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Oklahoma Ambulance Association (OKAMA) 2017 Spring Conference and Trade Show

May 23, 2017

CMS

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Acronym List

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Acronym	Definition
ALS	Advanced Life Support
BLS	Basic Life Support
CAH	Critical Access Hospital
CERT	Comprehensive Error Rate Testing
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology
EMT	Emergency Medical Technician
ESRD	End Stage Renal Disease
HCPCS	Healthcare Common Procedure Coding System
HICN	Health Insurance Claim Number

Additional Acronym List

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Acronym	Definition
ICD-10	International Classification of Diseases, Tenth Revision
IOM	Internet-Only Manual
LCA	Local Coverage Article
LCD	Local Coverage Determination
MAC	Medicare Administrative Contractor
MBI	Medicare Beneficiary Identifier
NCD	National Coverage Determination
OIG	Office of Inspector General
PECOS	Provider Enrollment, Chain and Ownership System
PCS	Physician Certification Statement
PHP	Partial Hospitalization Programs

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Additional Acronym List (Cont.)

Acronym	Definition
PTAN	Provider Transaction Access Number
SCT	Specialty Care Transport
SNF	Skilled Nursing Facility

Today's Presentation

- Agenda:
  - Medicare Compliance:
    - ✓ 2017 OIG Plan
    - ✓ OIG Report
    - ✓ CERT
  - Medicare Updates
  - Proper Documentation Requirements
  - Provider Enrollment:
    - ✓ Revalidation Overview
    - ✓ Helpful Hints and Reminders for Revalidation
  - Novitas Reminders
  - Self-Service Options

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Medicare Compliance

Compliance

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- Compliance definition:
  - A state of being in accordance with established guidelines, specifications or legislation, or the process of becoming so
- The importance and challenges of safeguarding the Medicare Trust Fund are greater than ever
- CMS stays committed to identifying program weaknesses and vulnerabilities to help prevent fraud, waste and abuse, and to improve quality of care in the Medicare program

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Medicare Compliance Initiatives

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- Many compliance initiatives carried out by Medicare contractors are to ensure providers have an understanding of the importance of being compliant by:
  - Documenting the services correctly
  - Filing claims properly with the correct information
  - Adhering to program guidelines and coverage policies (for example: proper origin and destination modifiers, diagnosis codes, etc.)
- All of these efforts help ensure that contractors and Medicare providers uphold and continue working toward paying claims right the first time, every time

MLN Provider Compliance Web Page

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- CMS page containing links to educational products that inform health care professionals on how to avoid common billing errors and other improper activities when dealing with CMS programs:
  - https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/providercompliance.html
- MLN Provider Compliance weekly fast facts:
  - Highlight relevant tips and corrective actions to help health care professionals understand and comply with Medicare policy
  - Example:
    - ✓ Do you know where to look for guidance on complying with federal fraud and abuse laws? Watch a brief video with guidance from the OIG

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Fraud

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- Fraud defined:
  - Intentional deception or misrepresentation that an individual makes, knowing it to be false and that could result in some unauthorized benefit to them:
    - ✓ Most frequent type of fraud arises from a false statement or misrepresentation that is material to entitlement or payment
  - If you would have, could have or should have know it is defined as fraud
- Examples:
  - Incorrect reporting of diagnoses or procedures to maximize payments
  - Billing for services not furnished and/or supplies not provided
  - Altering claim forms, electronic claim records, medical documentation, etc. to obtain a higher payment amount

Abuse

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- Abuse defined:
  - Incidents or practices that may, directly or indirectly, result in unnecessary costs to the program, improper payment, or payment for services that fail to meet professionally recognized standards of care, or that are medically unnecessary
  - Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has knowingly and intentionally misrepresented facts to obtain payment
- Examples:
  - Billing for services that were not medically necessary
  - Misusing codes on a claim, such as up-coding

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Tips for Avoiding Fraud and Abuse

- Accurate coding and billing
- Maintain accurate and complete medical records and documentation of services provided
- Keep up with Medicare rules and regulations
- Respond promptly and completely to Medicare inquiries
- Have good business sense

Reporting Suspected Fraud to MAC and ZPIC

- Novitas Customer Contact Center:
  - 1-855-252-8782
- Zone Program Integrity Contractor (ZPIC):
  - JH Part A and Part B-Colorado, New Mexico, Oklahoma and Texas:
    - ✓ Health Integrity
      4835 LJB Freeway Suite 300
      Dallas, TX 75244
  - Contact Information:
    - ✓ 1-866-886-2658
    - ✓ http://www.healthintegrity.org/contracts/zpic-4/

Reporting Suspected Fraud to OIG

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- Office of Inspector General (OIG) Hotline:
  - Phone: 1-800-HHS-TIPS (1-800-447-8477)
  - https://forms.oig.hhs.gov/hotlineoperations/report-fraud-form.aspx
  - Fax:
    - ✓ 1-800-223-8164
  - E-mail:
    - ✓ HHSTips@oig.hhs.gov
  - TTY:
    - ✓ 1-800-377-4950
  - Mail:

    Office of Inspector General
    US Department of Health and Human Services
    ATTN: HOTLINE
    P.O. Box 23489
    Washington, DC 20026

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2017 OIG Plan

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2017 OIG Work Plan

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- https://oig.hhs.gov/reports-and-publications/archives/workplan/2017/HHS%20OIG%20Work%20Plan%202017.pdf

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2017 OIG Ambulance Services

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- Supplier Compliance with Payment Requirements:
  - Medicare pays for:
    - ✓ Emergency and nonemergency ambulance services when a beneficiary's medical condition at the time of transport is such that other means of transportation would endanger the beneficiary
    - ✓ Different levels of ambulance services:
      - ➢ Including basic life support
      - ➢ Advanced life support
      - ➢ Specialty care transport
  - Prior OIG work found that Medicare made inappropriate payments for advanced life support emergency transports
  - OIG will determine whether Medicare payments for ambulance services were made in accordance with Medicare requirements
- OIG has focused its efforts on reducing improper payments and prevent and detecting fraud

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OIG Report

Office of the Inspector General (OIG) Report

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- Billing for Ambulance Transports:
  - In a September 2015 report, the OIG released results of a study of Medicare Part B ambulance claims
  - According to the report, almost 20 percent of ambulance suppliers had inappropriate and questionable billing for ambulance transport, creating vulnerabilities to Medicare Program integrity
  - OIG identified a number of key problems, including:
    - ✓ Ambulance transports for beneficiaries who did not receive any Medicare services at the point of origin or destination
    - ✓ Transports to non-covered destinations
    - ✓ Excessive mileage reported on claims for urban transports
    - ✓ Medically unnecessary transports to partial hospitalization programs
    - ✓ Inappropriate transport service levels
- Reference:
  - https://oig.hhs.gov/oei/reports/oei-09-12-00351.pdf

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OIG Questionable Billing for Ambulance Transports

- No Medicare Service at the Origin or Destination:
  - High percentage of a supplier's transports for which the beneficiaries did not receive Medicare services at the origin or destination indicated on the transport claim
  - Such transports may indicate billing for transports to non-covered destinations or transports that were not provided
- Excessive Mileage for Urban Transports:
  - High average mileage for transports for beneficiaries in urban areas
  - Such transports may indicate billing for more miles than suppliers actually drove or transports to facilities other than the nearest appropriate facilities

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

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- 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

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- 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
- Reference:
  - https://www.gpo.gov/fdsys/pkg/FR-2010-11-29/html/2010-27969.htm

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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

Additional OIG Questionable Billing for Ambulance Transports

- High Number of Transports per Beneficiary:
  - Among suppliers that provided dialysis-related transports, high average per-beneficiary number of transports:
    - ✓ Such transports may indicate billing for transports that were medically unnecessary
- Compromised Beneficiary Number:
  - Those that have been involved in or vulnerable to medical identity theft
  - High percentage of a supplier's transports with compromised beneficiary numbers:
    - ✓ Such transports may indicate billing for transports that were medically unnecessary or were not provided
- Beneficiary Sharing:
  - High average number of suppliers providing dialysis-related transports to the beneficiaries transported by a supplier:
    - ✓ Such transports may indicate misuse of beneficiaries' numbers or "shopping" by beneficiaries among suppliers to receive higher kickbacks

Additional OIG Questionable Billing for Ambulance Transports (cont.)

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- Inappropriate or Unlikely Transport Level:
  - High percentage of a supplier's transports with inappropriate or unlikely transport levels given the destinations:
    - ✓ Such transports may indicate up-coding or transport levels that were medically unnecessary
- Transports To or From Partial Hospitalization Programs (PHPs):
  - Supplier provided transports that were to or from PHPs
  - Such transports are likely to be medically unnecessary because beneficiaries who meet Medicare coverage requirements for PHPs generally do not meet the requirements for transports

Transports to PHPs

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- PHPs are considered to be at a hospital location; however, the patient must meet requirements for a PHP to participate in the program:
  - Likewise, patients must meet Medicare's requirements for coverage for non-emergency ambulance transportation
- Most patients do not meet both:
  - Therefore we would not expect to see claims for these types of transports

Requirements to Participate in a PHP

- Requirements to participate in a PHP are:
  - A minimum of 20 hours per week of therapeutic services as evidenced in the plan of care
  - Patient is likely to benefit from a coordinated program of services and requires more than isolated sessions of outpatient treatment
  - Patient does not require 24-hour care
  - Patient has an adequate support system while not actively engaged in the program
  - Patient has a mental health diagnosis
  - Patient is not judged to be dangerous to self or others
  - Patient has the cognitive and emotional ability to participate in the active treatment process and can tolerate the intensity of the PHP
- Note:
  - Patients must meet all requirements to participate in the program

Requirements for Ambulance Transports

- If a patient has conditions that could qualify him for an ambulance transport:
  - Diagnosed as either a danger to himself from active signs or symptoms of active psychiatric condition or acute substance withdrawal
  - Requires some degree of restraint to ensure there is no flight risk during transport to these hospitals; is disoriented, combative, and exhibits signs and/or symptoms of acute and severe anxiety and/or paranoia
  - Patient may meet the qualifications for an ambulance transport but would not meet the requirements for a PHP
  - Therefore, transports based on this instance may be denied as not medically necessary
- If the patient is not enrolled in a PHP (or does not meet all of the PHP requirements) and only meets the ambulance benefit (cannot be transported by any other means) and is being transported for group therapy or other psychotherapy services, then this would not qualify as an appropriate destination of “hospital” but as a “clinic” that has the ability of providing the service to patients at their origin

Arrangements

- When an arrangement between the PHP and ambulance supplier exists, the ambulance provider would expect reimbursement for the transport from the PHP and not from Medicare
- Arrangement is an agreement with the PHP that arranges the service and is paid by Medicare
- PHP is then responsible for payment to the contracted entities for the arranged service
- Many of these facilities have patient transportation included in their programs

Helpful Hints Prior to Transporting PHP Patients

- Prior to submitting the claim, suppliers should answer the following questions:
  - How is the facility classified and what is the patient's status with that entity?
  - Does the patient meet all of the PHP requirements?
  - Does the patient meet the ambulance benefit and cannot be transported by any other means?
    - ✓ Note: If the patient is transported due to being a danger to himself and/or others, he would not meet the PHP requirements and this would not be a covered destination
  - Can the service be brought to the patient cheaper than the patient to the service?

