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National Government Services

2019 Medicare Update for CAC Members

October 30, 2019

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Disclaimer

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Agenda

- Introduction Dr. Greg McKinney
- Presentation: Katherine Dunphy
- Topics
- Update on 2020 Proposed Rule
- Medicare Beneficiary Identifier – in place
- Annual Medicare Open Enrollment
- Targeted Probe and Educate Update - Mary King-Maxey
- Appropriate Use Criteria
- PECOS - MFA
- Preventive Services – tis the season
- LCD Reconsideration Process
- 2020 Coding Updates
- NGS Provider Education Programs

Awaiting the Final Rule for 2020

Awaiting release the 2020 Final Rule

Medical Record Documentation which supports Patient Care

- Clear and concise medical record documentation is critical to providing quality care and is necessary for physicians to receive accurate and timely payment.
- Medical records chronologically report the care a patient received and record pertinent facts, findings, and observations about the patient's health history.
- Medical record documentation helps physicians and other health care professionals evaluate and plan the patient's immediate treatment and monitor the patient's health care overtime.
- Many complain that notes written to comply with coding requirements do not support patient care and keep doctors away from patients

2021 Burden Reduction- Stay Tuned!

- Awaiting the publication of the final rule for 2020.
- CMS did suggest support of the AMA CPT recommendation for changes to E&M codes
- Implementation of blended payment rate for E&M visits levels 2-4 in 2021
- Payment to adjust base E&M visit rate(s) upward to account for visit complexity associated with non-procedural specialty care and primary care
- Payment to adjust base visit rate(s) upward to account for additional resource costs when practitioners need to spend significantly more time with particular patients

Proposed Conversion Factor Changes

- January 1, 2019 - $36.04
  - RVU= physician work, practice expense (rent, equip, supplies), malpractice
  - GPCI= geographic differences (established for each RVU
  - Conversion factor= CF converts RVUs into actual dollar amounts
  - Forecast January 1, 2020 - $36.09

CMS Reducing Provider Burden

Patients Over Paperwork

- Ongoing effort to reduce administrative burden and improve the customer experience, while putting patients first
  - Reduce unnecessary burden
  - Increase efficiencies
  - Improve the beneficiary experience

2019 New and Established Patients for E&M Office/Outpatient Visits

- What parts of the history can be documented by ancillary staff or the beneficiary starting in CY 2019?
  - Practitioners need not re-enter in medical record information on **patient's chief complaint and history** that has already been entered by ancillary staff or beneficiary
  - Policy is to simplify and reduce redundancy in documentation
  - Practitioners may simply indicate in medical record that s/he reviewed and verified the information

Patients Over Paperwork

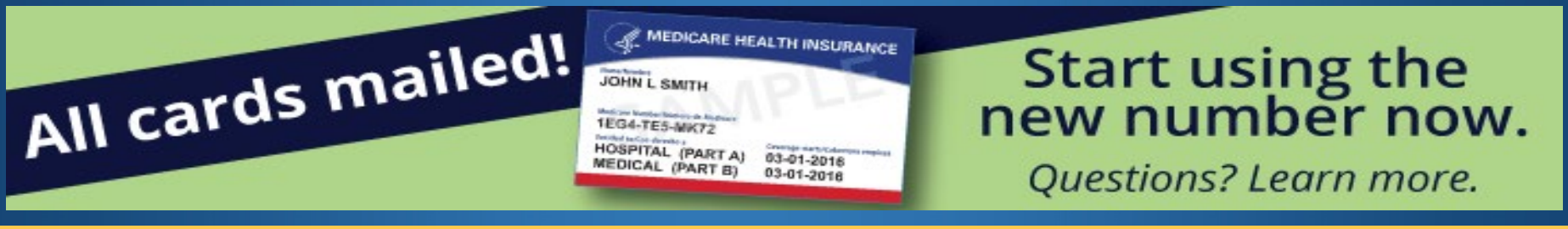
- Simplifying documentation of history and exam for new and established patients E&M office/outpatient visits
  - 99201–99205, 99211–99215, 99221–99223, 99231–99233
  - Clinicians can focus on what has changed since last visit
  - Review and verify rather than re-enter a Chief Complaint or other historical information already recorded by ancillary staff or by patient
  - No longer need to re-record defined list of required elements if there is evidence practitioner reviewed previous information and updated as needed
    - Practitioners should still review prior data, update as necessary, and indicate in medical record that they have done so
  - No longer need to re-enter in medical record information on **patient's chief complaint** and **history** that has already been entered by ancillary staff or beneficiary
    - Simply indicate in medical record reviewed and verified information

