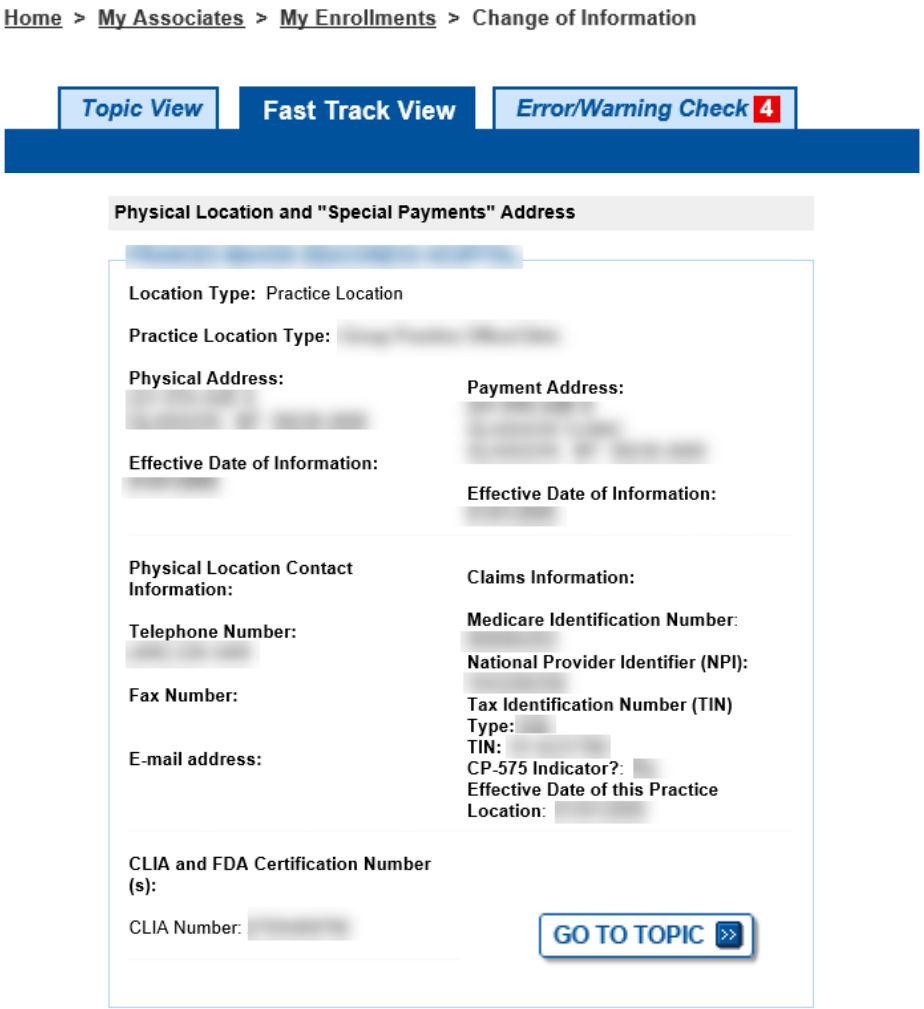
Enrollment Record2

FROM SECTION 4: PRACTICE LOCATION INFORMATION		
PHYSICAL LOCATION AND "SPECIAL PAYMENTS" ADDRESS		
# 1: [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		
• **Claims Detail**		
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



Application



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

noridian
Healthcare Solutions

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

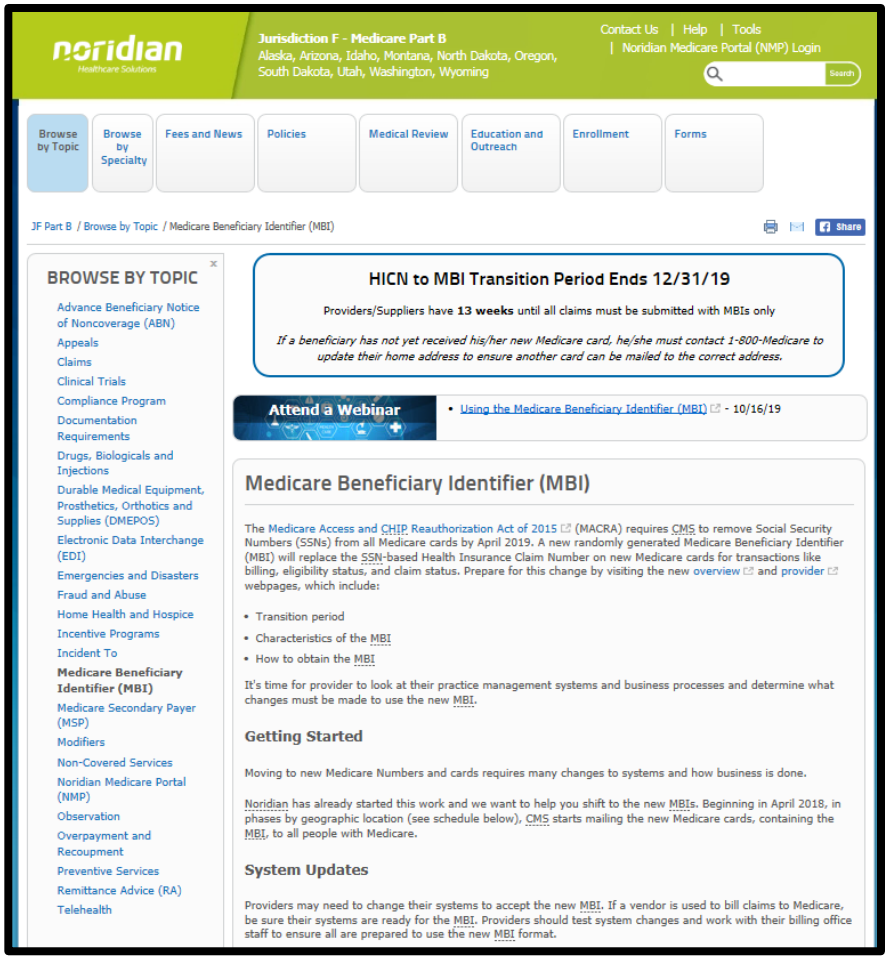
- Ask beneficiary for new Medicare card
- MBI lookup tool through NMP
- MBI displays on remittance advice (RA)
- Learn more
  - https://www.cms.gov/Medicare/New-Medicare-Card/Providers/Getting-MBIs.html