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CERT

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CERT

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- Program developed by Centers for Medicare & Medicaid Services (CMS) to monitor the accuracy of claims processing
- Designed to protect the Medicare trust fund and determine error rates nationally and regionally
- Random audits conducted on a monthly basis
- AdvanceMed request medical records for claims selected as part of the monthly random sample
- Medical record documentation supporting claim must be returned in designated time frame
- CERT page:
  - http://www.novitas-solutions.com/webcenter/spaces/CERT_JH

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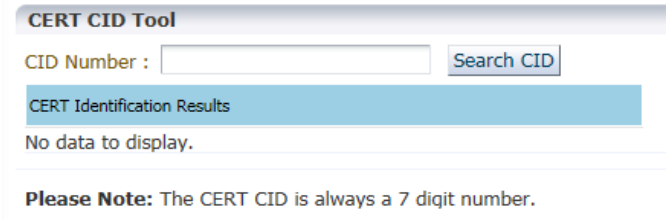
CERT Identification Online Tool

- Provides status information for sampled claims using the Claim Identification Number (CID) where a decision has been made by the CERT contractor:
  - Claim in Error- CERT error was assessed or not
  - Status Date- last date that CERT updated/reviewed the case
  - Status Decision- where the claim is with the CERT Review Contractor
  - Appealed- if an appeal was initiated and the appeal status
  - Error Code- errors assessed



CMS Provider Compliance: ALS Services

- Insufficient Documentation:
  - Ambulance suppliers often submit Medicare claims for ALS ambulance services which lack sufficient medical record documentation
  - 2015 CERT report states that the improper payment rate for ALS services was 14.5 percent with improper payments projected at $226 million
  - Most frequent errors occur when documentation:
    - ✓ Does not support the medical necessity of the ALS level of service
    - ✓ Lacks the patient's signature authorizing the supplier to bill Medicare for the service

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Medicare Updates

Social Security Number Removal Initiative

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- The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS to remove Social Security Numbers (SSNs) from all Medicare cards by April 2019
- Medicare Beneficiary Identifier (MBI) will replace the SSN-based Health Insurance Claim Number (HICN) on the new Medicare cards:
  - 11-characters in length
  - Made up only of numbers and uppercase letters (no special characters)
- Transition period:
  - Will begin no earlier than April 1, 2018 and run through December 31, 2019:
    - ✓ Either the HICN or the MBI can be used
    - ✓ Use the MBI or the HICN to check Medicare eligibility, after transition period ends use only the MBI
    - ✓ Use the MBI or HICN you used to submit the claim that's under appeal, even after the transition period

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What Providers Need to Know on The Social Security Number Removal Initiative (SSNRI)

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- How will providers get MBIs?:
  - During the transition period, the MBI will be on the remittance advice when you submit a claim using your patient's HICN
  - In the message field on the eligibility transaction responses it will let you know when a new Medicare card has been mailed to each person with Medicare
  - Your systems must be ready to accept the MBI by April 2018:
    - ✓ New Medicare cards will be sent no earlier than April 2018, people new to Medicare will only be assigned an MBI
- Claim forms:
  - Not changing:
    - ✓ During the transition period, you can use either the HICN or the MBI
    - ✓ Once the transition period ends, you must use the MBI
- Get more information about the SSNRI:
  - https://www.cms.gov/Medicare/SSNRI/Index.html

MBI Characteristics

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- Medicare Beneficiary Identifier (MBI) will have the following characteristics:
  - Same number of characters as the current HICN (11), but will be visibly distinguishable from the HICN
  - Contain uppercase alphabetic and numeric characters throughout the 11 digit identifier
  - Occupy the same field as the HICN on transactions
  - Be unique to each beneficiary (e.g. husband and wife will have their own MBI)
  - Be easy to read and limit the possibility of letters being interpreted as numbers (e.g. Alphabetic characters are upper case only and will exclude S, L, O, I, B, Z)
  - Not contain any embedded intelligence or special characters
  - Not contain inappropriate combinations of numbers or strings that may be offensive

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HICN and MBI Number

- Health Insurance Claim Number (HICN):
  - Primary Beneficiary Account Holder Social Security Number (SSN) plus Beneficiary Identification Code (BIC)
  - 9-byte SSN plus 1 or 2-byte BIC
  - Key positions 1-9 are numeric
- Medicare Beneficiary Identifier (MBI):
  - New Non-Intelligent Unique Identifier
  - 11 bytes
  - Key positions 2, 5, 8, and 9 will always be alphabetic
- Reference to CMS slides:
  - https://www.cms.gov/Medicare/SSNRI/SSNRI-ODF-slides-11-1-16.pptx

Ambulance Payment Extended

- Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 extended payment provisions of previous legislation
- Section 203 extends the provision:
  - Increasing Ambulance Fee Schedule amounts as defined by the zip code of the point of pickup:
    - ✓ By 2% for services originating in urban areas
    - ✓ By 3% for services originating in rural areas
  - Relating to payment for ground ambulance services that increased the base rate for transports:
    - ✓ Originating in an area that is within the lowest 25th percentile of all rural areas arrayed by population density (known as the “super rural” bonus)
  - This provision will expire on December 31, 2017
- Reference:
  - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AmbulanceFeeSchedule/afspuf.html

Ambulance Enrollment Moratoria

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- CMS extends, expands fraud-fighting temporary moratoria statewide:
  - Novitas shall process newly enrolling Part B emergency ambulance suppliers in the high risk category and perform all required screening and related activities for all previous moratoria areas, including Houston, TX
- Reference:
  - https://www.federalregister.gov/documents/2017/01/09/2016-32007/medicare-medicaid-and-childrens-health-insurance-programs-announcement-of-the-extension-of-temporary

Drugs

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- Drugs are part of the transport:
  - You cannot bill the patient
- Medicare will allow providers to submit a claim for secondary benefit denials:
  - Modifier GY can be used for statutorily excluded services
- Resource:
  - MM7489 Instructions to Accept and Process All Ambulance Transportation Healthcare Common Procedure Coding System Codes:
    - ✓ http://www.cms.gov/MLNMattersArticles/Downloads/MM7489.pdf

Proper Billing Of Drugs

- Ambulance transport and mileage codes price based on the point of pickup zip code
- Drug codes price based on the providers/suppliers billing address zip code
- Point of pickup and billing zip code are the same:
  - Report the full 9 digit zip code in loop 2310E – N403 and 2010AA – N403 and claims should not reject
- If the point of pickup and billing zip code are different:
  - Drug codes will need to be reported on a different claim:
    - ✓ Drug codes price off of the billing zip code and the ambulance price off of the point of pick up zip code

Ambulance Staffing Requirements

- Change Request 9761:
  - Effective: January 1, 2016
  - Implementation: December 12, 2016
- Key Points:
  - Revisions to the ambulance staffing requirements (80 FR 71078-71080)
  - Provides clarifications on the definitions for ground ambulance services:
    - ✓ ALS Level 1
    - ✓ ALS assessment
    - ✓ Application for ALS, Level 2 (ALS2)
    - ✓ Specialty Care Transport (SCT)
    - ✓ Paramedic Intercept (PI),
    - ✓ Emergency response and
    - ✓ Inter-facility transportation
- Reference:
  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9761.pdf

Vehicle Requirements for BLS

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- BLS ambulances:
  - Must be staffed by at least two people:
    - ✓ *Who meet the requirements of state and local laws where the services are being furnished and where:*
- *A*t least one of whom must:
  - Be certified *at a minimum* as an emergency medical technician-*basic* (EMT-*basic*) by the state or local authority where the services are being furnished
  - Be legally authorized to operate all lifesaving and life-sustaining equipment on board the vehicle

Vehicle Requirements for ALS

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- ALS vehicles must be staffed by at least two people:
  - *Who meet the requirements of state and local laws where the services are being furnished and where:*
- At least one of whom must:
  - *Meet the vehicle staff requirements above for BLS vehicles*
  - Be certified *as an EMT-Intermediate or an EMT-Paramedic* by the state or local authority *where the services are being furnished to perform one or more ALS services*

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Definition of Ambulance Services

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- There are several categories of ground ambulance services and two categories of air ambulance services under the fee schedule:
  - Note: Ground refers to both land and water transportation
- *All ground and air ambulance transportation services must meet all requirements regarding medical reasonableness and necessity as outlined in the applicable statute, regulations and manual provisions*

Emergency Level of Service

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- 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
  - 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
- *The nature of an ambulance's response (whether emergency or not) does not independently establish or support medical necessity for an ambulance transport.*
  - *Rather, Medicare coverage always depends on, among other things, whether the service(s) furnished is actually medically reasonable and necessary based on the patient's condition at the time of transport*

Ground Ambulance Services

- Basic Life Support (BLS) – A0428:
  - 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

Advanced Life Support, Level 1

- Advanced Life Support, Level 1 (ALS1) – A0426:
  - Medically necessary supplies and services and an ALS assessment by ALS personnel or the provision of at least one ALS intervention:
    - ✓ ALS intervention is a procedure beyond the scope of an EMT-Basic in accordance with state law
- Advanced Life Support, Level 1 (ALS1) – Emergency – A0427:
  - Patient's health is in serious jeopardy
  - Serious impairment to bodily functions
  - Serious dysfunction of any bodily organ or part
  - Immediate response

ALS Assessment and Intervention

- ALS Assessment:
  - Performed by an ALS crew as part of an emergency response that was necessary because the patient's reported condition at the time of dispatch was such that only an ALS crew was qualified to perform the assessment
  - Assessment does not necessarily result in a determination that the patient requires an ALS level of service
  - *In the case of an appropriately dispatched ALS emergency service, if the ALS crew completes an ALS assessment, the services provided by the ambulance transportation service provider or supplier may be covered at the ALS emergency level, regardless of whether the patient required ALS intervention services during the transport, provided that ambulance transportation itself was medically reasonable and necessary as defined in section 10.2:*
    - ✓ https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c10.pdf

