Texas Hospital Association
July 17, 2014

Novitas Medicare Update Q&A

1. **Why has Novitas not issued an LCD for ESA use in non-oncological conditions? CMS has left this up to the MAC, but Novitas has not given us any guidance on this!**

   Answer: *LCDs are data driven. Most of the utilization of ESA occurs with ESRD and Oncology events, and CMS provides guidance for these clinical scenarios. Non-oncologic conditions are covered per the label indications and CMS' off-label directives. Novitas data is not showing this as an area that requires an LCD at this time.*

2. **Can RACs audit a claim twice? We had a claim audited and received a RAC revised DRG then the same claim was audited again and denied for medical necessity. We recently had Prepay Claims that were denied more than 1 year ago, recently dismissed and no longer eligible for review by RACs. I called Novitas and the representative said they had no indication to pay the claim. I contacted our RAC and they said they had already sent the adjustment to be paid to Novitas. What can we do to make sure that these claims are justly reimbursed?**

   Answer: *Generally, a claim should not be audited twice by the Recovery Auditor (RA). Once the RA reviews a claim, the results letter is sent to the provider. The provider then has the opportunity to have a discussion period with the RA, which can result in a reversal of the initial decision. From reading the question it sounds as though the RA reviewed and revised the DRG, then the provider appealed with Novitas. Appeals would have the option to review for medical necessity, which could fully deny the claim. To make sure that claims are justly reimbursed providers should ensure that there is enough documentation to medically support the services and diagnoses that are being rendered to the beneficiary.*

3. **How do we find out who our direct Provider Representative is? Is there a specific representative assigned to certain areas/regions?**

   Answer: There are not specific provider representatives assigned to areas or regions within Jurisdiction H. We have several avenues available to help providers get the answers they need. The primary entry point is our Customer Service Center through 1-877-252-8782. Our website,

www.novitassolutions.com has a wide array of information available for providers. We also have education events on a wide variety of topics to help providers understand the changes in the Medicare program.

4. **When a type of bill 11I (FI initiated adjustment) is submitted shouldn't the original claim show as cancelled in FISS? If a PIP/Medical Auto policy pays as primary less than what the Medicare allowable is, shouldn't Medicare pay the difference as MSP?**

   Answer: When a MAC (Medicare Administrative Contractor) initiated adjustment is finalized, a cancelled date is posted to the original claim. A 11I adjustment works the same as a provider initiated adjustment, except the type of bill is a 117 instead of a 11I.
   If a PIP/Medical Auto policy pays as primary less than what the Medicare allowable is, then yes, Medicare generally would pay the difference only up to the allowable amount.

5. **I have problems with rebills. Return claims with condition code W2 and these rebills have dates of service prior to October 2013. There has been no refunds on claims recouped due to cuff showing patient was incarcerated when they were not.**

   Answer: We contacted the provider on this issue and are working with them concerning the incarcerated beneficiaries.

6. **I have several incarcerated benefits that still have not received payment back for. I have faxed my information to a Teresa and she said that she would get back with me and still has not.**

   Answer: Novitas is still working with CMS to identify possible claims that have not been reimbursed. There is a research process that Novitas has to follow to determine if payment was made or not and if not, why the payment was not repaid.

7. **Probe and educate audits that were conducted and claims were denied due to no records, the provider has proof of delivery of the records. Is there an accountable response from Novitas? The provider should not need to appeal due to an internal error with the contractor. Probe and educate reviews were being conducted for providers that do not have short stay admissions, such as LTAC's, psychiatric facilities. How can Novitas exclude providers with longer lengths of stay?**

   Answer: We have researched issue of not receiving or not being able to retrieve records (i.e. from a CD for instance) and will continue to work with providers to resolve these issues. If a provider still have issues they can call or email Debra Riegel at 717-526-6396 Debra.Riegel@novitas-solutions.com and we will research.

8. **Regarding the new Lab billing requirements. If a patient has pre-op labs done more than three days prior to an outpatient surgery, can the new modifier be added to the pre-op labs?**

   Answer: If the patient goes to the hospital and the hospital only collects the specimen and furnishes only laboratory services on that date of service, and no other services are rendered on this date of service, the new modifier (L1) should be appended to the laboratory services.
   Reference:
   - *MLN Matters Special Edition # SE1412 - http://www.nubc.org/aboutus/PDFS/SE1412_CR8572_014x.pdf*
   - *MLN Matters MM8776 - http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8776.pdf*

9. **Repayments on the incarcerated accounts have never been reimbursed. I understood that these should have been repaid by the end of March 2014.**

   Answer: We initially believed all payments for the incarcerated beneficiary accounts were made on December 2, 2013. If you have not yet received payment, we recommend calling into the Customer Contact Center at 1-855-252-8782 so one of our Customer Service Representatives can research why payment has not been made.

