2019 Texas Ambulance Association Annual Conference

April 11, 2019

INNOVATION IN ACTION

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Today's Presentation

- Agenda:
  - News, Updates and Reminders
  - Enrollment Reminders
  - Cycle 2 Revalidation
  - Novitasphere
  - New Instructions for New Local Coverage Determinations (LCDs)
  - Targeted Probe and Educate (TPE) Overview
  - Ambulance TPE Round One and Two Results
  - Ambulance Policy and Requirements for Coverage
  - Overview of Basic Life Support (BLS) Services and Mileage
  - Trip Record Documentation Requirements
  - Physician Certification Statement (PCS)

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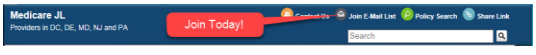
Acronyms

Acronym	Definition
ADR	Additional Development Request
BLS	Basic Life Support
CERT	Comprehensive Error Rate Testing
CMS	Centers of Medicare & Medicaid Services
HCPCS	Healthcare Common Procedure Coding System
MAC	Medicare Administrative Contractor
MLN	Medicare Learning Network
PCS	Physician Certification Statement
PECOS	Provider Enrollment, Chain and Ownership System
RA	Recovery Auditor Contractor
TPE	Targeted Probe and Educate
UPIC	Unified Program Integrity Contractor
ZPIC	Zone Program Integrity Contractor

News and Updates and Reminders

Subscribe to Novitas eNews!



- Receive current updates via email directly from Novitas Solutions:
  - Part A and Part B News
  - Issued every Tuesday and Friday
  - CMS MLN Connects issued Thursdays
- Subscribing is quick and easy:
  - Chick the Join E-Mail List from our website tool bar JH

Remain Enrolled

- A verification e-mail will be sent to you minutes after subscribing:
  - Click "Yes, subscribe me to the list"
- Didn't receive the verification or you stopped receiving eNews:
  - Your network firewall or spam filter is blocking us
  - Please alert your network IT personnel
  - Follow these simple steps to allow eNews:
    - ✓ https://mailchimp.com/about/ips/

New Novitas Learning Center

- Novitas strives to continually improve the services and resources provided to our customers. Our most recent innovation is the redesign of the Novitas Learning Center. Effective January 1, 2019, Novitas Learning Center users observed a few changes:
  - The username previously established to access a Novitas Learning Center account will be replaced by the user's email address.
  - Existing users will log into their account using the email address associated with the user account in the Novitas Learning Center.
  - All users will be prompted to reset their passwords after the January 1, 2019, transition.
    - ✓ Users will only need to reset their password one time.
  - Historical learning information associated with the Novitas Learning Center account will be migrated to the new system for all completed courses.
    - ✓ If a course is still in progress at the time of the transition, it will not be moved to the new system.

Medicare Deductible, Coinsurance and Premium Rates for 2019

- 2019 Part B –Medical Insurance:
  - Deductible: $185.00 a year
  - Coinsurance: 20 percent
- Reference:
  - 2019 Medicare Parts A & B Premiums and Deductibles Fact Sheet

Ambulance Inflation Factor (AIF) for CY 2019 and Productivity Adjustment

- MM11031:
  - Effective: January 1, 2019
  - Implementation: January 7, 2019
- Key Points:
  - AIF for Calendar Year (CY) 2019 is 2.3 percent

Revision of SNF CB Edits for Ambulance Services Rendered to Beneficiaries in a Part A Skilled Nursing Facility Stay

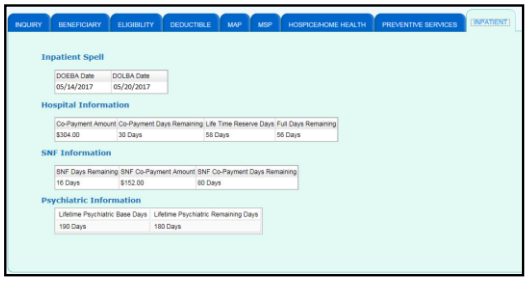
- MM10955:
  - Effective: April 1, 2019
  - Implementation: April 1, 2019
- Key Points:
  - Change Request (CR) 10955 revises the SNF Consolidated Billing (CB) edits to ensure accurate payment of ambulance services rendered to beneficiaries in a covered Part A SNF stay
  - The CR does not contain any new policy and only further revises existing claim system edits to ensure accurate payment of ambulance transports that are included in or excluded from SNF CB
  - Make sure your billing staffs are aware of these revisions

Novitasphere Inpatient Eligibilty

- Part A Hospital Data:
  - Spell Information
  - Lifetime Reserve Days
- Skilled Nursing Facility Spell Information:
  - Date of earliest/latest billing activity for spell of illness
  - Full SNF inpatient days remaining in the spell
  - The SNF inpatient co-payment days remaining
  - Amount of inpatient co-payment
  - If no information populates in the SNF spell fields, the beneficiary has all full and co SNF days available for the dates entered
- Lifetime Psychiatric Base days
- Lifetime Psychiatric Remaining days

Note: This eligibility is based on the most current claims processed

Novitasphere Inpatient Tab



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2019 Amounts in Controversy

Appeal Level	Time Limit for Filing Appeal	Amount in Controversy
Redetermination	120 days	$0.00
Reconsideration	180 days	$0.00
Administrative Law Judge (ALJ) Hearing	60 days	$160.00 for 2018 $160.00 for 2019
Medicare Appeals Council of the Departmental Appeals Board (DAB)	60 days	$0.00
Judicial Review in Federal District Court	60 days	$1600.00 for 2018 $1,630.00 for 2019

- Appeals JH

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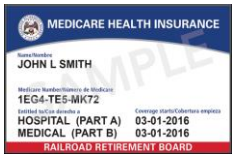
New Medicare Card Design

- New Medicare card:
  - Health and Human Services (HHS) logo
  - Gender and signature line removed

- Railroad Retirement MBI card:
  - Railroad Retirement Board logo will be the key identifier
  - Mailing began June 2018



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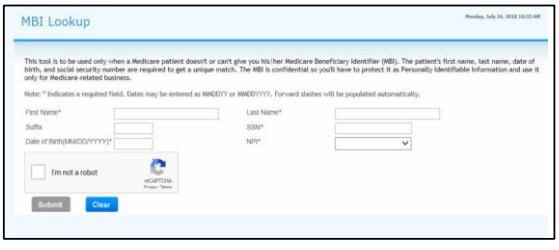
MBI Transition Period

- Transition period April 2018 through December 31, 2019
  - Submit either Medicare number or MBI
- Beginning October 2018 through transition period:
  - When submitting claim using the Medicare number:
    - ✓ Both Medicare number and MBI will be returned on remittance advice
  - MBI will be in same place you currently get the changed Medicare number:
    - ✓ 835 Loop 2100, Segment NM1 (corrected Patient/Insured Name)
    - ✓ Field NM109 (Identification Code)
  - Message field on eligibility transaction responses will indicate when new Medicare card has been mailed to each person
- Medicare number and MBI for the same patient in same batch of claims:
  - During the transition period:
    - All claims with either Medicare number and MBI can be in the same batch

After Transition Period

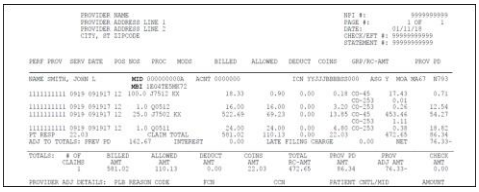
- Effective January 1, 2020, use MBIs on your claims
- Exceptions for Fee-for-Service claims:
  - For audits:
    - ✓ Use either the Medicare number or the MBI for audit purposes
  - For appeals:
    - ✓ Use either Medicare number or MBI for appeals and related forms
  - For claim status query:
    - ✓ Use either the Medicare number or MBI if the earliest date of service is before January 1, 2020
    - ✓ Status of dates of service after January 1, 2020 you have to use the MBI

Novitasphere MBI Lookup



Standard Remittance Advice Example with MBI

- Beginning October 1, 2018 through transition period:
  - MID field will reflect the Medicare identification submitted
  - MBI field will reflect the MBI when a valid and active Medicare number is submitted



PROVIDER NAME
PROVIDER ADDRESS LINE 1
PROVIDER ADDRESS LINE 2
CITY, ST ZIPCODE

NPI #: 9999999999
PAGE #: 1 OF 1
DATE: 01/11/18
CHECK/EFT #: 99999999999
STATEMENT #: 99999999999

PERF PROV	SERV DATE	POS MOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
NAME SMITH, JOHN L		MID 000000000A MBI 1EG4TE5MK72	ACNT 0000000				ICN YYJJJBBBBB2000		ASG Y MOA MEA7 M703	
1111111111	0919 091917 12	100.0 J7512 KX			18.33	0.90	0.00	0.18 CO-45 CO-253	17.43 0.01	0.71
1111111111	0919 091917 12	1.0 Q0512			16.00	16.00	0.00	3.20 CO-253	9.26	12.54
1111111111	0919 091917 12	25.0 J7502 KX			522.49	69.23	0.00	13.85 CO-45 CO-253	453.44 1.11	54.27
1111111111	0919 091917 12	1.0 Q0511			24.00	24.00	0.00	4.80 CO-253	0.38	18.82
PT RESP 22.03		CLAIM TOTAL			581.02	110.13	0.00	22.03	472.65	86.34
ADJ TO TOTALS: PREV PD 142.47		INTEREST			0.00		LATE FILING CHARGE	0.00	NET	74.33-

TOTALS:	# OF CLAIMS	BILLED AMT	ALLOWED AMT	DEDUCT AMT	COINS AMT	TOTAL RC-AMT	PROV PD AMT	PROV ADJ AMT	CHECK AMT
	1	581.02	110.13	0.00	22.03	472.65	86.34	74.33-	0.00

PROVIDER ADJ DETAILS: PLB REASON CODE PCN CCN PATIENT CNTL/MID AMOUNT

I N N O V A T I O N I N A C T I O N

Tips for Using MBI in the IVR

- Trouble using IVR to obtain beneficiary eligibility or claim status using an MBI?
  - When speaking an MBI in the IVR be sure to speak naturally, including normal pauses ever few characters
  - Example:
    - ✓ 1EG-4TE-5MK-72
  - Convert a MBI to a number that can be keyed into the IVR using the IVR Alphanumeric Conversion Tool JH
  - Consider using the Novitasphere for most self service inquiries JH

