Medicare Part B
What You Should Know
Presented by Provider Outreach and Education
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Agenda

• Contractor News
  – Enrollment Updates
  – Noridian’s Medicare Portal
• Top Appeals, Billing & Claim Errors
  – NCCI - Bundling vs Unbundling
  – Duplicate Billing
  – Ordering and Referring
• Reviews and Audits
  – SMRC
  – CERT
  – Recovery Auditor
• Open Question and Answer Session
Read All About It!!
Social Security Number Removal Initiative (SSNRI)

• CMS to remove Social Security Numbers (SSNs) from all Medicare cards by April 2019

• New randomly generated Medicare Beneficiary Identifier (MBI) replaces current HIC#

• Refer to:
  – https://www.cms.gov/Medicare/SSNRI/Providers/Providers.html
  – IOM 100-09, Chapter 6, Section 50.2.4.1
Provider Responsibility – CR 9708

• Medicare contractors assume providers know policy/rules when:
  – Federal regulation or manual
  – General notice to medical community
  – Written notice to individual providers

• Effective Feb. 21, 2017

• IOM 100-06, Chapter 3, Section 90
New ABN Form

- Effective June 21, 2017
- Includes language informing beneficiaries of rights to CMS nondiscrimination practices and how to request alternative format
- Form available on CMS website: https://www.cms.gov/medicare/medicare-general-information/bni/abn.html

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This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

<table>
<thead>
<tr>
<th>I. Signature:</th>
<th>J. Date:</th>
</tr>
</thead>
</table>

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.
New ABN Form 2
Option 1

• Wants the service
• Bill Medicare for decision
  – Medical necessity denial anticipated
• Pay now or later
• Appeal available

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ OPTION 1. I want the D.________ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn’t pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ OPTION 2. I want the D.________ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ OPTION 3. I don’t want the D.________ listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:
New ABN Form 3
Non-Participating Provider Instruction

• Non-participating suppliers/providers not accepting Medicare assignment:
  – Strike last sentence in Option 1 paragraph with single line:
    • If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
  – Single line strike can be included on ABNs printed specifically for issuance when unassigned items and services are furnished
Appeals Decision Tree

• Answer questions to determine if claim is appealable
• Located on Noridian website
  – Browse by Topic / Appeals / Decision Tree under Educational Resources
Preventive Services

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

SELECT A SERVICE | FREQUENTLY ASKED QUESTIONS | RESOURCES | TEXT-ONLY PDF VERSION | PRINT SERVICES

Medicare Learning Network
Official Information Health Care Professionals Can Trust
Noridian Medicare Portal (NMP)
Website
Browse by Topic / Noridian Medicare Portal
• [https://med.noridianmedicare.com/web/jeb/topics/nmp](https://med.noridianmedicare.com/web/jeb/topics/nmp)
Portal Homepage

Noridian Medicare Portal

- Eligibility
- Claim Status
- Appeals
- Remittance Advises
- Financials
- Same or Similar DME
- Prior Authorizations

System Notices
- System Normal
- System Offine

Alerts & Notices
Eligibility Unavailable July 1
Due to CMS maintenance, eligibility will be unavailable on Friday, July 1, 2016.

Eligibility
View a beneficiary's Medicare benefits: MBS, HMO, Home Health, Hospice, Hospital, DME and preventive services.

Claim Status
Locate the status of a claim, view a list of Additional Documentation Requests (ADR) and begin an appeal.

Appeals
Begin an appeal or view the status of existing appeals.

Remittance Advises
View and/or print single claim remittance advises. Part B providers may also view full remittance advises.

Financials
View recent checks issued with pending and approved summaries. Overpayments are available for DME suppliers.

Same or Similar DME
Check for previously provided DME and view the most recently paid claim for supplies, orthotics, prosthetics and vision codes.

