New Mexico Hospital Association
69th Annual Meeting

September 25, 2014
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- This presentation is a general summary that explains certain aspects of the Medicare program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings.

- Novitas Solutions does not permit videotaping or audio recording of training events.
I. Operations Overview  Laura Minter

II. Audit & Reimbursement Update  Steven Holubowicz

III. Provider Outreach & Education  Teresa Tatum

IV. Wrap Up
Operations Overview

- Operations running smoothly at Novitas:
  - Demonstrated improvements in knowledge skills and responsiveness to our customers

- Continue to focus on enhancing quality:
  - Claims team
  - Critical Inquiries Unit

- Reminders:
  - Available self-service tools
  - Revalidation

- Website Improvements:
  - Feedback requested (Education@Novitas-Solutions.com)
Audit & Reimbursement Update

Agenda

- Introduction
- FY 2015 IPPS Update
- Reimbursement Issues
- Audit Issues
- Wage Index Review
- Organizational Structure
FY 2015 IPPS Update

- IPPS Update
  - Payment Updates
  - Wage Index Revised CBSAs
  - Reasonable Compensation Equivalents (RCEs)
  - Extension of Existing Programs
  - Disproportionate Share Hospital (DSH)
FY 2015 IPPS Update

- Payment Update
  - FY 2015 Update to the Standard Rate
    - Acute Hospital update: 1.4% net increase
    - Excluded Hospital update: 2.9%
    - LTCH update: 2.2%
      - LTCH One-Time Prospective Adjustment of .98374 (Year 3)
FY 2015 IPPS Update

- Payment Update
  - IPPS Hospital Payment Adjustments
    - Market Basket: Starting point: 2.9%
    - Update to IPPS standardized rate (due to adjustments) 1.4%
  - Performance-Based Adjustments
    - Failure to submit quality data -.75%
    - Failure for EHR meaningful use: -.75%
    - Readmission reduction program -3.0%
    - Hospital Acquired condition reduction -1.0%
  - Value-Based Purchasing
    - Hospital Specific Adjustment

  - Hospital could have negative update factor, depending on performance
Payment Update

- Failure to submit quality data -0.75%

  ✓ Previously, hospitals that do not participate successfully in the Hospital IQR Program have their applicable percentage increase reduced by two percentage points. Since the implementation of this financial penalty, hospital participation has increased to well over 99 percent of Medicare-participating hospitals that are paid under the IPPS.

  ✓ Starting for the FY 2015 payment determination, however, that reduction will be approximately one quarter of a hospital’s annual payment increase that would otherwise apply.

  ✓ Majority of hospitals do participate in the Quality Reporting Program

  ✓ 63 Measures Reported

    ➢ 47 Required; 16 Voluntary
Payment Update

- Failure for EHR Meaningful Use -0.75%
  - CMS is preparing a comprehensive list of several hundred providers who have failed meaningful use
  - CMS will notify Novitas and we will send a letter to the provider informing them of the failure and reduction of .75% to their rate of increase
  - CAH’s who fail the MU standard will have see their payments reduced from the current 101% to 100.66%
    - Not material, but we are required to enter this into FISS
Payment Update

- Readmissions Reduction Program - 3.0%
  - Third year of the program (ACA, Section 3025)
  - CMS will assess hospitals’ readmission penalties using five readmissions measures endorsed by the National Qualify Forum (NQF):
    - Heart attack, heart failure, pneumonia, chronic obstructive pulmonary disease, and hip/knee arthroplasty.
    - CMS has finalized an updated methodology to take into account planned readmissions for these five existing readmissions measures, as well as refinement in the hip/knee arthroplasty readmission measure methodology.
    - CMS will add a new readmission measure beginning in FY 2017: readmissions for coronary artery bypass graft (CABG) surgical procedures.
  - Adjustments are made on a per claim basis; does not include IME, DSH, outlier, or low-volume adj. The cost report was modified to handle this.
FY 2015 IPPS Update

- Payment Update
  - Preventable Hospital-Acquired Conditions - 1.0%
    - FY 2015- Lowest performing quartile will have their inpatient payments reduced by 1%
    - CMS estimates that 753 hospitals will be affected
    - Overall payments would decrease $330 million, or an estimated $438,000 per affected hospital
Payment Update