I N N O V A T I O N I N A C T I O N

Reduction for Non-Emergency BLS Transports to and from ESRD Facilities

- Increased Ambulance Payment Reduction for Non-Emergency Basic Life Support (BLS) Transports to and from Renal Dialysis Facilities:
  - Dates of service on and after October 1, 2018, payment for non-emergency BLS transports to and from renal dialysis treatment facilities will be reduced by 23 percent
  - Payment for emergency transports and non-emergency BLS transports to other destinations (rural and urban) will remain unchanged
  - The reduction will be applied on claim lines containing code A0428 with modifier code “G” or “J”, in either the first position or second position

I N N O V A T I O N I N A C T I O N

Ambulance Zip Code 1500 Claim Form Reporting Reminder

- The 5 digit point of pick up ZIP code is required on all ambulance claims. The ZIP code must be reported in item 23 on the 1500 claim form
- The ZIP code is used for pricing
- More than one ambulance transport may be reported on the same paper claim for a beneficiary if all points of pickup have the same ZIP code
- Suppliers must prepare a separate paper claim for each trip if the points of pickup are located in different ZIP codes
- Effective on or after April 14, 2019, any ambulance claims that the ZIP code is omitted from item 23, will be rejected

Novitas Ambulance Mileage Edits

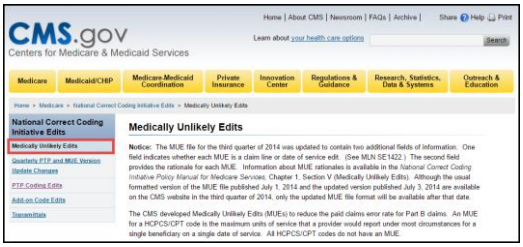
- Novitas began suspending claims received on March 15, 2016 for ambulance mileage billed with a Q/B (Quantity Billed) of 126 or greater:
  - Mileage codes A0425, A0435, and A0436
  - Ambulance claims that do not include sufficient justification/documentation will receive an ADR (Additional Documentation Request)
  - Documentation may be submitted in the:
    - ✓ Appropriate electronic fields
    - ✓ Freeform fields
    - ✓ Claim notes or other forms of documentation
    - ✓ At the time of submission, letter requesting the necessary information/documentation to support the mileage billed beyond 126 miles
- Due to the limited space on the CMS-1500 claim form, supporting documentation may need to be included/attached at the time of submission

Medically Unlikely Edits (MUEs)

- Definition:
  - A MUE for a HCPCS/CPT code is the maximum UOS reported:
    - ✓ For a single beneficiary
    - ✓ On a single date of service
- Purpose:
  - MUEs were developed to reduce the paid claims error rates:
    - ✓ Based on anatomic considerations
    - ✓ CPT instructions
    - ✓ CMS policies
    - ✓ Clinical judgement
- Updated quarterly
- Medically Unlikely Edits

Locating MUE Information

- Medically Unlikely Edits



MUE Table

- Updated quarterly
- Publishes MUE values
- MUE Edits Overview

Practitioner Services MUE Table

- Column A contains the HCPCS/CPT Code
- Column B is the MUE Value representing the maximum units of service
- Column C is the MUE Indicator
- Column D is the MUE Rationale

	A	B	C	D	E
9184	A0392	0	3 Date of Service Edit: Clinical	CMS Policy	
9185	A0394	0	3 Date of Service Edit: Clinical	CMS Policy	
9186	A0396	0	3 Date of Service Edit: Clinical	CMS Policy	
9187	A0398	0	3 Date of Service Edit: Clinical	CMS Policy	
9188	A0420	0	3 Date of Service Edit: Clinical	CMS Policy	
9189	A0422	0	3 Date of Service Edit: Clinical	CMS Policy	
9190	A0424	0	3 Date of Service Edit: Clinical	CMS Policy	
9191	A0425	250	1 Line Edit	Clinical; Data	
9192	A0426	2	3 Date of Service Edit: Clinical	Clinical; Data	
9193	A0427	2	3 Date of Service Edit: Clinical	Clinical; Data	
9194	A0428	4	3 Date of Service Edit: Clinical	Clinical; Data	
9195	A0429	2	3 Date of Service Edit: Clinical	Clinical; Data	
9196	A0430	1	3 Date of Service Edit: Clinical	Clinical; Data	
9197	A0431	1	3 Date of Service Edit: Clinical	Clinical; Data	
9198	A0432	1	3 Date of Service Edit: Clinical	Clinical; Data	
9199	A0433	1	3 Date of Service Edit: Clinical	Clinical; Data	

MUE Indicators

- MAI 1 - claim line edit:
  - Each line is counted by itself
  - Multiple lines of same procedure code under MUE may pay when coded correctly:
- MAI 2 - for all lines submitted on the same date of service:
  - Units billed over MUE are coding errors:
    - ✓ Based on statue or coding guidance
    - ✓ Regulation/sub regulatory instruction (policy)
- MAI 3 - date of service edit:
  - These are "per day edits based on clinical benchmarks":
    - ✓ Appealed additional units are considered if there is adequate documentation of medical necessity

Inquiries for MUE

National Correct Coding Initiative
Correct Coding Solutions, LLC
Attention: Niles R. Rosen, M.D., Medical Director and Linda S. Dietz, RHIA, CCS, CCS-P, Coding Specialist
P.O. Box 907
Carmel, IN 46082-0907
Fax #: 317-571-1745
Email: NCCIPTPMUE@cms.hhs.gov

Office of Inspector General (OIG) Report

- The OIG audited non-emergency claims billed between January 1, 2014 and December 31, 2016 using HCPCS codes A0426 and A0428 and identified 31,441 claims that were improperly billed to destinations not covered by Medicare
- Medicare Improperly Paid Providers for Nonemergency Ambulance Transports to Destinations Not Covered by Medicare
- Medicare made improper payments of $8.7 million to providers for non-emergency ambulance transports to destinations not covered by Medicare, including the identified ground mileage associated with the transports
- Medicare covers ambulance transports to only certain destinations, such as hospitals, skilled nursing facilities (SNFs) and beneficiaries' residences
- Medicare also covers these transports from a SNF to the nearest supplier of medically necessary services (diagnostic or therapeutic sites) when the beneficiary is a SNF resident and those services are not available at the SNF
- The majority of the improperly billed claim lines (59 percent) were for transports to diagnostic or therapeutic sites, other than a physician's office or a hospital, that did not originate from SNFs
- As of the publication of this report, the total improper payment amount of $8.7 million included claim lines outside of the 4-year claim-reopening period

What does the OIG Report Mean

- Overpayments will be conducted by Novitas:
  - Providers will receive an Initial Notice of Overpayment
  - Methods of Repayment on a Solicited Demand
  - Immediate Recoupment as a Means to Repay Medicare Debt:
    - ✓ Can be submitted via the Novitasphere portal or
    - ✓ Faxing the Immediate Recoupment/Offset Request Form
  - Follow the Overpayment guidelines
- Providers/supplies still have the right to appeal
  - Follow the appeals guidelines
    - ✓ Can be submitted via the Novitasphere portal or
    - ✓ Can be faxed using the redetermination form

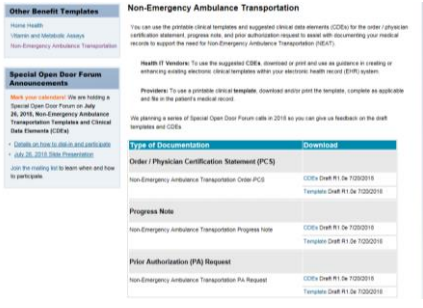
I N N O V A T I O N I N A C T I O N

Non-Emergency Ambulance Transportation (NEAT) Templates and Clinical Data Elements (CDEs) Overview

- A CMS Special Open Door Forum (SODF) was held on July 26, 2018 to allow physicians, provider and supplier professional associations, and/or all other interested parties to provide feedback on the draft Templates and CDEs for NEAT services that are posted on the CMS.gov website
- The printable clinical templates and suggested CDEs describe the data elements that CMS believes would be useful in supporting the documentation requirements for coverage of scheduled and repetitive NEAT services, as follows:
  - Order / Physician Certification Statement (PCS)
  - Progress Note
  - Prior Authorization (PA) Request
- The NEAT Templates and CDEs are be available on the CMS.gov website and can be accessed through the link below:
  - https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and- Systems/Electronic-Clinical-Templates/Other-Benefit-Templates/Other-Templates-Non-Emergency-Ambulance-Transportation.html

I N N O V A T I O N I N A C T I O N

Ambulance Templates



I N N O V A T I O N I N A C T I O N

Non-Emergency Ambulance Transportation (NEAT) Templates and Clinical Data Elements (CDEs) Overview (cont.)

- Providers and vendors can choose whether or not to use the printable clinical templates and/or the suggested CDEs
- The suggested CDEs aren't a form, but a tool that vendors can integrate into electronic health record (EHR) systems to create prompts to assist providers with their medical record documentation for Medicare purposes
- The templates and CDEs are intended to be a helpful guide, but every section may not apply to all types of patients' services
- Providers can choose the information or CDEs that do apply. Once completed by the physician or other practitioner, the resulting documentation would become part of the medical record
- To better assist providers in medical record documentation, for Medicare Fee for Service purposes, CMS has developed lists of clinical elements within a printable clinical template. This development will allow EHR vendors to create prompts to assist the practitioner when documenting
- Feedback and questions on the drafts can be sent to: clinicaltemplates@cms.hhs.gov.