ALS Intervention

- ALS Intervention:
  - A procedure that is, in accordance with state and local laws, "required to be furnished by ALS personnel":
    - ✓ An unsuccessful attempt to perform an ALS intervention (e.g., endotracheal intubation was attempted, but was unsuccessful) may qualify the transport for billing at the appropriate ALS level provided that the intervention would have been reasonable and necessary had it been successful

Advanced Life Support, Level 2

- Advanced Life Support, Level 2 (ALS2) – A0433:
  - Medically necessary supplies and services:
    - ✓ At least three separate administrations of one or more medications by IV push/bolus or by continuous infusion OR
    - ✓ The provision of at least one of the following ALS procedures:
      - ➢ Manual defibrillation/cardioversion
      - ➢ Endotracheal intubation
      - ➢ Central venous line
      - ➢ Cardiac pacing
      - ➢ Chest decompression
      - ➢ Surgical airway
      - ➢ Intraosseous line
- CMS added several examples under the application section for ALS procedures

Specialty Care Transport

- Specialty Care Transport (SCT) – A0434:
  - Inter-facility transportation of a critically injured or ill beneficiary by ground vehicle
  - Includes the provision of medically necessary supplies and services beyond the scope of the EMT paramedic
  - When a patient's condition requires ongoing care that must be provided by one or more health professionals in an appropriate specialty area
  - Example:
    - ✓ Emergency or critical care nursing, emergency medicine, respiratory care, cardiovascular care or a paramedic with additional training

CMS Definition of SCT

- SCT is the inter-facility transportation of a critically injured or ill beneficiary by a ground ambulance vehicle:
  - Including the provision of medically necessary supplies and services, at a level of service beyond the scope of the EMT-Paramedic
- SCT is necessary when a beneficiary's condition requires ongoing care that must be furnished by one or more health professionals in an appropriate specialty area:
  - For example, emergency or critical care nursing, emergency medicine, respiratory care, cardiovascular care, or *an EMT*-Paramedic with additional training

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

SCT Application

- Application:
  - SCT is necessary when a beneficiary's condition requires ongoing care that must be furnished by one or more health professionals in an appropriate specialty area
  - *EMT-Paramedic level of care is set by each state:*
    - ✓ *Medically necessary care that is furnished at a level above the EMT-Paramedic level of care may qualify as SCT*
    - ✓ *To be clear,* if EMT-Paramedics - without specialty care certification or qualification - are permitted to furnish a given service in a state, then that service does **not** qualify for SCT
  - The phrase "EMT-Paramedic with additional training" recognizes that a state may permit a person who is not only certified as an EMT-Paramedic, but who also has successfully completed additional education as determined by the state in furnishing higher level medical services required by critically ill or injured patients, to furnish a level of service that otherwise would require a health professional in an appropriate specialty care area (for example, a nurse) to provide
  - "Additional training" means the specific additional training that a state requires a paramedic to complete in order to qualify to furnish specialty care to a critically ill or injured patient during an SCT

Inter-facility Transportation

- *Definition:*
  - *For purposes of SCT payment, an inter-facility transportation is one in which the origin and destination are one of the following:*
    - ✓ *A hospital or skilled nursing facility that participates in the Medicare program*
    - ✓ *A hospital-based facility that meets Medicare's requirements for provider-based status*
- SCT approved facilities:
  - Medicare hospitals include, but are not limited to, rehabilitation hospitals, cancer hospitals, children's hospitals, psychiatric hospitals, CAH, inpatient acute-care hospitals and Sole Community Hospitals (SCHs)

Paramedic Intercept

NOVITAS SOLUTIONS

- Paramedic Intercept (PI) - A0432:
  - Rural area transport furnished by a volunteer ambulance company, which is prohibited by state law from billing third-party payers
  - Based on the definition of paramedic intercept, suppliers/providers are not meeting the definition when billing the paramedic code
  - The JH states do not prohibit a volunteer ambulance company from billing a third-party payer
- Coverage:
  - Presently, only the state of New York meets the Medicare requirements for paramedic intercept. Contractors will deny all other states
- Reference:
  - CMS IOM 100-04 Chapter 15:
    - ✓ http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c15.pdf

Ambulance Coverage Destinations

NOVITAS SOLUTIONS

- Covered to the following destinations:
  - Hospital
  - CAH
  - SNF
  - Beneficiary's home
  - Dialysis facility for an ESRD patient who requires dialysis
- Nearest appropriate facility
- Mileage to the nearest appropriate facility covered

INNOVATION IN ACTION

Appropriate Facilities

- 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:
  - 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 (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

Free-Standing Emergency Facility

NOVITAS SOLUTIONS

- Must be a provider-based off campus facility to qualify for the H origin/destination otherwise if not provider based then it is a P origin/destination and not covered
- Refer to 42 CFR 413.65 to determine if the Free Standing Emergency Facility is provider based or not:
  - http://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol2/pdf/CFR-2011-title42-vol2-sec413-65.pdf
- Reference:
  - This information was provided during the CMS Ambulance Open Door Forum on April 21, 2015

Determining Who to Bill Part A or Part B

NOVITAS SOLUTIONS

- Guidelines for determining who to bill Part A or Part B:
  - CMS IOM 100-02 Chapter 10, Section 10.3.3:
    - ✓ http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c10.pdf

INNOVATION IN ACTION

Ambulance Transports Require Dual Diagnoses

- All ground ambulance transports require dual diagnoses for services rendered October 1, 2015 and after:
  - Providers should report the most appropriate ICD-10-CM code that adequately describes the patient's medical condition at the time of transport as the primary diagnosis
- One diagnosis from the ambulance article or a valid ICD-10-CM Code from the ICD-10-CM manual:
  - LCA– Ground Ambulance Services – A54574
- A secondary diagnosis must be reported from the LCD:
  - LCD- Ground Ambulance Services - L35162
- FAQ:
  - http://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00083570
- Reference:
  - http://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00024343

Dual Diagnoses FAQ #1, #2 and # 3

- Question:
  - What if a secondary code from the LCD list does not get reported on the claim?
- Answer:
  - It will deny
- Question:
  - How will the claim be processed if a diagnosis is used from the ICD-10 manual that is not listed in the Article?
- Answer:
  - The ICD-10 code from the manual will be considered
- Question:
  - Does it matter which code is submitted first the article code/ICD-10 manual code or the LCD Code?
- Answer:
  - No, no order is required as long as one code from the LCD and one code from the article codes/ICD-10 manual codes are submitted

Dual Diagnoses FAQ #4 and #5

- Question:
  - Can more than one of the secondary codes listed in the LCD be submitted on the claim?
- Answer:
  - We recommend only using one of the secondary codes from the LCD
- Question:
  - What if the claim is filed with the GY modifier and the code Z76.89 is not submitted on the claim?
- Answer:
  - The claim will deny

Dual Diagnoses FAQ #6 and #7

- Question:
  - When filing a claim for an Aid Call is one of the secondary codes listed in the LCD required?
- Answer:
  - No, only an ICD-10 code from the Ambulance article or ICD-10 code from the manual is required
- Question:
  - When filing a claim with the QL modifier is one of the secondary codes listed in the LCD required?
- Answer:
  - No, only an ICD-10 code from the Ambulance article or ICD-10 code from the manual is required

Claims that are Denied

- To correct any initial submissions:
  - Resubmit the claim:
    - ✓ Ensure that you report the primary diagnosis code as the most appropriate ICD-10 code that adequately describes the patient's medical condition at the time of transport. In addition, a secondary diagnosis code must be reported, which reflects the patient's need for the ambulance service and ambulance personnel at the time of transport
  - Request a reopening of the claim:
    - ✓ Use the Medicare Redetermination and Clerical Error Reopening Request Form
    - ✓ Include a revised copy of the claim highlighting the service in question and include the appropriate primary and secondary ICD-10 code:
      - ➢ http://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00088692
  - Claim corrections can also be submitted electronically via Novitasphere:
    - ✓ Diagnosis code
    - ✓ Modifiers

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

Submitting Supporting Mileage Documentation

NOVITAS SOLUTIONS

- To submit additional documentation for an electronic claim, follow the instructions provided in the:
  - Electronic Billing Guide: Chapter 11 – Submitting Medical Documentation for Part A/B 5010 Electronic Claims:
    - ✓ http://www.novitas-solutions.com/webcenter/spaces/MedicareJH/page/pagebyid?contentId=00004552
- Failure to return information requested in an ADR will result in denial of the line item detail with:
  - Claim Adjustment Reason Code (CARC) 50
  - Remittance Advice Remark Code (RARC) N102
- If your claim denies, you have the right to appeal the decision along with documentation/justification for mileage billed beyond 126 miles
- Reference:
  - http://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00121964

NOVITAS SOLUTIONS

Proper 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 CPT/HCPCS code must describe the services performed

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

NOVITAS SOLUTIONS

- 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

Available Documentation

NOVITAS SOLUTIONS

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

INNOVATION IN ACTION

Insufficient Documentation

- LCD list examples of insufficient statements to justify medical necessity:
  - Hypertension
  - Chest Pain
  - Patient unable to sit, stand or walk
- References:
  - Local Coverage Determination Ground Ambulance Services - L35162:
    - ✓ http://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00080465
  - Local Coverage Article – Ground Ambulance Services – A54574:
    - ✓ http://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00024343

Signature Guidelines for Medical Review Purposes

- 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
- Reference:
  - Special Edition Article SE1419:
    - ✓ http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1419.pdf

Signature Guidelines for Medical Review Purposes (Cont.)

