Corporate Structure

- **GudeWell Source**
  - (100% interest)

- **First Coast Service Options (First Coast)**
  - Formed in 1998 as a for profit, Florida corporation
  - Primarily focused on performing Medicare program administration for CMS as a Medicare Administrative Contractor (MAC)

- **Novitas Solutions (Novitas)**
  - Formed in 2006 as a for profit, Pennsylvania corporation
  - Primarily focused on performing Medicare program administration for CMS as a MAC

- **TriCenturion (TriC)**
  - (50% interest)
  - Formed in 1998 as a for profit, Delaware LLC (subsequently converted to a corporation)
  - Primarily focused on performing anti-fraud work for CMS as a Program Safeguards Contractor
Involved in Medicare administration since the inception of the program nearly 50 years ago

Novitas incorporated as separate subsidiary in 1998

Novitas currently serves as the Medicare Administrative Contractor (MAC) for JH (AK, CO, LA, MI, NM, OK, and TX) and JL (PA, NJ, MD, DE and DC)

Novitas is also the administrator of the nationwide Section 1011 contract (federal reimbursement of emergency services provided to undocumented aliens)

Recently awarded Marketplace contract
MAC Jurisdictions

Consolidated A/B MAC Jurisdictions
## Jurisdiction Level Statistics

<table>
<thead>
<tr>
<th>STATISTIC</th>
<th>JURISDICTION L * (DC, DE, MD, NJ and PA)</th>
<th>JURISDICTION H ** (AR, CO, LA, OK, MS, NM and TX)</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Claims Processed</td>
<td>113 million</td>
<td>151 million</td>
<td>264 million</td>
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<tr>
<td>Annual Claims Payments</td>
<td>$39 billion</td>
<td>$47 billion</td>
<td>$86 billion</td>
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<tr>
<td>Medicare Providers</td>
<td>102,031</td>
<td>112,999</td>
<td>215,030</td>
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<tr>
<td>Medicare Hospitals</td>
<td>533</td>
<td>1,209</td>
<td>1,742</td>
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<tr>
<td>Medicare Fee-For-Service Beneficiaries</td>
<td>3,767,742</td>
<td>5,211,967</td>
<td>8,979,709</td>
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<tr>
<td>Percent of National Part A/B Workload</td>
<td>10.9%</td>
<td>13.2%</td>
<td>24.1%</td>
</tr>
</tbody>
</table>


Medicare Administrative Contractor (MAC):

- Claims Processing and Payment
- Redeterminations on appeals of claims
- Customer Service
- Provider Enrollment
- Program Integrity (Medical Review, Error Prevention, Informatics, ZPIC Support)
- Provider Outreach and Education
- Provider Audit and Reimbursement
- Benefits Accounting
- Medical Policy
- Electronic Data Interchange
MAC Functions:

- Claims Processing and Payment:
  - Process traditional fee-for-service Medicare claims, except durable medical equipment and home health
- Redeterminations on appeals of claims:
  - Process first level provider and beneficiary appeals of initial claim determinations
- Customer Service:
  - Provide service to Medicare providers via interactive voice response (IVR), written, critical and telephone inquiries
- Provider Enrollment:
  - Handle initial enrollment applications, change of information and reassignments for the provider community
MAC Functions (cont’d):

• Program Integrity:
  ✓ Perform data analysis and medical review activities on both a pre-payment and post-payment basis to improve claims payment accuracy; error prevention; Zone Program Integrity Contractor (ZPIC) and law enforcement support.

• Provider Outreach and Education:
  ✓ Develop data driven provider education programs; maintain websites and portal; support operations with data analysis.

• Provider Audit and Reimbursement:
  ✓ Ensure the accurate fee-for-service reimbursement for Part A providers by setting interim payment rates and auditing provider cost reports; includes hospitals, skilled nursing facilities, community mental health centers and renal dialysis facilities.
MAC Functions (cont’d)

• Benefits Accounting:
  ✓ Perform provider and beneficiary collection and referral activities for claim overpayments

• Medical Policy:
  ✓ Create and revise Local Coverage Determinations (LCDs) and Local Coverage Articles, participate in Administrative Law Judge hearings, handle local contractor pricing

• Electronic Data Interchange (EDI):
  ✓ Promote and encourage EDI through electronic means such as the Novitasphere Portal, PC-ACE, Medicare Remit Easy Print (MREP), PC-Print, and Electronic Remittance Advices (ERAs)
Medicare Administrative Contractors