- Value-Based Incentive Payments
  - Third year of the program – funded through payment reduction to operating DRG payments FY 2015 - 1.5% (approximately $1.4 billion)
  - Redistributed to IPPS hospitals based on performance compared to peers
  - 80% of the measures assess health outcomes, patient experience and cost
  - Final rule updates the FY 2017 measure set by adding two new Safety measures and one new Clinical Care and removing six “topped-out” clinical process measures
    - Hospital-onset methicillin-resistant Staphylococcus aureus (MRSA) bacteremia and Clostridium difficile infection
    - Clinical Care - Process measure: early elective deliveries
    - Adjustment factors for each hospital released 10/2014 – CMS website

Hospital Specific Adjustment
Payment Update

- Outlier Fixed Loss Threshold
  - FY 2015 formula is still the DRG + IME + DSH + Add on for new technology
  - Threshold was raised to $24,758 from $21,748 in FY 2014
  - Obtaining outlier payments will be even harder in FY 2015
Reimbursement Issues

- Wage Index Revised CBSAs

- FY 2015 CMS will use the revised OMB Core Based Statistical Area

  - 37 counties and 12 hospitals losing urban status - Nationally
    - ✓ New Mexico – No counties going to rural (based on pg 49953 of final rule)
  
  - 105 counties and 81 hospitals losing rural status - Nationally
    - ✓ New Mexico - No counties going to urban (based on pg 49954 of final rule)
  
  - Affects MDH and SCH status
    - ✓ New Mexico – not impacted
  
  - CAH status – three year transition if made urban
    - ✓ New Mexico doesn’t have any impacted CAHs
FY 2015 CMS Updated the Reasonable Compensation Equivalents (RCEs)

- Based on American Hosp. Assoc. of Periodic Survey of Physicians data
- Effective for cost reporting periods beginning on or after January 1, 2015
- Applies to salaried physicians for providers that are payable on a reasonable cost basis under Medicare – Part A component
  - Does not apply to Critical Access Hospitals
- Minimal impact to a IPPS facility unless they have a cost-based component
### FY 2015 CMS Updated the RCEs

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Reimbursement Issues

- Extension of Existing Programs
- Medicare-Dependent Hospital and Low-Volume Adjustment
  - MDH and Low-Volume adjustment programs now expire April 1, 2015
  - Provider must inform MAC regarding whether it can meet the Low-Volume adjustment by 9/1/14
  - Low Volume Adjustment reverted to 200 discharges (down from 1,600) in April 2015
    - Only 10 hospitals qualified
    - Congress is considering an extension and retroactive application
      - May not happen until second quarter of 2015
ACA, Section 3133 - Disproportionate Share

- Effective for discharges on or after 10/1/2013
- Expands DSH to more hospitals, due to expanded Medicaid programs
  - Empirically Justified Amount – 25% of estimated DSH payments (current method) – no changes
  - Uncompensated Care Amount – 75% of estimated DSH payments - three factors
    - Factor 1 – estimation of 75% of global DSH payment
    - Factor 2 – reduction based on estimated decrease in uninsured
    - Factor 3 – individual hospital's proportion of uncompensated care to all DSH hospitals’ uncompensated care
  - Uncompensated care payments are based on an estimate
    - CMS not accepting the uncompensated care amounts on WS S-10
ACA, Section 3133 - Disproportionate Share

- Proxy for 2015 – CMS provides this data
  - Inpatient days of Medicaid patients from March, 2014 Hospital Specific File for the FY 2012 cost report, WS S-2 plus
  - Inpatient days of Medicare SSI patients from the FY 2012 cost report
  - Not sure how long the proxy will be used

- Essentially a pre-determined amount for the year paid during the year based on Medicare discharges
  - Example – pre-determined that a provider will receive $20M during the FY
  - During the year they only receive $19M, the additional $1M will be a cost report add-on

- Special rules for newly eligible hospitals, merged hospitals, and new hosp
CRNA Exception Criteria

In order for a provider to qualify for the CRNA exception and be paid on a bi-weekly basis, a provider must perform less than 800 surgeries and total CRNA hours work must be less than 2,080.

Providers are required by law to make a formal request to Novitas and the request MUST be RECEIVED prior to 1/1/2015. Reviews will occur, additional info requested if needed, determination letter sent for Exception effective 1/1/14. Requests received after 1/1/2015 will be denied.