Emergency Triage, Treat, and Transport (ET3) Model

- Background:
  - Currently, Medicare regulations only allow payment for emergency ground ambulance services when individuals are transported to hospitals, critical access hospitals, skilled nursing facilities, and dialysis centers. Most beneficiaries who call 911 with a medical emergency are therefore transported to one of these facilities, and most often to a hospital ED, even when a lower-acuity destination may more appropriately meet an individual's needs
- Emergency Triage, Treat, and Transport (ET3):
  - Is a voluntary, five-year payment model that will provide greater flexibility to ambulance care teams to address emergency health care needs of Medicare beneficiaries following a 911 call
  - Under the ET3 model, the Centers for Medicare & Medicaid Services (CMS) will pay participating ambulance suppliers and providers to:
    - ✓ Transport an individual to a hospital emergency department (ED) or other destination covered under the regulations,
    - ✓ Transport to an alternative destination (such as a primary care doctor's office or an urgent care clinic),or
    - ✓ Provide treatment in place with a qualified health care practitioner, either on the scene or connected using telehealth.
  - The model will:
    - ✓ Allow beneficiaries to access the most appropriate emergency services at the right time and place.
    - ✓ Encourage local governments, their designees, or other entities that operate or have authority over one or more 911 dispatches to promote successful model implementation by establishing a medical triage line for low-acuity 911 calls
  - As a result, the ET3 model aims to improve quality and lower costs by reducing avoidable transports to the ED and unnecessary hospitalizations following those transports

Emergency Triage, Treat, and Transport (ET3) Model Participation

- The key participants of the ET3 model will be Medicare-enrolled ambulance service suppliers and hospital-owned ambulance providers
- In addition, to advance regional alignment, local governments, their designees, or other entities that operate or have authority over one or more 911 dispatches in geographic areas where ambulance suppliers and providers have been selected to participate in the model will have an opportunity to access cooperative agreement funding
- Any individual who calls 911 and is connected to a dispatch system that has incorporated a medical triage line under the model would be screened for eligibility for medical triage services prior to ambulance initiation
- Upon arriving on scene, participating ambulance suppliers and providers may triage Medicare FFS beneficiaries to one of the model's interventions upon ambulance dispatch following a 911 call. As part of a multi-payer alignment strategy, the Innovation Center will encourage ET3 model participants to partner with additional payers, including state Medicaid agencies, to provide similar interventions to all people in their geographic areas

Emergency Triage, Treat, and Transport (ET3) Model Funding

- The Innovation Center anticipates releasing a Request for Applications (RFA) in Summer 2019 to solicit Medicare-enrolled ambulance suppliers and providers
- Once participants have been selected and announced, the Innovation Center anticipates issuing a Notice of Funding Opportunity (NOFO) in Fall 2019 for up to 40 two-year cooperative agreements, available to local governments, their designees, or other entities that operate or have authority over one or more 911 dispatches in geographic locations where ambulance suppliers and providers have been selected to participate
- The Innovation Center anticipates utilizing a phased approach with up to three rounds of RFAs, up to two releases of NOFOs, and staggered performance start dates
- The staged approach across multiple application rounds is designed to advance key design elements of the ET3 model and optimize overall impact, including regional uptake of its innovations and multi-payer alignment

Emergency Triage, Treat, and Transport (ET3) Model Timing and Resources

- Timing:
  - The ET3 model will have a five-year performance period
  - The anticipated start date is January 2020
  - The performance period for all participants, regardless of start date, will end at the same time; thus, only applicants selected through the first RFA will be able to participate through the full five years
- Resources:
  - If you are interested in additional information or have questions about the Emergency Triage, Treat, and Transport (ET3) Model, please contact ET3model@cms.hhs.gov
  - Emergency Triage, Treat, and Transport (ET3) Model - Overview

Enrollment Reminders

Enrollment Information

- Enrollment:
  - There are two ways for providers/suppliers to enroll in the Medicare program:
    - ✓ Paper applications
    - ✓ Provider Enrollment, Chain, and Ownership System
      - ➢ Efficient – faster than completing and submitting a paper enrollment application
      - ➢ Secure – handled through a secure environment that meets all required government security standards
      - ➢ Easy – built in front-end editing and help screens
  - 2019 Application Fee of $586.00 must be paid prior to submitting the application:
    - ✓ Fee applies to Ambulance suppliers:
      - ➢ Initial Enrollment
      - ➢ Revalidation
      - ➢ Addition of Practice Location
- Fee can be paid using PECOS or Pay.gov

I N N O V A T I O N I N A C T I O N

National Site Visit Verification Initiative

- Definition:
  - Screening mechanism used to validate the operational capacity of a site by using pre-determined requirements
- Purpose:
  - Prevent questionable providers/suppliers from enrolling into Medicare
- Below are some of the most common situations where site visits are performed:
  - Provider/Suppliers in the moderate or high screening category
  - Practice location cannot be verified on United States Postal Service
  - Contracted to MSM Security Services LLC
- Medicare Learning Network (MLN) Matters Article: SE1520 – National Site Visit Verification (NSV) Initiative

I N N O V A T I O N I N A C T I O N

Implementation of Fingerprint-Based Background Checks

- Background:
  - As part of the screening provisions in the Affordable Care Act, CMS has implemented fingerprint-based background checks
- Purpose:
  - To perform a fingerprint-based background check on individuals/suppliers:
    - ✓ Who are initially enrolling as a supplier in the high risk category
    - ✓ With a 5 percent or greater ownership interest in a provider or supplier that falls under the high risk category
    - ✓ Who have been elevated to the high risk category for certain reasons identified by CMS
- Contracted to Accurate Biometrics
- Medicare Learning Network (MLN) Matters Article: SE1417 – Implementation of Finger-Based Background Checks

I N N O V A T I O N I N A C T I O N

Timely Reporting of Provider Enrollment Information Changes

- All physicians, non-physicians, physician and non-physician organizations and IDTFs must report the following changes within 30 days:
  - Change of ownership
  - Change of adverse legal action
  - Change in practice location
- All providers and suppliers not previously identified above must report the following changes within 30 days:
  - Change of ownership- including change in authorized/delegated officials:
    - ✓ All other informational changes must be reported within 90 days
- Changes can be reported via the Internet-based PECOS or the CMS-855 paper enrollment application
- Failure to do so could result in the revocation or deactivation of your Medicare billing privileges or payment suspension

Submission Methods

- There are two ways for providers/suppliers to enroll in the Medicare program:
  - Provider Enrollment, Chain, and Ownership System
    - ✓ Efficient – faster than completing and submitting a paper enrollment application
    - ✓ Secure – handled through a secure environment that meets all required government security standards
    - ✓ Easy – built in front-end editing and help screens
  - Paper applications

Internet-Based PECOS

- Definition:
  - Provider Enrollment, Chain, and Ownership System (PECOS) is a CMS established internet-based system online enrollment process
- Purpose:
  - Allows physicians, non-physician practitioners, and provider and supplier organizations/facilities the option of enrolling, making a change in their Medicare enrollment information, or tracking the status of their Medicare enrollment applications throughout the Internet submission process
- Providers must have a web user account (user ID/password) established in the Identity and Access System
- Physicians, Non-Physician practitioners, or users on their behalf will access the Internet-based PECOS with the same user ID and password that is utilized for NPI Registry

Benefits of using PECOS

- Advantages of using PECOS include:
  - Completely paperless process, including electronic signature and Digital Documentation Repository:
    - ✓ Supporting Documentation
  - Faster processing time than paper-based enrollment
  - Tailored application process, only supply information relevant to the application and specialty
  - More control over enrollment information, including reassignments
  - Easy to check and update your information for accuracy
  - Less staff time and administrative costs to complete and submit enrollment to Medicare
  - Check pending Revalidation due date
  - Receive approval letter when application gets approved in PECOS
- We encourage you to use PECOS instead of paper Medicare enrollment applications

Internet-based PECOS Signature Submissions

- For PECOS applications only submit one of the following:
  - Electronic Signature:
    - ✓ Internet-based PECOS allows for the provider or Authorized/Delegated Official to electronically sign the application submission
    - ✓ Ensures for faster processing
  - Upload Certification Statement:
    - ✓ Print the Certification Statement
    - ✓ Upload the Certification Statement as a supporting document

Paper Applications

- Definition:
  - Paper applications are downloaded into hardcopy form, completed and mailed to the contractor in order to facilitate the enrollment process
- Purpose:
  - Enrollment can be facilitated through the submission of CMS-855 Medicare enrollment applications:
    - ✓ Applications are available on Novitas Solutions or CMS website
- It is recommended applications be:
  - Typed
  - Legibly written with ink
- Mail all hardcopy applications along with any supporting documentation:
  - It is recommended that you retain a copy of the application and supporting documentation for your records
- Signatures must be handwritten when mailing in paper applications

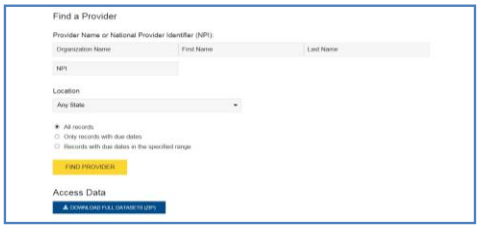
Cycle 2 Revalidation

Due Dates in Cycle 2

- Due dates for Revalidations are displayed on the revalidation lookup tool, if due within six months:
  - "TBD" (To Be Determined) displayed in the due date field for all other providers/suppliers:
    - ✓ Unsolicited revalidation submissions will be returned
  - No extensions of the due date
- Providers/suppliers who are within two months of their listed due date, but have not received a revalidation letter are encouraged to submit their revalidation application
- Revalidation Notices sent via mail:
  - Novitas Solutions will send a revalidation notice three to four months prior to your revalidation due date to at least two of your reported addresses:
    - ✓ Correspondence, special payments and/or your primary practice address

Medicare Revalidation Lookup Tool

- Medicare Revalidation Lookup Tool:
  - Lookup tool for revalidation due dates



Gap in Coverage

- Failure to respond to revalidation request by due date or development request within 30 days:
  - There will be a gap in coverage (no payments) between the date of deactivation and the new Medicare effective date:
    - ✓ Providers/suppliers will maintain their original PTAN
    - ✓ Reactivation date after period of deactivation will be based on the receipt date of the new, full, and complete application
    - ✓ Following the Medicare effective date guidelines, retroactive billing privileges can be granted

INNOVATION IN ACTION

Revalidation Steps

- Steps for existing providers/suppliers to revalidate:
  - Provider/suppliers will be sent a revalidation letter and/or they may look up their due date at data.cms.gov
  - Providers/suppliers need to submit a complete CMS-855 application by Internet—based PECOS or use the appropriate paper application:
    - ✓ Any unsolicited revalidation applications submitted more than six months prior to their due date will be returned
    - ✓ **Revalidation must be selected on the application:**
    - ✓ Failure to select revalidaion will result in deactivation of your Medicare privileges
  - Revalidation application is required to be received by the due date listed on the letter/data.cms.gov website:
    - ✓ Failure to submit the enrollment forms as requested will result in deactivation of your Medicare privileges
  - Send in all required documentation:
    - ✓ The most recent CMS-855 application
    - ✓ All supporting documentation
    - ✓ The CMS-588 Electronic Funds Transfer Agreement (if applicable)

INNOVATION IN ACTION

Enrollment or Revalidation Mailing Address

- Paper enrollment forms and supporting documentation, certification statements/supporting documentation for Internet-based PECOS submitted applications, and other enrollment forms (e.g., CMS-460, CMS-588) must be sent through the U.S. mail to the following addresses:
  - Mailing Address:

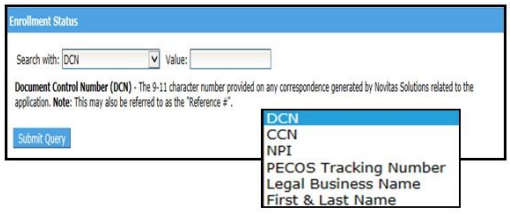
    Novitas Solutions
    Provider Enrollment Services
    P.O. Box 3095
    Mechanicsburg, PA 17055-1813
  - Priority Mail / Commercial Courier:

    Novitas Solutions
    JH Provider Enrollment Services
    2020 Technology Parkway, Suite 100
    Mechanicsburg, PA 17050

INNOVATION IN ACTION

Provider Enrollment Status Inquiry Tool

- Receipt date is the date we receive your Medicare application
- Once uploaded into our system, you will receive a DCN
- Enrollment Status Tool



I N N O V A T I O N I N A C T I O N

Processing Timeframes

Type of Enrollment	Paper Applications	Internet Based Pecos
Initial Enrollments, Revalidations and Reactivations ***Note: Processing timeframes may vary***	60-210 calendar days from receipt 80 percent of applications will be processed within 60 – 80 calendar days	45-120 calendar days from receipt 80 percent of applications will be processed within 45 – 80 calendar days
Reassignments/ Change Requests ***Note: Processing timeframes may vary***	60-120 calendar days from receipt 80 percent of applications will be processed within 60 calendar days	45-90 calendar days from receipt 90 percent of applications will be processed within 45 calendar days

I N N O V A T I O N I N A C T I O N

Top Enrollment Development Trends

I N N O V A T I O N I N A C T I O N

Invalid Signatures Resolution

- Error:
  - Invalid signatures resulting from missing name/date/signature, incorrect date, wrong individual(s) who signed
- Resolution:
  - Signature section is required on each enrollment application at the time of submission:
    - ✓ If the application is for a group/supplier, the signature(s) must be the current Authorized/Delegated Officials
    - ✓ If the application is for an individual, the individual practitioner must sign the application

Missing Supporting Documentation

- Error:
  - Missing supporting documentation
- Resolution:
  - Not all applications require supporting documentation, but if there is supporting documentation:
    - ✓ Mail it in with your paper application
    - ✓ Upload it onto PECOS with your PECOS submission
  - Required documentation:
    - ✓ CMS 588 Electronic Funds Transfer Agreement- Bank letterhead/voided check
    - ✓ Newly enrolling group/supplier- IRS document confirming LBN/EIN
    - ✓ CMS-855B Section 5- organizational flowchart

Legal Business Name Discrepancy

- Error:
  - Legal Business Name on application does not match supporting documentation
- Resolution:
  - Legal Business Name must match exactly:
    - ✓ Enrollment file (if already active)
    - ✓ Application
    - ✓ IRS document
    - ✓ NPI Registry
    - ✓ Voided check/Bank letterhead
  - If submitting through PECOS and Legal Business Name does not fit:
    - ✓ Provide the name exactly until no character space is left

CMS-855B Section 6 Ownership and/or Managing Control Information (Individuals)

- Error:
  - Missing information in Section 6/ missing individuals who should be reported in Section 6
- Resolution:
  - Section 6 individual information required:
    - ✓ First and Last Name
    - ✓ Date of Birth/ Social Security Number
    - ✓ List PTANs and NPI numbers (if issued)
  - Individuals to be reported in this section include:
    - ✓ Persons with more than five percent direct or indirect ownership interest
    - ✓ Officers and directors
    - ✓ Managing employees
    - ✓ Individuals with a partnership interest
    - ✓ Authorized and delegated officials
  - Furnish effective date of ownership/ managing control as applicable

Novitasphere

What is Novitasphere?

- Definition:
  - Free, secured web-based Portal which allows enrolled users access to time-saving features
- Purpose:
  - Allows enrolled users access to Eligibility, MBI Lookup, Claim Information, Remittance Advice, Appeal Requests, Medical Review Records and much more
- For demonstrations and more information on Novitasphere visit:
  - JH Providers

Enrollment Forms

- Step 1: Provider Novitasphere Enrollment form:
  - Providers in JH will complete the 8292PJH
  - Carefully follow the instructions for the completion of your form:
    - Instructions for completing the form (JH)
- Step 1: Billing Service/Clearinghouse Novitasphere Enrollment form:
  - JH Third Party billers will complete the 8291PJH
  - Carefully follow the instructions for the completion of your form:
    - ✓ 8291P/8291PJH instructions

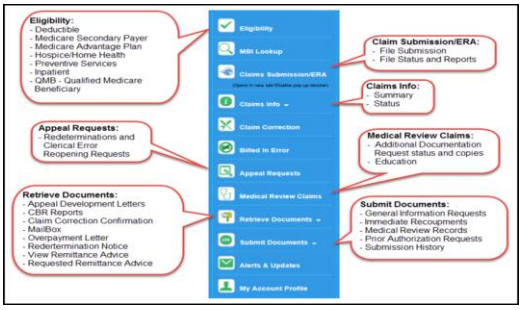
EIDM Registration

- Provides user identity:
  - Ensures only authorized/registered user can access protected information
- Step 2: OA will create a User ID and password
- Step 3: OA will request the appropriate Novitasphere role for access:
  - Register a Multi-Factor Authentication (MFA) Device
- OBA and End Users will enroll for access under organization:
  - OA or OBA MUST approve the EIDM request for End Users
- Novitasphere Frequently Asked Questions:
  - Part B

Keep your Novitasphere Access Active

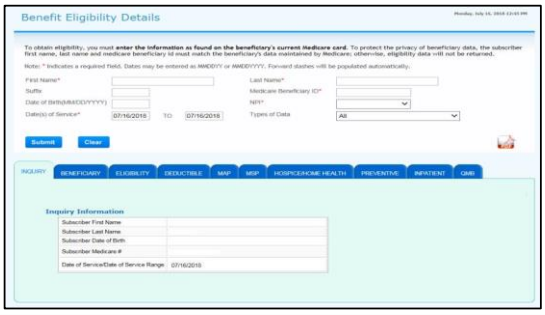
- All users **must** log in at least once every 30 days, or their Novitasphere access will be removed
- If your office is already enrolled, please share this reminder with users in your organization

Novitasphere Feature List



INNOVATION IN ACTION

Eligibility



INNOVATION IN ACTION

Eligibility Information

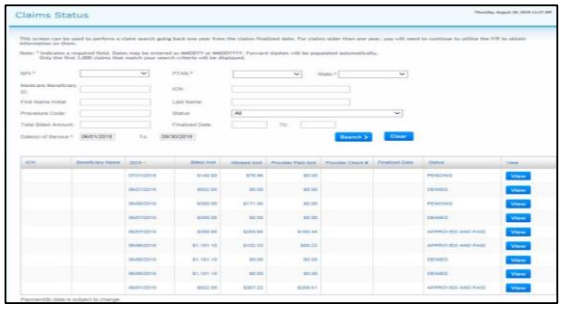
- Eligibility
  - Part A and B Eligibility Effective and Termination Dates
  - End Stage Renal Disease (ESRD) dates and information
- Deductible
  - Part B Total Deductible Remaining for Calendar year
  - Occupational, Physical and Speech Therapy amounts applied to the capitation limits
  - Rehabilitation Session counts
- Medicare Advantage Plan (MAP)
  - Contract Name, Number, Address and Telephone Number
  - Plan number and Plan name
  - Type of Medicare Advantage Plan
  - The Bill Option code of the Plan type
  - Effective and Termination Dates
- Medicare Secondary Payer (MSP)
  - The reason Medicare is secondary
  - Effective and Termination Dates
  - MSP Diagnosis code
  - Name of Insurance Company and Address
- Hospice/Home Health
  - Certification codes and dates
  - Home Health Episode Start and End Dates
  - Home Health Episode termination date
  - Provider NPI Number of the Home Health Facility
- Preventive Services
  - Number of Smoking Sessions remaining
  - Medicare Diabetes Prevention Program (MDPP) usage
  - Preventive Service Procedure Code
  - Preventive Technical and Professional Dates
  - Deductible Applied for the Calendar Year
  - Deductible Remaining for the Calendar Year
  - Coinsurance Remaining for the Calendar Year
- Inpatient
  - Date of earliest and latest billing activity for the spell of illness
  - Hospital Information
  - Skilled Nursing Facility Information
- QMB
  - QMB Effective and Termination Dates
  - QMB Deductible and Coinsurance Remaining QMB Inpatient Spell, Hospital Information and SNF Information

INNOVATION IN ACTION

Claim Submission/ERA

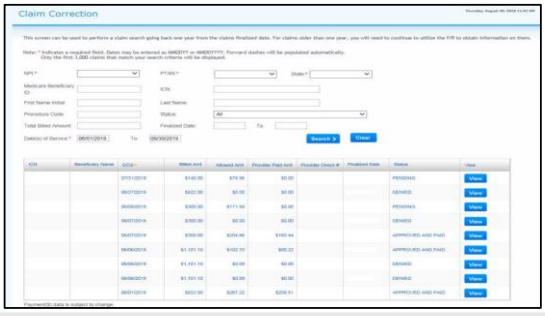
INNOVATION IN ACTION

Claims Status



INNOVATION IN ACTION

Claim Correction



INNOVATION IN ACTION

When the Claim Corrections Feature can be Utilized

- The following common clerical errors can be corrected on finalized claims and certain previously reopened adjusted claims through the Novitasphere Claim Correction feature:
  - Change the referring provider name and NPI
  - Changes to the number of services or units
  - Add or change the claim diagnosis codes
  - Add, change, or delete certain modifiers
  - Procedure code changes
  - Date of service changes
  - Place of service changes
  - Billed amount charges
  - History corrections

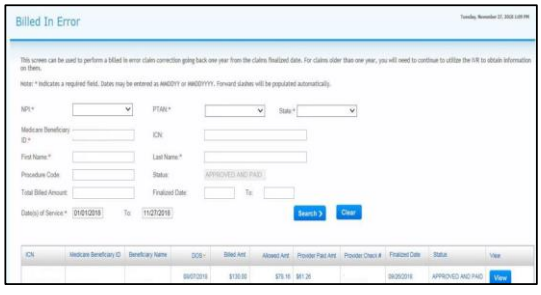
I N N O V A T I O N I N A C T I O N

History Corrections

- History Corrections - Reprocess an entire claim for the following scenarios only:
  - The beneficiary's record has been corrected to indicate:
    - ✓ Medicare is now primary for the date(s) of service of the denied claim
    - ✓ The beneficiary is entitled to Medicare Part B for the date(s) of service of the denied claim
    - ✓ The beneficiary's Hospice election period no longer conflicts with the date(s) of service of the denied claim
    - ✓ The beneficiary is no longer covered by a Medicare Advantage Plan for the date(s) of service on the denied claim
  - Medically Unlikely Edits (MUE) denials involving two claims that were submitted at the same time; resulting in a MUE denial along with a duplicate claim denial