The Hub of the Medicare Fee-for-Service Program

MACs and 8 of CMS’ Functional Contractors

- Recovery Auditors (RAs)
- Qualified Independent Contractors (QICs)
- Medicare Secondary Payer Recovery Contractor (MSPRC)
- Zone Program Integrity Contractors (ZPICs)
- Beneficiary Contact Center (BCC)
- Enterprise Data Centers (EDCs)
- Quality Improvement Organization (QIO)
- Healthcare Integrated General Ledger Accounting System (HIGLAS)
Beneficiary Contact Center (BCC):
  • 1-800-MEDICARE - Answer beneficiary inquiries

Zone Program Integrity Contractor/Program Safeguard Contractor (ZPIC/PSC):
  • Use data sources to develop Medicare fraud referrals to law enforcement; prepayment medical record review; support law enforcement investigations (Zone 7)
  • Fraud investigations

Qualified Independent Contractor (QIC):
  • Handles reconsideration level (C2C Solutions)

Administrative Law Judge (ALJ):
  • Handles appeals after the QIC
Coordinating with other Contractors

- Comprehensive Error Rate Testing program (CERT):
  - Determine Medicare claims processing accuracy
  - Estimates payment error rate and dollars

- Recovery Auditor (RA):
  - Reduce Medicare improper payments mainly through post pay recoupments (do some prepay reviews)
  - Use data analysis and review of medical records to identify improper Medicare claim payments

- Supplemental Medical Review Contractor (SMRC):
  - Medical review activities
Coordination with other Contractors

- Quality Improvement Organization (QIO):
  - Improve the effectiveness, efficiency, economy and quality of services delivered to Medicare beneficiaries
  - Quality of care issues
- Healthcare Integrated General Ledger and Account System (HIGLAS):
  - General ledger accounting system for Medicare benefit payments
- Benefits Coordination & Recovery Center (BCRC):
  - Recovers overpayments where Medicare is not primary payer
- Enterprise Data Center (EDC):
  - Serves as platform for claims processing software systems for Medicare claims
Provider Audit Update

Steven Holubowicz, Sr. Director
Topics

- Questions Raised by Providers
- Recent Changes in Novitas Audit
- Wage Index
- PS&R Problems
- MAC Developments – (non-cost report)
- Medicare SSI Percentages
What is the audit process of the Medicare cost report and timeline?

- All hospital cost reports are desk reviewed
- Audit selection process requires CMS approval
- Desk review process:
  - CMS checklist and a list of exceptions is maintained – providers have three weeks
  - Contacts provider for resolution or adjustment – providers generally have two weeks to respond
- Audit process:
  - Engagement letter (4-6 weeks notice)
  - Pre-exit is last day of field work or when preliminary adjustments are presented
  - Additional documentation is due within 4 weeks of the pre-exit conference
  - The final exit conference will be a maximum of 12 weeks after the pre-exit conference
Questions Raised by Providers

- These are general timelines, but there CMS has required some cost reports be held due:
  - SSI Holds
  - PS&R issues (negative charges or RAC adjustments at PIP providers)
  - Bankruptcy
  - CMS request

- Also reference CMS Pub 100-06, Chapter 8 – Contractor Procedures for Provider Audits

- Who reviews the audit before preparation of the NPR?
  - Desk Reviews – senior auditor, or team lead, or manager;
  - Audits – audit manager; or both team lead and audit manager
Why do the auditors NPR a cost report they know has an issue and tell us to reopen at a later date instead of correcting the issue before NPR?

- NPR deadlines closely monitored by CMS and Novitas is required to meet the timeliness deadlines
- Contractors workload and budget:
  - We are extremely constricted when it comes to fitting in additional hours. If a reopening is requested we can budget those hours in the next CLIN period.
- CMS written instructions:
  - Allows contractors to not consider documentation submitted after established timeframes in the initial NPR issuance. If a reopening is later granted or a timely appeal filed, the late documentation may be considered at that time.
Questions Raised by Providers

How are you handling the “Hospital Acquired Condition” (HAC) adjustment?