MBI Resources for Beneficiaries

New Card Not Received

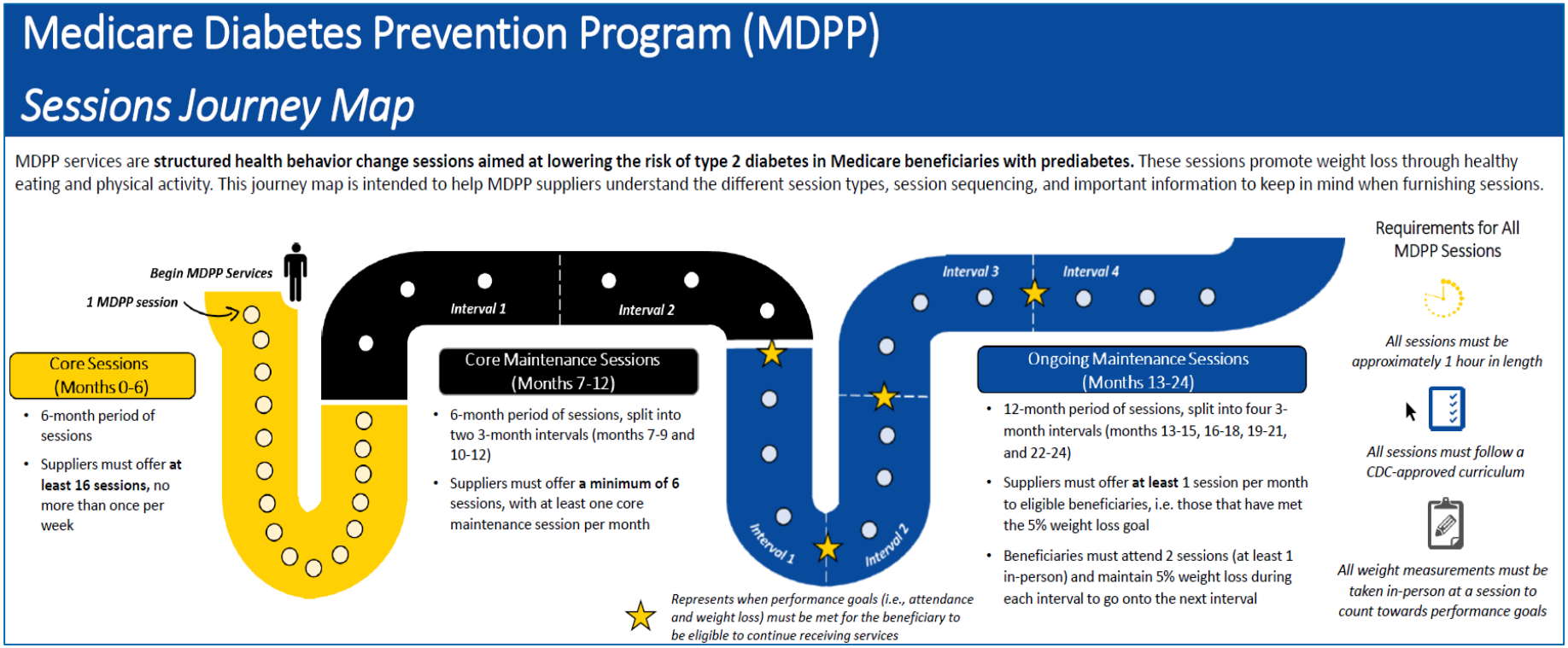
- New card won't be received if address is incorrect
  - Call Social Security
  - Log into online account at: http://www.ssa.gov/myaccount

Noridian's MBI Webpage



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

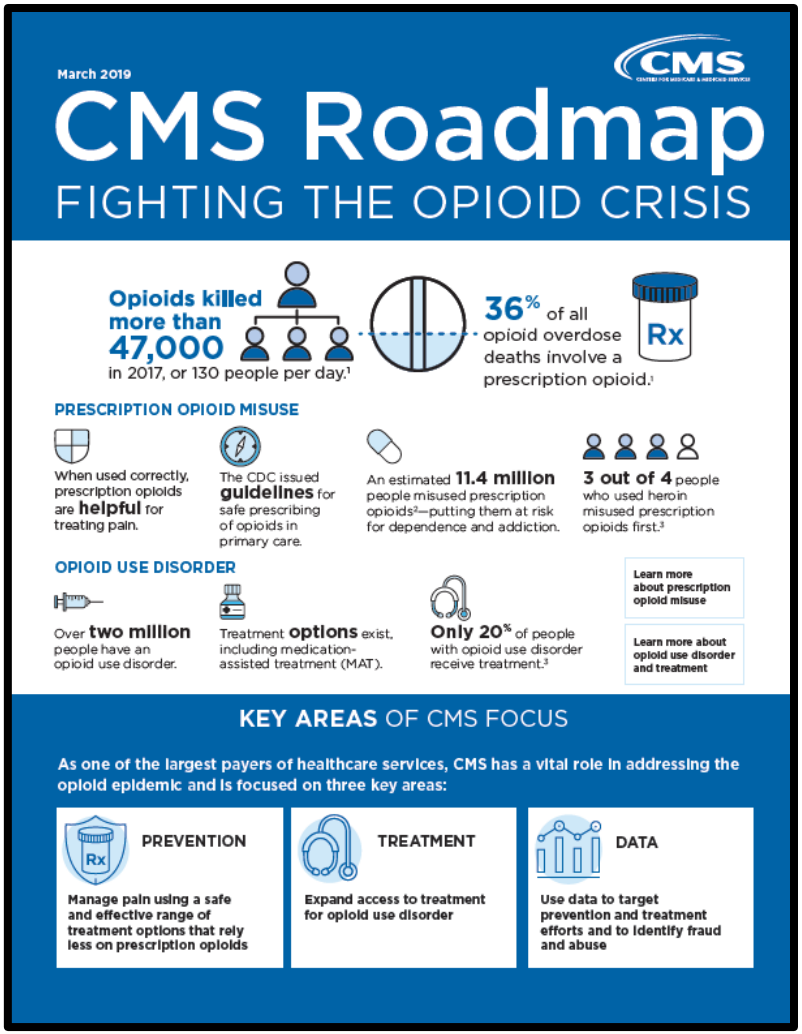
Medicare Diabetes Prevention Plan (MDPP)