Prior Authorizations
Access the status of Power Mobility Device Prior Authorization Requests.
NMP - Multi-Factor Authentication (MFA)

- CMS-requirement that adds second layer of security to NMP accounts
- One-time passcode
  - Email or text
- New users enrolled on/after April 1, 2017 required to use MFA
- Users enrolled prior to April 1, 2017 will receive email one week in advance informing of date MFA is required with each login
## Eligibility Inquiry

### Eligibility Benefits Response

<table>
<thead>
<tr>
<th>Beneficiary:</th>
<th>Provider/Supplier:</th>
<th>Related Inquiries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender:</td>
<td></td>
<td>View Claim Status</td>
</tr>
<tr>
<td>DOB:</td>
<td>NPI:</td>
<td></td>
</tr>
<tr>
<td>Date of Death:</td>
<td>PTAN:</td>
<td></td>
</tr>
<tr>
<td>HICN:</td>
<td>TIN or SSN:</td>
<td></td>
</tr>
<tr>
<td>Transaction ID:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

[View All] [Eligibility] [HMO/MCO] [MSP] [HHEH] [Hospice] [Hospital] [SNF] [ESRD] [Preventive]
Claim Status Inquiry

**Provider/Supplier Details**

- **TIN or SSN:** Please Type or Select
- **NPI:** Please Type or Select
- **PTAN:** Please Type or Select

- **Program:**

**Beneficiary Details**

- **HICN:**
- **First Name:**
- **Last Name:**
- **Date of Birth:** mm/dd/yyyy

View my Provider/Supplier Combinations
# Claim Status Results

<table>
<thead>
<tr>
<th>ICN</th>
<th>Date of Service</th>
<th>Status</th>
<th>Total Charges/Billed Amount</th>
<th>Finalized Date</th>
<th>Check/EFT#</th>
<th>Provider Paid Amount</th>
<th>View Claim Details</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>View Claim</td>
</tr>
</tbody>
</table>
# Claim Status Details

**ICN:**
- **Status:** DENIED
- **Billed Amount:** $1,000.00
- **Finalized Date:** 09/15/2016
- **Provider Paid Amount:** $0.00
- **Specialty:** 11
- **Total Deductible:** $0.00

**Receipt Date:** 09/02/2016
- **MSP Ind:** N
- **Crossover Ind:** N
- **Last Worked Date:** 09/15/2016
- **Check/EFT #:**

**Related Inquiries**
- Submit Appeal
- View Financials
- View Full Remittance
- Claim Specific Remittance
- Self Service Reopening

## Claim Diagnosis Code and Pointer Details

<table>
<thead>
<tr>
<th>Diagnosis Pointer</th>
<th>Diagnosis Code</th>
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<tbody>
<tr>
<td>A</td>
<td>D2312</td>
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<tr>
<td>B</td>
<td>Z789</td>
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</table>

## Claim Status Line Details

<table>
<thead>
<tr>
<th>Line</th>
<th>From DOS</th>
<th>To DOS</th>
<th>HCPCS/CPT</th>
<th>Modifier</th>
<th>Units</th>
<th>POS</th>
<th>Primary Diagnosis Pointer</th>
<th>Billed Amount</th>
<th>Allowed Amount</th>
<th>Provider Paid</th>
<th>Reason Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>11/01/2015</td>
<td>11/01/2015</td>
<td>64494</td>
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<td></td>
<td>11</td>
<td>A</td>
<td>$400.00</td>
<td>$0.00</td>
<td>$0.00</td>
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<tr>
<td>2</td>
<td>11/01/2015</td>
<td>11/01/2015</td>
<td>64493</td>
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<td></td>
<td>11</td>
<td>A</td>
<td>$600.00</td>
<td>$0.00</td>
<td>$0.00</td>
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</tbody>
</table>
Self-Service Reopenings

Claim Status Details

ICN:
Status: DENIED
Billed Amount: $1,000.00
Finalized Date: 09/15/2016
Provider Paid Amount: $0.00
Specialty: 11
Total Deductible: $0.00
Receipt Date: 09/02/2016
MSP Ind: N
Crossover Ind: N
Last Worked Date: 09/15/2016
Check/EFT#: 

Related Inquiries
Submit Appeal
View Financials
View Full Remittance
Claim Specific Remittance
Self Service Reopening

Claim Diagnosis Code and Pointer Details

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<td>$600.00</td>
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<td></td>
<td>$0.00</td>
<td></td>
</tr>
</tbody>
</table>
Reopening's Available Through NMP

• The following clerical corrections may be made:
  – Add, replace or remove diagnosis code
  – Add, replace or remove modifier
  – Billed in error
  – Reprocess claim

• Reopenings are available for claims that meet the following criteria:
  • Claim was processed within one year
  • Claim is finalized
Reopening's Available Through NMP

- No Additional Documentation Request (ADR) was sent
- Claim was not reviewed
- Claim was not previously appealed
- Procedure code and modifier are not too complex
- After the reopening has been submitted, End Users may view the adjustment through the Claim Status option after one business day.