NOVITAS SOLUTIONS

- 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

NOVITAS SOLUTIONS

- LCA– Ground Ambulance Services - A54574:
  - http://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00024343
- LCD- Ground Ambulance Services - L35162:
  - http://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00080465
- CMS Ambulance Service Center:
  - http://www.cms.gov/Center/Provider-Type/Ambulances-Services-Center.html
- Novitas Specialty Ambulance Center:
  - http://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00134575
- Ambulance services:
  - IOM 100-2; Chapter 10 http://www.cms.gov/manuals/Downloads/bp102c10.pdf
  - IOM 100-4; Chapter 15 http://www.cms.gov/manuals/downloads/clm104c15.pdf

INNOVATION IN ACTION

Additional Ambulance and Signatures Resources

NOVITAS SOLUTIONS

- Use the following resources to avoid documentation errors:
  - Medicare Ambulance Transports Booklet::
    - ✓ https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Medicare-Ambulance-Transports-Booklet-ICN903194.pdf
  - 42 Code of Federal Regulations 424.36 - Signature Requirements:
    - ✓ https://www.gpo.gov/fdsys/granule/CFR-2012-title42-vol3/CFR-2012-title42-vol3-sec424-36/content-detail.html
  - Guidance on Beneficiary Signature Requirements for Ambulance Claims:
    - ✓ https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AmbulanceFeeSchedule/Downloads/Guidance_on_Beneficiary_Signature_Requirements_for_Ambulance_Claims.pdf
  - April 2016 Medicare Quarterly Provider Compliance Newsletter:
    - ✓ https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedQtrlyComp-Newsletter-ICN909309.pdf
  - Ambulance Fee Schedule Fact Sheet:
    - ✓ https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AmbulanceFeeSched_508.pdf
  - Medicare Claims Processing Manual, Chapter 15:
    - ✓ https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c15.pdf

NOVITAS SOLUTIONS

Provider Enrollment

INNOVATION IN ACTION

Enrollment Information

- Enrollment:
  - Must enroll prior to billing Medicare
  - Must keep all information current
  - 2017 Application Fee of $560.00 must be paid prior to submitting the application:
    - ✓ Fee applies to Ambulance suppliers
- There are two ways for providers/suppliers to submit or update their application:
  - Internet-based PECOS:
    - ✓ https://pecos.cms.hhs.gov
  - Paper application:
    - ✓ http://www.novitas-solutions.com/webcenter/spaces/Enrollment_JH
- Reference:
  - http://www.novitas-solutions.com/webcenter/portal/Enrollment_JH/Enrollment

Timely Reporting of Provider Enrollment Information Changes

- Special Edition Article SE1617
- Key Points:
  - All physician and non-physician practitioners and physician and non-physician organizations must report the following changes within 30 days:
    - ✓ A change of ownership
    - ✓ An adverse legal action
    - ✓ A change in practice location
  - All other changes must be reported to your MAC within 90 days of the change
  - All providers and suppliers not previously identified above must report any changes of within 30 days:
    - ✓ A change of ownership
    - ✓ Including a change in an authorized or delegated official
  - All other informational changes within 90 days
  - Changes can be reported via the Internet-based PECOS or the CMS 855 paper enrollment application
- Reference:
  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1617.pdf

Processing Timeframes- Paper Applications

NOVITAS SOLUTIONS

- Initial Enrollments, Revalidations and Reactivations:
  - 60-210 calendar days from receipt
  - 80% of applications will be processed within 60-80 calendar days
- Reassignments/Change Requests:
  - 60-120 calendar days from receipt
  - 80% of applications will be processed within 60 calendar days
- Processing timeframes will vary contingent upon the number of development requests and whether or not a site visit is required:
  - To help avoid delays, ensure all sections of the enrollment applications are completed and any supporting documentation is provided

Processing timelines- Internet-based PECOS Applications

NOVITAS SOLUTIONS

- Initial Enrollments, Revalidation, Reactivations:
  - 45-120 calendar days from receipt
  - 80% of applications will be processed within 45-80 calendar days
- Reassignments and Change Requests:
  - 45-90 calendar days from receipt
  - 90% of applications will be processed within 45 calendar days
- Processing timeframes will vary contingent upon the number of development requests and whether or not a site visit is required:
  - To help avoid delays, ensure all sections of the enrollment applications are completed and any supporting documentation is provided

NOVITAS SOLUTIONS

Revalidation Overview

INNOVATION IN ACTION

Revalidation Defined

NOVITAS SOLUTIONS

- In accordance with 42 CFR §424.515, to maintain Medicare billing privileges, a provider or supplier must resubmit and recertify the accuracy of its enrollment information generally every five years:
  - Revalidation ensures that your enrollment information on file with Medicare remains complete and up-to-date
  - Section 6401 (a) of the Affordable Care Act established a requirement for all enrolled providers/suppliers to revalidate their Medicare enrollment information under new enrollment screening criteria. CMS has completed its initial round of revalidations and began Cycle 2 in March 2016
  - Each provider/supplier is required to revalidate their entire Medicare enrollment record to include all active practice locations and/or current reassignments

INNOVATION IN ACTION

Changes to Cycle 2

- CMS has established due dates by which you must revalidate
- Unsolicited revalidation submissions will be returned
- Providers/suppliers who are within two months of their listed due dates, but have not received a revalidation notice are encouraged to submit their revalidation application
- Revalidation letters/notifications will be sent to at least two addresses on file (correspondence, special payments, and/or practice address)
- Non-response to revalidation or development requests will result in a hold on Medicare payments and deactivation of your enrollment
- Reactivation will occur when a complete application is received
- There will be a gap in coverage (no payments) between the date of deactivation and the receipt date of the new, completed application:
  - Retroactive billing privileges back to the period of deactivation will not be granted

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 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 EFT (if applicable)

Using Internet-based PECOS

NOVITAS SOLUTIONS

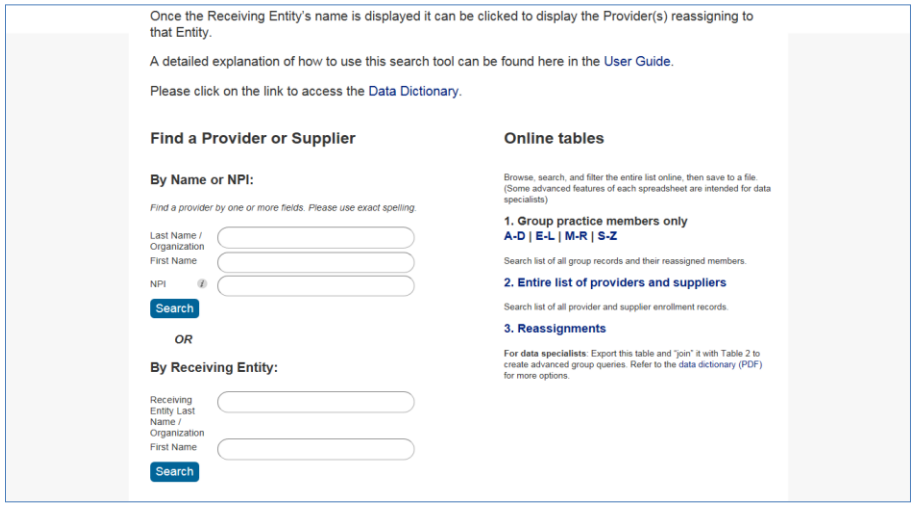
- Most efficient way to submit your revalidation information is by using the Internet-based PECOS located at:
  - https://pecos.cms.hhs.gov/pecos/login.do
- PECOS allows you to review information currently on file, update and submit your revalidation via the Internet
- You must either electronically sign the revalidation application or print, sign, date, and mail the paper certification statement to your MAC
- In addition, please either upload any supporting documentation into PECOS or mail it along with your paper certification statement
- Please do so IMMEDIATELY in order to avoid delays

Due Dates in Cycle 2

NOVITAS SOLUTIONS

- CMS has established due dates for when you must revalidate:
  - Due dates will always be on the last day of the month
- Posted due dates on https://data.cms.gov/revalidation:
  - Revalidation due date displayed, if due within six months
  - "TBD" (To Be Determined) displayed in the due date field for all other providers/suppliers
  - Revalidation due date posted up to six months in advance to allow time for provider/supplier to comply
  - NO extensions of the due date
- Revalidation notices sent via mail:
  - Novitas Solutions will send a revalidation notice two-three 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 – data.cms.gov/revalidation


Once the Receiving Entity's name is displayed it can be clicked to display the Provider(s) reassigning to that Entity.

A detailed explanation of how to use this search tool can be found here in the User Guide.

Please click on the link to access the Data Dictionary.

Find a Provider or Supplier

By Name or NPI:

Find a provider by one or more fields. Please use exact spelling.

Last Name / Organization

First Name

NPI

Search

OR

By Receiving Entity:

Receiving Entity Last Name / Organization

First Name

Search

Online tables

Browse, search, and filter the entire list online, then save to a file. (Some advanced features of each spreadsheet are intended for data specialists)

1. Group practice members only

A-D | E-L | M-R | S-Z

Search list of all group records and their reassigned members.

2. Entire list of providers and suppliers

Search list of all provider and supplier enrollment records.

3. Reassignments

For data specialists: Export this table and "join" it with Table 2 to create advanced group queries. Refer to the data dictionary (PDF) for more options.

Avoid Deactivation

- Avoid deactivation due to non-response:
  - Submit a complete revalidation application by the due date
  - Respond to all development requests within 30 days:
    - ✓ Avoid a hold on your Medicare payments
    - ✓ Avoid deactivation of your Medicare billing privileges
  - Applications or additional requested information received after the due date will result in your provider enrollment record being deactivated

Deactivation: Non-Response to Revalidation

- If you are deactivated due to non-response:
  - Providers/suppliers deactivated will be required to:
    - ✓ Submit a new full and complete application:
      - ➢ In order to reestablish their provider enrollment record and related Medicare billing privileges
  - Provider/supplier will maintain their original PTAN but:
    - ✓ Interruption in billing will occur during the period of deactivation resulting in a gap in coverage
  - Reactivation after a period of deactivation is based on the receipt date of the new full and complete application
  - No retroactive billing privileges will be granted

Overview of the Enrollment/Revalidation Process

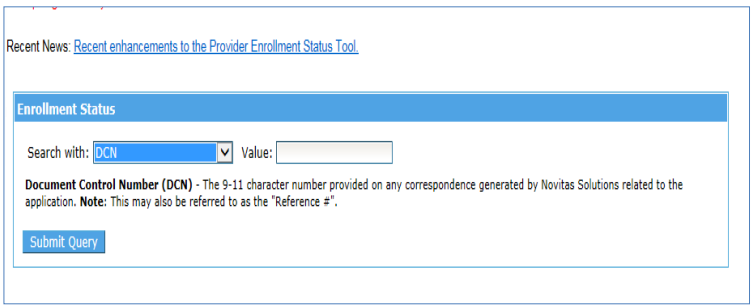
- Submit a CMS-855 Medicare enrollment application by using internet-based PECOS, or by mailing a hardcopy application:
  - Internet-based PECOS:
    - ✓ Providers/suppliers must have an active NPI and have a web user account established in NPPES
    - ✓ Physicians and non-physician practitioners will access internet-based PECOS with the same user ID and password that they use for NPPES:
      - ➢ https://pecos.cms.hhs.gov
  - Paper Applications:
    - ✓ To enroll via paper, download the appropriate, current CMS-855 Medicare Enrollment Application
    - ✓ Mail all hardcopy applications/supporting documents to the correct address depending on your location

Mailing Address For Revalidation

- JH providers revalidation mailing address:
  - Novitas JH Provider Enrollment Services
    P.O. Box 44137
    Jacksonville, FL 32231

Provider Enrollment Status Inquiry Tool

- Enrollment Status Tool:
  - http://www.novitas-solutions.com/webcenter/spaces/MedicareJH/page/pagebyid?contentId=00004864



Further Details on the Revalidation of Provider Enrollment Information

NOVITAS SOLUTIONS

- Special Edition Article SE1605
- Key Point:
  - CMS has implemented several revalidation processing improvements included in this article
- Reference:
  - http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1605.pdf

