national government SERVICES

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MEANINGFUL • INFORMATIVE • SIMPLIFIED EDUCATION

# Annual Government Payer Meeting

Massachusetts Association of Patient Account Management (MAPAM)

12/15/2022

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

# Today's Presenter

- Lori Langevin
  - Provider Outreach and Education, Consultant

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# No Recording

- Attendees/providers are **never** permitted to record (tape record or **any** other method) our educational events
  - This applies to our webinars, teleconferences, live events and any other type of National Government Services educational events

# Agenda

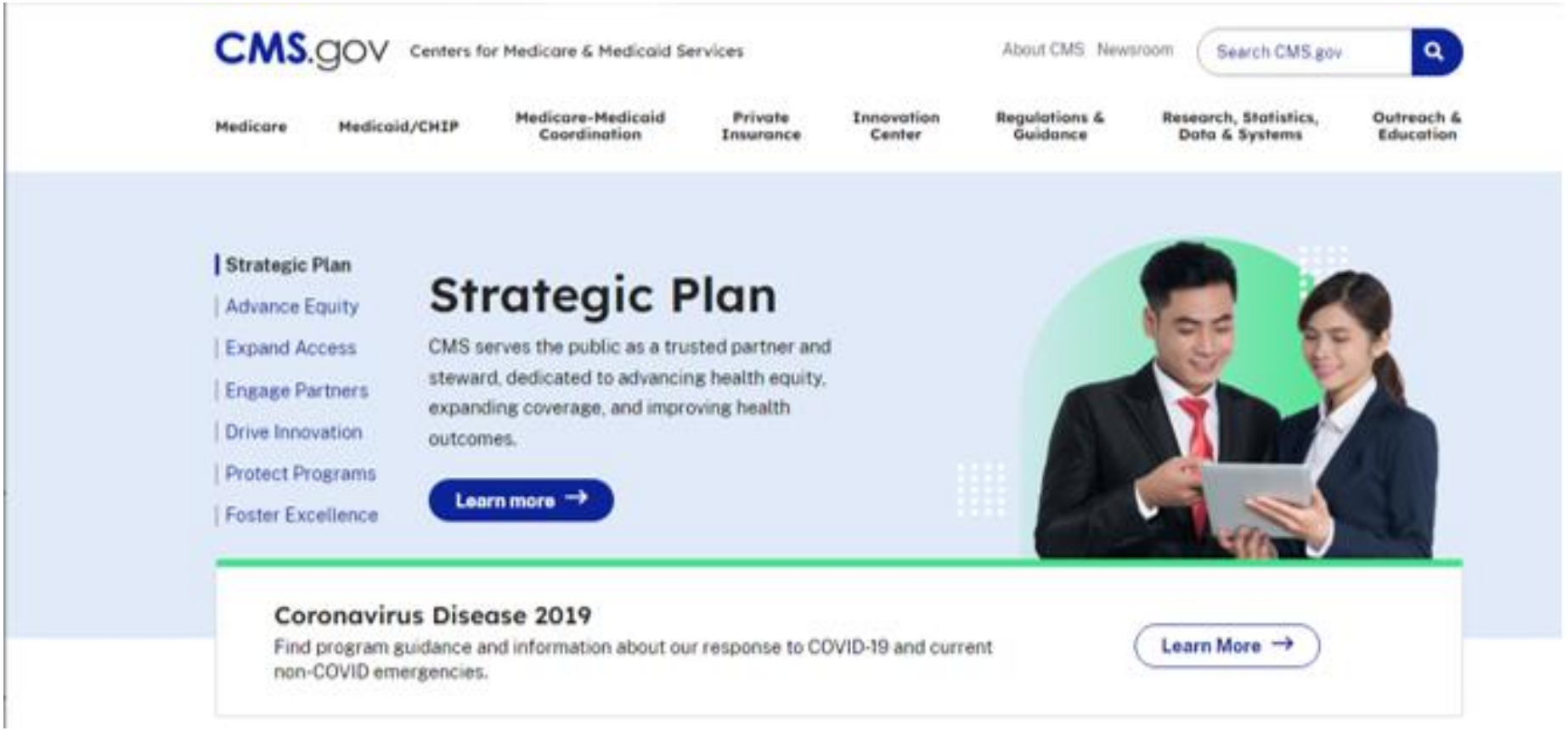
- Staying Informed
- Telehealth Services
- Provider Enrollment
- Reducing Appeals Inventory