• See the User Manual and self-paced tutorial for step-by-step instructions.
View Adjusted Claim Status

• Claim Status Inquiry
• Part B
  – Adjusted claim viewable after one business day
• DME
  – Adjusted claim viewable immediately after submitting reopening

<table>
<thead>
<tr>
<th>ICN</th>
<th>Date of Service</th>
<th>Status</th>
<th>Total Charges/Billed Amount</th>
<th>Finalized Date</th>
<th>Check/EFT#</th>
<th>Provider Paid Amount</th>
<th>View Claim Details</th>
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## Appeal Submission

### Claim Status Details

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<th>Receipt Date:</th>
<th>Related Inquiries</th>
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</thead>
<tbody>
<tr>
<td>Status:</td>
<td>MSP Ind:</td>
<td>Submit Appeal</td>
</tr>
<tr>
<td>Billed Amount:</td>
<td>Crossover Ind:</td>
<td>View Financials</td>
</tr>
<tr>
<td>Finalized Date:</td>
<td>Last Worked Date:</td>
<td>View Full Remittance</td>
</tr>
<tr>
<td>Provider Paid Amount:</td>
<td>Check/EFT#:</td>
<td>Claim Specific Remittance</td>
</tr>
<tr>
<td>Specialty:</td>
<td></td>
<td>Self Service Reopening</td>
</tr>
<tr>
<td>Total Deductibles:</td>
<td></td>
<td></td>
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</tbody>
</table>

### Table

<table>
<thead>
<tr>
<th>Eligibility</th>
<th>Claim Status</th>
<th>Remittance Advices</th>
<th>Financials</th>
<th>Same or Similar DME</th>
<th>Prior Authorizations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

### Appeal Status Inquiry

- Appeal Status Inquiry
- Begin New Appeals
# View Appeal Status

## Appeal Status Results:

<table>
<thead>
<tr>
<th>Document ID</th>
<th>Document Name</th>
<th>Date Submitted</th>
<th>View</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>View Document</td>
</tr>
</tbody>
</table>

- **HICN:**
- **Appeal Status:**
- **Confirmation #:**

- **Provider/Supplier:**
- **NPI:**
- **PTAN:**
- **TIN or SSN:**
Enrollment Changes and Revalidations
ENROLLMENT

- Opt Out of Medicare
- Potential Providers
- MEDPAR
- Enroll/Report Changes
- Revalidation
- Forms
- Provider Enrollment Contacts

Revalidation

- Overview
- Revalidation Tools
- Revalidation Application Submission
- Failure to Revalidate
- Resources

Overview

History of Revalidation

The Patient Protection and Affordable Care Act established a requirement for all enrolled providers/suppliers to revalidate their Medicare enrollment information roughly every five years.

- CMS has completed Cycle 1 Revalidation. There were three phases to Cycle 1 revalidation:
  - The first phase was to get everyone into PECOS. This helped clean up the claims system.
  - Phase two was making sure all organizations were revalidated.
  - Phase three revalidated everyone else.
- Cycle 2 Revalidation began February 2016. This will start to establish the five-year cycle.
  - All actively enrolled providers/suppliers will be required to revalidate and do not have to revalidate.
  - Providers opted out of Medicare or enrolled solely to order and refer do not have to revalidate.

Revalidation Future
Enrollment Revalidation

• Use search tool for due date
  – https://data.cms.gov/revalidation
  – Search by individual provider or organization

• Ensure revalidation submitted timely
  – Risk deactivation

• Submit application via PECOS

• If TBD listed, due date is coming
  – Do nothing and only submit revalidation when due date provided
Enrollment on Demand

• Self-paced tutorials
• Guides provider through application process
• Jurisdiction E:
  https://med.noridianmedicare.com/web/jeb/enrollment/potential-providers/medicare-part-b-specialties
Enrolled for Sole Purpose of Ordering/Referring Services

- Complete the 855O
- Must include statement they are enrolling only to order and refer and will not be submitting claims

---

A. REASON FOR SUBMITTING THIS APPLICATION

Check one box and complete the sections of this application as indicated.