CY 2019 E&M Changes

- Eliminating requirement for documenting medical necessity of furnishing visits in patient's home versus in office
  - 99341-99350
  - Removing potentially duplicative requirements of certain notations previously documented by residents or other members
  - No longer need to document the medical necessity of performing an E&M visit in home rather than in office setting

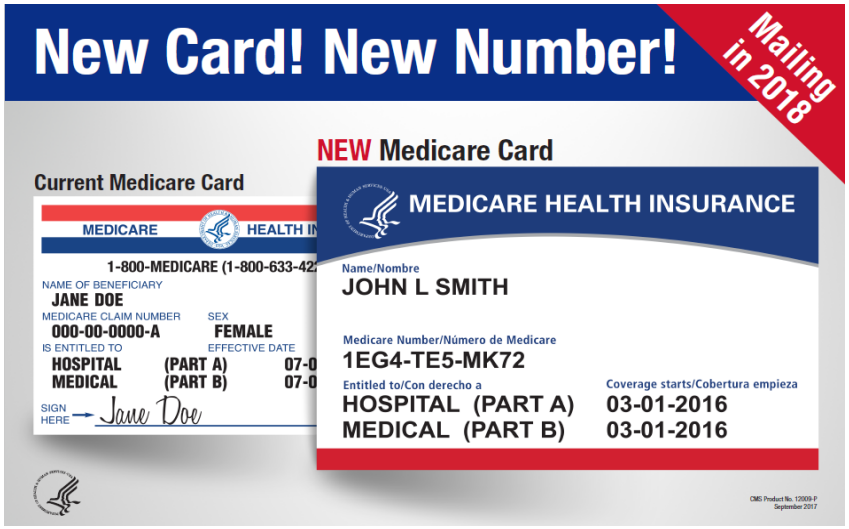
2020 Quality Payment Program

- CMS has made major efforts to streamline and simplify the Quality Payment Program.
- CMS offers direct, customized technical assistance to clinicians in small practices through our Small, Underserved, and Rural Support initiative.
- We also encourage clinicians to contact our Quality Payment Program Service Center for immediate support at 1-866-288-8292 (TTY)
- Contact QPP@cms.hhs.gov and visit the Quality Payment Program website for educational resources, information, upcoming webinars, and an unparalleled user experience.
- Take advantage of contractors working in your states – New England QIN/QIO, IPRO, Lake Superior QIN,

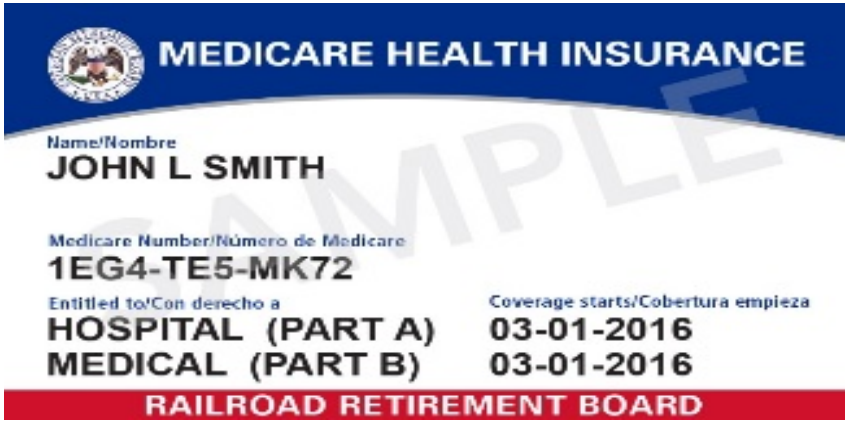


- Transition period through December 31, 2019
  - Medicare will return the MBI on every remittance advice when you submit claims with a valid and active Health Insurance Claim Number (HICN)
- MBI on Remittance Advice (SE1800)

The New Medicare Card Project



Railroad Retiree Example



What's Different?