Information and questions can be directed to Catherine Rushing, Novitas Solutions, 532 Riverside Avenue, Jacksonville FL 32202. Information required includes all current CRNA/AA contracts, CRNA licenses, and surgery logs from 1/1 through 9/30/14 which supports the volume.
Audit Issues

- HITECH
  - Matching your EHR payment period to the correct cost report period
    - The Medicare Cost Report is used to determine the final payment amount for the EHR Incentive so it is important to use the correct cost report period
    - Must be a 12-month cost report period (between 360 and 371 days)
  - The cost report period is determined using the hospital’s meaningful use effective date and the federal fiscal year.
    - As specified by the HITECH UDR Program, we select the correct cost report period by determining “which cost reporting period for the Hospital begins during the Federal Fiscal Year that the Hospital’s Meaningful Use Effective Date falls in.”
    - Example provided on the next slide
Audit Issues

- HITECH - FISS Data for 06/30 FYE Provider

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Audit Issues

- Choosing the Correct Cost Report Period
- **Example:** FYE 06/30 Provider

A Provider with a Meaningful Use Effective Date of 10/01/2011 occurs in Federal Fiscal Year (FFY): 2012

<table>
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Wage Index Review

- 2016 Timetable
- Wage Review issues
FY2016 Timetable - May 23, 2014

- Release of preliminary FY 2016 wage index file based on unaudited FY 2012 Worksheet S-3 wage data file (cost report FYE 12/31/2012)
  - The FY 2012 wage data file includes Worksheet S-3 wage data from cost reports submitted to MACs through approximately 5/14/14
  - The file excludes hospitals designated as CAHs
  - 10/6/14 - deadline for hospitals to request revisions to their WS S-3 wage data and occupational mix data as included in the preliminary PUFs and to provide documentation to support the request
  - MAC’s must receive supporting documentation by this date
  - MACs will have approximately nine weeks to complete their reviews, make determinations, and transmit revised data to CMS’s Division of Acute Care (DAC)
Wage Index Review

- FY2016 Timetable
  - December 8, 2014
    - Deadline for MACs to notify State hospital associations regarding hospitals that fail to respond to issues raised during the desk reviews.
      - The purpose of the letter is to inform the State association and its member hospitals that a hospital’s failure to respond to matters raised by the MAC can result in lowering an area’s wage index value and, therefore, lower Medicare payments for all hospitals in the area.
  - December 16, 2014
    - Deadline for MACs to complete all desk reviews for hospital wage and occupational mix data and transmit revised Worksheet S-3 wage data and occupational mix data to DAC
      - Novitas must complete all wage reviews prior to this date. To prevent poor data being transmitted to CMS, please work with your MAC auditor well in advance of this deadline.
FY2016 Timetable

- February 13, 2015
  - Release of revised FY 2016 wage index and occupational mix PUFs on the CMS Web site.
  - This data will go through a desk review and verification by the MACs before being published.
  - A file including each urban and rural area’s average hourly wages for the FYs 2015 (final) and 2016 (preliminary) wage indexes will be provided on the CMS website.
Wage Index Review

• FY2016 Timetable
  • March 2, 2015
    ✔ Deadline for hospitals to submit requests (including supporting documentation) for:
      ➢ Corrections to errors in the February PUFs due to CMS or MAC mishandling of the wage index or occupational mix data
      ➢ Revisions of desk review adjustments to their wage index or occupational mix data as included in the February PUFs (and to provide documentation to support the request). MACs must receive the requests and supporting documentation by this date.
      ➢ No new requests for wage index and occupational mix data revisions will be accepted by the MACs at this point, as it is too late in the process for MACs to handle data that is new in a timely manner.
Wage Index Review

- FY2016 Timetable
  - April/May 2015
    ✓ Approximate date proposed rule will be published; includes proposed wage index, which is calculated based on the revised wage index data from February; 60-day public comment period and 45-day withdrawal deadline for hospitals applying for geographic reclassification.
    ✓ April 8, 2015 - Deadline for the following:
      - MACs to transmit final revised wage index data (in HCRIS HDT format) to DAC for inclusion in the final wage index
      - MACs must also send written response to hospitals regarding the hospitals' March 2, 2015, correction/revision requests by this date
Wage Index Review

- FY2016 Timetable
  - April 15, 2015
    - Deadline for hospitals to appeal MAC determinations and request CMS’ intervention in cases where the hospital disagrees with the MAC.
    - CMS does not consider issues such as the adequacy of a hospital’s supporting documentation, as CMS believes that the MACs are generally in the best position to make evaluations regarding the appropriateness of these types of issues (which should have been resolved earlier in the process).
    - The request must include all correspondence between the hospital and MAC that documents the hospital’s attempt to resolve the dispute earlier in the process. Data that was incorrect in the preliminary or February wage index data PUFs, but for which no correction request was received by the March 2, 2015 deadline, will not be considered for correction at this stage.
FY2016 Timetable

April 15 (cont’d)

- Hospitals shall send an electronic and a hard copy of the appeal with complete documentation supporting their request; appeals submitted via fax will NOT be accepted. Electronic copies (including all supporting documentation) shall preferably be sent in PDF files to ensure compatibility with CMS software. Spreadsheets can be sent in Excel.