- You are registering for the sole purpose of ordering/referring
- You are currently registered solely to order and refer and are updating your information
- You are voluntarily withdrawing your Medicare registration to solely order and refer

B. REASON YOU ARE REGISTERING SOLELY TO ORDER OR REFER

You are registering in Medicare solely to order or refer because you are (check one):

- Employed by the DVA
- Employed by the PHS
- Employed by the DOD/Tricare
- Employed by the IHS or a Tribal Organization
- Employed by a Medicare-enrolled FQHC
- Employed by a Medicare-enrolled RHC
- Employed by a Medicare-enrolled CAH
- Physician not employed by any of the above
- Non-physician practitioner not employed by any of the above
- Licensed intern resident or fellow not employed at any of the above
- Non-Licensed intern, resident or fellow not employed at any of the above
- Dentist not employed by any of the above
- Pediatrician not employed by any of the above
- Other (Specify):
EDISS News Page

What's New

**EDISS Gateway Transition Extension** [PDF]
To assist our remaining California submitters with completing the transition to the new EDI Gateway we will be extending the timeframe for this transition. The final portion of our transition will be broken down into phases, please go to the link above to view the list.

If you do not know your login information for the new EDI Gateway, please submit an e-mail to support@edisswcb.com requesting your credentials for the new EDI Gateway be resent. Please include 'New EDI Gateway Credentials' in the subject line of the e-mail. Your billing NPI, and also the fax number the credentials should be sent to will need to be included in the body of the e-mail.

**EDISS Gateway Transition Has Begun!**
The EDI Support Services (EDISS) Gateway is getting an upgrade! The Gateway transition is scheduled to begin in Quarter 2, 2016, and will continue throughout 2016. We are excited about the enhanced support capabilities and the new tools this transition will provide to our EDI support staff to better assist our Submitter Community!

**Password Information for EDISS Gateway and EDISS Connect** [PDF]
Due to high call volume due to our EDISS Gateway transition, EDISS is providing our users experiencing password issues with some helpful tips and tricks. Please take a moment to review and try these tips prior to calling.

**Interested in Getting Your Remittance Advice Faster?**
Look no further! Sign up today in EDISS Connect for the electronic remittance advice (835) to begin receiving your remittance advice the same day your claims finalize. Additional Electronic Remittance Advice Benefits

Production Alerts

**Report and Remittance Advice Delay**
For All New Gateway Submitters
Posted: 3/6/17

EDI Support Services (EDISS) has identified a small subset of 999, 277CA Acknowledgement Reports and Remittance Advices from March 2, 2017, through March 3, 2017, did not successfully deliver to submitter mailboxes in the new Gateway. A follow-up email will be sent once the delivery issue has been resolved.

Production Alert Archives
https://accountmgt2.edissweb.com/

Registration

Getting Started
- Advantages of Electronic Claims
- Frequently Asked Questions (PDF)
- Benefits of Electronic Remittance Advice
- FAQ on 5010 Electronic Remittance Advice (ERA)
- Password Information for EDISS Gateway and EDISS Connect (PDF)

Online Registration
EDISS 'Connect' is a user-friendly online registration tool that allows providers to update basic facility information, manage billing NPIs, update lines of business, add or change vendor associations, and select electronic transactions online.

The use of Connect is required for all providers. Begin your online enrollment today by clicking on the following link: EDISS 'Connect'.

Connect User Guides
- Provider User Guide (PDF)
- Vendor User Guide (PDF)

Provider Connect Tutorials
- Registration
- Adding Transactions
- Managing Transactions
- Provider Account Management

Vendor Connect Tutorials
- Registration
- Managing Transactions
- Managing Providers
- Vendor Account Management
EDISS Log in Screen

Welcome

EDISS Connect - Registration & Management

Gain access to this free user-friendly online registration and management tool that allows providers to manage billing NPIs, update lines of business, add/or change vendor associations, select and test electronic transactions online.

Register Now

Questions about the process? Read Getting Started

Already have an account?

Log In

Username

Password

Log In

Forgot username? »
Forgot password? »

Not registered?? Register Now »
To Bundle or
To Unbundle

NCCI and MUEs
Rationale for Procedure to Procedure Edit (PTP)

- Sequential procedure
- CPT “Separate procedure” definition
- More extensive procedure
- Reserved for future use
- Gender-specific procedures
- Standards of medical/surgical practice
Rationale for PTP Edit

• Anesthesia service included in surgical procedure
• Laboratory panel
• Deleted/modified edit for NCCI
• Misuse of column two code with column one code

https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html
Distinct Procedural Service

• Modifier 59 may be necessary to indicate distinct or independent services performed on same day
  – Not normally reported together but are appropriate under circumstances documented
• Another established modifier may be more appropriate than modifier 59
• Evaluation and Management – Modifier 25
Other Modifiers to Consider First

• Anatomic NCCI-associated modifiers:
  – RT, LT, E1-E4, FA, F1-F9, TA, T1-T9, etc.