- SSN is removed
- Signature line is removed
- Patient sex is removed
- 1-800-MEDICARE moved to the back
- No more suffix or prefix
- RRB identified at the bottom
- New card is paper

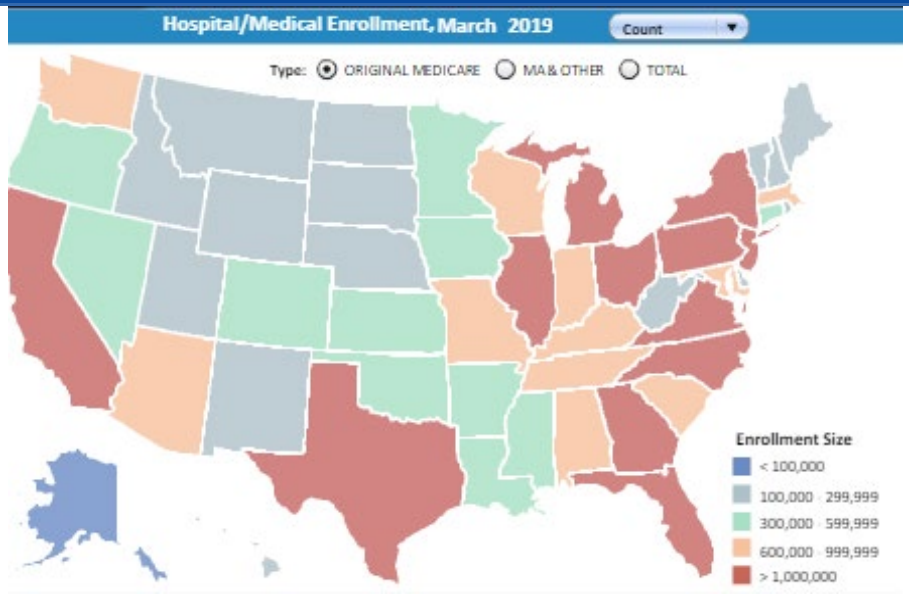
Eligibility Lookup Tool

- Lookup tool available on NGSConnex
  - CMS-required search criteria
    - Patient first name
    - Patient last name
    - Patient date of birth
    - Patient Social Security Number
    - National Provider Identifier
- Remittance Advice
  - MBI will be returned on every remittance advice when you submit claims with a valid and active HICN through the transition period (SE1800)
- Resources
  - Medicare Beneficiary Identifiers (MBIs) web page
  - New Medicare Card Mailing Strategy

Basic Eligibility Checks

- Providers shall check beneficiary's Medicare eligibility frequently
  - ❑Entitled to Medicare Part A, Part B
  - ❑Enrolled in Medicare Advantage (MA)
  - ❑Enrolled with another insurance that is primary over Medicare
  - ❑In open 60-day HH PPS (Home Health Prospective Payment System) episode
  - ❑Prior/current hospice election period
  - ❑Met their deductible requirements
  - ❑Met the therapy cap for the calendar year

Medicare Enrollment Numbers



Year	Month	Original Medicare	Medicare Advantage (MA) and Other Health Plans	Total
2019	March	38,091,004	22,653,699	60,744,703

Basic Eligibility Checks

- Yearly open enrollment
  - Oct 15th–Dec 15th
- Private health plans for members' on Medicare Advantage (MA) plans – have new benefits available
- Be aware of Medicare Supplemental changes
- Screen beneficiaries prior to submitting claims

Use NGS provider self service tools

- IVR or NGSConnex

2019 Medicare Part B Premium and Deductibles

2019 Premium and Deductibles	Amounts
Monthly Part B Premium *Individual income above $85,000 up to $107,000 pay higher part B Premium	$135.50 *$189.60
Part B Deductible	$185
Part B Coinsurance	20%
Mental Health Services	80%
Part A IH Deductible (first 60 days)	$1364
Days 61st -90th Days	$341
Lifetime reserve day	$682
Skilled Nursing Facilities (21st-100th days)	$170.50