NOVITAS SOLUTIONS

Helpful Hints and Reminders for Revalidation

INNOVATION IN ACTION

Revalidation Helpful Hints/Reminders

NOVITAS SOLUTIONS

- Check your due date
- Complete the correct CMS-855 application
- Complete the application as if a new enrollee:
  - Use submission reason "You are revalidating your Medicare enrollment"
- In the event of a business structure change, please include a copy of your tax document
- Include the cover sheet when faxing, emailing or mailing the responses
- Use current CMS-855 and CMS-588 paper forms and tutorials:
  - http://www.novitas-solutions.com/webcenter/spaces/MedicareJH/page/pagebyid?contentId=00004821

INNOVATION IN ACTION

Tips for Completing the Enrollment Application

NOVITAS SOLUTIONS

- Completely fill out the revalidation application as if an initial enrollment:
  - Novitas JH Provider Enrollment
    P.O. Box 44137
    Jacksonville, FL 32231
- Helpful hints and tips can be found:
  - http://www.novitas-solutions.com/webcenter/spaces/MedicareJH/page/pagebyid?contentId=00024849

INNOVATION IN ACTION

Supporting Documents Needed for Revalidation

NOVITAS SOLUTIONS

- Mandatory for all provider/supplier types:
  - Licenses, certifications and registrations required by Medicare or state law
  - Federal, state, and/or local (city/county) business licenses, certifications and/or registrations required to operate a health care facility
  - Written confirmation from the IRS confirming your Tax Identification Number with the Legal Business Name (e.g., IRS CP 575)
  - Completed Form CMS-588, Authorization Agreement for EFT:
    - ✓ Note: If you have submitted a CMS-588/EFT Agreement to your MAC after May, 2010 or September, 2013, then you have the most recent version of the EFT form on file, so a new EFT form is not required to be submitted with your revalidation application

Application Form Checklist

NOVITAS SOLUTIONS

- Review application before sending:
  - Ensure the correct form is being used
  - Verify all of the correct fields are completed
  - Ensure all required documentation is enclosed/attached
  - Print or type all information so it is legible:
    - ✓ Do not use pencil:
      - ➢ Blue ink is preferred
  - Sign and date the application:
    - ✓ Submit the application with the original signature

INNOVATION IN ACTION

Paying Application Fees

- Providers who submit applications online via the internet-based PECOS:
  - Proceed through the internet-based PECOS application process; if a fee is required, you will be prompted to submit your payment:
    - ✓ Once your payment transaction is completed, you will be automatically returned to the PECOS website to complete the remaining part of your application
- Providers using the CMS-855 paper enrollment application will submit your application fee by accessing the Medicare Enrollment Application Fee Form:
  - https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do
  - At the conclusion of the collection process, you will receive a receipt indicating the status of your payment:
    - ✓ Please print a copy for your records
    - ✓ We strongly recommend that you attach this receipt to the completed CMS-855 application submitted to your Medicare contractor

FAQs #1 and #2

- **Question 1:**
  - None of the information on my file has changed; will I still be required to submit a revalidation application?
- **Answer 1:**
  - Yes, a complete CMS-855B is required even if there has been no change to your information
- **Question 2:**
  - I have an established enrollment record in PECOS. How do I select "Revalidation" as the reason for submission?
- **Answer 2:**
  - If you do have a PECOS enrollment record established, under "My Enrollment", you should first select "View Enrollments", then select "Revalidation"

FAQ #3

NOVITAS SOLUTIONS

- **Question 3**:
  - How many revalidation letters are being sent to each supplier?
- **Answer 3:**
  - Revalidation letters including all PTANs/CMS Certification number (CCNs) identified by CMS are sent to each affected provider/supplier
  - Novitas Solutions will mail letters to at least two addresses on file:
    - ✓ The correspondence address, special payment address, and/or primary practice address
  - If a provider/supplier is enrolled in more than one state in our jurisdiction, and is required to revalidate in each, separate letters will be issued:
    - ✓ Separate revalidation applications are required for each state in which you were asked to revalidate

FAQs #4 and #5

NOVITAS SOLUTIONS

- **Question 4:**
  - I just recently sent an application. Why do I have to revalidate?
- **Answer 4:**
  - Revalidation does not change other aspects of the enrollment process
  - Providers/suppliers should continue to submit changes
  - If you have a request for revalidation from Novitas, respond separately to that request
- **Question 5:**
  - I did not receive a revalidation notice but I am billing Medicare. I have not submitted a CMS-855 application since 2003 and I am not in PECOS. Should I submit a revalidation application?
- **Answer 5:**
  - Yes, you should submit a revalidation application. It is possible that the address information on file is outdated and we received returned mail

FAQs #6 and #7

NOVITAS SOLUTIONS

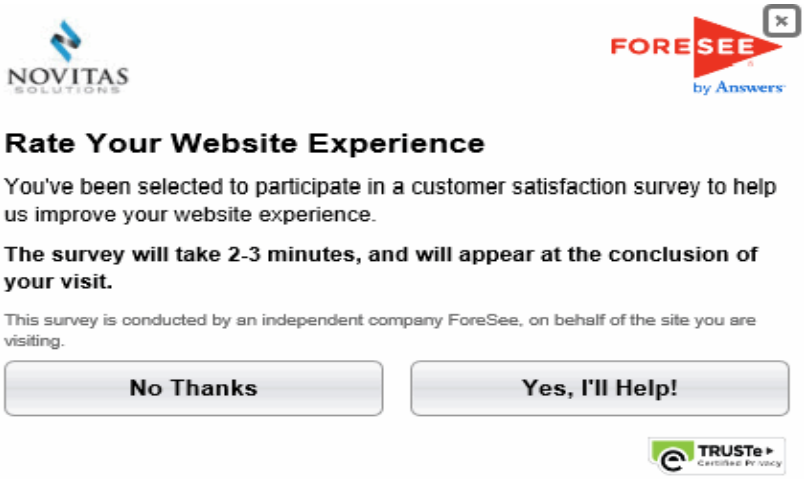
- **Question 6:**
  - I received a revalidation letter. How do I revalidate my Medicare file?
- **Answer 6:**
  - Make sure to mark “revalidation” as the reason for the submission
  - Submit application to Novitas along with the other needed documents including the CMS-588 Electronic Funds Transfer (EFT) Authorization Agreement and a voided check OR a statement from bank confirming bank account information (if needed)
  - The most efficient way to submit your revalidation information is by using the Internet-based PECOS web application
- **Question 7:**
  - I read somewhere that I have to pay to revalidate?
- **Answer 7:**
  - Yes, ambulance providers revalidating their enrollment information and submitting a CMS-855B will need to pay a fee

NOVITAS SOLUTIONS

Novitas Reminders

INNOVATION IN ACTION

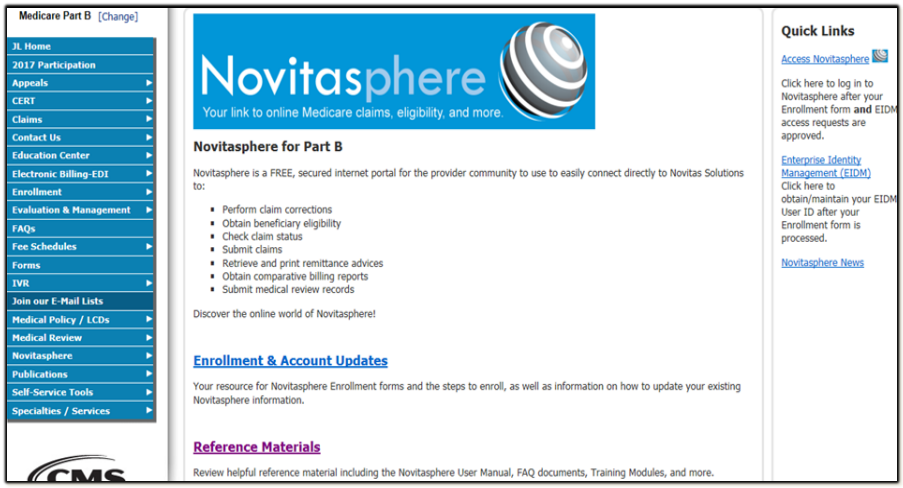
Website Satisfaction Surveys



What is Novitasphere?

- Free, secure web-based portal
- Part B - access to:
  - Eligibility
  - Claim information
  - Claim submission with file status
  - Electronic Remittance Advice (ERA)
  - Claim correction
  - Secure messaging and a mailbox
- Live Chat feature
- Dedicated help desk- 1-855-880-8424
- For demonstrations and more information:
  - http://www.novitas-solutions.com/webcenter/portal/Novitasphere_JH/

Novitasphere Web Page



Enrollment Three Basic Steps

1. Complete the Novitasphere Portal Enrollment form
2. Register for Enterprise Identity Management (EIDM) User ID and password
3. Register Novitasphere role in EIDM:
   - Register a Multi-Factor Authentication (MFA) Device

Enrollment Form for Provider Office

- Complete the appropriate Novitasphere Portal Enrollment form:
  - 8292PJH:
    - ✓ http://www.novitas-solutions.com/webcenter/spaces/MedicareJH/page/pagebyid?contentId=00081357
  - Carefully follow the instructions for the completion of your form:
    - ✓ 8292PJH instructions:
      - ➢ http://www.novitas-solutions.com/webcenter/content/conn/UCM_Repository/uuid/dDocName:00024654

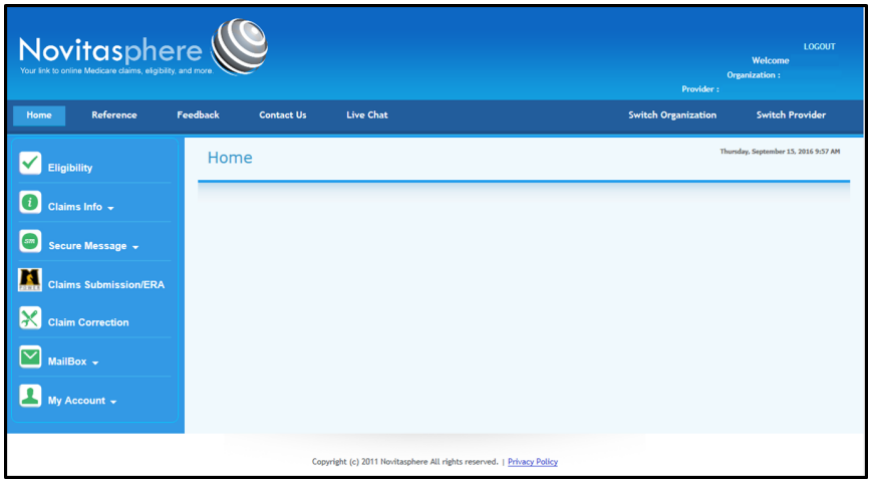
I N N O V A T I O N I N A C T I O N

Enrollment Form for Billing Service/Clearinghouse

- Complete the appropriate Novitasphere Enrollment form:
  - 8291PJH:
    - ✓ http://novitas-solutions.com/cs/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&dDocName=00094673&allowInterrupt=1
  - Carefully follow the instructions for the completion of your form:
    - ✓ 8291PJH instructions:
      - ➢ http://novitas-solutions.com/cs/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&dDocName=00096118&allowInterrupt=1