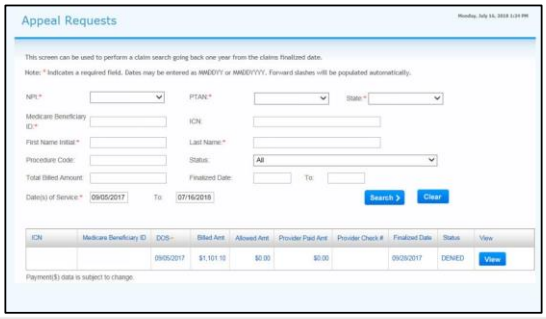
I N N O V A T I O N I N A C T I O N

Billed in Error



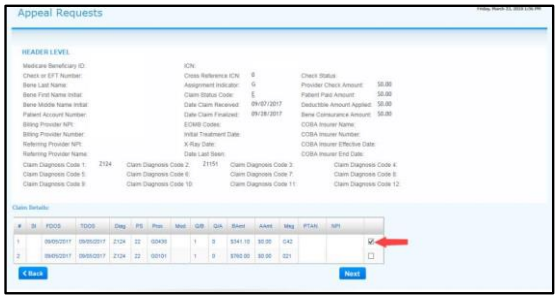
I N N O V A T I O N I N A C T I O N

Appeal Requests



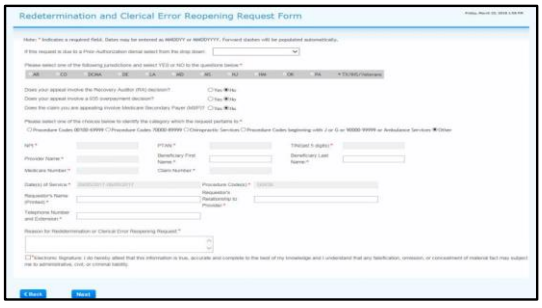
INNOVATION IN ACTION

Appeal Request – Select Lines



INNOVATION IN ACTION

Redetermination and Clerical Error Reopening Request Form

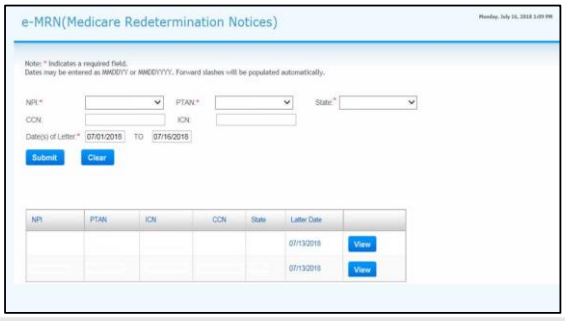


INNOVATION IN ACTION

Appeal Requests File Upload

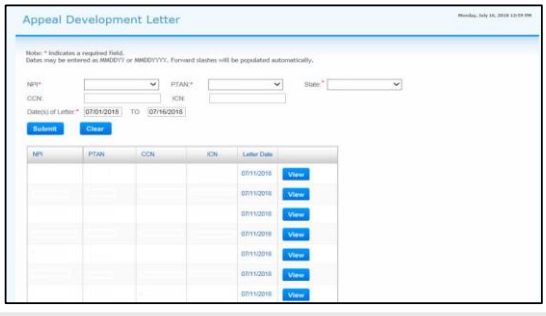
INNOVATION IN ACTION

Redetermination Notice



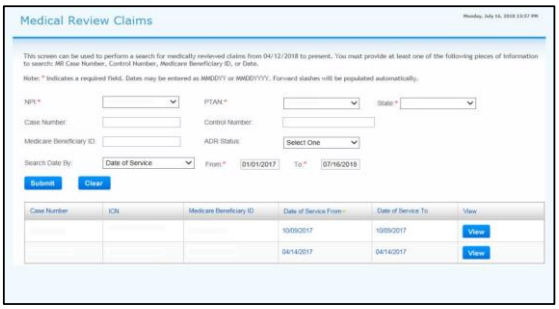
INNOVATION IN ACTION

Retrieve Documents - Appeal Development Letter



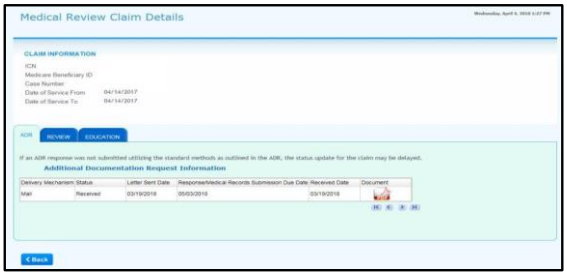
INNOVATION IN ACTION

Medical Review Claims



INNOVATION IN ACTION

Additional Documentation Request (ADR) Tab



INNOVATION IN ACTION

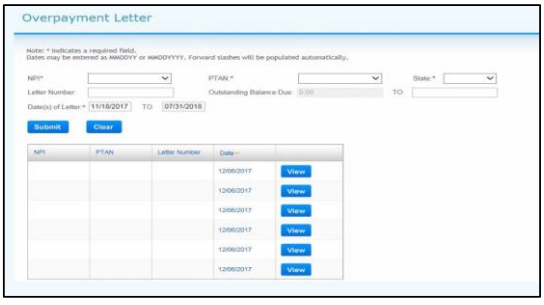
Review Tab

INNOVATION IN ACTION

Education Tab

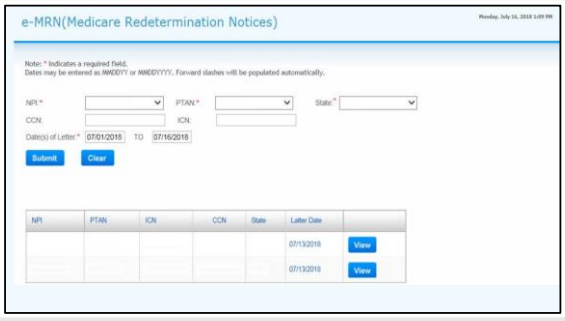
INNOVATION IN ACTION

Overpayment Letter



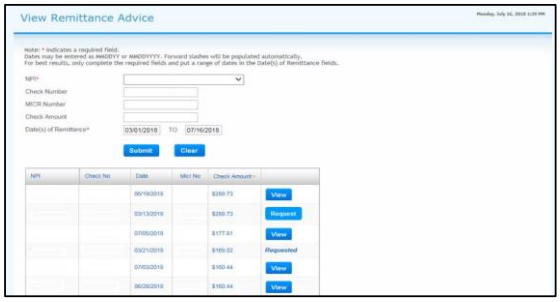
INNOVATION IN ACTION

Redetermination Notice



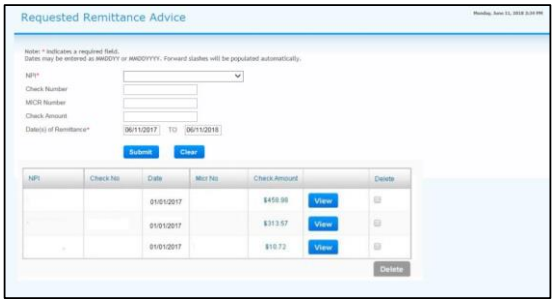
INNOVATION IN ACTION

View Remittance Advice



INNOVATION IN ACTION

Requested Remittance Advices

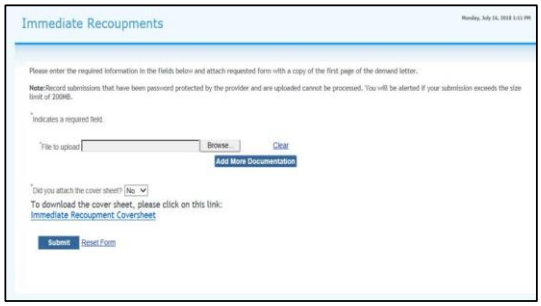


INNOVATION IN ACTION

Submit Documents - General Information Requests

INNOVATION IN ACTION

Immediate Recoupments



Coming in 2019

- Provider Enrollment Welcome Letters (A&B)
- Appeal Redetermination Status (A&B)
- Financial Information (B)

New Instructions for New Local Coverage Determinations (LCDs)

Introduction

- Background:
  - According to Section 1862(a)(1) of the Social Security Act, the CMS and its contractors may develop standards outlining what is "reasonable and necessary" for coverage under Medicare
- Purpose:
  - LCDs are administrative and educational tools to assist providers in submitting correct claims
- Overview:
  - MM10901 provides detailed changes to LCD process beginning January 8, 2019
  - Help to increase transparency, clarity, consistency, reduce provider burden and improve public relations while retaining ability to be responsive to local clinical and coverage policy concerns

INNOVATION IN ACTION

Summary of Changes

- Requests for New LCDs:
  - Informal meetings
- Purpose of CAC:
  - CAC members
- Minor changes to Open meetings
- Comment and Notice period changes
- Waitlist/Prioritization Process
- All coding being removed from LCDs and added to companion coding articles

INNOVATION IN ACTION

Requirements For a New LCD

- New LCD Request can be from:
  - Beneficiaries residing or receiving care in JH
  - Health care professions doing business in JH
  - Any interested party doing business in JH
- Requirements of a valid request for a new LCD:
  - Must be in writing
  - Clearly identifies the statutorily-defined Medicare benefit category the requester believes the item/service applies
  - Identifies the language wanted in LCD
  - Includes justification supported by peer-reviewed evidence:
    - ✓ Full copies of published evidence must be included or request is invalid
  - Addresses the relevance, usefulness, clinical health outcomes, or medical benefits of the item/service
  - Fully explains the design, purpose and/or method, as appropriate, of using the item/service
- Optional informal meeting conducted via teleconference for customers to discuss how to submit valid new LCD request

INNOVATION IN ACTION

New LCD Process

- Materials will be reviewed within 60 calendar days to determine whether request is complete or incomplete:
  - If incomplete, response will be sent in writing explaining why request was incomplete
  - If complete, process will be followed as outlined in Medicare Program Integrity Manual 100-08, chapter 13 – Local Coverage Determination, section 13.2
- Experts clinical guidelines, consensus documents and consultation will be summarized and included in the proposed draft and final

Waitlist/Prioritization Process

- Valid requests for new LCDs will be added to an internal waitlist and will be prioritized for development