10. **The new modifier for Labs - L1. Clarify that we really won't be paid for labs when conducted on same date as say an x-ray or PFT or ECHO. I understand for surgery procedures, but doesn't make sense that we are doing labs for free when diagnostic in nature**

    Answer: When the hospital provides outpatient lab services and they are clinically unrelated to other hospital outpatient services furnished on the same day, the lab test would be eligible to be reported with the modifier L1 to trigger separate payment.
    a. *Unrelated means the laboratory test is ordered by a different physician other than the physician who ordered the other hospital outpatient services, for a different diagnosis.*
    b. *If the definition for unrelated is not met, modifier L1 would not be reported and the lab payment would be packaged into another separately payable service.*

    Reference:
    - *MLN Matters Special Edition # SE1412 - http://www.nubc.org/aboutus/PDFS/SE1412_CR8572_014x.pdf*
    - *MLN Matters MM8776 - http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8776.pdf*

11. **We have ADR issues where claim denied as records not received over a 100 claims, we spoke with supervisor who asked us to send proof of delivery and spreadsheet, we have and now can't get answers after many tracks open no one seems to be able to help. We are told received and we should see movement. This has gone on for 6 months. Never receive call backs on tracks**

    Answer: Medical Review recently contacted this provider and researched the claims in question. In investigating all have been reviewed and some are still denied for other reasons. There are only 2 of the 13 that are still being researched.

12. **We know Novitas does not have the calculations for the EHR incentive payments. We have tried to obtain documentation from the staff referred to us by Novitas for this documentation and still cannot obtain documentation of the calculations. Please can you help us obtain the EHR calculations for our hospitals for each year we have been paid? Thank you for any assistance.**

    Answer: Novitas can obtain the EHR calculations for their hospitals. Please have them contact Bruce Snyder. Bruce.snyder@novitas-soultions.com .

13. **What is the process for disputing denials for cases that have already been denied and overturned? What is the recommend process for disputing claims denied using rationale and expectations for documentation cited in NCD/LCD when the claim was made for services prior to the effective date of the LCD/NCD?**

    Answer: The administrative appeal process is available for any time you disagree with a claim determination. Each level of the appeal process provides guidance as to the next steps should you disagree with the findings. If you have a specific claim in question please email Gregory.hart@novitas-solutions.com and we'll work with you to answer your questions.

14. **What is the required turnaround time by Novitas to address claims in Suspense pending action/activity by Novitas? We have some cases still residing in Suspense (not due to errors related to facility billing that we can rectify) for multiple months and when calling we have been informed nothing can occur until Novitas pushes those claims thru. I currently have approximately $400,000 in reimbursement held in Suspense as this time.**

    Answer: The CMS claims processing requirement is to process 95% of clean claims within 30 days. Novitas consistently exceeds this requirement, processing approximately 99.7% of clean claims within 30 days. There are, however, some

claims that suspend to locations that contain a higher level of claim inventory and processing can go beyond the 30 days. Additionally, when there are system issues, Novitas will sometimes hold claims within a suspense location until the Shared System Maintainer issues a fix. This enables Novitas to automate the processing of those claims from the hold location. Novitas posts issues on our Web site and includes the hold location to keep providers informed of claim status when the Shared System Maintainer acknowledges a claim issue. Novitas would be happy to review the claims you have in suspense. Please forward claim examples to Deb Hall.

15. **Why is rate setting/tentative settlement process so inefficient? One hospital with 3 subunits results in 5 separate rate letters and numerous retro payments (no cross-application). Every other MAC includes hospital and subunits in a single rate letter and a single retro letter. Very inefficient and costly for MAC and provider.**

    Answer: Due to the sheer volume of rates Novitas has to complete and the timing differences for completion, (type of provider, number of rates), they are rarely, if ever completed at the same time. For example, an IPPS hospital may require 2 rates due to GME so the two rates are spread over the year and completed at certain intervals. If the provider has a psych or rehab subunit, usually only 1 rate is required so the timing of the rate is different than the hospital.

    Novitas does include the hospital and subunit tentatives in a single letter since it is received as one cost report and processed as such.

16. **When will the LCD's be available? When our collectors are trying to locate the LCD information, they are not getting the LCD information when they click on the LCD link. The example below for the EKG HCPCS code 93005, shows that there is a LCD but it has a future effective date. Then, once you click on the active LCD link – there is no supporting ICD 9 information to support medical necessity. Also, if we are able to locate LCD information on the Novitas website, the LCD has ICD 10 codes listed that support medical necessity instead of ICD 9 coding.**

    Answer: Procedure code 93005 is included in the final Independent Diagnostic Testing Facility (IDTF) LCD that will become effective on 7/24/2014. The IDTF LCD does not include diagnoses codes because the purpose of the LCD is to address the structure, approved services, and credentialing requirements for an IDTF.