• Definition of HAC:
  ✓ Medical errors or serous infections patients contract while in the hospital.
  ✓ The bottom 20% of hospitals are subject to the HAC

• Effective for discharges after October 1, 2014
• Cost report exhibit 5
• Revision of Tentatives of FYE December 31, 2014:
  ✓ Due to timing of the HAC adjustment, we are going back to issue second tentatives if the impact exceeds $10,000
How are you handling the “Payment Adjustment for Medicare Eligible Hospitals and CAHs that are not meaningful users of EHR technology”? 

- American Recovery and Reinvestment Act of 2009:
  - Mandates that payment adjustments be applied to eligible hospitals that could not qualify as a meaningful user
  - The payment adjustment will be applied beginning today, October 1, 2015 for all Medicare eligible hospitals
  - The 50% reduction will be applied to the percentage increase of the update to the IPPS standardized amount
  - CMS has identified the hospitals that are subject to the 2016 negative payment adjustment
  - Novitas mailed the letter to all impacted hospitals by September 16, 2015
  - An appeals process is outlined in the letter
Recent Changes in Novitas Provider Audit

- Client Letter for Correspondence:
  - Standardized across all eight audit offices
  - Pulls contact information from STAR, if your contacts are outdated you need to notify us.
  - Eliminates the need for a second overpayment letter. NPR letter and overpayment letter have been merged.

- Paisley for Audit Workpapers:
  - Started in April, 2015 all electronic workpapers

- New Audit Manager in Jacksonville Office:
  - Nicole Boyer (904) 363-5414
Wage Index Timeline Summary:

- November 4, 2015 – MAC notification to State Hospital Associations for failure to respond
- November 13, 2015 – Complete all Wage Index desk reviews as well as transmission all the HCRIS to CMS/DAC
- February 16, 2016 – Deadline for MACs to receive requests and documentation to show mishandling or incorrect MAC adjustments:
  - No new data or backup should be included with this request
Wage Index Timeline Summary (cont’d):

- March 24, 2016 – MACs submit final revised HCRIS wage data to CMS/DAC as well as and send written responses to requests received by February 16, 2016 noted above
- April 5, 2016 – Deadline for Hospitals to appeal to CMS (appeals go to CMS, not MAC)
- May 23, 2016 – Deadline for Hospitals to submit corrections for mishandling of data submitted prior to February 16, 2016 and not in April 21, 2016 posting to CMS website
Pension expense timing change:

- FY 2017 index and all future years to be based on pension contributions in base cost report year plus the prior two years:
  
  ✓ Therefore the defined benefit pension costs used for FY 2016 are the same as for FY 2017, and MACs shall ensure that the defined benefit pension amount from FY 2016 is carried over to FY 2017

  ✓ Providers may request a revision for 2017, if the hospital did not include the defined benefit pension costs in 2016
Negative Charges on PS&R:

- If negative ancillary charges exceed $10,000, the cost report settlement is held until this is resolved.
- The PS&R maintainer is aware of this issue and currently they do not have a time-frame for a resolution.
- CMS has directed a hold on settlement because the provider would be underpaid.
RAC / PIP Hospitals:

- Definition of Issue:
  - Claim adjustments from a RAC audit are not accurately captured in PS&R
  - Cost reports are currently held, to avoid an underpayment

- Hospitals on Periodic Interim Payment (PIP):
  - PIP hospitals are on hold if outlier payments are out of balance:
    - PS&R - compare the “Outlier payments” to the “Actual Claim Payments PIP field in the PS&R”
    - If they agree, we can proceed to settlement
    - If they are out of balance, CMS has directed us to hold pending the PS&R maintainers creating a fix
MAC Developments – (non-cost report)

- MAC contracting update:
  - H.R. 2 – Medicare Access and CHIP Reauthorization Act:
    - Contains a provision that allows CMS the flexibility to extend current and future contracts for up to ten years
    - Yearly renewal options will remain tied to contractor performance
    - Prior law required a rebid every five years
MAC Developments – (non-cost report)

- Provider Enrollment – Major Changes in the next five-year round of Revalidations:
  - Email becomes primary communication vehicle
  - MACs will drive the revalidation mailing schedule
  - Monthly systematic deactivation for non-billing (12 month):
    - Reduced provider response timeframes and MAC contacts before payment pend/deactivation occurs
    - No reopenings once deactivated; new number assigned
    - New workflow design assumes MACs have OCR capability
    - Extensive new PECOS, MCS, and FISS automation/capability
    - Transition to an “expiration date” model
Introducing Novitasphere (web portal):