Contractor Advisory Committee (CAC) Meetings

- Formal mechanism for healthcare professionals to be informed of the evidence used in developing the LCD and promote communications with healthcare community:
  - CAC members will also include non-physician healthcare professionals such as Dentist, Certified Registered Nurse Anesthetist (CRNA), Physical Therapist (PT) and Licensed Clinical Social Worker (LCSW)
- Meetings will be open to interested parties to observe:
  - Locations and times will be posted to our website
- One CAC meeting will be held per jurisdiction:
  - CAC members from each state will be invited to attend

Open Meetings

- Combine JH and JL meeting to discuss the review of the evidence and rationale for proposed LCDs with stakeholders after draft LCD is made public
- Presentations can be made related to the proposed LCDs by providers, physicians, vendors, manufacturers, beneficiaries, caregivers, any interested parties
- Interested parties may also request to attend as an observer and members of CAC may also attend
- Dates and locations will be posted to our website
- For security purposes, only registered participants will be allowed into the meeting
- Anyone who is not registered under their own name will not be permitted to attend
- Open Meetings

Comment Period

- Open comment periods of 45 calendar days for public comment for each new LCD:
  - Comments can be mailed, faxed or emailed to Novitas:
    - ✓ Do not send multiples of same comment via different formats
- In the past, we've allowed extra time for notice periods, but going forward all comment periods will end on day 45
- After comment period ends; all comments are reviewed by Contractor Medical Directors (CMDs):
  - Summary and response document posted to website also when final LCDs are posted for notice

Notice Period

- After all comments are considered and revisions made as needed, effective date follows minimum notice period of 45 calendar days:
  - Future effective date
- In the past, we've allowed extra time for notice periods, but going forward all notice periods will end on day 45
- Medicare Coverage Database

Summarization of the New Instructions for New LCDs

- Optional informal teleconference to discuss how to submit a request for new LCD
- Will consider all new LCD requests from beneficiaries, healthcare professions and any interest party doing business in jurisdiction
- All CAC meetings will be open to the public to attend and observe
- CAC members will now also include members who are non-physician healthcare professionals
- Comment and Notice period will end on day 45
- Waitlist/Prioritization Process

New Instructions for LCD Reconsideration Request

Introduction of Reconsideration Request

- Purpose:
  - A mechanism by which a beneficiary or stakeholder can request a revision to an LCD
- Overview:
  - Reconsideration process differs from an initial request in that it is only available for final effective LCDs
    - Whole LCD or any provision of LCD may be reconsidered
    - Novitas has discretion to revise or retire LCDs at any time

LCD Reconsideration Process

- Reconsideration can be from:
  - Beneficiaries residing or receiving car in JH and/or JL
  - Providers doing business in JH and/or JL
  - Any interested party doing business in JH and/or JL
- Can only accept reconsideration requests on final LCDs
- Whole LCD or any provision of LCD may be reconsidered
- Must be submitted in writing
- Must identify language that requestor wants added or deleted
- Must include justification supported by new evidence:
  - Copies of published evidence must be full text articles
- LCD Reconsideration Process JH

Reconsideration Process

- Cannot accept a LCD reconsiderations request on:
  - NCDs
  - Coverage provisions in interpretive manuals
  - Proposed LCDs
  - Retired LCDs
  - Individual claim determinations
  - Bulletins, articles, training materials

The LCD Reconsideration Request

- Materials will be reviewed within 60 calendar days to determine whether request is valid or invalid:
  - If invalid, response will be sent in writing explaining why request was invalid
  - If valid, process will be followed as outlined for a new LCD or included on waitlist:
    - ✓ Response will be sent in writing notifying of acceptance or on a waitlist
- Change in coverage will require a comment and notice period:
  - In these circumstances, requests will be added to waitlist
  - This change may delay LCD revisions for a reconsideration request

Summarization of New Instructions for LCD Reconsideration Request

- LCD reconsideration request resulting in change in coverage will require a comment and notice period:
  - In these circumstances, requests will be added to waitlist
  - This change may delay LCD revisions for a reconsideration request

Important Changes

Other Important Changes

- Will finalize or retire all proposed LCDs within one calendar year of publication date on Medicare Coverage Database (MCD)
- No longer appropriate to include CPT or ICD-10 codes in LCDs instead they will be placed in billing and coding articles linked to LCD:
  - This process could take up to 1 year to complete
- LCD Reconsideration requests that results in coding updates only, such as adding diagnosis code, will be handled through a revision to the related companion local coverage article:
  - Links will appear at the bottom to the other related documents

Changes to the Ambulance LCD and Article

- Local Coverage Determination (LCD): Ambulance Services (Ground Ambulance) (L35162):
  - Revised and published on 3/21/2019 in response to CR 10901 to remove CPT and ICD-10 codes and national language that is contained in manuals and/or regulations
  - All coding information has been added to the Billing and Coding Ambulance Article Services (Ground Ambulance), A54574
  - There is no change to the coverage indications/limitations content with this revision
- Local Coverage Article: Billing and Coding: Ambulance Services (Ground Ambulance) (A54574):
  - Revised and published on 03/21/2019 to add secondary diagnosis codes and relevant coding and billing direction that was removed from LCD, L35162 Ambulance Services in response to CR 10901

Ambulance Article Group Codes

- ICD-10 Codes that are Covered
  - Group 1 Codes:
    - ✓ Is a list of suggested ICD-10 codes that may be used as a primary diagnosis for transport to acute care, or for the transport on to another facility for specialty or other care
      Please note that a secondary diagnosis code is required. Secondary diagnosis codes are listed in Group 3
  - Group 2 Codes:
    - ✓ Is a list of suggested ICD-10 codes that may be used as a primary diagnosis for post treatment transfer (e.g. transfer to home, nursing facility, SNF, IRF, IPP)

Ambulance Article Group Codes (cont.)

- Group 3 Codes:
  - The following codes are secondary diagnosis codes that must be reported in addition to a primary diagnosis:
    - ✓ Z74.01 Bed confinement status
    - ✓ Z74.3 Need for continuous supervision:
      - ➢ Note: Use code Z74.3 to denote cardiac/hemodynamic monitoring required en route
    - ✓ Z78.1 Physical restraint status:
      - ➢ Note: Use code Z78.1 to denote patient safety: danger to self and others - monitoring other and unspecified reactive psychosis
    - ✓ Z99.89 Dependence on other enabling machines and devices
      - ➢ Note: Use code Z99.89 to denote the need for continuous IV fluid(s), "active airway management", or the need for multiple machines/devices

ICD-10 Codes that are Not Covered

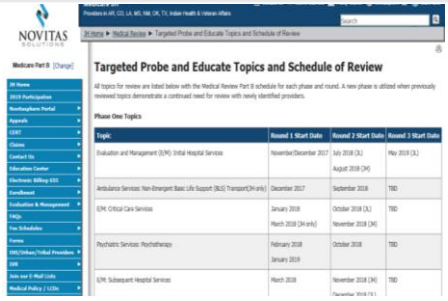
- Z76.89Persons encountering health services in other specified circumstances:
  - Note: Z76.89 should be reported for patients who were transported by ambulance, but did NOT require the services of an ambulance crew
- Modifier GY should be appended

Targeted Probe and Educate (TPE) Overview

Targeted Probe and Educate (TPE)

- Background:
  - Targeted Probe and Educate (TPE) is one process that a MAC can utilize when providers are selected by Medical Review
- The process:
  - Includes three rounds of a prepayment (or post-payment) probe review with education:
    - ✓ Sample limited for each probe "round" to a minimum of twenty (20) and a maximum of forty (40) claims
  - If there are continued high denials after the first three rounds of reviews
  - MACs will refer the provider and results to the CMS
- CMS will determine additional action, which may include:
  - Extrapolation
  - Referral to the Unified Program Integrity Contractor (UPIC) or Recovery Auditor (RA) contractor
- MACs will focus on specific providers/suppliers:
  - That bill a particular item or service rather than all providers/suppliers billing a particular item or service
  - Who have the highest claim denial rates or who have billing practices that vary significantly from their peers:
    - ✓ Based on Data Analysis and CERT error rates
- Part B TPE Topics for Review (JH):
  - Ambulance BLS Services
    - ✓ Round One and Two Results
  - Documentation Checklists:
    - ✓ JH Ambulance Services

TPE Topics and Schedule



INNOVATION IN ACTION

Ambulance Checklist

Checklist: Non-Emergent Ambulance Services Documentation

This checklist is intended to provide Healthcare providers with a reference for use when responding to Medical Documentation Requests for Non-Emergent Ambulance services. Healthcare Providers retain responsibility to submit complete and accurate documentation.

Check	Documentation Requirements
	Documentation is for the correct date of service.
	Each page of the record identifies the correct beneficiaries, medical professional and date of service
	The Physician Certification Statement (PCS) is complete, legible, signed and dated by the attending physician.
	Medical conditions listed on the PCS support a non-emergent ambulance transport and are supported by the attached medical records.
	The medical credential (i.e. MD or DO) is printed next to the signature.
	Documentation supports total, actual mileage and includes the origin to the destination street addresses.
	Documentation supports necessity for transport to facility, other than nearest facility (if applies)
	Documentation supports necessity for transport by air ambulance (if applies)
	Evidence that an Advanced Beneficiary Notice of Non-Coverage was provided to the beneficiary (if applies)
	Documentation contains signature of beneficiary or their authorized representative.

The Centers for Medicare & Medicaid Services (CMS) maintains official guidelines for Ambulance Services on their website at https://www.cms.gov/Center/Provider-Type/Ambulances-Services-Center.html . Healthcare providers are encouraged to reference these guidelines when preparing documentation in response to Additional Documentation Requests (ADRs).