    Novitas currently does not have any other LCD specific to 93005. Novitas does not maintain an LCD for every procedure code.

    In the absence of a Local Coverage Determination (LCD), National Coverage Determination (NCD), or CMS Manual Instruction, Reasonable and Necessary guidelines still apply. Section 1862(a) (1) (A) of the Social Security Act (SSA) directs the following:

"No payment may be made under Part A or Part B for any expenses incurred for items or services not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."

Therefore, to be considered "reasonable and necessary" the patient's medical record must clearly document all of the following:

- *The item or service is for the diagnosis or treatment, or to improve the functioning of a malformed body member*
- *The item or service is appropriate for the symptoms and diagnosis or treatment of the patient's condition, illness, disease or injury*
- *The item or service is furnished in accordance with current standards of good medical practice*
- *The item or service is not primarily for the convenience of the patient or physician or health care provider*
- *The item or service is the most appropriate supply or level of service that can be safely provided to the patient*
- *The item or service is delivered in the most appropriate setting*
- *The item or service is ordered and/or furnished by qualified personnel*

For any service reported to Medicare, it is expected that the medical record documentation clearly demonstrates that the service meets all of the above criteria. All documentation must be maintained in the patient's medical record and be available to the contractor upon request.

17. What is the process to bill repeat - related admissions?

<u>Answer</u>: Patient is discharged and later readmitted for a related condition
Hospitals should adjust an original claim generated by an original stay when a patient is discharged/transferred from an acute care PPS hospital and is readmitted to the same acute care PPS hospital on the same day for symptoms related to, or for evaluation and management of, the prior stay's medical condition. Adjust the claim by combining the original and subsequent stay onto a single claim. If services were rendered by another entity during a combined stay, the acute care PPS hospital will be responsible for payment of those services per common Medicare practice.
NOTE: Medicare does not reimburse other entities for services performed during two inpatient acute care PPS stays that are combined onto a single claim. However, the other entity's services may be considered and billed as covered services, when appropriate, by the acute care PPS hospital.

Patient is discharged and later readmitted for an unrelated condition
When a patient is discharged/transferred from an acute care PPS hospital and is readmitted to the same acute care PPS hospital on the same day for symptoms unrelated to, and/or not for evaluation and management of, the prior stay's medical condition, hospitals should bill as follows: Place Condition Code (CC) B4 on the claim. Ensure that the claim contains an admission date equal to the prior admissions discharge date. Upon the request of the A/B MACs or the Fiscal Intermediary (FI), hospitals must submit medical records pertaining to the readmission.

Patient is discharged and readmission is unexpected but related
When a patient is discharged and the later readmission is unexpected but related, the provider should bill two separate claims and not combine them. The patient was discharged under the premise that their condition had improved to the point that they could be discharged. Even though the patient returned to the facility for the same condition, the "readmission" would be a new admission because the patient and facility had to go through the admittance procedures again. The QIO may decide to review the claims and may advise the provider to combine the two. However, until that time, the provider needs to file as two separate claims.

References The Centers for Medicare & Medicaid Services' (CMS') Internet-Only Manuals, Publication 100-04, Chapter 3, Section 40.2.5 (Repeat Admissions) and 40.2.6 (Leave of Absence) - http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c03.pdf

18. When will providers be able to bill provider liable claim electronically?

Answer: I don't recall any formal direction given to providers stating they had to bill DDE as a workaround. I do know there have been several issues with the implementation of the use of the M1 Occurrence Span Code (OSC) since the MLN Matters article 8445 was released late 2013. This issue has been posted to the website in March of 2014 and still continues to be an issue. We do have an approved work around from CMS, which is changing the OSC M1 to a 79. But, to answer the original question, I am not aware of any direction stating these had to be submitted DDE only.

At this point, the providers should be able to submit them electronically and we will hold them to apply the workaround. .

References

- *Part A Current Open Claims Issues: http://www.novitas-solutions.com/webcenter/spaces/MedicareJL/page/pagebyid?contentId=00003625*
- *MLN Matters Article 8455 http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8445.pdf*

19. We do not get timely responses to tickets, often we are never called back.

Answer: We apologize that promised callbacks have not been made. We have recently made updates to both our callback and supervisor callback procedures. You should begin seeing improvements immediately. Please let us know if you continue to experience problems regarding this matter.

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