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



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 AWV; 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

noridian
Healthcare Solutions

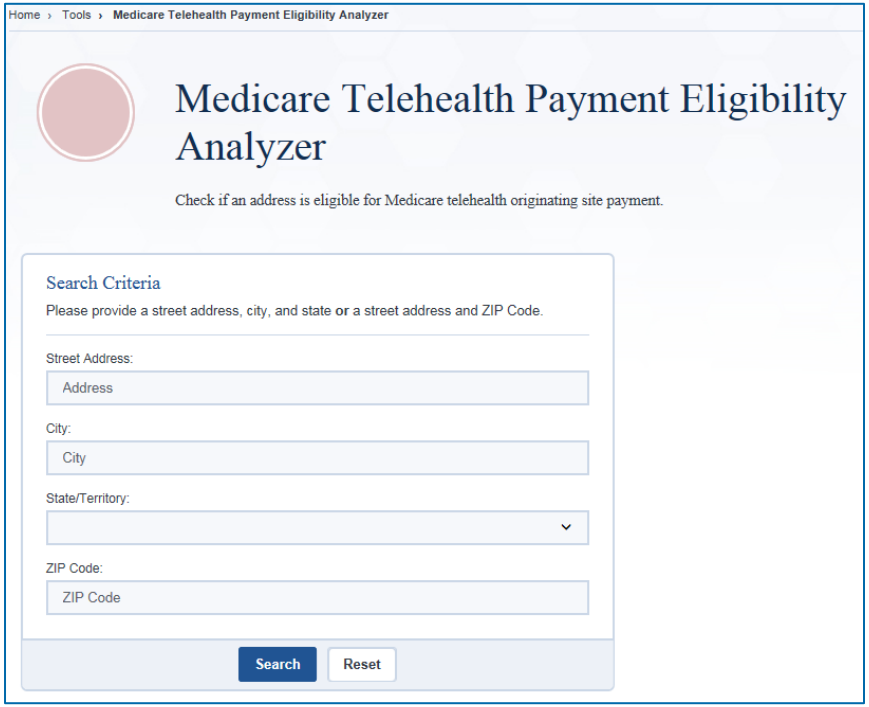
Telehealth vs Telemedicine

Telehealth

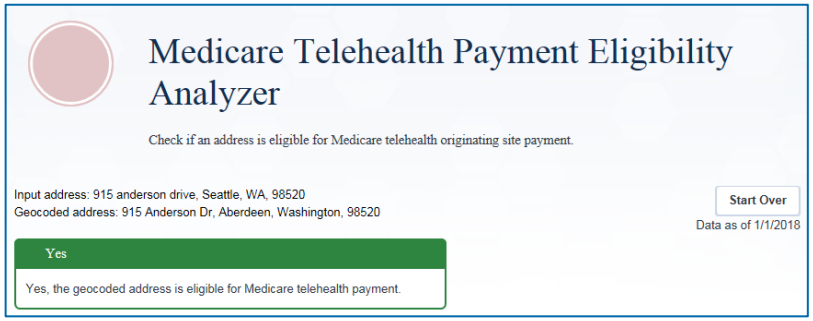
- Eligibility criteria
  - Patient must be at originating site
  - Health Professional Shortage Area (HPSA)
  - Non-MSA geographic location
  - Originating site fee billed HCPCS Q3014
- Providers located at distant site
  - Must be enrolled as Medicare provider
  - Bill services to MAC where performed

Telehealth Eligibility Search Analyzer

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



Eligible



Not Eligible

Originating Billing Guidelines

Originating Site	Payment Methodology	Type of Bill	Revenue Code
Outpatient Hospital	Outside of OPPS	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

noridian
Healthcare Solutions

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

noridian
Healthcare Solutions

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 (UPIC)
- 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) Reopening2