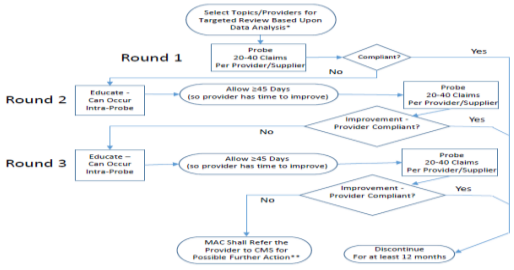
INNOVATION IN ACTION

TPE Rounds of Review Process

TPE Process	Round 1 Initial Probe	Round 2	Round 3	CMS Corrective Actions After Round 3
Provider Notification	X	X	X	N/A
Pre-Probe Education	X	X	X	N/A
ADR request	X	X	X	N/A
Medical Review (education if necessary)	X	X	X	N/A
Results letter	X	X	X	N/A
Post-Probe Education	X	X	X	N/A
Referral (if applicable)	N/A	N/A	X	N/A
Extrapolation, referral to UPIC or RA or 100% prepay review	X	X	X	X

INNOVATION IN ACTION

Targeted Probe & Educate Flow Chart



INNOVATION IN ACTION

Ambulance Target Probe and Educate Round One and Two Results

INNOVATION IN ACTION

Round One and Two Results

- Round One:
  - December 2017-May 2018:
    - ✓ 116 Total Reviews Selected for Round One:
      - 38 Total Reviews with Minor Classification
      - 38 Total Reviews with Moderate Classification
      - 33 Total Reviews with Major Classification
      - 7 Total Reviews with Insufficient Sample
- Round Two:
  - September 2018 – February 2019:
    - ✓ 53 Total Reviews Selected for Round Two
      - 28 Total Reviews with Minor Classification
      - 14 Total Reviews with Moderate Classification
      - 9 Total Reviews with Major Classification
      - 2 Total Review with Insufficient Sample
  - Summary of Round Two Results:
    - ✓ Overall 53 reviews were selected for Round Two.
    - ✓ Out of the 53 reviews, 25 will potentially be moving on to round three due to an insufficient sample, moderate or major error rate classification
    - ✓ Novitas feels these results are a positive reflection of the educational efforts conducted before and during the review process
    - ✓ All round two reviews have been educated on their results
    - ✓ Round Three Ambulance TPE is scheduled to begin around July 2019

INNOVATION IN ACTION

Education

- Minor error classification receive one-on-one educational call to discuss issues found during the probe
- Moderate/Major error classification will receive a teleconference educational call to discuss issues found during the probe:
  - Contact person from provider should invite anyone they feel would benefit from education
- Insufficient Sample:
  - Submitted medical documentation is inadequate to support payment for the services billed, or a specific documentation element that is required as a condition of payment is missing (for example: PCS)

Top Denial/Partial Denial Reasons

Not Medically Reasonable and Necessary Transport

- The ambulance transport benefit under Medicare Part B covers a medically necessary transport of a beneficiary by ambulance to the nearest appropriate facility that can treat his or her condition when any other methods of transportation are contraindicated:
  - Below is a list of common denial reasons for services being not medically reasonable and necessary for transport:
    - ✓ Beneficiary could be transported by other methods:
      - ➢ The documentation submitted for review was lacking evidence that the Medicare beneficiary could not be safely transported by other modes of transport
    - ✓ Invalid Physician Certification Statement (PCS):
      - ➢ The documentation was lacking a valid PCS form or missing credentials to support the PCS was made by a valid provider who was knowledgeable of the beneficiary to support transport
    - ✓ Missing beneficiary signature

Insufficient Documentation

- Insufficient documentation was provided to support the services as billed to Medicare
- Novitas Medical Review makes multiple attempts to correct these error types before completion of the review
- Below is the following denial reasons for insufficient documentation that we were not able to resolve:
  - Incorrect beneficiary:
    - ✓ The documentation submitted for review did not support the beneficiary billed on the claims
  - Incorrect Date of Service:
    - ✓ The documentation submitted did not support the date of service billed on the claim
  - No response to Additional Documentation Requests (ADRs):
    - ✓ Documentation was not submitted to Novitas in a timely manner in order to support the services billed to Medicare
- Billing Error:
  - Upon receipt of the ADR request, the provider deemed the service was billed in error to Medicare

Education Provided

Education

- Prior to implementing ADRs, providers selected were notified of the upcoming TPE review and process through initial notification letters and phone contact
- Providers were educated on the TPE process and expectations during the initial phone contact
- During the TPE review process, intra-probe education was offered when easily curable errors were discovered and to answer any provider questions
- Providers were sent detailed results letters with education at the conclusion of the review
  - The results letter also included a detailed summary of each claim determination made by Medical Review
- An educational phone contact was offered to all providers who underwent TPE review to go over the results and provide education on all errors
- Providers who will be moving to round three were also notified via letter and phone contact

Avoiding the Top Denial/Partial Denial Reasons

Not Medically Reasonable and Necessary Transport

- CMS Definition of Bed-Confinement:
  - Unable to get up from bed without assistance
  - Unable to ambulate
  - Unable to sit in a chair or wheelchair
- Note:
  - All three must be meet and documentation must support all:
    - ✓ Non-emergency ambulance transportation is not covered for patients who are restricted to bed rest by a physician's instructions but who do not meet the above three criteria
  - The term "bed confined" is not synonymous with "bed rest" or "non-ambulatory"
    - ✓ Statements about the patient's bed-bound status must be validated in the record with objective observations and findings as to the patient's functional physical and/or mental limitations that have rendered him/her bed-bound
  - Bed-confinement, by itself, is neither sufficient nor is it necessary to determine the coverage for Medicare ambulance benefits
  - It is simply one element of the beneficiary's condition that may be taken into account in the MAC's determination of whether means of transport other than an ambulance were contraindicated
  - If some means of transportation other than an ambulance (i.e., private car, wheelchair van, etc.) could be utilized without endangering the individual's health, regardless if such other transportation is actually available, no payment may be made for ambulance service

Not Medically Reasonable and Necessary Transport (cont.)

- Non-emergency ambulance services:
  - May be those that are scheduled in advance – scheduled services being either repetitive or non-repeating
  - Is not covered if transportation is provided for the patient to receive a service that could have been safely and effectively provided in the point of origin (residence, SNF, hospital, etc.):
    - ✓ Such transportation is not covered even if the patient could only have gone for the service by ambulance
- The presence of ESRD and the requirement for hemodialysis do not alone qualify a patient for ambulance transportation:
  - To be considered reasonable and necessary, patients transported to and from hemodialysis centers must have other conditions to support the service as medically reasonable and necessary; and adequate documentation of those conditions must be in the ambulance supplier's run reports and in the medical records of other providers involved with the patient's care
- Medicare will not pay for an ambulance service when the ambulance was used simply for convenience or because other means of transportation was not available

Insufficient Documentation

- Provide complete, legible medical record documentation to support the service reported to Medicare
- Ensure the date of service reported in the documentation matches the date of service submitted on the claim and should be reflective of the date the service was provided to the Medicare beneficiary
- Ensure medical record documentation is appropriately signed

Billing Reminders

- Keep up with all Medicare rules and regulations:
  - Attend Provider Outreach and Education seminars to remain current on Medicare updates.
- Reference the various publications available to Medicare providers including, but not limited to:
  - Local Coverage Determinations LCDs)
  - CMS Publication: *Internet Only Manuals (IOM)* *
  - Alerts, News and Bulletins: Part B
- Accurately code and bill services to Medicare
- Respond promptly and completely to Medicare inquiries and ADR requests
- Maintain accurate and complete medical records and documentation of services provided and billed to the Medicare program

Targeted Probe and Educate Resources

- CMS
  - CMS Internet Only Manual (IOM), Publication 100-08, Medicare Program Integrity Manual, Chapter 2
  - CMS Targeted Probe and Educate Center
  - CMS Targeted Probe and Educate FAQs
  - CMS "Reducing Provider Burden"
  - CMS TPE Flow Chart
- Novitas
  - Medical Review Center
  - Targeted Probe and Educate Information
  - Medical Review Additional Development Request Process

Ambulance Policy and Requirements for Coverage

CMS National Policy

- Covered only if furnished to a beneficiary whose medical condition at the time of transport is such that transportation by other means would endanger the patient's health
- Not covered when the patient's condition permits transport in any type of vehicle other than an ambulance
- Payment dependent on patient's condition at actual time of transport regardless of diagnosis
- Patient must require the transportation and level of service provided

Additional CMS National Policy

- Medicare covers both emergency ambulance transportation and non-emergency ambulance transportation based on medical necessity:
  - Patient's condition requires the vehicle itself and/or the specialized services of the trained ambulance personnel
  - The needed services of the ambulance personnel were provided and clear clinical documentation validates medical need and their provision in the record of the service (usually the run sheet)
- Actual transportation of the beneficiary occurs
- Services must be reasonable and necessary
- Transportation is to the closest appropriate facility

Ambulance Coverage Destinations

- Only to the following destinations:
  - Hospital
  - Critical Access Hospital (CAH)
  - Skilled Nursing Facility (SNF)
  - Beneficiary's home.
  - Dialysis facility for End Stage Renal Disease (ESRD) patient who requires dialysis
- Covered to the nearest appropriate facility
- Mileage to the nearest appropriate facility covered

Appropriate Facilities

- The term appropriate facilities means that the institution is generally equipped to provide the needed hospital or skilled nursing care for the illness or injury involved
- In the case of a hospital, it also means that a physician or a physician specialist is available to provide the necessary care required to treat the patient's condition

Origin and Destination Modifiers

Modifier	Description
D	Diagnostic or therapeutic site other than P or H when these are used as origin codes
E	Residential, domiciliary, custodial facility (other than 1819 facility)
G	Hospital-based ESRD facility
H	Hospital
I	Site of transfer (e.g. airport or helicopter pad) between modes of ambulance transport
J	Freestanding ESRD facility
N	Skilled Nursing Facility
P	Physician's office
R	Residence
S	Scene of accident or acute event
X	Intermediate stop at physician's office on way to hospital (destination code only)

First position equals the origin; Second position equals destination

Example: HN = Hospital (origin) to Skilled Nursing Facility (destination)

CMS Definition of Bed-Confinement

- Definition:
  - Unable to get up from bed without assistance
  - Unable to ambulate
  - Unable to sit in a chair or wheelchair
- Note:
  - All three must be meet and documentation must support all
  - The term "bed confined" is not synonymous with "bed rest" or "non-ambulatory"
  - Bed-confinement, by itself, is neither sufficient nor is it necessary to determine the coverage for Medicare ambulance benefits
  - It is simply one element of the beneficiary's condition that may be taken into account in the MAC's determination of whether means of transport other than an ambulance were contraindicated

Overview of Basic Life Support (BLS) Services and Mileage

Emergency Level of Service

- Emergency level depends on how the ambulance was dispatched and how it responded
- Documentation should include the information that was reported to the dispatcher at the time of call
- Emergency does not depend on whether an assessment was furnished after the ambulance arrived
- Covered when medically necessary, meet destination limits of the closest appropriate facilities, and provided by an ambulance service that is licensed by the state

Emergency Response

- Responding immediately at the BLS or ALS1 level of service to a 911 call or the equivalent in areas without a 911 call system
- Immediate response:
  - An immediate response is one in which the ambulance supplier/provider begins as quickly as possible to take the steps necessary to respond to the call
- Immediate medical condition that could result in the following:
  - Placing the patient's health in serious jeopardy
  - Serious impairment to bodily functions
  - Serious dysfunction of any bodily organ or part