# Staying Informed

# Suggested Actions

- During the COVID-19 Public Health Emergency, information and instructions may change
  - U.S. Department of HHS Public Health Emergency
- It's vital to receive the latest information – take the following steps to ensure access to the latest updates
  - Sign up for listserv messaging from
    - CMS Listserv and
    - National Government Services Email Updates
- Routinely check
  - CMS Current Emergencies webpage
  - NGS COVID-19 News page

# CMS Website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Engage Partners
Drive Innovation
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Strategic Plan
CMS serves the public as a trusted partner and steward, dedicated to advancing health equity, expanding coverage, and improving health outcomes.
Learn more
Coronavirus Disease 2019
Find program guidance and information about our response to COVID-19 and current non-COVID emergencies.
Learn More

# NGSMedicare Website

# Modifier CR

- Modifier CR (catastrophe/disaster related)
  - Used on professional and outpatient institutional claims
  - CR modifier is not required on telehealth services
- Mandatory coding for any claim for which Medicare payment is conditioned on the presence of a “formal waiver” including the Section 1135 waiver
- Used to identify claims that are/may be impacted by specific payer/health plan policies related to a national or regional disaster

# CS Modifier

- CS modifier waives cost sharing requirements
- MLN Matters® *SE20011 Revised: Medicare FFS Response to the PHE on COVID-19*
- DOS on/after 3/18/2020: Cost-sharing does not apply for COVID-19 testing-related services, which are medical visits
  - Append CS modifier to E/M service performed
    - When E/M service leads to COVID-19 testing
    - Allows E/M to be paid at 100% of the fee schedule

# Telehealth Services

# Medicare Telehealth Services

- Categories
  - Category 1
    - Services that are similar to professional consultations, office visits, and office psychiatry services that are currently on the list of telehealth services
  - Category 2
    - Services that are not similar to the current list of telehealth services
  - Category 3 (temporary category)
    - Services added to the list during the PHE for the COVID -19 pandemic
    - Services will remain on the list through the calendar year in which the PHE ends

# Medicare Telehealth Services

- CY2023
- Category 1 code additions:
  - G0316, G0317, and G0318, G3002, and G3003
- Category 2 codes have no new additions
- Category 3 codes added for the PHE will remain on the list either
  - To the end of 12/31/2023 or
  - At least for a period of 151 days following the end of the PHE
  - Allowing time for evidence and comments on permanent additions or deletions
    - List of Telehealth Services
- Additions of CPT codes 90901, 97150, 97530, 97537, 97542, 97763, and 98960-98962
  - Services could no longer be furnished by therapists as Medicare telehealth services
- Pre-PHE rules will take effect if both the PHE and the 151-day period following the expiration of the PHE both end in CY 2023

# Medicare Telehealth Services

- Telephone E/M Services
- CPT codes 99441–99443 will **not** be added as a Category 3
- Will remain on the Medicare Telehealth Services List through expiration of the 151-day period following the end of the PHE
  - After that point they will revert to bundled status

# Medicare Mental Health Telehealth Services

- Effective immediately on and after the official end of the PHE Mental Health Disorders may continue to be offered as telehealth services
- Service for the purpose of diagnosis, evaluation and treatment of mental health disorders will **no longer** be restricted to beneficiaries residing in rural areas
- Originating sites expanded to include
  - Beneficiary Home
  - Temporary Lodging (hotels, homeless shelters, nursing homes)
  - Originating site facility fee does not apply