- Targeting a role out in Spring of 2016
- Allows providers to file the annual cost report and all supporting documentation electronically
- Officer certification is the only exception
- Eliminates lost or misplaced data
- Significantly reduces PHI or PII risk
- Will include incoming and outgoing documentation exchange between registered providers
- Looking for beta test group volunteers
Baystate v Leavitt - the district court ordered CMS to recalculate the SSI percentage:

- District court concluded that CMS did not use the best data available in determination of the SSI rate
- CMS did not appeal
On April 29, 2010 Ruling 1498R was issued, addressing three recurring issues:

- The data matching process used to calculate the SSI fraction
- Exclusion from the Disproportionate Patient Percentage ("DPP") of non-covered Inpatient hospital days for patients entitled to Medicare Part A and days for which the Patient’s Part A inpatient hospital days were exhausted
- Exclusion of Labor and Delivery days from the DPP
- The ruling states that the PRRB and other Medicare appeals and tribunals lack jurisdiction over bullets 1 and 2 and ordered the Medicare contractors to resolve each properly pending appeal related to the SSI fraction by applying a suitably revised matching process for recalculating the DSH payment.
Relief on appeals is handled through the remand process. Provider representatives will be required to request either a standard or alternative remand from the PRRB on each issue:

- The PRRB then remands the issue back to the MAC to resolve

On April 22, 2015 Ruling 1498R2 was issued:

- Ruling impacted only the Medicare SSI fractions and the interaction between SSI fractions that were revised to address the data matching process issue
- In effect CMS has effectively revised the SSI percentage for cost reports with a FYE 2004 and earlier
Challenges:

- Volume is extremely high and much of the information will come from other MACs as many of the remands are group appeals
- Many of the cost reports are very old (back as far as 1986) and some of them do not have adequate cost report software
- Fiscal Intermediary and MAC transitions:
  - Transitions within transitions
  - Need to find cost report workpapers as far back as 1986
  - CMS is considering alternatives
Questions?
Provider Outreach and Education Update

Teresa Tatum, Provider Outreach and Education Specialist
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- Novitas Solutions does not permit videotaping or audio recording of training events.

INNOVATION IN ACTION
Novitas Solutions, Inc.

- Medicare Administrative Contractor for Jurisdiction H (JH)
- Specific to providers in JH include: Arkansas, Colorado, Louisiana, Mississippi, New Mexico, Oklahoma, and Texas
- This education contains specific contractor guidance:
  - If you are not a provider in JH, please contact your Medicare contractor for specific guidance
Agenda and Objectives

- **Agenda:**
  - Medicare Updates
  - Novitas Initiatives
  - Comprehensive Error Rate Testing (CERT) Program
  - Provider Resources

- **Objectives:**
  - Identify and understand the current Medicare changes
  - Learn how to apply the new guidelines
  - Identify and utilize the education resources and information
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
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<tbody>
<tr>
<td>CERT</td>
<td>Comprehensive Error Rate Testing</td>
</tr>
<tr>
<td>CMS</td>
<td>Centers of Medicare &amp; Medicaid Services</td>
</tr>
<tr>
<td>EDI</td>
<td>Electronic Data Interchange</td>
</tr>
<tr>
<td>ICD</td>
<td>International Classification of Diseases, 10th Edition</td>
</tr>
<tr>
<td>IPPS</td>
<td>Inpatient Prospective Payment System</td>
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<tr>
<td>LCD</td>
<td>Local Coverage Determination</td>
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<tr>
<td>MLN</td>
<td>Medicare Learning Network</td>
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<tr>
<td>OPPS</td>
<td>Outpatient Prospective Payment System</td>
</tr>
<tr>
<td>PCS</td>
<td>Procedure Coding System</td>
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</table>
MEDICARE UPDATES
Mandatory payment reduction of 2% continues through March 31, 2016:

- For more information:
ICD-10 PCS – Special Edition Article SE 1519:

- Key points:
  - Effective October 1, 2015
  - Used for reporting inpatient hospital procedures
  - Section X New Technology Separate section for certain new procedures:
    - Found in the ICD-10 PCS index or the tables

- Reference:
Includes communications sent to providers:
  • ICD-10 readiness and flexibility

Provides additional in-person training through the “Road to 10” for small physician practices.