2020 Projected Medicare Premium and Deductibles

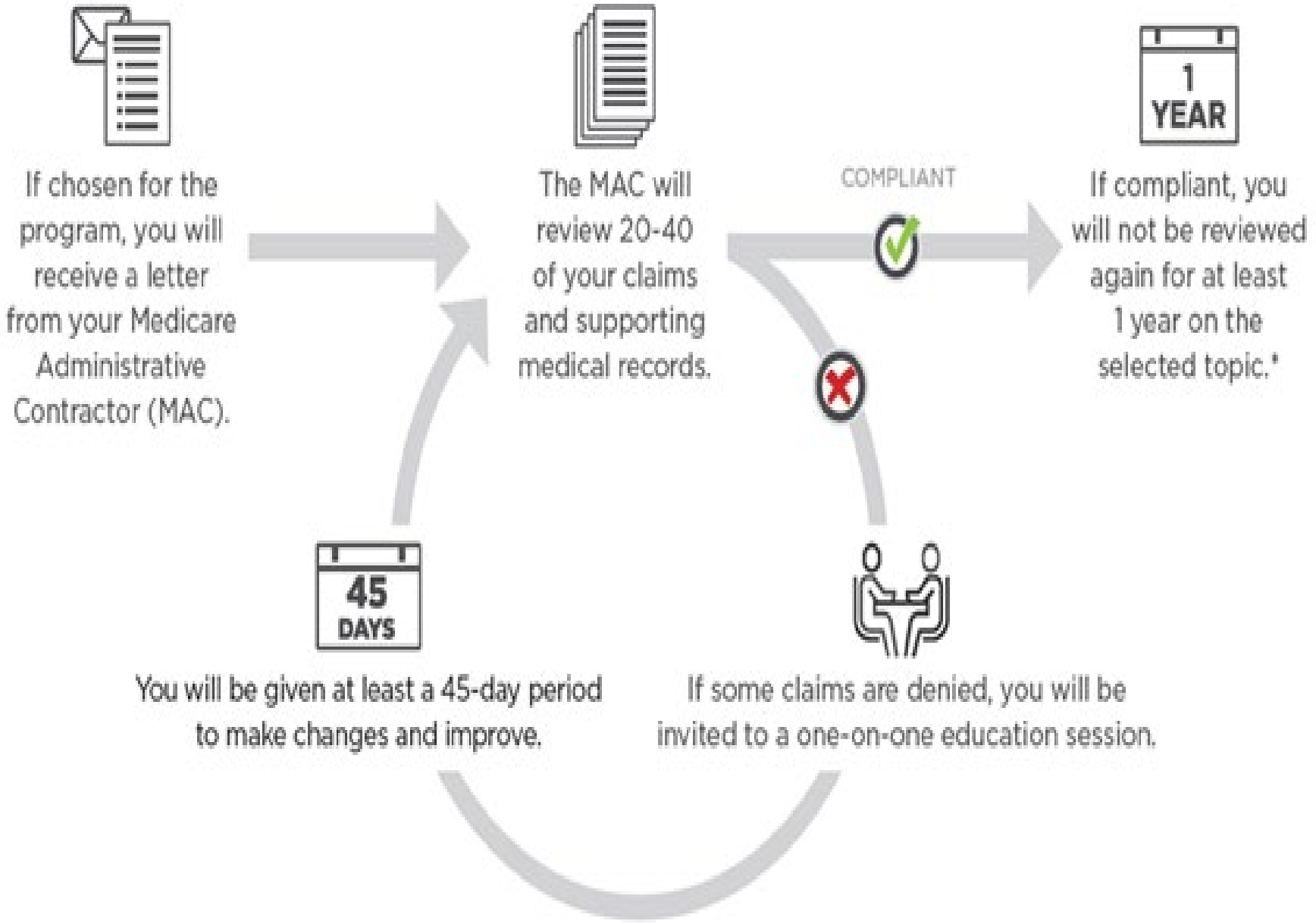
- Increase is forecasted
- Data will be issued by CMS CR
- Stay Tuned….. SSA announced a 1.6% COLA increase

2019 Premium and Deductibles	Amounts
Monthly Part B Premium Individual income above $85,000 up to $107,000 pay higher part B Premium	+
Part B Deductible	+
Part A IH Deductible (first 60 days)	+

Changes to Medicare Supplemental Insurance

- On or after January 1, 2020, Medigap carriers cannot sell policies that provide coverage of the Part B deductible
  - Carriers are prohibited from selling standardized Plans C or F to people "newly eligible" for Medicare
    - Turning 65 as of January 1, 2020, or later
    - Entitled to Part A on the basis of age, disability, or ESRD as of January 1, 2020, or later
  - A person who isn't "newly eligible" for Medicare can apply with a carrier to purchase a Plan C or F and the carrier wouldn't be precluded from selling the policy
  - Carriers may sell Plans C or F to those getting Medicare retroactively with Part A start date before January 1, 2020

Medicare - Targeted Probe and Educate


If chosen for the program, you will receive a letter from your Medicare Administrative Contractor (MAC).
The MAC will review 20-40 of your claims and supporting medical records.
COMPLIANT
If compliant, you will not be reviewed again for at least 1 year on the selected topic.*
1 YEAR
45 DAYS
You will be given at least a 45-day period to make changes and improve.
If some claims are denied, you will be invited to a one-on-one education session.