# Medicare Mental Health Telehealth Services

- Audio only communication is permitted for **established patients** in their home if
  - Beneficiary doesn't have the technical capacity
  - Does not have the availability of real-time audio and visual interactive telecommunication
- Medical record should support the reason for using audio-only communication

# Medicare Mental Health Telehealth Services

- The Consolidated Appropriations Act of 2021 required an in-person, nontelehealth service with the physician or practitioner within **six months** prior to the initial telehealth service
- Beginning CY 2022, there must be a non-telehealth service every **12 months** thereafter
  - Exceptions may be made based on beneficiary circumstances
- Providers in the same specialty, same group may provide subsequent visits

# Medicare Telehealth POS

- Telehealth services furnished on or after the 152nd day after the end of the PHE
- POS 02 – Is redefined as telehealth provided other than in patient's home
  - Patient is not located in their home when receiving services through telecommunication technology
- POS 10 – Telehealth provided in patient's home
  - Patient is located in their home (which is a location other than a hospital or other facility where the patient receives care in a private residence) when receiving services through telecommunication technology

# Medicare Telehealth Modifiers

- Continue to bill modifier 95 through the latter of the end of the year in which the PHE ends or CY2023
- DOS on or after the 152nd day after the end of the PHE will revert to pre-PHE rules and will no longer require modifier 95

# Medicare Mental Health Telehealth Modifiers

- Effective 1/1/2023
- **Modifier 93** – Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system
  - All providers including RHCs, FQHCs, and OTPs
- Modifiers were required as of 4/1/2022
  - CMS has approved two service-level modifiers to identify mental health telehealth services furnished to a beneficiary at home to describe specific communications technology
  - **Modifier FQ** = A telehealth service was furnished using real-time audio-only communication technology
  - **Modifier FR** = A supervising practitioner was present through a real-time two-way, audio/video communication technology

# Medicare Telehealth Services





## List of Telehealth Services

List of services payable under the Medicare Physician Fee Schedule when furnished via telehealth.

List of Telehealth Services for Calendar Year 2023 (ZIP) - Updated 11/02/2022

### Medicare Telehealth Originating Site Facility Fee, Q3014

| Time Period | MEI (%) | Facility Fee for Q3014 |
|---|---|---|
| 2023 | 3.8% | $28.64 |
| 2022 | 2.1% | $27.59 |
| 2021 | 1.4% | $27.02 |

# Telehealth Origination Site Facility Fee Payment Amount

- Since 1/1/2003 the origination site facility fee is increased by the percentage increase in the Medicare Economic Index
- MEI increase for 2023 is 3.8%
- HCPCS code Q3014
- 2023 fee $28.64

# Reminders for Telehealth Services

- On/after 3/1/2020 and for duration of PHE
  - Bill audio or audio/video telehealth service with modifier 95 (professional telehealth service from a distant site)
  - POS equal to what it would have been (if were performed face-to-face) in the absence of a PHE
  - CR modifier not required on telehealth services
  - Telehealth services are professional services billed as distant site

# Telephone Services

- 99441–99443
  - Telephone E/M service by a practitioner or qualified health care professional
  - **4/30/2020 added to telehealth services; use modifier 95**
  - Physicians (including osteopaths, podiatrists, and optometrists), dentists, nonphysician practitioners (including nurse practitioner, clinical nurse specialist, physician assistant, certified nurse midwife) and maxillofacial surgeon
- 98966–98968
  - Telephone assessment and management service
  - **Not on the CMS list of telehealth codes**
  - Clinical psychologists, PT/OT/SLP, optometrists, nonphysician practitioners (including nurse practitioner, clinical nurse specialist, physician assistant, certified nurse midwife), LCSWs, registered dietitians and nutrition professionals