Establishes Ombudsman for physicians and other providers

Advises there will be no penalties on 2015 quality reports
Get Ready for ICD-10

- Coding must be consistent with LCD or NCD policy
- Coverage policies that currently require a specific diagnosis under ICD-9 will continue to require a specific diagnosis under ICD-10
- Codes must be valid, carried out to the highest level of specificity
- Maintain emphasis on coding productivity
- No medical review denials the first year related to coding errors:
  - Applicable for services paid under the Medicare Fee-for-Service Part B physician fee schedule
References

- CMS and AMA news release:

- CMS and AMA news release FAQs:

- Clarifying FAQs from CMS and AMA news release:

- CMS letter to Medicare providers, July 7, 2015:
Tools and Fact Sheets

- ICD-10 Fact Sheets:
  - Intro Guide to ICD-10
  - The ICD-10 Transition
  - ICD-10 Basics for Medical Practices
  - Talking to Your Vendors About ICD-10: Tips for Medical Practices
  - ICD-10 and CMS eHealth: What’s the Connection?
  - Online ICD-10 Implementation Guide
  - ICD-10 CM/PCS Billing and Payment FAQs
Tools and Fact Sheets

- ICD-10 Quick Start Guide
- ICD-10 Infographic
- ICD-10 Website Wheel Educational Tool:
  - http://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html
- CMS sponsored ICD-10 teleconferences:
- MedScape modules:
  - http://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html
Tools and Fact Sheets

- Novitas Website:

- Information and Resources for Submitting Correct ICD-10 Codes to Medicare:
Billing Instructions for Fee-For-Service Claims that Span the ICD-10 Implementation Date

- Special Edition Article SE1325:
  - Only claims that span this single implementation date (October 1, 2015) will be impacted
  - Split claims for an encounter spanning the ICD-10 implementation date, maintain all charges with the same Line Item Date of Service (LIDOS) on the correct corresponding claim for the encounter
  - Single item services whose time-frame cross over midnight on September 30, 2015 (e.g., Emergency Room Visits and Observation), are not split into 2 separate charges, rather the single item service should be placed in the claim based upon the LIDOS
Update of the Hospital Outpatient Prospective Payment System (OPPS)

- Change Request 9298:
  - Effective - October 1, 2015
  - Implementation - October 5, 2015
  - New Separately Payable Procedure Code C9743
  - Use HCPCS code Q9977 to report compounded drug combinations
  - Coding Guidance for Intraocular or Periocular Injections of Combinations of Anti-Inflammatory Drugs and Antibiotics
Place of Service Codes (POS) for Outpatient Hospitals

- Change Request 9231:
  - Effective: January 1, 2016
  - Implementation: January 4, 2016
  - POS 19 Off Campus--Outpatient Hospital
  - POS 22 On Campus-Outpatient Hospital
  - POS 17 Walk-in Retail Health Clinic
  - POS 26 Military Treatment Facility
Partial Hospitalization Program (PHP) Claims Coding & CY2015 per Diem Payment Rates

- Special Edition Article SE1512:
  - CY 2015 final corrected per diem payment rates for PHP services
Change Request 8926:

- Effective: October 1, 2013
- Implementation: October 5, 2015
- Model 4 of the BPCI provides a prospectively determined bundled payment to the hospital that encompasses all services furnished during the inpatient stay by the hospital, physicians, and other practitioners
- In order for Part B claims to be processed correctly when the associated Part A claim has been denied as not medically necessary, instructs FISS to remove the demonstration code 64 so that the claim will process, close out the Model 4 episode, and allow the Part B claims to process
Modifiers for Distinct Procedural Services

- Change Request 8863:
  - Effective: January 1, 2015
  - Implementation: January 5, 2015
  - Four new modifiers to define specific subsets of the 59 modifier:
    - XE Separate Encounter
    - XS Separate Structure
    - XP Separate Practitioner
    - XU Unusual Non-Overlapping Service
Use of Modifier 59 after January 1, 2015

- Special Edition Article SE1503:
  - Effective: January 1, 2015
  - Implementation: January 5, 2015
  - Providers may continue to use modifier 59 when appropriate
  - Modifiers XE, XP, XS or XU may be used in place of modifier 59
  - Additional guidance and education forthcoming from CMS
  - Inquiries about the new X modifiers:
    ✓ NCCIPTPMUE@cms.hhs.gov
Until CMS provides official guidance, Novitas offers suggestions in this article for the use of the -X {EPSU} modifiers, should you decide to use them:

Timeframe for Response to Additional Documentation Requests (ADR)

- Change Request 8583:
  
  - Effective: April 1, 2015
  
  - Implementation: April 6, 2015
  
  - For prepayment review providers and suppliers have 45 calendar days to respond to an ADR letter
  
  - Failure to respond within 45 days of a pre-payment review ADR will result in denial of the claim(s) related to the ADR
  
Ordering and Certifying Documentation Maintenance Requirements

- Change Request 9112:
  - Effective: July 20, 2015
  - Implementation: July 20, 2015
  - Under 42 CFR § 424.516(f)(1), a provider or supplier that furnishes covered ordered DMEPOS items, clinical laboratory services, imaging services, or covered ordered/certified home health services is required to:
    - Maintain documentation for 7 years from the date of service, and
    - Upon the request of CMS or a Medicare contractor, provide access to that documentation
Requests to Reopen Claims that are Beyond the Claim Filing Timeframes

- **SE1426 Revised, Related CR 8581:**
  - Effective: Claims received on or after January 1, 2016
  - Implementation: January 1, 2016
  - Due to ICD-10 implementation, currently scheduled for October 2015, the NUBC is going to delay implementation of the new bill type and condition codes until January 1, 2016
  - Provide additional information, coding instructions and scenarios for requesting a reopening of a claim that is beyond the filing timeframe
  - Institutional reopenings must be submitted with a “Q” frequency code to identify them as a Reopening
Change Request 9222:

- Effective: October 1, 2015
- Implementation: October 5, 2015
- Contains updates to the payment rates used under the Prospective Payment System (PPS) for Skilled Nursing Facility (SNF) for Fiscal Year (FY) 2016, as required by statute

SE1517 – Reminder to Billing Procedures Related to the Department of Veterans Affairs (VA):


Two-Midnight Rule:

Quarterly/Annual Updates

- Inpatient Rehabilitation Facility (IRF) Annual Update: Prospective Payment System (PPS) Pricer Changes for FY 2015:

- Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Fiscal Year (FY) 2016:

- July 2015 Integrated Outpatient Code Editor (I/OCE) Specifications Version 16.2:
Quarterly/Annual Updates

- Correct Coding Initiative (CCI) Edits, Version 21.3, Effective October 1, 2015:

- Calendar Year (CY) 2015 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment:

- HCPCS Drug/Biological Code Changes - July 2015 Update:

- Claim Status Category and Claim Status Codes Update:
CMS Website

- CMS Internet Only Manuals (IOMs)
- Medicare Learning Network (MLN) Matters Articles
- Open Door Forum
- A full description of the videos are available on the MLN Connects™ Videos web page:
- MLN Connects™ Videos are a part of the Medicare Learning Network®:
NOVITAS INITIATIVES
Website Improvements

- Based on your feedback we continue to improve our website
- Recent website improvements:
  - Content pages now include ‘Last Updated’ date
  - Continued cleanup of outdated documents
  - Quick access rolling banner spotlighting Medicare news
We'd welcome your feedback!

Thank you for visiting Novitas Solutions, Inc. You have been selected to participate in a brief customer satisfaction survey to let us know how we can improve your experience. The feedback you provide will help Novitas Solutions enhance its Web site and serve you better in the future.

The survey is designed to measure your entire experience, please look for it at the conclusion of your visit.

This survey is conducted by an independent company ForeSee, on behalf of the site you are visiting.

No, thanks
Yes, I'll give feedback
Novitas Solutions, Inc. (Novitas) proudly serves as an administrative services processing company for government-sponsored health care programs on behalf of the federal government. We employ more than 1,000 staff in the Mechanicsburg and Harrisburg, Pa. areas. Nearly 1,000 other associates are located in field offices in Hunt Valley, Md.; Pittsburgh and Williamsport, Pa.; Dallas, Texas; Milwaukee, Wis.; and Jacksonville, Fla. Novitas currently administers:

- The Medicare Administrative Contract (MAC) Jurisdiction L (JL), which spans Pennsylvania, New Jersey, Maryland, Delaware and Washington D.C.;
- The Medicare Administrative Contract (MAC) Jurisdiction H (JH), which spans Colorado, Oklahoma, New Mexico, Texas, Arkansas, Louisiana, Mississippi, Indian Health Service (IHS) and Veterans Affairs (VA); and
- The payment processing for the Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens contract, as authorized under Section 1011 of the 2003 Medicare Modernization Act.