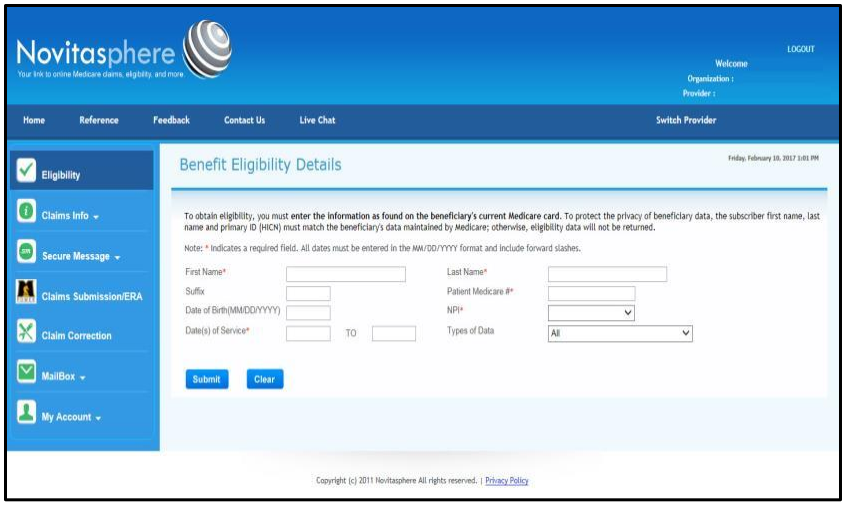
I N N O V A T I O N I N A C T I O N

Novitasphere Homepage



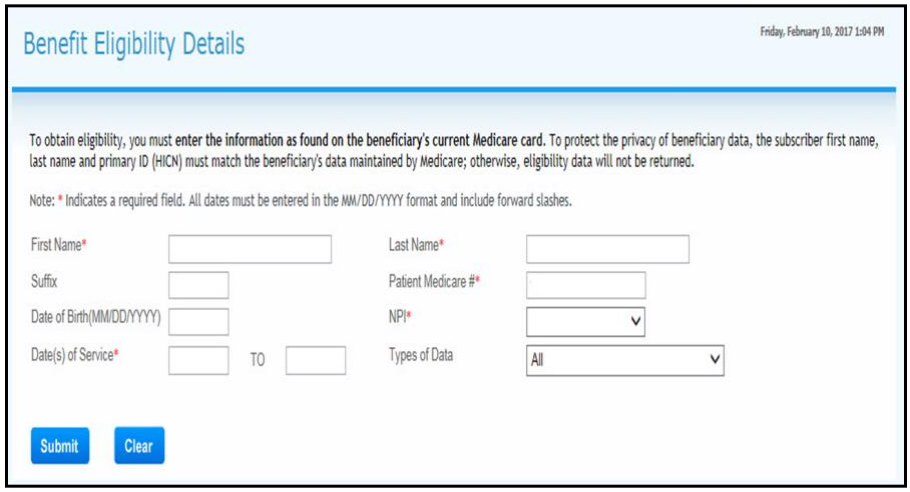
I N N O V A T I O N I N A C T I O N

Eligibility

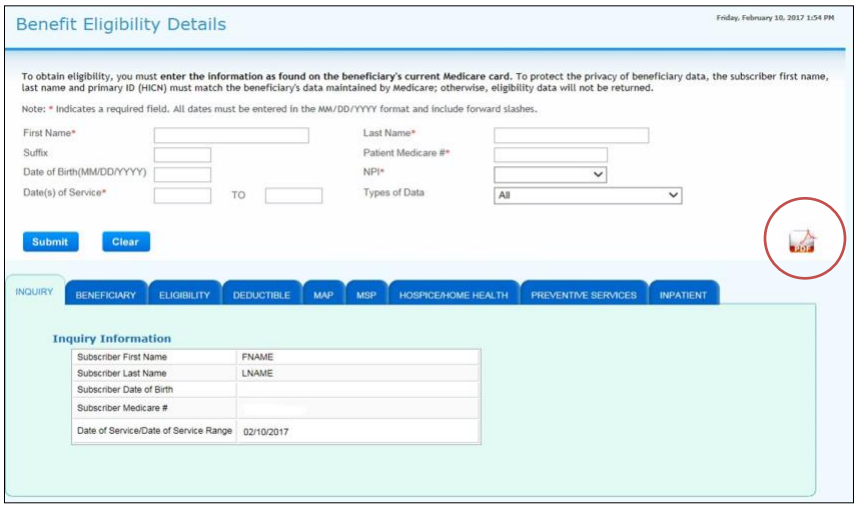


I N N O V A T I O N I N A C T I O N

Benefit Eligibility Search



Eligibility Information



PDF Version

Novitasphere
Your link to online Medicare claims, eligibility, and more.

03/23/2017 09:05 AM

Disclaimer: The information is accurate only at the time of publication.

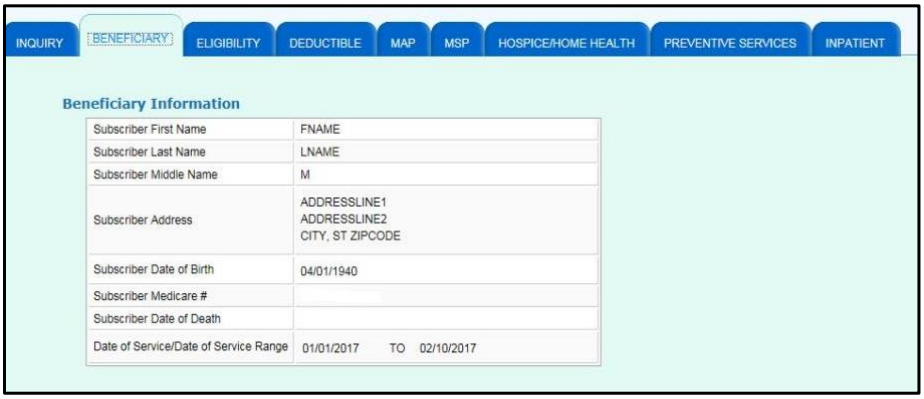
Inquiry Information

Subscriber First Name:	FNAME
Subscriber Last Name:	LNAME
Subscriber Date of Birth:	
Subscriber Primary ID (HICN):	#########A
Date of Service/Date of Service Range:	03/23/2016 - 03/23/2017

Beneficiary Information

Subscriber First Name:	FNAME
Subscriber Last Name:	LNAME
Subscriber Middle Name:	M
Subscriber Name Suffix:	

Beneficiary Tab

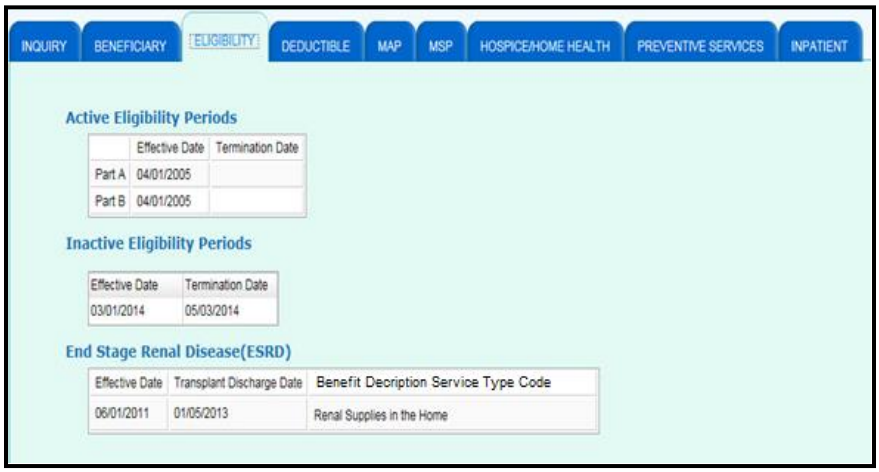


INQUIRY | BENEFICIARY | ELIGIBILITY | DEDUCTIBLE | MAP | MSP | HOSPICE/HOME HEALTH | PREVENTIVE SERVICES | INPATIENT

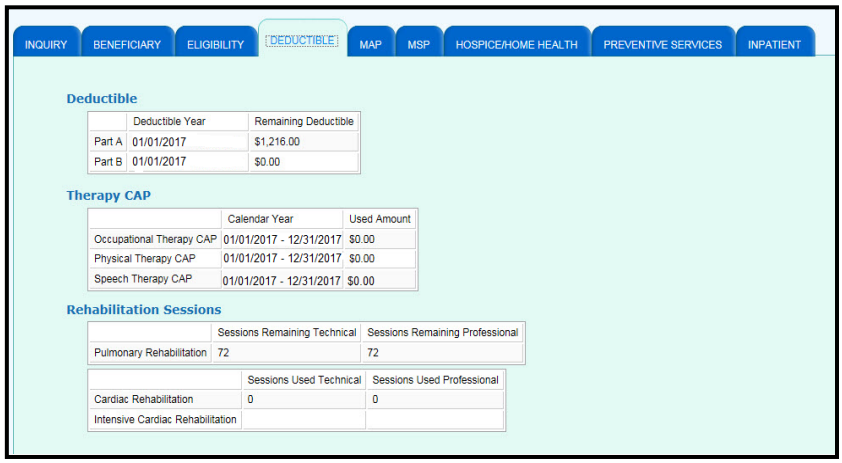
Beneficiary Information

Subscriber First Name	FNAME
Subscriber Last Name	LNAME
Subscriber Middle Name	M
Subscriber Address	ADDRESSLINE1 ADDRESSLINE2 CITY, ST ZIPCODE
Subscriber Date of Birth	04/01/1940
Subscriber Medicare #	
Subscriber Date of Death	
Date of Service/Date of Service Range	01/01/2017 TO 02/10/2017