- 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

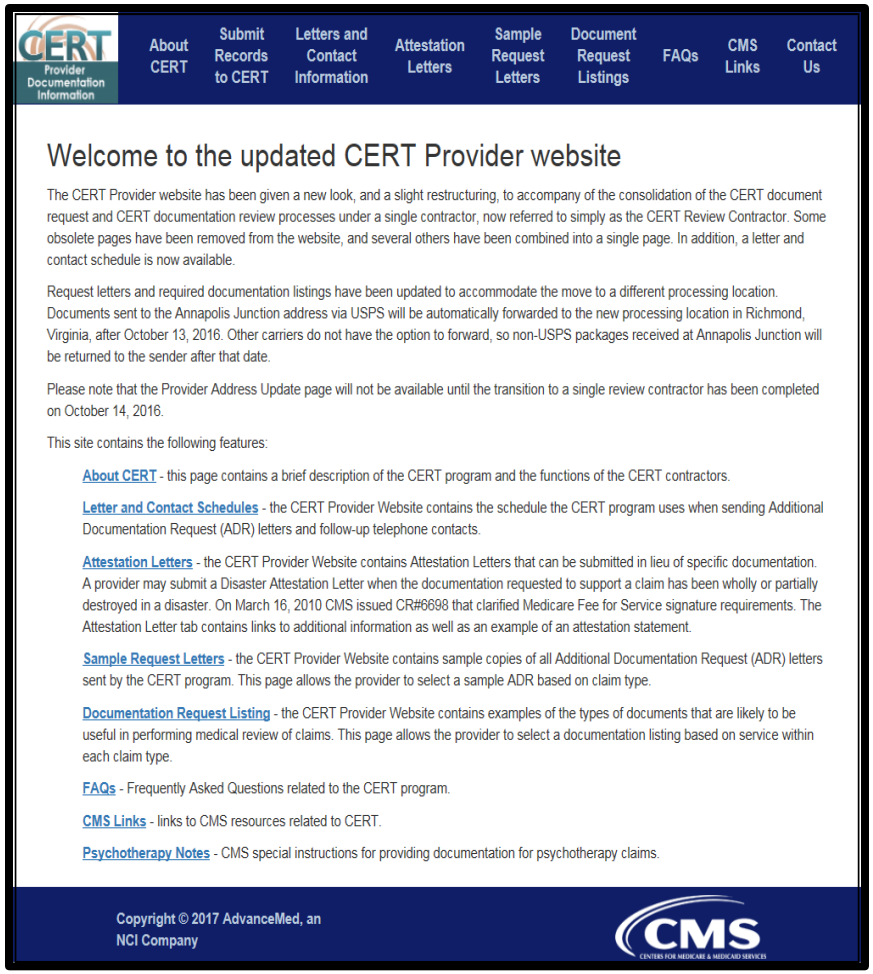
- If not responding to Additional Development Requests (ADRs), Noridian refers provider to ZPIC/UPIC, RAC, etc.
- If high denial rates continue after 3 rounds, MACs will refer to CMS for additional action, which may include
  - 100% prepayment review
  - Extrapolation
  - Referral to ZPIC/UPIC, RAC,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



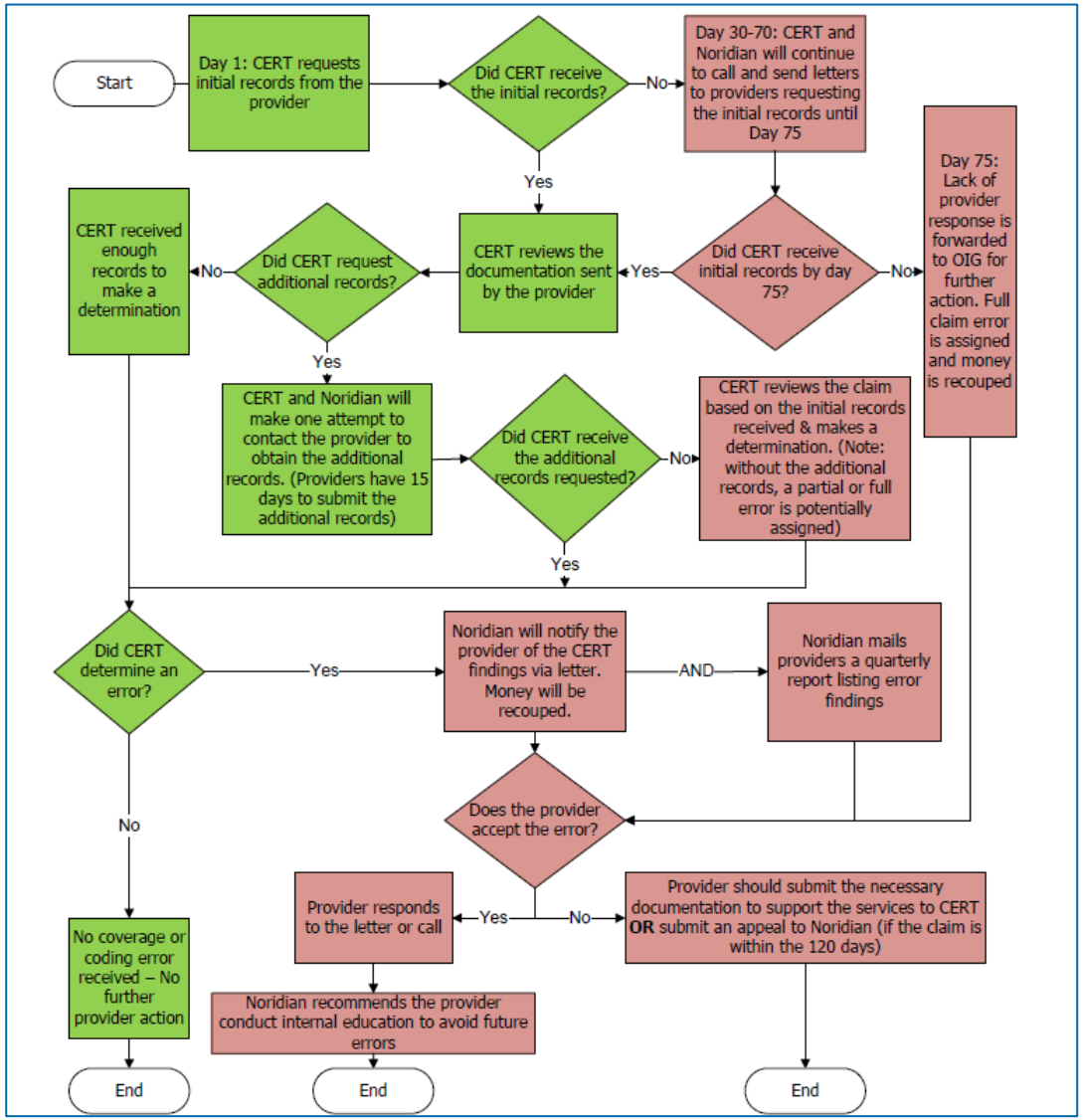
MAC Contact Information

- 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
- Noridian Part B, send an email to 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