Targeted Probe and Educate
Great progress – Education is the key

- TPE consists of three rounds, if the provider continues to have a high payment error rate:
  - Round 1 (Initial Probe)
  - Round 2
  - Round 3
- Additional rounds of review will include:
  - 1:1 education with medical review after each round of review
  - Additional development request approximately 45-56 days after the education is complete
  - Detailed results letter

Documentation Request

- Round/Probe
  - ADR between 20-40 claims from the provider
    - Provider notification letter will advise your agency of how many claims will be requested
  - Provider has 45 days to respond to the contractor with medical records
    - This includes mail time and contractor processing time to a medical review location
    - Highly recommend as an internal best practice of sending documentation **within 30 days**
  - No response counts as an error
  - Notification letters and results letters will be sent out in **PINK** envelopes

Medical Review Topics Under Review

- Office Visits
- Nursing Home Visits
- Critical Care Codes
- Hospital Visits
- Chronic Care Management (coming)
- Advanced Care Planning (coming)

Specific Procedures

- Nail Trimming
- Debridement Services

Physical Therapy Services

Ambulance Services

- Basic Life Support
- Ground mileage

Diagnostic Services

- Ophthalmology Testing
- Vitamin D

Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging

Appropriate Use Criteria (AUC) HCPCS Modifier QQ (MM10481)

- Modifier QQ: ordering professional consulted qualified clinical decision support mechanism for this service and related data was provided to furnishing professional
- AUC used when:
  - Furnishing professional is aware of result of ordering professional's consultation with Clinical Decision Support Mechanism (CDSM) for that patient
    - CDSMs are the electronic portals through which practitioners access appropriate use criteria (AUC) during patient workup
    - CDSM will provide ordering professional with determination of whether order adheres, or does not adhere, to AUC, or if there is no AUC applicable. A list of qualified CDSMs is available with MLN Matters MM10481
  - Reported on same claim line as the CPT code for an advanced diagnostic imaging service furnished in an applicable setting and paid for under an applicable payment system
  - Modifiers are reported on both facility and professional claims

Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging

- Starting January 1, 2019
  - Significant hardship criteria in AUC program to include:
    - Insufficient internet access
    - Electronic health record (EHR) or clinical decision support mechanism (CDSM) vendor issues; or
    - Extreme and uncontrollable circumstances
  - Adding independent diagnostic testing facilities (IDTFs) as an applicable setting
  - Allowing consultations performed by clinical staff under direction of ordering professional

Claims Processing Requirements HCPCS Modifier QQ (MM10481)

- Full implementation is expected January 1, 2020
  - Providers are not required to participate and report until full implementation 2020 is a transitional year. 2021 final date
- Ordering practitioner will be required to consult a qualified Clinical Decision Support Mechanism (CDSM)
  - CDSMs are the electronic portals through which practitioners access appropriate use criteria (AUC) during the patient workup
  - CDSM will provide a determination of whether the order adheres, or does not adhere, to AUC, or if there is no AUC applicable
- A list of qualified CDSMs is available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Appropriate-Use-Criteria-Program/index.html
- MLN Matters Number: MM11268

New Access to PECOS

Provider Enrollment
Multi-Factor Authentication in PECOS

- **What is Multi-Factor Authentication?** Multi-Factor Authentication (MFA) is a security system that requires more than one method of authentication from independent categories of credentials to verify the user's identity for a login or other transaction
- **Why is CMS implementing this?** This is to improve identification and authentication security for the four public facing applications I&A, NPPES, PECOS and HITECH, starting with I&A in **September 2019**
- **Existing I&A users:** You will be prompted with an option to set up your MFA devices as you login to your application. You will have a grace period of up to 30 days to delay setting up your MFA devices.
- **New I&A users:** You will be prompted to set up your MFA devices as you set up your account. You will not be able to get an I&A account unless your MFA setup is completed

Use of the PECOS is recommended Assistance and Training!!

- For any questions relating to your I&A MFA setup (Initial setup, MFA login, account reset … etc.) contact EUS Support
- I&A Helpdesk:
  - Website: https://eus.custhelp.com/
  - By E-mail: EUSSupport@cgi.com
  - By Phone: 1-866-484-8049 (TTY/TDD: 1-866-523-4759)
  - www.ngsmedicare.com for Provider Enrollment and Education – weekly webinars

Preventive Services

Flu season Check for correct billing

- 2019 season - increased need for people with Medicare.

- **Administration Code:** G0009
- **Diagnosis Code:** Z23
- We aware of the annual wellness visit (and IPPE) rules

- Seasonal Influenza Vaccines Pricing - attached

Pneumococcal Vaccine

- **Administration Code:** G0009
- **Diagnosis Code:** Z23
- **90670** – Pneumococcal conjugate vaccine, for intramuscular use (initial vaccine)
- **90732** – Pneumococcal polysaccharide vaccine, second pneumococcal vaccine 1 year after the first vaccine was administered (after a full year.)