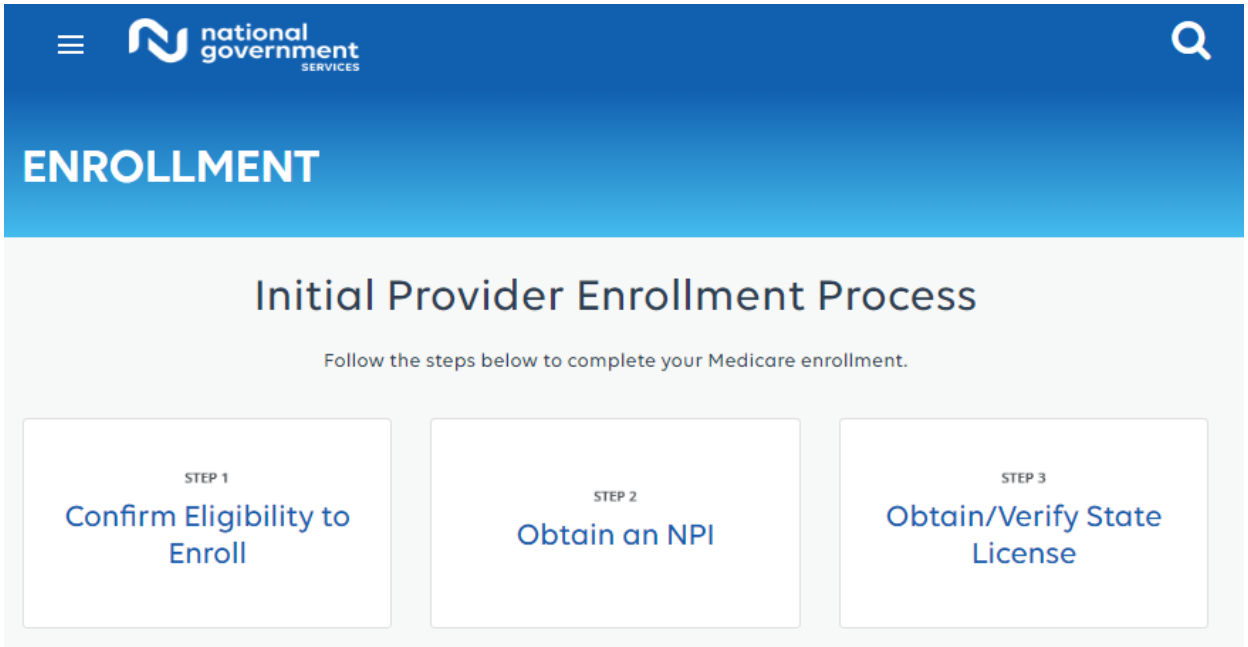
# Telehealth Documentation

- Same as any face-to-face patient encounter, except a statement needed indicating service was telehealth, along with
  - Patient location
  - Provider location
  - Names of all persons participating in the telemedicine service and their role in the encounter
  - Time-based services, document start/stop time or total time
  - Teaching physician may use audio/video telecommunications during key portions of service

# Provider Enrollment

# Provider Enrollment

- Enrollment




  - Resources >Tools & Calculators > Provider Enrollment Application Fee Decision Tree