• Repeat modifiers NOT related to NCCI edits
  – 76 (repeat procedure by same physician)
  – 77 (repeat procedure by another physician)
  – 91 (repeat clinical diagnostic laboratory test)
Ordered and Referred Services
Requirements & Documentation

Reminders and Updates
Orders for Diagnostic Lab Tests

• Order is defined as communication from treating physician or NPP requesting diagnostic test be performed

• A physician order is not required to be signed
  – Physician must clearly document, in medical record his/her intent that test be performed
Physician Intent

• Order or requisition signed by physician
  – Not valid on its own
• Notation in patient’s record is needed
• Verbal/telephone order documented at treating physician’s office
• Email from physician to be verified
• May need physician signature attestation
Documentation Requirements

• Maintain in patient medical records
  – Orders/communications from ordering physician/ NPP
    • Orders delivered in writing, via phone or emailed
    • Additional, conditional tests requested
  – Test results
    • Record date service was performed
Signature Requirements

• Unsigned physician orders or unsigned requisitions alone do not support physician intent
• Physicians should sign all orders for diagnostic services to avoid potential denials
• If signature is missing on progress note, ordering physician must complete attestation statement and submit it with response
• Attestation statements are not acceptable for unsigned physician orders/requisitions
Duplicate Billing
Duplicate Claim/Service Denials

• Duplicate denials continue to be top billing error
• Unnecessary duplicate filing of Medicare claims cost provider's office valuable time and resources as well as Medicare's time and money to process them
Duplicate Claim is…

Claim or claim line that exactly matches another claim or claim line:

- HIC Number
- Provider Number
- From Date of Service
- Through Date of Service
- Type of Service
- Procedure Code
- Place of Service
- Billed Amount
Tip to Avoiding Denials

• Check remittance advice for previously posted claim
• Verify reason initial claim was denied
  – Do not resubmit to correct denial
• Use IVR or Noridian Medicare Portal to check claim status
• Make sure billing service/clearinghouse waits appropriate time frame
Appeals
What's at the Top
Appeals

• Evaluation/Management (E/M)
  – 99233 (subsequent hospital inpatient care)
    • Charge exceeds fee schedule

• Laboratory
  – 88305
    • Missing modifier
Most Common Appeal

• Non-covered services (medical necessity)
  – Based upon policy coverage criteria
• Service partially or fully furnished by another provider (duplicate charge)
Written Correspondence
Top Return/Dismissal Reasons

• Incomplete provider inquiries
  – No indication what was needed
  – Not including necessary authentication info
• Duplicate inquiries or appeals
  – Do **NOT resend** previous appeals/inquiries
• Do not appeal “unprocessable” claims
• Beneficiary in HMO/MA plan
• Check boxes not marked
Noridian Medical Review – Part B

Non-complex Review Notifications and Findings

Noridian performs Non-Complex Review in accordance with the CMS Internet Only Manual (IOM), Publication 100-08, Medicare Program Integrity Manual, Chapter 3.

<table>
<thead>
<tr>
<th>Review Criteria</th>
<th>Start Date</th>
<th>End Date</th>
<th>States Affected</th>
<th>Findings/Review Dates</th>
</tr>
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<td>Critical Care 99291 and 99292</td>
<td>04/01/15</td>
<td>12/01/16</td>
<td>AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY</td>
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<td>• Type of Review: Non-complex</td>
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<td>• E/M Resources</td>
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<tr>
<td>• E/M Required Documentation</td>
<td></td>
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<tr>
<td>Hospital Discharge Day Management, 99239 (more than 30 minutes)</td>
<td>03/11/16</td>
<td>12/8/16</td>
<td>AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY</td>
<td>View Final Findings 09/08/16-12/06/16</td>
</tr>
<tr>
<td>• Type of Review: Non-complex</td>
<td></td>
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<td></td>
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<tr>
<td>• E/M Resources</td>
<td></td>
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<tr>
<td>• E/M Required Documentation</td>
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</tbody>
</table>
My Results Letter