Non-Emergency Service

- Covered in the absence of an emergency condition:
  - Patient being transported has, at the time of ground transport, a condition such that all other methods of ground transportation (e.g., taxi, private automobile, wheelchair van or other vehicle) are contraindicated; and/or
  - Patient is bed-confined before, during and after transportation

Basic Life Support

- Basic Life Support (BLS) – A0428:
  - The ambulance must be staffed by an individual who is qualified in accordance with state and local laws as an Emergency Medical Technician-Basic (EMT-Basic)
  - These laws may vary from state to state
- Basic Life Support (BLS) – Emergency – A0429:
  - Patient's health in serious jeopardy
  - Serious impairment to bodily functions
  - Serious dysfunction of any bodily organ or part
  - Immediate response

Ground Mileage

- Ground Mileage, Per Statute Mile – A0425:
  - Mileage can be allowed to the nearest appropriate facility when the ambulance transfer is covered
  - Only the actual number of "loaded" miles from the point of pickup to the point of destination can be reported as mileage
  - Miles must be reported as fractional units

Reporting Ground Mileage

- Fractional mileage must round the total miles up to the nearest tenth of a mile and report the resulting number with the appropriate HCPCS code for ambulance mileage:
  - Decimal must be used in the appropriate place (e.g., 99.9)
- Trips totaling 100 covered miles and longer report mileage rounded up to the next whole number mile without the use of a decimal:
  - 998.5 miles should be reported as 999
- Tips totaling less than one mile:
  - Enter a "0" before the decimal (e.g., 0.9)
- Fractional mileage reporting applies only to ambulance services billed on a Form CMS-1500 paper claim, ANSI X12N 837P or 837I electronic claims:
  - Note: Does not apply to providers billing on the UB-04 form

Capture and Document Loaded Mileage

- Mileage can be documented in a number of different ways including:
  - Trip odometer readings
  - GPS systems,
  - Navigation computers
  - Mapping programs (e.g., MapQuest)
- Please ensure that you maintain the acceptable forms of documentation in the patient's record and that the documentation is available to Medicare upon request
- Complete name and address of the origin and destination should be documented in the trip report completed by the ambulance supplier

Non-Covered Mileage

- Non-Covered Mileage – A0888:
  - Miles traveled beyond closest appropriate facility
  - When a beneficiary wishes to be transported to a facility that is not the closest appropriate facility, Medicare does not cover the additional mileage
  - This code will deny when submitted

Trip Record Documentation Requirements

INNOVATION IN ACTION

Documentation Requirements

- All documentation must be maintained in the patient's medical record and made available to the contractor upon request
- Every page of the record must be legible and include appropriate patient identification information (e.g., complete name, dates of service(s))
- Documentation must include the legible signature of the person who is responsible for and providing the care to the patient
- Submitted records must support the use of the selected diagnosis and the HCPCS code must describe the services performed

INNOVATION IN ACTION

Trip Documentation Requirements

- Trip documentation:
  - Detailed description of the patient's condition at the time of transport
  - Documentation must "paint a picture" of the patient's condition and must be consistent with documentation found in other supporting medical record documentation (including the PCS)
  - Complete and legible information
  - Indication of emergency or non-emergency situation:
    - ✓ This information should come from the reported condition of the patient at the time of dispatch

Patient's Condition Requirements

- Trip documentation must include:
  - Reason for the transport (why the patient could only travel by ambulance):
    - ✓ Concise explanation of symptoms reported by the patient and/or other observers and details of the patient's physical assessments that explain why the patient requires ambulance transportation and cannot be safely transported by an alternative mode
  - Objective description of the patient's physical condition in sufficient detail to demonstrate that the patient's condition or functional status at the time of transport meets Medicare limitation of coverage for ambulance services
  - Description of the traumatic event when trauma is the basis for suspected injuries
  - Detailed description of existing safety issues
  - Detailed description of special precautions taken (if any) and explanation of the need for such precautions

Assessment Documentation

- Trip documentation:
  - Description of specific monitoring and treatments required, ordered or performed/administered
  - Assessment and clinical evaluations, which should include:
    - ✓ Vital signs
    - ✓ Neurological assessment
    - ✓ Cardiac information
  - Procedures and supplies provided, such as:
    - ✓ Oxygen administered
    - ✓ Cardiac rhythm monitoring
    - ✓ IV therapy
    - ✓ Respiratory therapy
    - ✓ Intubation
    - ✓ Cardiopulmonary Resuscitation (CPR)
    - ✓ Drug therapy
    - ✓ Restraints
  - Treatment should be medically necessary based on the patient's condition and documentation should reflect the medical necessity

Additional Documentation Requirements

- Trip documentation:
  - Patient's progress (responses to treatment and changes as treatment is given)
  - Point of pickup:
    - ✓ Complete name and address of origin and destination
  - Hospital-to-hospital transports:
    - ✓ Trip record must clearly indicate the precise treatment or procedure that is available only at the receiving hospital
  - Number of loaded miles
  - Date and legible identity of the observer

Additional Documentation Records and Reports

- Ensure you include any additional available documentation that supports medial necessity:
  - Emergency Room report
  - Hospital record
  - SNF record
  - End Stage Renal Disease (ESRD) facility record
  - Dispatch record
  - Documentation supporting the number of loaded miles

Insufficient Documentation Examples

- Examples of insufficient statements to justify medical necessity:
  - Hypertension
  - Chest Pain
  - Patient unable to sit, stand or walk

Physician Certification Statement (PCS)

Physician Certification Statement (PCS)

- Required for scheduled and non-scheduled non-emergency transports for patients who are under the direct care of a physician
- Not required:
  - Emergency transports
  - Non-scheduled non-emergency transports of patients residing at home or in facilities where they are not under the direct care of a physician
- Suppliers/providers are required to obtain written orders from the patient's attending physician certifying that the medical necessity requirements are met

PCS Form

- The signed PCS does not, by itself, demonstrate that the transport was medically necessary and does not absolve the ambulance provider from meeting all other coverage and documentation criteria:
  - Be patient-specific
  - Contain pertinent medical information
  - Confirm or support information on run sheet
  - For repetitive services, the PCS may include the expected length of time ambulance transport would be required but may not exceed 60 days
  - The signature of the medical professional completing the PCS must be legible (or accompanied by a typed or printed name) and include credentials
  - Signatures on the PCS must be dated at the time they are completed

Requirements for Non-Emergency Non-Scheduled

- Requirements for Non-Emergency Non-Scheduled or Scheduled on a Non-Repetitive Basis Transport:
  - Before submitting the claim, a certification must be signed by the attending physician within 48 hours after the transport
  - If unable to get the attending physician to sign within 48 hours, either a:
    - ✓ Physician Assistant (PA)
    - ✓ Nurse Practitioner (NP)
    - ✓ Clinical Nurse Specialist (CNS)
    - ✓ Registered Nurse (RN)
    - ✓ Discharge planner employed by the facility with knowledge of the patient's condition can sign the form

Requirements If Unable To Obtain Certification

- Requirements for Non-Emergency Non-Scheduled or Scheduled on a Non-Repetitive Basis Transport:
  - If unable to obtain a signed PCS by the attending physician within 21 days, the ambulance supplier must document efforts to obtain certification
  - Letter via United States Postal Service certified mail with return receipt and proof of mailing or other similar service demonstrating delivery of the letter as evidence of attempt to obtain the PCS
  - United States Postal Service Certificate of Mailing, Form 3817, is acceptable alternative to certified mail

Requirements for Non-Emergency Scheduled

- Requirements for Non-Emergency Scheduled, Repetitive Transports:
  - The PCS must be signed and dated by the attending physician prior to the transport:
    - ✓ Signature of the medical professional completing the PCS must also be legible (or accompanied by a typed or printed name) and include credentials
  - The PCS must be dated no earlier than 60 days in advance of the transport for those patients who require repetitive transports
  - For repetitive services, the PCS may include the expected length of time ambulance transport would be required but may not exceed 60 days

Definition of Repetitive Services

- Repetitive Services:
  - Non-emergency ambulance services may be those that are scheduled in advance (scheduled services being either repetitive or non-repeating)
  - A repetitive ambulance service is defined as medically necessary ambulance transportation that is furnished:
    - ✓ Three or more times during a 10-day period or
    - ✓ At least once per week for at least three weeks
- Transportation to hemodialysis is a common example of repetitive ambulance services

Signature Guidelines for Medical Review Purposes

- Special Edition Article SE1419
- Medicare requires that services provided/ordered be authenticated by the author:
  - Method used shall be a handwritten or an electronic signature
  - Stamped signatures are not acceptable
- These guidelines impact the ambulance trip/run sheets and the PCS
- Signature of the medical professional completing the PCS must be:
  - Legible (or accompanied by a type or printed name) and include credentials
  - Dated at the time they are completed
- All signature requirements are effective for CERT
- All signature requirements for Affiliated Contractors (AC), MACs and Zone Program Integrity Contractors (ZPICs) are applicable for reviews conducted

Additional Ambulance and Signatures Resources

- Use the following resources to avoid documentation errors:
  - Medicare Ambulance Transports Booklet
  - 42 Code of Federal Regulations 424.36 - Signature Requirements
  - Guidance on Beneficiary Signature Requirements for Ambulance Claims
  - April 2016 Medicare Quarterly Provider Compliance Newsletter
  - Ambulance Fee Schedule Fact Sheet

Additional Signature Guidelines for Medical Review Purposes

- Trip/Run sheet signature requirements:
  - Must contain the date and legible signature of the observer and their credentials
  - Can print their name under the signature
  - Can submit a signature log

Ambulance References

- LCA– Ground Ambulance Services - A54574
- LCD- Ground Ambulance Services - L35162
- CMS Ambulance Service Center
- Ambulance services:
  - IOM 100-2; Chapter 10
  - IOM 100-4; Chapter 15
- Novitas Specialty Ambulance Center
- Medicare Ambulance Transports
- Medicare Payments for Ambulance Transports
- Ambulance Billing Guide
- Ambulance Modifiers
- Trip/Run Record Documentation
- Physician Certification Statement (PCS)

Ambulance Specialty Page

Summary

- Discussed News, Updates and Reminders
- Covered Enrollment Reminders and Revalidation
- Reviewed the Novitasphere
- Provided an overview of the Targeted Probe and Educate Process
- Discussed the Ambulance TPE Round One and Two Results
- Reviewed the Ambulance Policy and Requirements for Coverage, Basic Life Support (BLS) Services and Mileage
- Reviewed the Trip Record Documentation Requirements and Physician Certification Statement (PCS)

Thank You

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