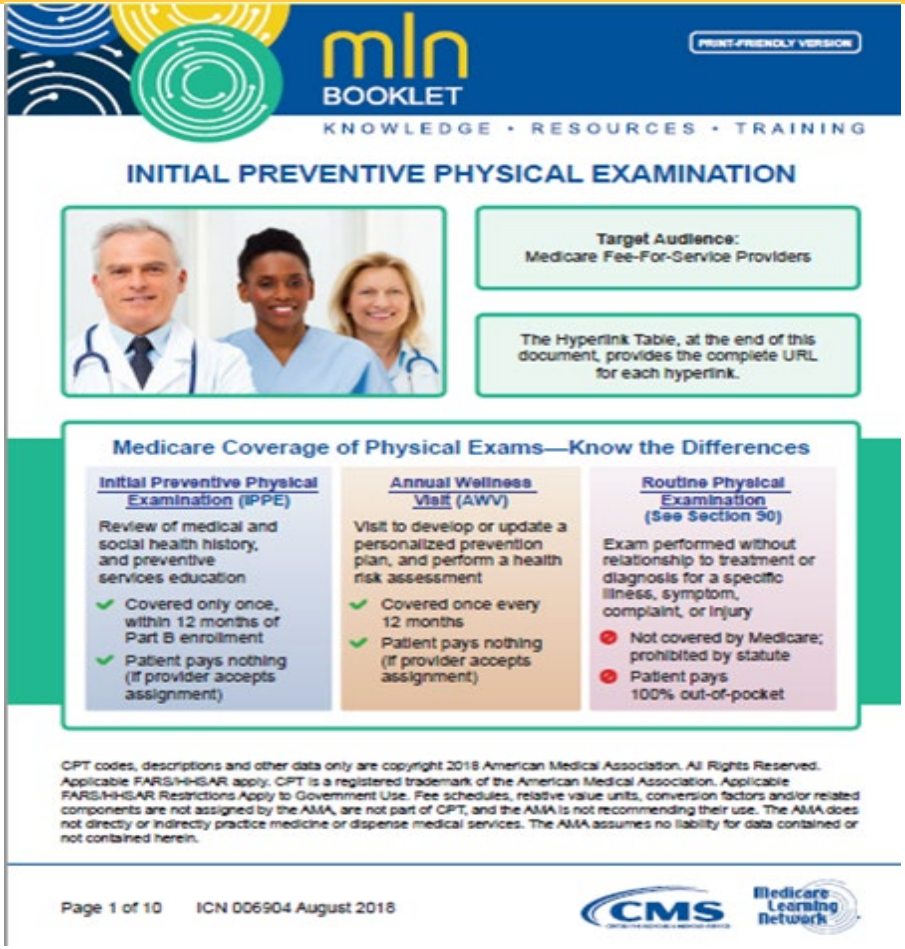
MLN Preventive Booklet
ICN 006559

Preventive Services Educational Tool

- Learn About Codes
- Who is Covered
- Frequency
- What the Beneficiary Pays
- ICD-10-CM Codes

Medicare Coverage of Physical Exams—Know the Differences

- New booklet available – August 2018
- ICN 006904
- Initial Preventive Physical Examination
- Annual Wellness Visit - Billing Tips



mln BOOKLET

KNOWLEDGE • RESOURCES • TRAINING

INITIAL PREVENTIVE PHYSICAL EXAMINATION

Target Audience:
Medicare Fee-For-Service Providers

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

Medicare Coverage of Physical Exams—Know the Differences

Initial Preventive Physical Examination (IPPE)	Annual Wellness Visit (AWV)	Routine Physical Examination (See Section 90)
Review of medical and social health history, and preventive services education	Visit to develop or update a personalized prevention plan, and perform a health risk assessment	Exam performed without relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury
✔ Covered only once, within 12 months of Part B enrollment	✔ Covered once every 12 months	⊘ Not covered by Medicare; prohibited by statute
✔ Patient pays nothing (if provider accepts assignment)	✔ Patient pays nothing (if provider accepts assignment)	⊘ Patient pays 100% out-of-pocket

CMS Medicare Learning Network

Review of Opioid Use during the Initial Preventive Physical Examination (IPPE) and Annual Wellness Visit (AWV) (SE18004)