Eligibility Tab



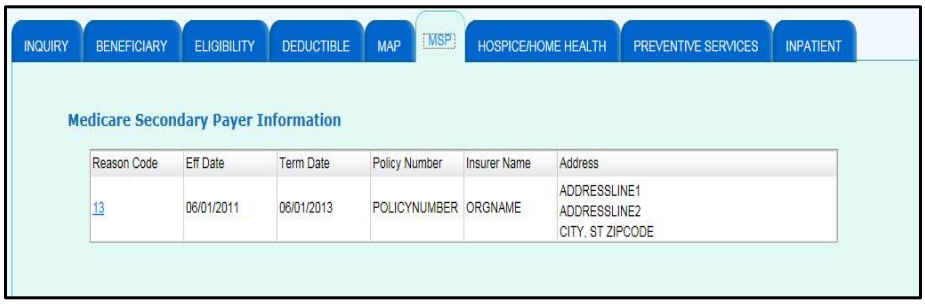
Deductible Tab



Medicare Advantage Plan (MAP) Tab

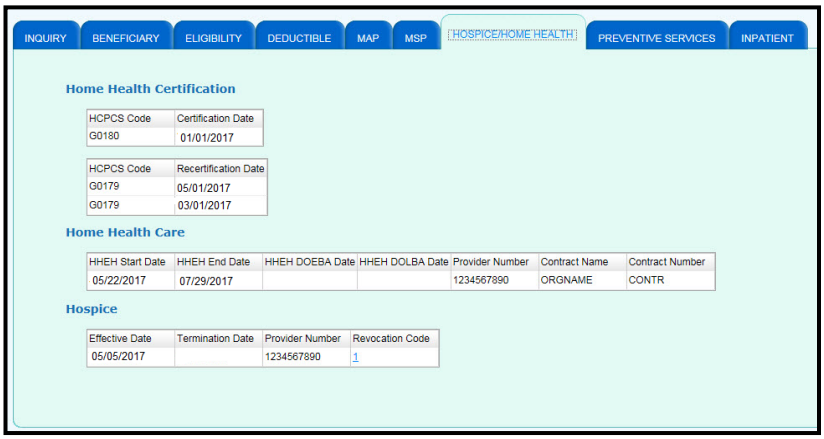
Contract Name	Contractor #	Plan Type	MCO Bill Opt Code	Eff Date	Term Date	Address	Tel Number
ORGNAME	S0000999	Part D		01/01/2013		ADDRESSLINE1 ADDRESSLINE2 CITY, ST ZIPCODE www.website.com	AAABBBCCCC
ORGNAME	H0000999	IN	MCOBillOptionCode-C	01/01/2009		ADDRESSLINE1 ADDRESSLINE2 CITY, ST ZIPCODE www.website.com	AAABBBCCCC
ORGNAME	H0000999	HN	MCOBillOptionCode-C	01/01/2009		ADDRESSLINE1 ADDRESSLINE2 CITY, ST ZIPCODE www.website.com	

Medicare Secondary Payer (MSP) Tab

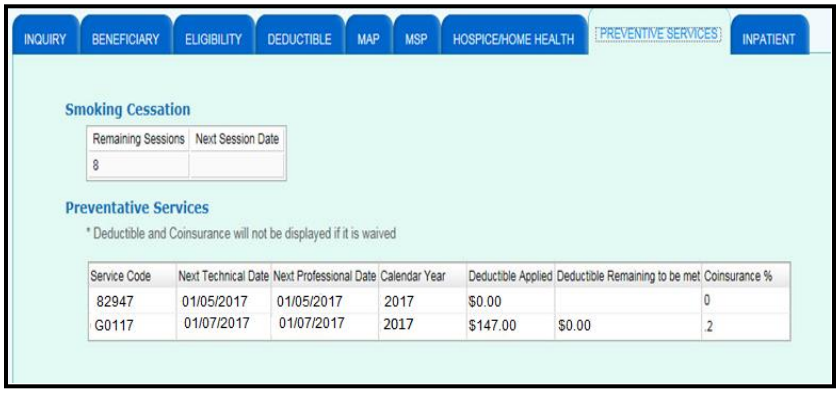


Reason Code	Eff Date	Term Date	Policy Number	Insurer Name	Address
13	06/01/2011	06/01/2013	POLICYNUMBER	ORGNAME	ADDRESSLINE1 ADDRESSLINE2 CITY, ST ZIPCODE

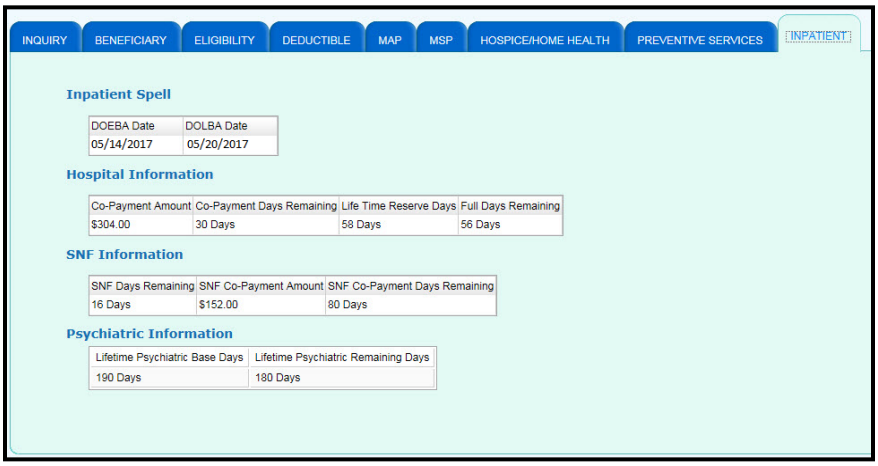
Hospice/Home Health Tab



Preventive Tab



Inpatient Tab



Eligibility FAQ #1

- Question:
  - How do we know the eligibility information retrieved is accurate?
- Answer:
  - Novitasphere interfaces directly with the CMS Health Insurance Portability and Accountability Act (HIPAA) Eligibility Transaction System (HETS) to obtain eligibility information
  - HETS is considered the authoritative source for beneficiary information

Eligibility FAQ #2

- Question:
  - Can I search for patient eligibility with just the patient's name and date of birth, or by just the SSN?
- Answer:
  - No. Novitasphere connects directly with the Medicare Eligibility Transaction System (HETS) system to provide eligibility
  - Patient's Medicare number, first and last name are required and must match
  - If your patient has lost or misplaced their Medicare Card, please refer the patient to the Social Security Administration Office at 1-800-772-1212

Eligibility FAQ #3

- Question:
  - How quickly is patient coordination of benefits information updated in Novitasphere?
- Answer:
  - Once the information is updated by CMS in Eligibility Transaction System (HETS), the data will display in Novitasphere

Accuracy Matters

NOVITAS SOLUTIONS

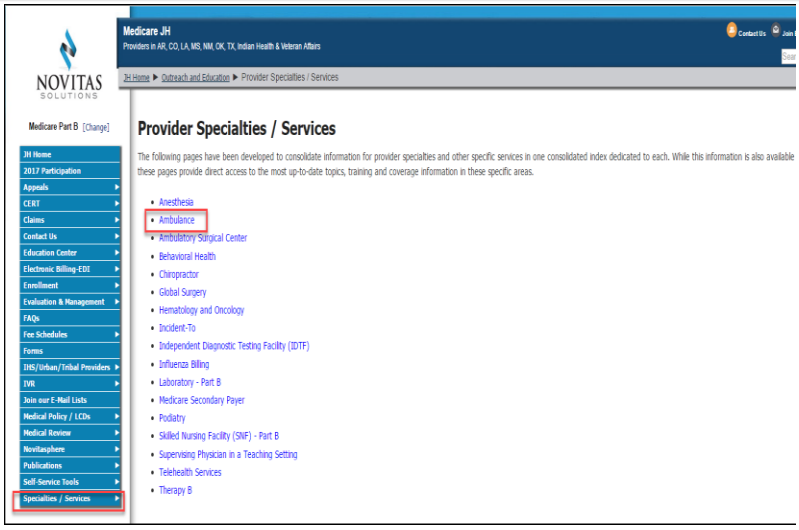
- **Did you know that Novitas receives 1.7 million claim corrections requests per year?**
  - Claim corrections or clerical error reopenings are corrections to minor errors or omissions on your submitted Medicare Part B claim
  - This extra work costs your office extra time and money:
    - ✓ Reduce rework and the accompanying costs by submitting your Medicare claims accurately the first time

Achieve Accuracy Using Our Online Self-Service Tools and Resources

NOVITAS SOLUTIONS

- Claim Center - Coding Guidelines:
  - CPT and HCPCS
  - National Correct Coding Initiative(NCCI)/Medically Unbelievable Edits(MUEs)
  - Place of Service (POS) Codes
  - ICD-10 Help and Resources
- Fee Schedules:
  - Physician Fee Schedule
  - Ambulatory Surgical Center
  - Ambulance
  - Clinical Lab
- Medical Policies:
  - LCD
  - NCD
- Provider Specialty Pages:
  - Anesthesia
  - Ambulance
  - Chiropractor
  - Global Surgery
  - Incident-to
- Interactive Voice Response (IVR):
  - Telephone Inquiry Quick Reference
  - IVR User Guide
  - IVR Claim Corrections Guide
  - IVR Name to Number Conversion Tool
  - IVR Alphanumeric Conversion Tool

Provider Specialties / Services



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

Modifier Home Page

Modifiers

Modifiers indicate that a service or procedure performed has been altered by some specific circumstance, but not changed in its definition or code. They are used to add information or change the description of service in order to improve accuracy or specificity. Modifiers can be alphabetic, numeric or a combination of both, but will always be two digits. Some modifiers cause automated pricing changes, while others are used for information only. When selecting the appropriate modifier to report on your claim, please ensure that it is valid for the date of service billed.

For modifiers that can be used for more than one topic, please refer to the Additional HCPCS or Other CPT for definition.

Type of Modifier	Modifiers Listed
Additional Healthcare Common Procedure Coding System (HCPCS) Modifiers	AE, AF, AG, AI, AK, AM, AT, AZ, BL, CA, CB, CG, CP, CR, CT, DA, ET, FB, FC,FX, G7, GC, GE, GG, GJ, GU, J1, J2, J3, JC, JC, JD, JW, L1, M2, PD, PI, PO, PN, PS, PT, Q0, Q1, Q3, Q4, Q5, Q6, RD, RE, SC, SF, SS, SW, TC, TS, UJ, UN, UP, UQ, UR, US, XE, XP, XS, XU, ZA
Advance Beneficiary Notice of Noncoverage (ABN) Modifiers	GA, GX, GY, GZ
Ambulance Modifiers	D, E, G, H, I, J, N, P, R, S, X, GM, QL, QM, QN
Anatomical Modifiers (Coronary Artery, Eye Lid, Finger, Side of Body, Toe)	E1, E2, E3, E4, FA,F1,F2,F4, F5, F6, F7, F8, F9, LC, LD, LM, LT, RC, RI, RT, TA, T1, T2, T3, T4, T5, T6, T7, T8, T9 **Note:** These modifiers should be used in place of modifier 59 whenever possible.