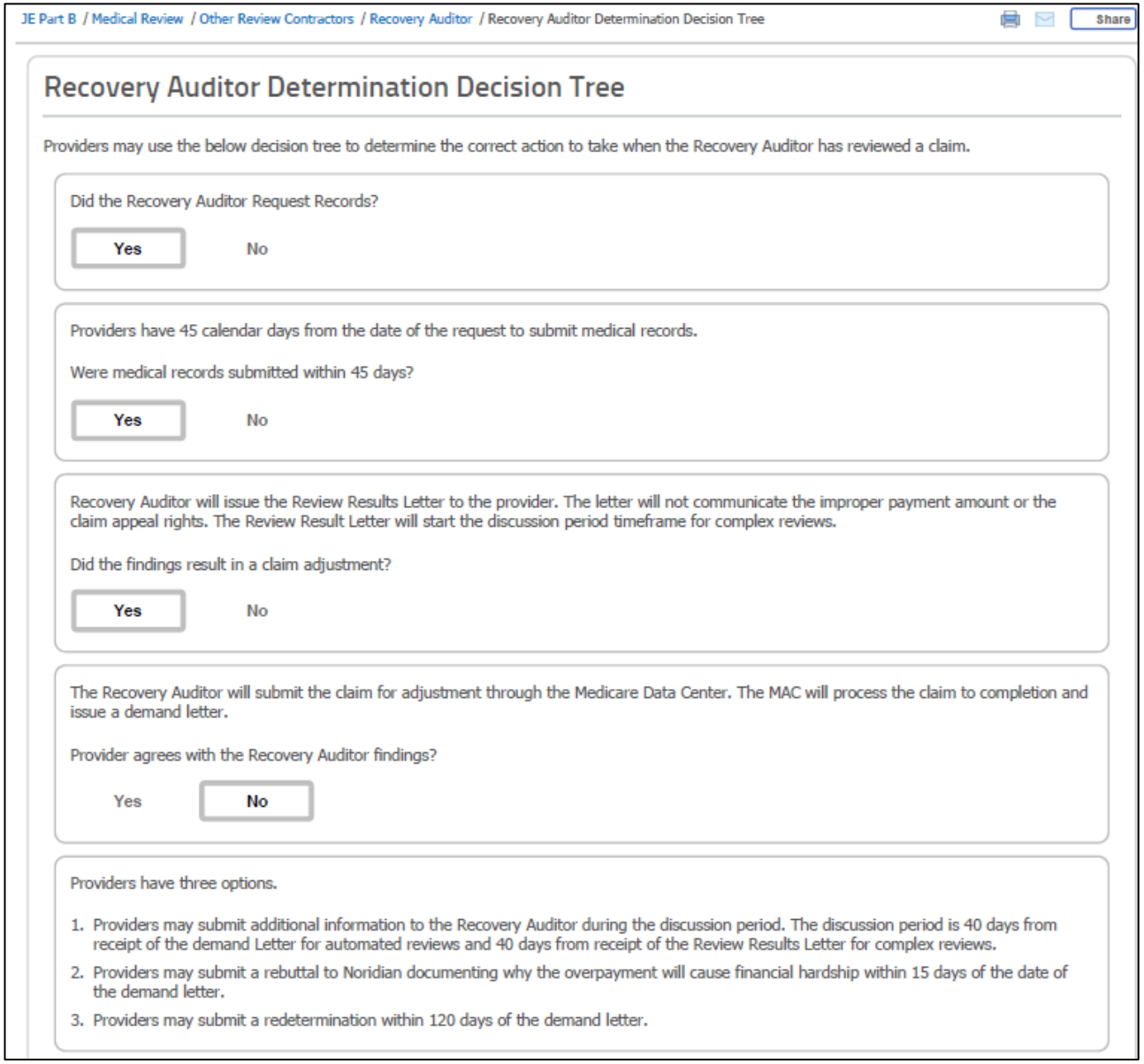
Recovery Auditor (RAC) Issues

- 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. RAC2

- 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

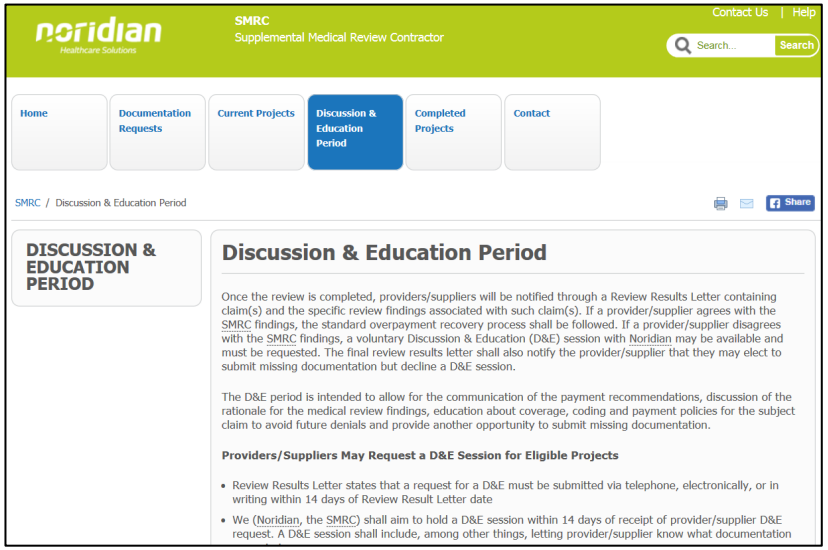
- CMS provides Livanta monthly universe of eligible paid provider claims with less than two midnight
  - May be picked once within 6-month round
  - High or increasing number of short stay claims per area
  - 25 cases sampled

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

PRINT-FRIENDLY VERSION

KNOWLEDGE • RESOURCES • TRAINING

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.

CMS Medicare Learning Network

Acute Care Hospitals

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.