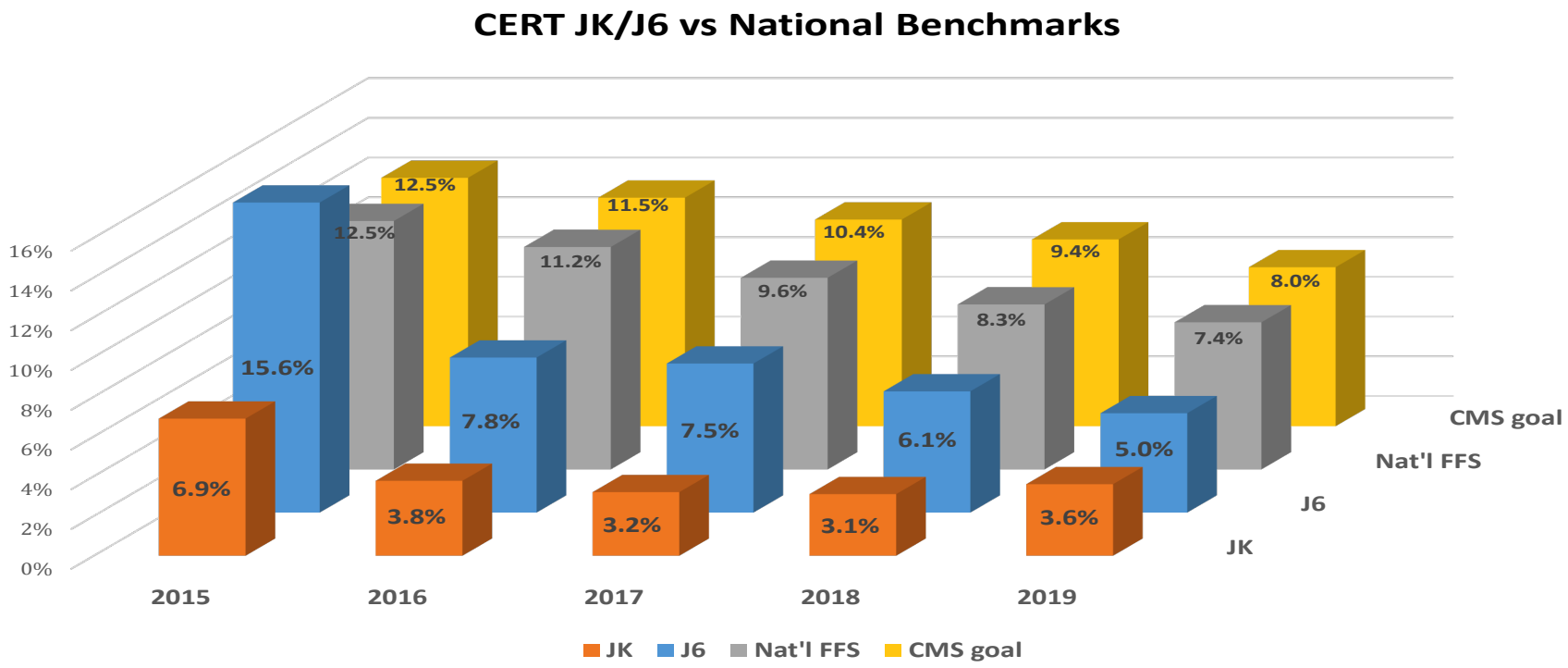
- **IPPE/AWV**
  - Added to review the patient's medical and social history
    - *Medicare would like to emphasize that review of opioid use is a routine component of this element, including OUD. If a patient is using opioids, assess the benefit from other, non-opioid pain therapies instead, even if the patient does not have OUD but is possibly at risk*

Prolonged Preventive Services

- Applies to preventive services performed only in office or outpatient setting
- Requires 30 > minutes of direct patient contact beyond usual service time
  - G0513: Provider must spend at least 15 minutes of time to fulfill the definition of G0513
  - G0514: May not be added until provider completed full 30 minute expectation of G0513 and spent an additional 15 minutes of time into next half hour
- Prolonged time must be medically necessary as supported by patient's condition, limitations or other time-related factor (e.g., need for a translator)
- Medicare Preventive Services ICN 006559

Great progress continues at NGS

JK/J6 NGS CERT Progress



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Article for LCD Reconsideration Process A52842

- Requesting a revision to a **final** LCD
- Submit written request
- Identify language that requestor wants added/deleted from LCD
- Copies of published authoritative evidence
  - Scientific data or research studies published in peer-reviewed medical journals not previously reviewed or listed in sources of information
  - Consensus of expert medical opinion (recognized authorities in the field)
  - Medical opinion derived from consultations with medical associations or other healthcare experts

Reconsideration Process

- **Submission of electronic request is preferred**
  - NGS.lcd.reconsideration@anthem.com
  - Fax: (315) 442-4011
- **Mail to:**
  - National Government Services, Inc.
    Medical Policy Unit
    Attention: LCD Reconsideration Request
    P.O. Box 7108
    Indianapolis, IN 46207-7108