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

Novitasphere Claim Corrections Feature can be Utilized

NOVITAS SOLUTIONS

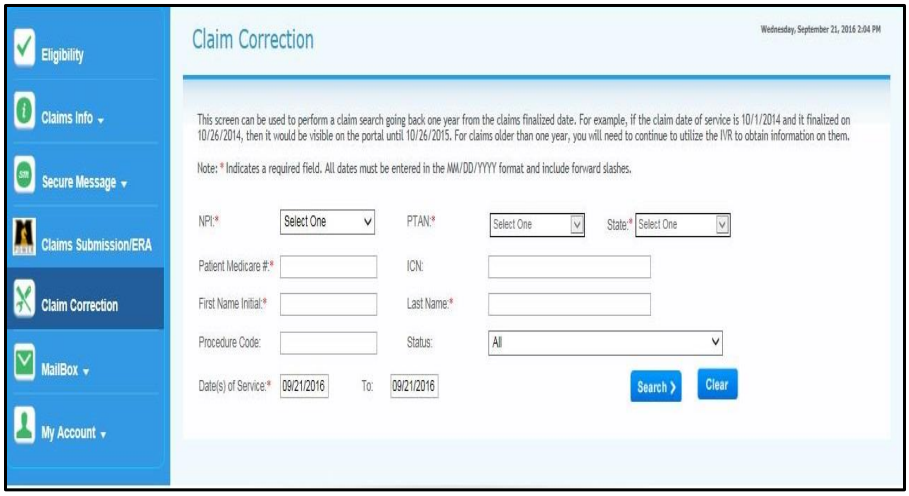
- The following common clerical errors can be corrected on finalized claims through the Novitasphere Claim Correction feature:
  - Add, change, or delete certain modifiers
  - Change the referring provider name and National Provider Identifier (NPI)
  - Changes to the number of services or units
  -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

Novitasphere

NOVITAS SOLUTIONS

Claim Correction
Denied Claim/Lines – Reopen/Search

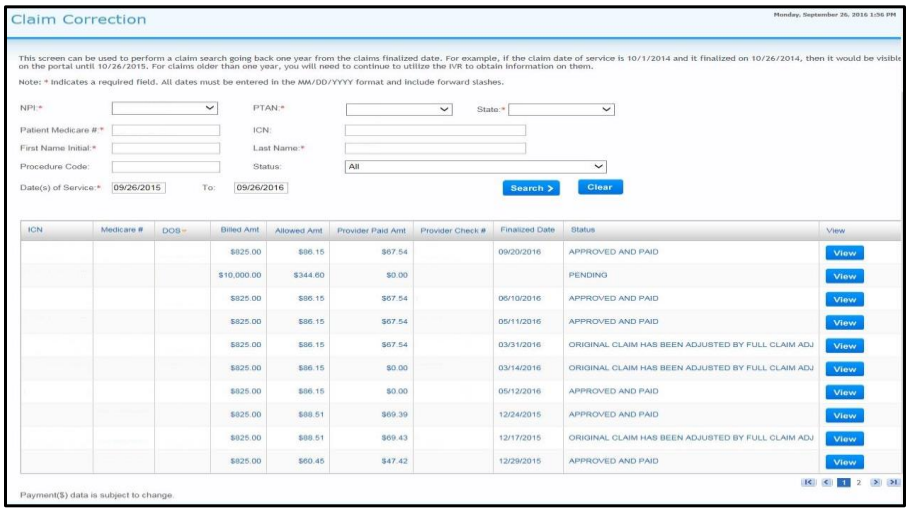
NOVITAS SOLUTIONS



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

Claim Correction
Denied Claim/Lines
Reopen/Results

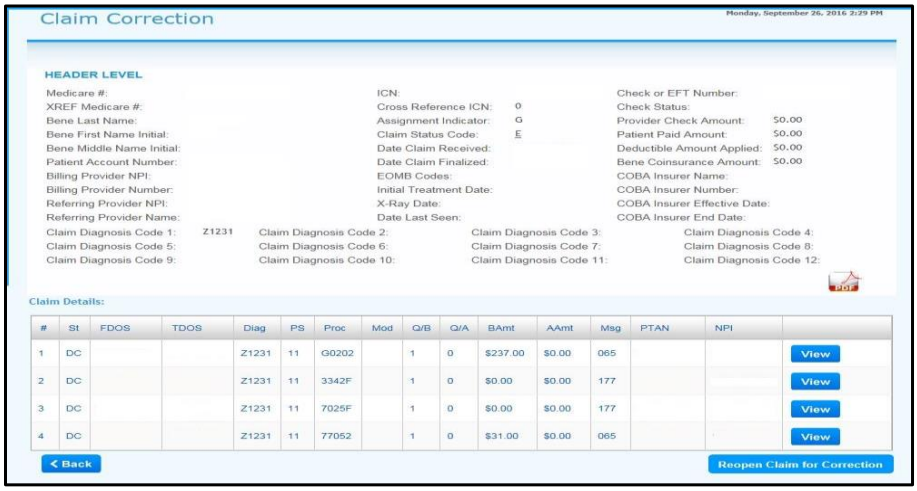
NOVITAS SOLUTIONS



ICN	Medicare #	DOB	Billed Amt	Allowed Amt	Provider Paid Amt	Provider Check #	Finalized Date	Status	View
			$825.00	$86.15	$67.54		09/20/2016	APPROVED AND PAID	View
			$10,000.00	$344.60	$0.00			PENDING	View
			$825.00	$86.15	$67.54		06/10/2016	APPROVED AND PAID	View
			$825.00	$86.15	$67.54		05/11/2016	APPROVED AND PAID	View
			$825.00	$86.15	$67.54		03/31/2016	ORIGINAL CLAIM HAS BEEN ADJUSTED BY FULL CLAIM ADJ	View
			$825.00	$86.15	$0.00		03/14/2016	ORIGINAL CLAIM HAS BEEN ADJUSTED BY FULL CLAIM ADJ	View
			$825.00	$86.15	$0.00		05/12/2016	APPROVED AND PAID	View
			$825.00	$88.51	$69.39		12/24/2015	APPROVED AND PAID	View
			$825.00	$88.51	$69.43		12/17/2015	ORIGINAL CLAIM HAS BEEN ADJUSTED BY FULL CLAIM ADJ	View
			$825.00	$60.45	$47.42		12/29/2015	APPROVED AND PAID	View

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

Claim Correction
Denied Claim/Lines – Reopen (Header Detail)



Claim Correction

Monday, September 26, 2016 2:29 PM

HEADER LEVEL

Medicare #:
XREF Medicare #:
Bene Last Name:
Bene First Name Initial:
Bene Middle Name Initial:
Patient Account Number:
Billing Provider NPI:
Billing Provider Number:
Referring Provider NPI:
Referring Provider Name:

ICN:
Cross Reference ICN: 0
Assignment Indicator: G
Claim Status Code: E
Date Claim Received:
Date Claim Finalized:
EOMB Codes:
Initial Treatment Date:
X-Ray Date:
Date Last Seen:

Check or EFT Number:
Check Status:
Provider Check Amount: $0.00
Patient Paid Amount: $0.00
Deductible Amount Applied: $0.00
Bene Coinsurance Amount: $0.00
COBA Insurer Name:
COBA Insurer Number:
COBA Insurer Effective Date:
COBA Insurer End Date:

Claim Diagnosis Code 1: Z1231
Claim Diagnosis Code 2:
Claim Diagnosis Code 3:
Claim Diagnosis Code 4:
Claim Diagnosis Code 5:
Claim Diagnosis Code 6:
Claim Diagnosis Code 7:
Claim Diagnosis Code 8:
Claim Diagnosis Code 9:
Claim Diagnosis Code 10:
Claim Diagnosis Code 11:
Claim Diagnosis Code 12:

Claim Details:

#	St	FDOS	TDOS	Diag	PS	Proc	Mod	Q/B	Q/A	BAmt	AAmt	Msg	PTAN	NPI	
1	DC			Z1231	11	G0202		1	0	$237.00	$0.00	065			View
2	DC			Z1231	11	3342F		1	0	$0.00	$0.00	177			View
3	DC			Z1231	11	7025F		1	0	$0.00	$0.00	177			View
4	DC			Z1231	11	77052		1	0	$31.00	$0.00	065			View

Back

Reopen Claim for Correction

Part B Automated Claim Correction Using the Interactive Voice Response (IVR)

- New feature for all Part B providers allowing an unlimited number of claims to be corrected using the IVR:
  - Adding, changing or deleting a modifier
  - Changing a primary diagnosis code
  - Changing an ordering/referring provider
  - Changing a procedure code (and billed amount)
  - Changing the quantity billed (and billed amount)
  - Changing a date of service
  - Completing a history correction
- Correct claims within one year of finalized date using the IVR
- Claims billed in error must be corrected using:
  - Return of Monies to Medicare Form
  - Part B Redetermination and Clerical Error Reopening Request Form
- Claim corrections not accepted via IVR may use:
  - Novitasphere
  - Part B Redetermination and Clerical Error Reopening Request Form

Novitasphere and Interactive Voice Response (IVR) Resources

NOVITAS SOLUTIONS

- Novitasphere webpage:
  - http://www.novitas-solutions.com/webcenter/portal/Novitasphere_JH/Novitasphere
- Automated Claim Correction available via the IVR:
  - Hours for providers Monday – Friday 8 am - 4 pm CT:
    - ✓ http://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00132380
  - User Guide:
    - ✓ http://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00086538
  - Frequently Asked Questions:
    - ✓ http://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00132381

NOVITAS SOLUTIONS

Self-Service Options

INNOVATION IN ACTION

Join Our Email List Today

- Stay current with Medicare by receiving emails twice a week
- Available email lists (not all-inclusive):
  - Jurisdiction H
  - Part B Electronic Billing
  - Novitasphere Portal
  - ABILITY| PC-ACE
  - Medicare Remit Easy Print (MREP) Users
- Join using:
  - http://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00007968

Part B Publications

- Latest Part B News and Web Site Updates
- News Bulletins and Articles
- Novitas e-News
- Medicare Reports:
  - Medicare medical policy
  - Reimbursement updates
  - Specialty billing information
  - Claim reporting tips and more
- Published online at:
  - http://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00025469

On-Demand Education

- Frequently Asked Questions
- Podcasts
- Educational Videos and Tutorials:
  - Watch and learn about the Medicare program and our website's features
  - http://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00082787

Thank you for attending!

INNOVATION IN ACTION