Coverage and Billing Guidelines – Acute Care Hospitals

COVERED TRANSPORTS	BILLING GUIDELINES
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.	The ambulance provider or supplier bills the MAC separately under Part B.
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.	The first hospital bills the MAC under Part A.
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.	The first hospital, LTCH, IPF, or IRF bills the MAC under the appropriate Prospective Payment System.
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	The ambulance provider or supplier bills the MAC separately under Part B.
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.	The ambulance provider or supplier bills the MAC separately under Part B.
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.	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.

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 Claims2

- 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
Healthcare Solutions

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

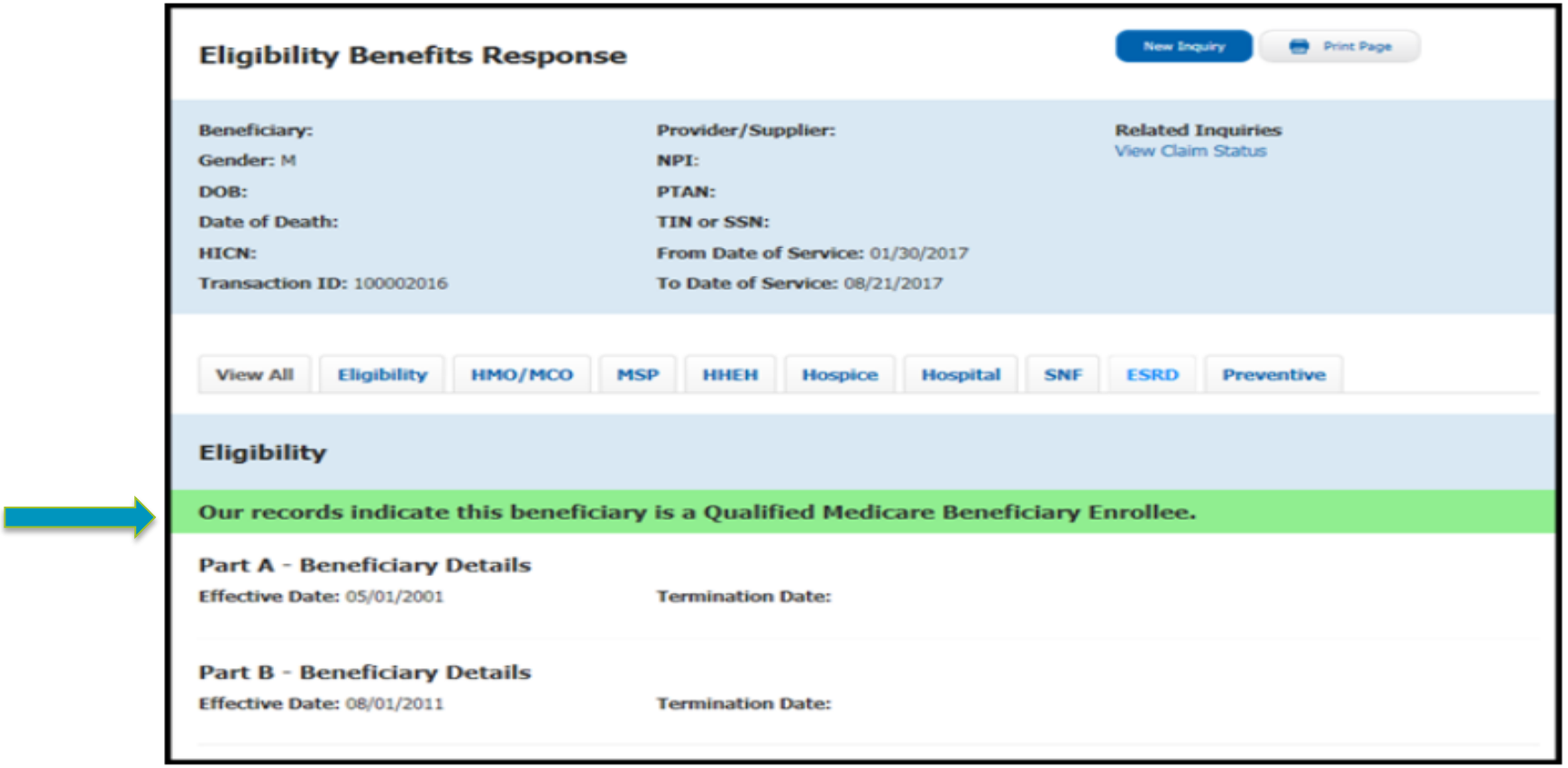
- MSP - Displays pertinent MSP diagnosis codes
- MDPP - Includes MDPP Preventive Service Codes, etc.
- HMO or MCO - Displays HMO/MCO plan benefit number and name

NMP Expanded Denial Details

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

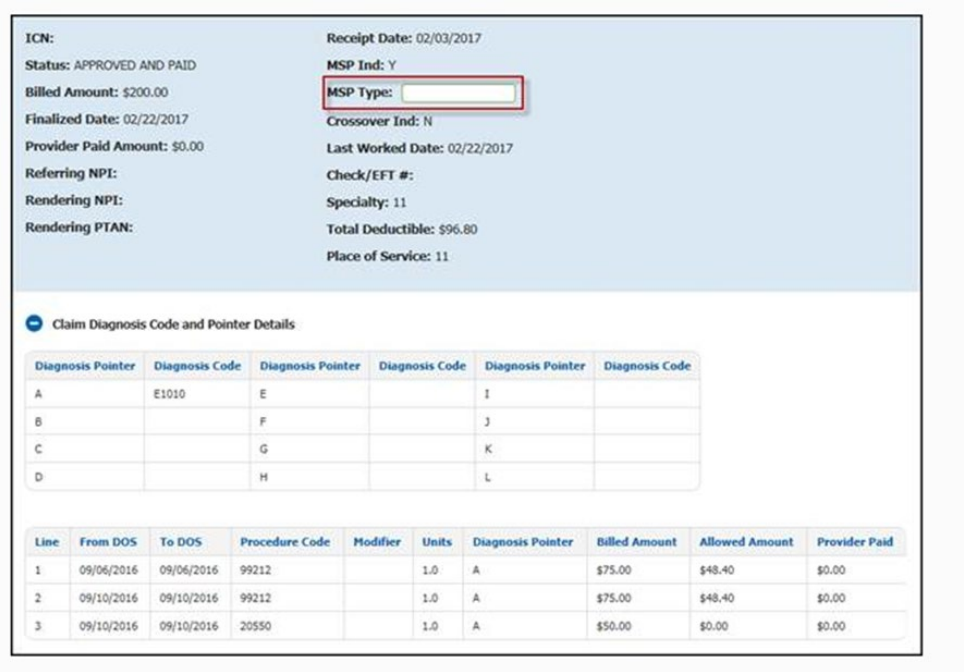
Qualified Medicare Beneficiary (QMB)