Requesting Addition of ICD-10 Code

- Providers may request that an LCD be **revised** to **add coverage for additional diagnosis codes**
- Does not qualify as a reconsideration
- Can send a request to
  - ✓ NGS.lcd.reconsideration@anthem.com
- Include clinical rationale if no peer-reviewed literature is available
  - Remember no PHI or PII can be sent electronically

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Medical Policy Unit Contact

- Effective June 1, 2018
- Inquiries related to medical policy, including LCDs and clinical questions
  - Submit to our Contractor Medical Director at NGSCMD@anthem.com for clinical issues related to Medicare coverage only
- General inquiries related to Medicare coverage, local and national coverage determinations, billing and reimbursement must be directed to our Provider Contact Center
  - JK 866-837-0241

ICD-10 and Other Coding Revisions to National Coverage Determinations (NCDs) (MM10859)

- Effective January 1, 2020
- Maintenance update of the ICD-10 conversions and other coding updates specific to National Coverage Determinations (NCDs)
  - Changes include newly available codes, coding revisions to NCDs released separately, or coding feedback received

2020 ICD-10-CM October 1, 2019

https://www.cms.gov/Medicare/Coding/ICD10/2020-ICD-10-CM.html

Patients Over Paperwork Moving Forward Together Reducing Provider Burden 4.0

Registration is Open!!!

National Government Services Fall Virtual Event!!!!

November 6 – November 7, 2019

8:30 a.m. – 5:15 p.m. EST

- ✓ **25+ Unique Sessions**
- ✓ *MSP, Telehealth, Incident To, MBI, Top Billing Errors, NCCI, MUEs, NGSConnex and many more!!!* **Register for as many as you'd like!**
- ✓ Part A, Part B, FQHC
- ✓ AAPC CEUs will be offered!

Don't miss out on this educational opportunity!

We look forward to educating you!

National Government Services

Free Webinars-Check Our Calendar!

- NGSConnex
- Provider Enrollment
- Reduce Claims Submissions Errors
- Preventive Services
- Overpayment
- Duplicate Claims
- Appeals

Patients

Over Paperwork Moving Forward Together Reducing Provider Burden 4.0

Visit our Educational Web Page NGSMedicare.com To Register

- Determine and select your Medicare contract business type
- On the provider-specific home page, Click on Education tab located at the top of the page; select the Webinars, Teleconferences & Events link to the right of the web page
- The event sessions are listed in date order; to register click on the "Register," link.
  - ***Note:*** *Materials for the session will be sent to registrants prior to the session.*
- Your registration is complete only when you receive a confirmation at your email address immediately after submitting your registration

Register for as many sessions as you'd like

Each session will be awarded

1.5 Medicare University Credits and AAPC CEUs

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Policy Education Topics

- Ambulance Services
- Billing
- Cardiac
- Chiropractic Services
- Coding and Edits (Including MUEs)
- Diabetes Related
- Documentation
- Drugs and Vaccines
- Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)
- Evaluation and Management
- Global Surgery
- Home Health Benefit
- Incident To Services
- Laboratory Services
- Mental Health Services
- Modifiers
- Opioid Epidemic in America
- Organ Transplant
- Outpatient Observation Services
- RuralServ

Policy Education Topics – Evaluation & Management

- CMS Evaluation and Management Services Guide
- Critical Care Services: CPT Codes 99291-99292
- Definition of New Patient for Billing E&M Services
- E&M Documentation Training Tool
- **Evaluation and Management Frequently Asked Questions**
- E&M Services: 1995 Documentation Guidelines
- E&M Services: 1997 Documentation Guidelines
- Low Vision Services
- Non-physician Practitioners: E&M Services
- Prolonged Services: Face-to-Face
- Prolonged Services: Non-Face-to-Face
- Prolonged Services: Comparative Differences of Face-to-Face/Non-Face-to-Face CPT Codes
- Time-Based Evaluation and Management Services
- General E/M Information / Documentation
- History /Examination/Medical Decision Making
- Admission and Discharge Services
- Split/Shared and Incident To Services
- Observation Services
- Consultations
- Time Based Services
- Prolonged Services
- Chronic Care Management
- Critical Care Services
- IPPE and AWV
- Provider Specialty
- Teaching Environment E/M Services
- Scribes
- Fee-For-Time Compensation Arrangements
- New vs. Established Patients
- Emergency Department
- Separately Identifiable Service
- Global Period Services
- Behavioral Health Services
- Transitional Care Management
- Advanced Care Planning
- Modifiers
- Urgent Care
- Preoperative Clearance

Thank You!

Your questions!