Click one of the images below to visit our provider websites for each of our contracts:

**Medicare Administrative Contract Jurisdiction L**

**Medicare Administrative Contract Jurisdiction H**

**Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens Section 1011**

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**Career Opportunities**

View and apply to open Novitas positions here.
Customized Content

Medicare: Jurisdiction H website
Thank you for visiting the Novitas Solutions, Inc. provider website. This website is intended exclusively for Medicare providers and health care industry professionals to find the latest Medicare news. To enable us to present you with customized content, please select your preferences below.

Which best describes you:  ○ HealthCare Professional  ○ Medicare Patient
Which best describes your area of interest:
  ○ Part A: Hospitals & other Facilities
  ○ Part B: Physicians & other health care professionals

Set Preference

*In order to save your preferences, please enable cookies in your browser settings
Updated customized “Policy Search Application” August 14, 2015:
• Current, retired or draft policies
• ICD-9 LCDs and Articles
• ICD-10 LCDs and Articles
• National Coverage Determinations (NCDs)

Gives more search power, more accurate results, the new options allows for search by date of service

Searching LCDs Video:

Policy Search:
Local Coverage Determinations (LCDs) and Articles Updated

- The following LCDs have been revised effective September 11, 2015:
  - Biomarkers Overview (L33638)
  - Intraoperative Neurophysiological Testing (L32605)
  - Outpatient Sleep Studies (L32711)
  - Services That Are Not Reasonable and Necessary (L31686)
  - Treatment of Varicose Veins and Venous Stasis Disease of the Lower Extremities (L32678)

- The following JH Local Coverage Article has been revised:
  - Approved Drugs and Biologicals Includes Cancer Chemotherapeutic Agents (A52018)
The New FISS Training Manual replaces the FISS User Guide

Everything you need to navigate within FISS is now organized in a more user-friendly format with Chapters and Sections

No more scrolling through a large document to find what you need

Novitas Educational Tips and Tools (NETTs)

- Requested documents are created to highlight important Medicare information, claims processing points, and provide details in a manner that is easy to understand and easy to follow.

- These documents will explain the issue; give you a resolution along with tips, background and links to reference information thus providing you, our customer, the necessary tools and access to information with just the click of a mouse.

What’s New For Credit Balance?

- Providers can now fax in both the CMS-838 Certification Pages indicating a zero balance and your CMS-838 Detail Pages when there are credit balances to report.
- It is extremely important that you use the correct version of the CMS-838 Credit Balance Report.
- Typing directly into this version of the form is strongly encouraged to ensure your report is legible.
- Once completed in full, the report should be printed for signatures.
As your Medicare Administrative Contractor, Novitas is responsible to ensure compliance with the Credit Balance reporting process.

The information provided in this article offers a brief explanation of how the CMS-838 Credit Balance Reports should appear before mailing or faxing to Novitas.

Credit Balance Reports Article:

Forms Decision Tree

- Help guide you in making the right choice
- Link to the decision tree:
Medicare Learning Center

Features:
- Create an individualized education account
- Register for webinars, teleconferences, and workshops
- Download your Continuing Education Unit (CEU) Certificates
- Be placed on a waitlist if the educational event you register for is closed

Benefits:
- Centralized location for all educational materials
- Track all of the educational events you’ve attended
- Access Medicare education 24 hours a day, 7 days a week with web-based training modules

Calendar of Events

- Our Education and Training Center offers a wide variety of education
- Join us for Workshops, Teleconferences, and Webinars
Stay Up-to-Date

- **Electronic Mailing List:**
  - Daily E-mail of the latest Medicare Updates

- **Podcast:**
  - Podcast of the latest Medicare Updates and other informative topics

- **Educational Videos and Tutorials:**
COMPREHENSIVE ERROR RATE TESTING (CERT) PROGRAM
Comprehensive Error Rate Testing Program

- Developed by CMS to randomly audit claims monthly to determine if they processed correctly
- To protect the Medicare trust fund and determine error rates nationally and regionally
- A request for medical records from AdvanceMed alerts you that one of your claims has been selected as part of the monthly random sample
- A letter will be sent to your office requesting the medical documentation. You need to comply in a timely manner with the request
- Novitas CERT Center:
Common Errors