Dual-eligible Medicare/Medicaid beneficiaries



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:
Status: APPROVED AND PAID
Billed Amount: $200.00
Finalized Date: 02/22/2017
Provider Paid Amount: $0.00
Referring NPI:
Rendering NPI:
Rendering PTAN:

Receipt Date: 02/03/2017
MSP Ind: Y
MSP Type:
Crossover Ind: N
Last Worked Date: 02/22/2017
Check/EFT #:
Specialty: 11
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

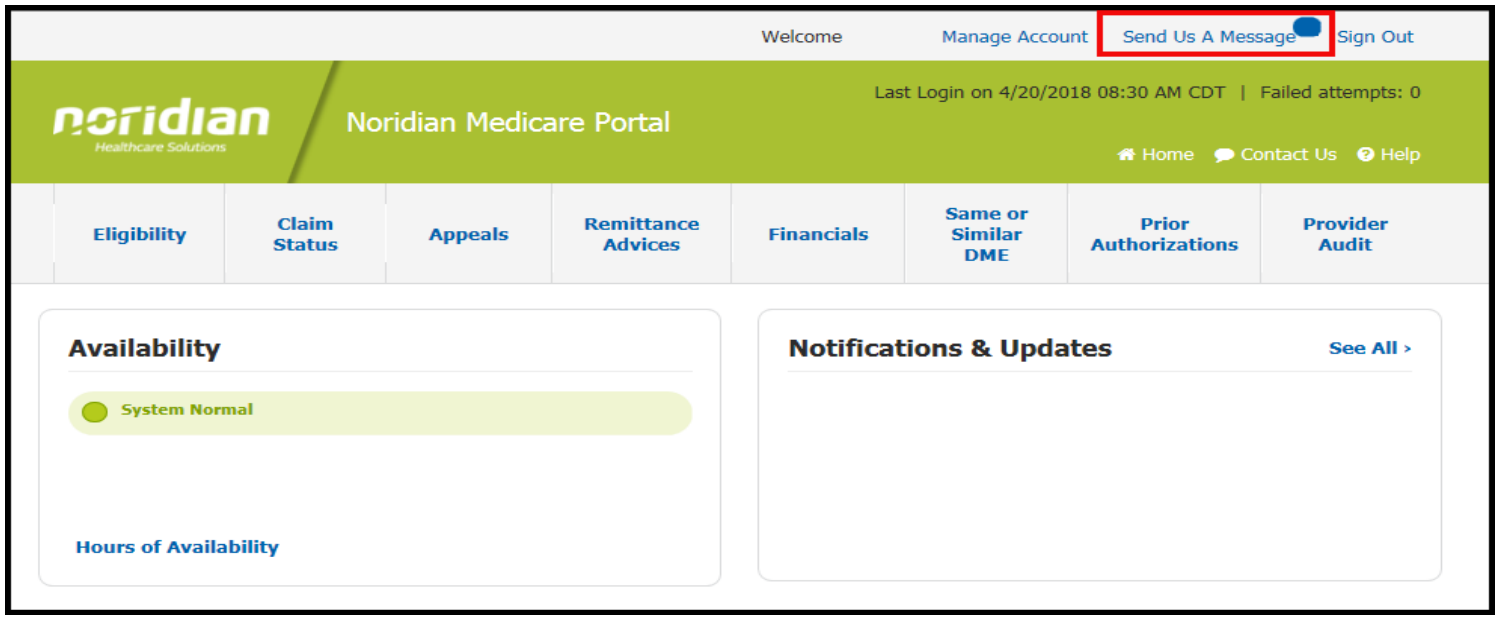
12	Working Aged
13	ESRD
14	Auto/No Fault
15	Worker's Compensation
16	Federal
19	Worker's Compensation Set-aside
41	Black Lung
43	Disability
44	Liability Insurance Medicare Set-aside
45	No-Fault Insurance Medicare Set-aside
47	Liability