# Provider Enrollment

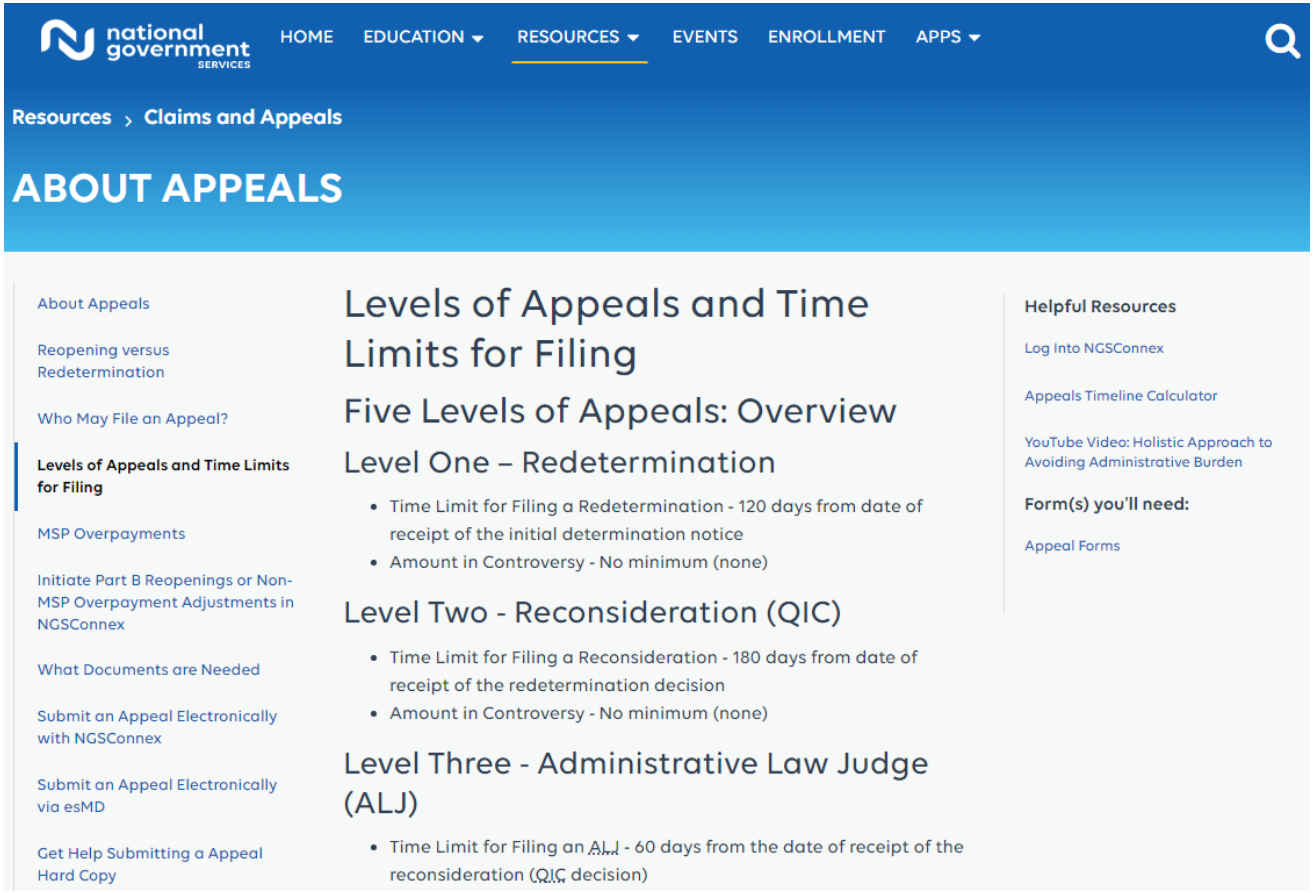
- Enrollment

# Top Development Reasons

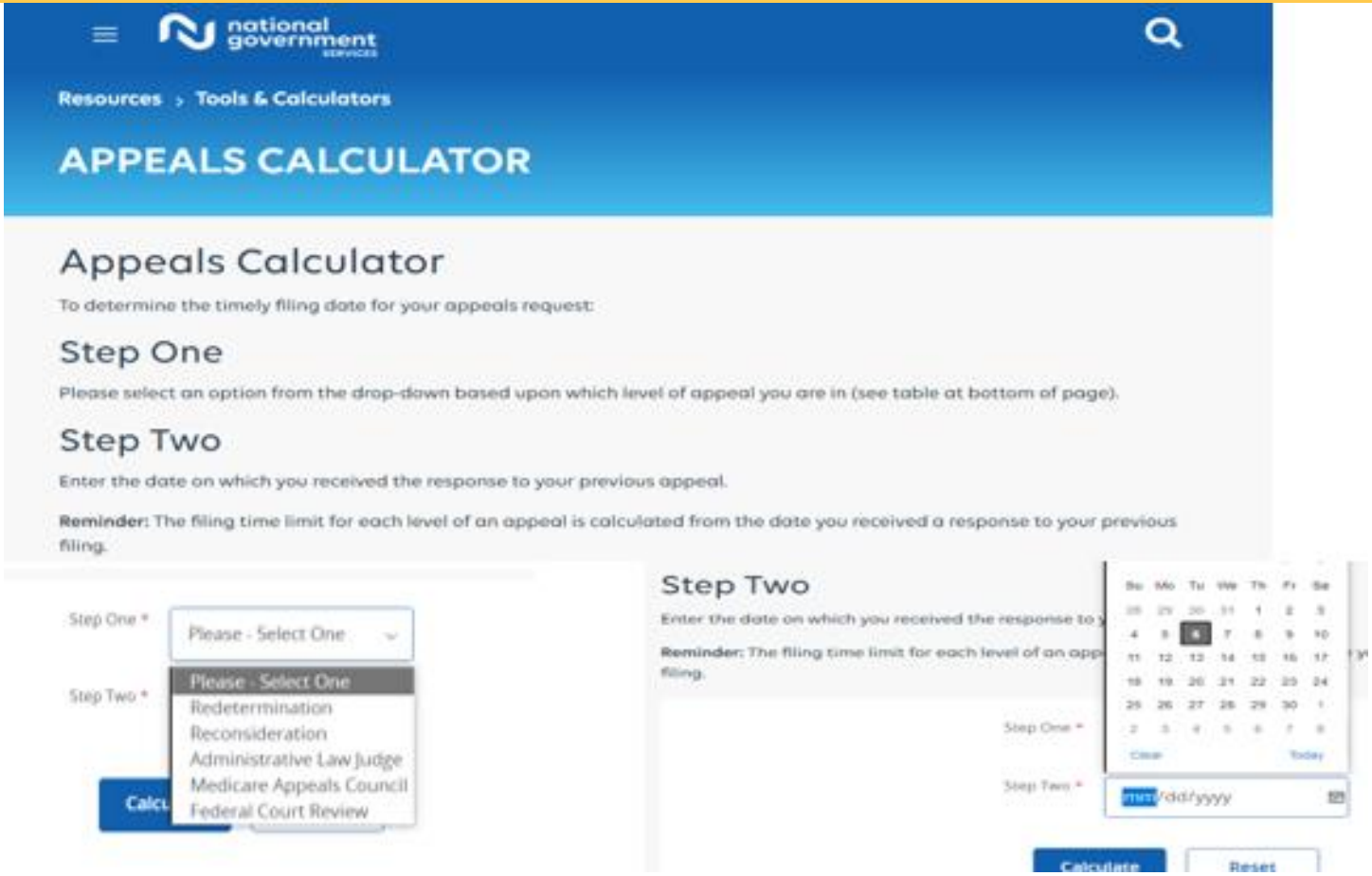
- Part B Paper
  - Completed Signature
  - Initially enrolling groups, voided check or bank letter for the CMS-588 and or EFT, LBN, NPPES does not match IRS document
  - EFT corrections or missing information
  - Physician-nonphysician wrong specialty type selected
  - Incorrect AO/DO signer on the CMS-855B and the CMS-855R
  - Supporting documentation: nonphysician certifications/degree, IRS document, voided check/bank letter
- Part B Web
  - Completed Signature
  - Initially enrolling groups, voided check or bank letter for the CMS-588 and or EFT, LBN NPPES does not match IRS document
  - EFT corrections or missing information
  - Incorrect AO/DO signer on the CMS-855B and the CMS-855R
  - Supporting documentation: nonphysician certifications/degree, IRS document, voided check/bank letter
  - Missing dependent application: (i.e. 855I or 855B for Sole Owners)