- Insufficient documentation:
  - Lacking valid physician’s order
  - Missing documentation to support minimum 15 hours per week of combined therapy
  - Contains insufficient diagnosis to support procedure or service billed
  - Skilled Nursing Facility (SNF) 3 day qualifying stay

- Medical necessity errors:
  - Need for an inpatient stay

- Other errors:
  - Diagnosis Related Group (DRG)
  - Laboratory services
Appeals vs. Claim Adjustments

- We are instructing providers to cease the practice of cancelling and adjusting claims that are selected in the CERT review process:
  - Notify CERT if an error has been made on the claim DO NOT cancel or adjust claims

- When the CERT adjustment has been made in the FISS system, it will appear as an XXH bill type:
  - Once finalized, proper appeals process should be followed to appeal CERT related claims

- Article:
Medicare Signature Requirements - Educational Resources for Health Care Professionals

- Special Edition Article SE1419:
  - Medicare services provided/ordered must be authenticated by the author using an acceptable signature
  - Links to a variety of educational products to help you understand signature requirements for Medicare-covered services
CERT/RA Errors From Compliance Newsletter

- **CERT Errors:**
  - Nasal Endoscopy (physicians and other health care providers)
  - Lithotripsy using extracorporeal shock wave (physicians and other health care providers)
  - Lumbar Spinal Fusion (physicians and suppliers)

- **RA Errors:**
  - Bevacizumab Medical Necessity (outpatient providers)
  - Facility vs. Non-Facility (physicians)
  - Pulmonary Diagnostic Procedures
  - Evaluation & Management (E&M) Services (professional services)
  - Injections of the Tendon,
  - Ligament, Ganglion Cyst, Tunnel Syndromes and Morton’s Neuroma not supported by Diagnosis JE (Previously J1) (professional-physician/nonphysician)
  - Incorrect Billing of Hydration Therapy – OP (outpatient hospitals-unspecified)
Guidance to address billing errors:


Volume 5, Issue 4 – July 2015:

PROVIDER RESOURCES
Customer Contact Information
1-800-252-8782

- Customer Service Representative:
  - Monday - Friday: 8:00 am – 4:00 pm CT/MT

- Interactive Voice Response (IVR):
  - Eligibility and General Information:
    - 24 Hours a day 7 Days a week
  - Full IVR Options:
    - Mondays: 5:00 am – 7:00 pm CT
    - Tuesday – Friday: 3:00 am – 7:00 pm CT
    - Saturdays: 5:00 am – 3:00 pm CT
  - Step-by-Step Guide:
    - JH Part A:
    - JH Part B:
Beneficiary Contact Information

- Patient / Medicare Beneficiary:
  - 1-800-MEDICARE (1-800-633-4227):
Fiscal Intermediary Standard System (FISS) Hours

- Monday – Friday:
  - 5 am – 7pm MT

- Saturday:
  - 5 am – 2pm MT
Appeal Request Forms by Fax

- Important reminders for providers when faxing Part A Redeterminations/Clerical Reopening requests to Novitas:
  - Fax is available 24 hours, 7 days a week: 1-888-541-3829
  - Complete our on-line form, Part A Redetermination and Clerical Error Reopening (Form 1000):
    - Fill in ALL required fields
  - Submit one form for each claim in question
  - Do not copy the form
  - Complete form on website, print and sign
  - Do not submit more than 1,500 pages per fax

- For complete instructions, please reference the online tutorial, completing the Part A Redetermination/Clerical Error Request form:

INNOVATION IN ACTION
Using Internet-based PECOS is Easy!

- Advantages of Internet-based Provider Enrollment Chain and Ownership System (PECOS):
  - Completely paperless process
  - Electronic signature and digital document features available
  - Processed faster than paper-based enrollment
  - Tailored process – you supply only the information relevant to your application
  - More control over your enrollment information, including reassignments
  - Easy to check status and update your information
  - Less time and cost to submit applications to Medicare

- Provider Enrollment Status Inquiry Tool:

- Upcoming Revalidation Mailings:
  - [http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Revalidations.html](http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Revalidations.html)
Summary

- Discussed the current change requests, providing key points and links
- Reviewed the Novitas tools that are helpful in keeping our customers updated
- Provided valuable resources from the CMS and Novitas websites
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Thank you for your participation!