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



noridian
Healthcare Solutions

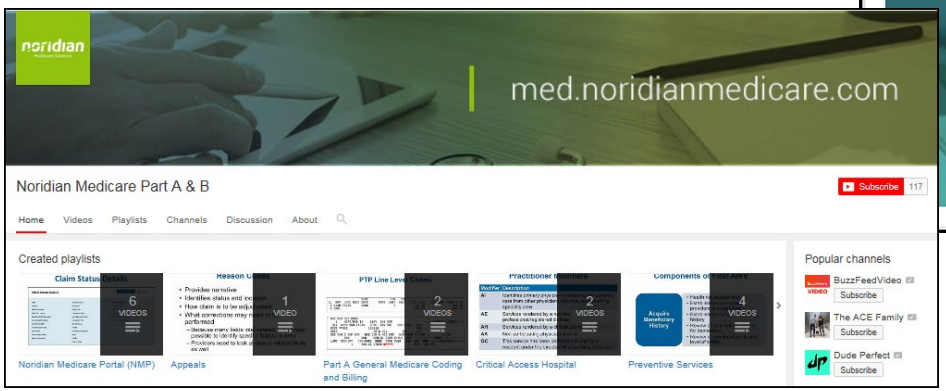
Education Team

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

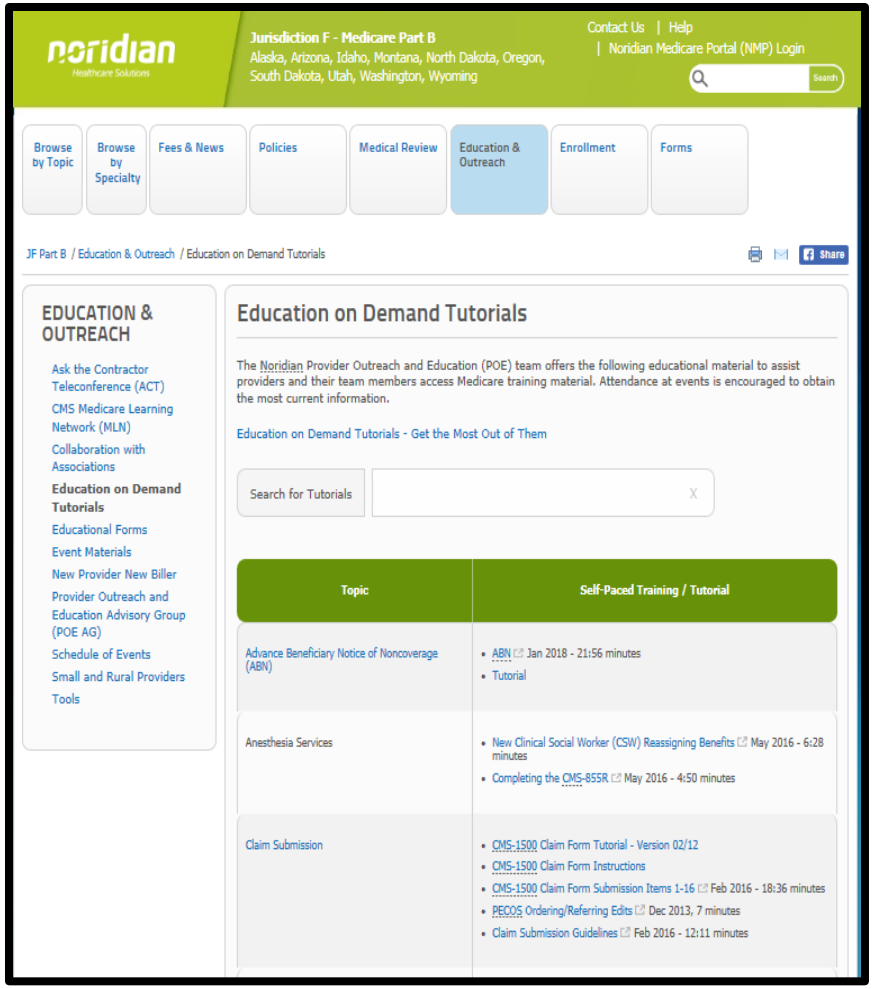


Upcoming Webinars

- 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

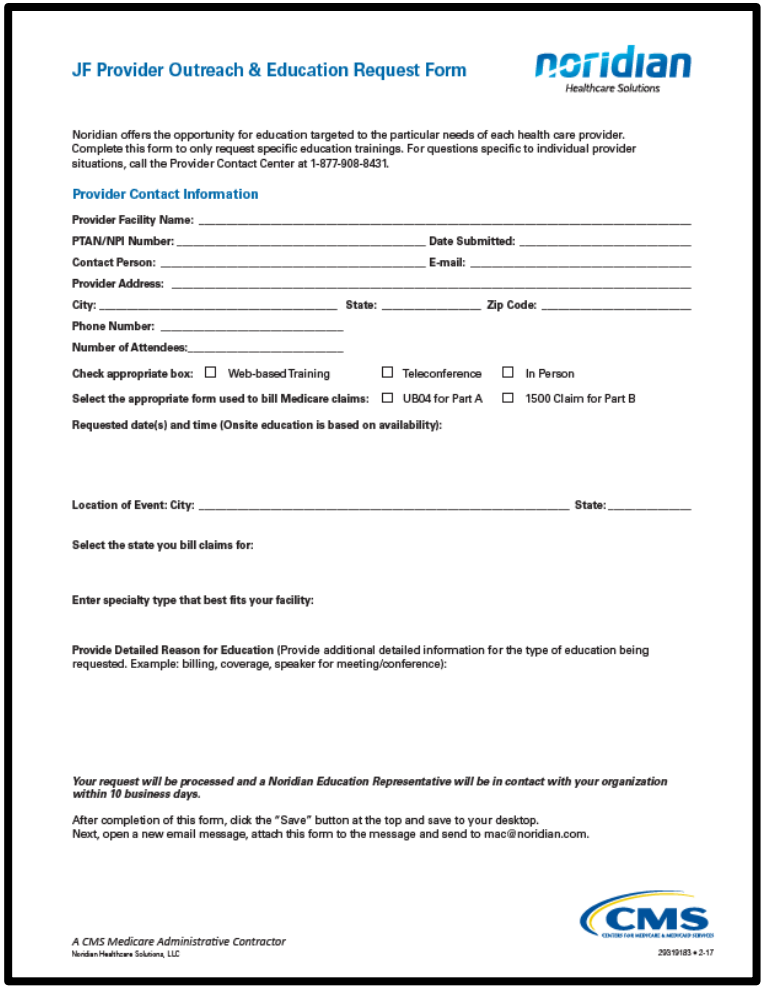
Online Provider Education

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



Provider Outreach & Education Request Form

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



JF Provider Outreach & Education Request Form

noridian Healthcare Solutions

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.

A CMS Medicare Administrative Contractor

Noridian Healthcare Solutions, LLC

CMS

29519183 • 2-17

noridian
Healthcare Solutions

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Questions?

Thank you!