• Details provider specific findings for service specific reviews
• Noridian MR will respond with a detailed letter
  – Letter includes detailed claim findings
    • May take up to two weeks to be completed
• Email MR to request “My Results”
  – Part A: myresults@noridian.com
  – Part B: medicalreviewpartb@noridian.com
Targeted Probe & Educate with Extrapolation (TPEE)

• In 2016 CMS authorized TPEE review for JF states as part of a pilot program
• Three rounds of prepayment probe review
  – Fourth round option if denial rate is still high after first three rounds includes post payment review and extrapolation
• Topics selected by Noridian based on CMS regulations
Supplemental Medical Review Contractor (SMRC)

Current SMRC Projects

The selection of topics and time frames to be reviewed is determined by and at the direction of CMS. The Supplemental Medical Review Contractor (SMRC) is assigned each project through Technical Direction Letters (TDL) issued by CMS.

The focus of the projects may include, but are not limited to issues identified by Federal agencies, such as the Office of Inspector General (OIG), Government Accountability Office (GAO), CMS internal data analysis, the Comprehensive Error Rate Testing (CERT) program, professional organizations and First-Look Analysis Tool for Hospital Outlier Monitoring (FATHOM) report and Program for Evaluating Payment Patterns Electronic Report (PEPPER). The SMRC is conducting medical review based on the analysis of national claims data versus data that is limited to a specific jurisdiction as performed by Medicare Administrative Contractors (MACs).

The SMRC will be performing medical review projects in accordance with CMS regulations, CMS Publication 100-08 (known as the Program Integrity Manual) and other current and future CMS PCG/DMRE initiatives.
Current SMRC Reviews

- Y2P39 — Inpatient Psychiatric Facility Services (11/05/2104)
- Y3P69 — Diagnostic Radiology Services (01/23/2015)
- Y3P0144 — Intensity Modulated Radiation Therapy (IMRT) (09/04/15)
- Y3P0216 — Bariatric Surgery – Morbid Obesity (09/04/15)
- Y3P0219 — Positive Airway Pressure (PAP) Supplies (10/29/15)
- Y3P0220 — Oxygen and Oxygen Equipment (09/04/2015)
- Y3P0221 — Nebulizer Equipment and Related Medications and Supplies (09/04/15)
- Y4P0422 – Inpatient Rehabilitation Facilities (IRFs) (08/16/16)
- Y3P0225 — Blepharoplasty and Other Related Facial Procedures (09/04/15)
- Y3P0239 — Ophthalmology Services (08/11/16)
- Y4P0430 — MACRA Outpatient Rehabilitation Therapy Cap (05/17/16)
- Y4P0432 — Skilled Nursing Facilities (SNF) Therapy Services (08/11/16)
- Y4P0434 — Chiropractic Services (08/11/16)
- Y4P0435 — Ranibizumab (Lucentis®) (08/11/16)
Comprehensive Error Rate Testing (CERT)

- All provider CIDs will be sent letter explaining findings and necessary steps to correct error
- CMS placing more ownership on providers
- Goal is to reduce appeals and focus on repeat providers
Recovery Auditor (RA) Contractor

• HMS Federal Solutions (HMS)
  – New name for Region 4 post pay auditor
  – Region 4 is all Noridian states (JE/JF A/B)
• Previously, HealthDataInsights (HDI)
  – Both HMS/HDI wholly owned subsidiaries of HMS Holdings Corporation
• [https://racinfo.healthdatainsights.com/home.aspx](https://racinfo.healthdatainsights.com/home.aspx)
Office Of Inspector General (OIG) 2017 Work Plan Released

- [http://oig.hhs.gov](http://oig.hhs.gov)
- ACO
- Ambulance
- CCM/TCM
- Chiropractic
- Clinical Lab
- Drug Waste-Single Vials
- Physical Therapist
  - Not all inclusive list
MLN Provider Compliance

• Medicare Quarterly Provider Compliance Newsletter Archive
  – Archive of newsletters
  – Updated Quarterly
  – Downloadable and viewable in Adobe PDF
Provider Outreach Educational Resources
## Upcoming Part B Webinars