# Reducing Appeals Inventory

# Levels of Appeals and Time Limits for Filing



# Appeals Calculator



# Redetermination Timeframe

- National Government Services shall issue decision on appeals within 60 days
- If you have not heard, please do not resubmit another request
- Submit one redetermination request for all lines in question on a claim
- If you're a current NGSConnex user, you can check the status of your appeal at NGSConnex
- Please do not submit the appeal via paper and NGSConnex

# Unprocessable Claims

- Rejected claim or MA130 denial
  - Claim contains incomplete/invalid information
  - No appeal rights – claim unprocessable
  - No reopening rights
- Fix error(s) and resubmit
  - Resubmit as a new claim
  - Do not indicate corrected claim
- Do not appeal

# Helpful Hints

- The beneficiary name, Medicare number, date(s) of service and item/service at issue are required for any appeal to be processed
- Ensure all items are completed
- If there is not enough room on the form, please include an attachment that details the required information
- If there is insufficient information with your appeal request, it may be dismissed
- If you are submitting your appeal past the time limit, please include an explanation for the delayed request
- Include all medical record documentation that supports your request
  - The medical record documentation must be signed and dated by the physician

# Tips to Help Avoid Unnecessary Claim Denials

- Verify all data pertaining to the service is correct
  - NPI of billing physician/rendering physician
  - Assignment or nonassignment of claim
  - Beneficiary's Medicare number
  - ZIP code of the place of service
  - All related diagnoses reported with the highest degree of specificity
  - NPI of referring physician
  - Date of service/place of service

# Tips to Help Avoid Unnecessary Claim Denials

- Procedure code
- Modifiers when applicable
- Number of service(s) and billed amount for each service
- CLIA number for laboratory services
- The last visit date, X-ray date, initial treatment date for podiatry, physical therapy and chiropractic services
- Primary payer data

# Tips to Help Avoid Unnecessary Claim Denials

- Appropriate modifier scenarios include
  - Service or procedure has both a professional (26) and technical component (TC)
  - Duplicate service or procedure was performed by more than one physician (77)
  - Only part of a service was performed (54 or 55)
  - Bilateral procedure was performed (50)

# Tips to Help Avoid Unnecessary Claim Denials

- Modifier 76 – duplicate service or procedure was provided by the same physician
  - Document a repeat or duplicate service to reflect it is a distinct and separate service
    - Failure to document a repeat or duplicate service will result in a denial
  - Report clarifying information pertaining to repeat or duplicate services using Item 19 of the CMS-1500 claim form (02/12) or in the Extra Narrative Data segment (Loop 2300/2400) of the ANSI ASC X12 837 versions of an electronic claim
    - Utilize this field to report the time of each subsequent or repeat service or the number of times this service is needed to be performed

# Tips to Help Avoid Unnecessary Claim Denials

- Report body site modifiers to indicate more than one of the same service is performed but on different body parts/sites, e.g., LT, RT, TA, T9
- Report modifier 59 to indicate a distinct procedural service
  - This may represent a different session or patient encounter, different procedure or surgery, different site, or organ system, separate incision/excision, or separate injury (or area of injury in extensive injuries)

# Tips to Help Avoid Unnecessary Claim Denials

- Modifier 22 – service or procedure has been increased
  - Represents increased procedural services
  - The work required to provide a service is substantially greater than typically required
  - Documentation must support the substantial additional work and the reason for the additional work (e.g., increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required)

# Tips to Help Avoid Unnecessary Claim Denials

- Modifier 52 – service or procedure has been reduced
  - Represents reduced services and when under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion
  - Explanation can be submitted by entering the information in Item 19 (CMS-1500 form) or in the Extra Narrative Data segment (Loop 2300/2400 of an electronic claim) or submitting the supporting documentation
  - Modifier 52 Claim Submission Billing Reminder