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Topic</th>
<th>Format</th>
</tr>
</thead>
<tbody>
<tr>
<td>5/23/17</td>
<td>1:00 PM – 1:45 PM PDT</td>
<td>Noridian Medicare Website Tour for Part B Providers</td>
<td>Web-based Workshop</td>
</tr>
<tr>
<td>5/24/17</td>
<td>8:00 AM – 9:00 AM PDT</td>
<td>Nebulizers &amp; Inhalation Medications</td>
<td>Web-based Workshop</td>
</tr>
<tr>
<td>5/25/17</td>
<td>11:00 AM – 12:00 PM PDT</td>
<td>New Provider Biller - Part II</td>
<td>Web-based Workshop</td>
</tr>
<tr>
<td>5/25/17</td>
<td>1:00 PM – 2:00 PM PDT</td>
<td>Eye Care Services</td>
<td>Web-based Workshop</td>
</tr>
<tr>
<td>5/31/17</td>
<td>11:00 AM – 12:30 PM PDT</td>
<td>Supplemental Medical Review Contractor (SMRC)</td>
<td>Web-based Workshop</td>
</tr>
<tr>
<td>5/31/17</td>
<td>1:00 PM – 1:30 PM PDT</td>
<td>Mammography, Pap Test, Pelvic Exam, and Cervical Cancer with HPV Tests</td>
<td>Web-based Workshop</td>
</tr>
<tr>
<td>6/6/17</td>
<td>11:00 AM – 12:30 PM PDT</td>
<td>Ambulance Basics</td>
<td>Web-based Workshop</td>
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<tr>
<td>6/7/17</td>
<td>1:00 PM – 2:30 PM PDT</td>
<td>Noridian Medicare Portal Registration and Functionality</td>
<td>Web-based Workshop</td>
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<tr>
<td>6/8/17</td>
<td>11:00 AM – 12:30 PM PDT</td>
<td>Modifier 59</td>
<td>Web-based Workshop</td>
</tr>
<tr>
<td>6/13/17</td>
<td>11:00 AM – 12:30 PM PDT</td>
<td>Understanding National and Local Coverage Determinations</td>
<td>Web-based Workshop</td>
</tr>
</tbody>
</table>
Medicare “After Hours” Webinars

- 6 p.m. PT / 8 p.m. CT
- Webinars also during day - earlier same week
- All webinars earn 1.0 CEU
- Register at Schedule of Events

<table>
<thead>
<tr>
<th>Date</th>
<th>Topic</th>
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</thead>
<tbody>
<tr>
<td>6/15/17</td>
<td>Understanding National and Local Coverage Determinations</td>
</tr>
</tbody>
</table>
Request Education

Located on the Education & Outreach Part A webpages

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### PROVIDER OUTREACH & EDUCATION REQUEST FORM

Noridian offers the opportunity for education targeted to the particular needs of each healthcare provider. Complete this form to only request specific education trainings. For questions specific to individual provider situations, please call the Provider Contact Center at 977-355-9431.

#### PROVIDER CONTACT INFORMATION

<table>
<thead>
<tr>
<th>Provider Name:</th>
<th>Data Submitted:</th>
</tr>
</thead>
<tbody>
<tr>
<td>NPI Number:</td>
<td>E-mail:</td>
</tr>
<tr>
<td>Contact Person:</td>
<td></td>
</tr>
<tr>
<td>Provider Address:</td>
<td></td>
</tr>
<tr>
<td>City:</td>
<td>State:</td>
</tr>
<tr>
<td>Phone Number:</td>
<td>Zip Code:</td>
</tr>
</tbody>
</table>

#### Check appropriate box:
- [ ] Web-based Training
- [ ] Teleconference
- [ ] In Person

Select the appropriate form used to bill Medicare claims:
- [ ] UB04 for Part A
- [ ] 1500 Claim for Part B

Requested date(s) and time (Online education is based on availability):

<table>
<thead>
<tr>
<th>Location of Event City:</th>
<th>State:</th>
</tr>
</thead>
</table>

Select the state you bill claims for:

- [ ]

Enter specialty type that best fits your facility:

<table>
<thead>
<tr>
<th>Reason for Education (Provide additional detailed information for the type of education being requested. Examples: billing, coverage, speaker for meeting/conference):</th>
</tr>
</thead>
</table>

Your request will be processed and a Noridian Education Representative will be in contact with your organization within 10 business days.

After completion of this form, click the “Save” button at the top and save to your desktop. Next, open a new email message, attach this form to the message and send to info@noridian.com.

A CMS Medicare Administrative Contractor
Noridian Healthcare Solutions, LLC
Collaboration with External Entities
Form

- New form for associations
- Send to: mac@noridian.com
  - Subject line: Collaboration Request
Questions

Thank you!