# Tips to Help Avoid Unnecessary Claim Denials

- Enter description of an unlisted procedure code (NOC code) or a 'not otherwise classified' code
  - Failure to describe the NOC will result in a denial
  - Must be entered into Item 19 of the CMS-1500 claim form or in the Extra Narrative Data segment (Loop 2300/2400) of an electronic claim
- Please use the link below for NOC code instructions
  - Unlisted and Not Otherwise Classified Procedure Codes

# Tips to Help Avoid Unnecessary Claim Denials

- Item 19 Extra Narrative Data segment is also used to describe other billing scenarios as follows
  - Enter the drug's name and dosage
  - Enter all applicable modifiers when modifier 99 (multiple modifiers) is entered
  - Enter the statement, "Testing for hearing aid" when billing services involving the testing of a hearing aid(s) is used to obtain intentional denials when other payers are involved
  - When dental examinations are billed, enter the specific surgery for which the exam is being performed
  - Enter the specific name and dosage amount when low osmolar contrast material is billed, but only if HCPCS codes do not cover them
  - Enter the date for a global surgery claim when providers share postoperative care

# Tips to Help Avoid Unnecessary Claim Denials

- Comply with requests for supporting documentation
  - Failure to comply with the request will result in a denial
  - NGS may solicit for more information from the provider by issuing an ADR
  - We will specify in the ADR the documentation needed to make the coverage or coding determination
  - Responses to ADRs should be received within the 45-day timeframe
  - We will complete the review within 60 days of receiving all requested documentation and notify the provider of the claim determination
  - Record or documentation requests where no timely response was received will result in denial indicating denial was made without reviewing the medical record

# Tips to Help Avoid Unnecessary Claim Denials

- Supporting documentation must include an acceptable signature
  - Must include rendering physician's signature
  - Failure to provide valid signature will result in denial
  - Medicare contractors require a legible identifier for services provided or ordered
  - Only acceptable method of documenting provider signature is by written or electronic signature or, attestation or signature log
  - Stamped signatures are not acceptable
    - CMS will permit the use of a rubber stamp for signature in accordance with the Rehabilitation Act of 1973 in the case of an author with a physical disability that can provide proof to a CMS contractor of his/her inability to sign their signature due to their disability

# Tips to Help Avoid Unnecessary Claim Denials

- When Medicare is the secondary payer, the claim must include information from the primary insurer
  - Failure to include this information will result in a denial
  - To submit MSP claims using the CMS-1500 claim form (02/12), refer to CMS IOM Publication 100-05, *Medicare Secondary Payer (MSP) Manual,* Chapter 3
  - To submit MSP claims electronically, refer to Medicare Secondary Payer Manual for Electronic Submitters/ANSI Specifications for 837P
  - Obtaining primary insurance information from the beneficiary is the provider's responsibility
    - Claim filing extensions will not be granted because of incorrect insurance information

# Appeal Submission Reminders

- Make sure you use the correct form
  - Part B Appeals Request Form: Redetermination: First Level of Appeal
- If your request is regarding general information, please send a letter with your specific question
- Not all claim determinations can be appealed or corrected
  - If your claim has the MA130 group reason code on the provider remittance, the claim must be resubmitted with the complete/ correct information
- Reference PTAN number; not NPI number on redetermination form
- Include ICN for Part B claim in question on redetermination form

# Appeal Submission Reminders

- Submit one redetermination request for all lines in question on the claim; do not submit a redetermination form for each individual line of the claim
- Submit one redetermination form per claim; do not submit one redetermination form for multiple claims
- If using NGSConnex to submit a request, do not also mail your request
  - Also for submission via NGSConnex; do not submit the same appeal multiple times

# Thank You!

- Questions?

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