- Appeals shall be sent electronically to wageindexreview@cms.hhs.gov

- Hard Copies shall be sent to the CMS Central Office at:
  Centers for Medicare & Medicaid Services c/o Wage Index, CMM/HAPG/DAC
  Room C4-08-06
  7500 Security Boulevard
  Baltimore, Maryland 21244-1850
Wage Index Review

- FY2016 Timetable
  - Late April, 2015
    - MACs to alert hospitals to the availability of the final wage index and occupational mix data files for their review in the May 1, 2015 PUF
    - Final opportunity to request corrections to errors in the final data
    - Changes to data will be limited to situations involving errors by CMS or the MAC that the hospital could not have known about before review of the final May PUFs
    - Data that was incorrect in the preliminary or February 2015 wage index data PUFs, but for which no correction request was received by the early March 2, 2015 deadline, will not be considered for correction at this stage
Wage Index Review

- **FY2016 Timetable**
  - **May 1, 2015**
    - Release of final FY 2016 wage index and occupational mix data PUFs on CMS Web page. Hospitals will have approximately one month to verify their data and submit correction requests to both CMS and their MAC to correct errors due to CMS or MAC mishandling of the final wage and occupational mix data.
  - **June 1, 2015**
    - Deadline for hospitals to submit correction requests to both CMS and their MAC to correct errors due to CMS or MAC mishandling of the final wage and occupational mix data as posted in the 5/1/15 PUF. Changes to data will be limited to situations involving errors by CMS or the MAC that the hospital could not have known about before review of the final May 1, 2015 PUFs.
Wage Index Review

- FY2016 Timetable
  - August 1, 2015
    ✓ Approximate date for publication of the FY 2016 final rule; wage index includes final wage index data corrections
  - October 1, 2015
    ✓ Effective date of FY 2016 wage index
Wage Review Issues

Dietary and Housekeeping

- Some providers report *neither* internal expense nor contracted expense. Some costs MUST be reported. Novitas will be contacting you if needed.
- The contracted costs have to be actual and not estimated. CMS has MACs test for the costs to be within certain reasonable ranges, zero is not an option.

Employee Benefits

- WS- A, line 4, column 1, is only for the staff working in the Employee Benefits Department – it is not for reporting benefits of all hospital employees. Many providers put PTO of the entire hospital into this line.
- PTO must be reported in the salary column (1) of all various department cost center lines.
Organizational Structure of Novitas PARD Area

- Personnel and roles:
  - Steve Holubowicz, Sr. Director Audit and Reimbursement (JH and JL)
  - Tim LeJeune, Director of JH Audit
  - Bruce Snyder Acting, Manager of Reimbursement and Settlement
  - Jackie Burke, Manager of Audit (primarily J7 and some of J4)
  - Lisa Travis, Manager of Audit (primarily J4)
  - Jennifer Garrett, Supervisor of Reimbursement
  - Carrie Rudy, Supervisor of Settlement
Any Questions - Please Contact:

Sr. Director – Audit and Reimbursement
steve.holubowicz@novitas-solutions.com

Director of Audit -
timothy.lejeune@novitas-solutions.com

Manager of Reimbursement and Settlement -
bruce.snyder@novitas-solutions.com
Outreach & Education Update

Teresa Tatum
Provider Outreach & Education Specialist
442.400.7422
Teresa.Tatum@novitas-solutions.com

Gregory Hart
Jurisdiction H Provider Outreach & Education Supervisor
501.690.2931
Gregory.Hart@novitas-solutions.com
Outreach & Education Update

- Agenda
  - Medicare Updates
  - Comprehensive Error Rate Testing (CERT)
  - Website Updates
MEDICARE UPDATES
Medicare Updates

- Two Midnight Rule
- Inpatient hospital payment under Medicare Part A acceptable when the physician
  - Admits the patient to the hospital based on expectation that patient stay will cross at least two midnights
Medicare Updates

- Purpose and Medical Review Strategy of Inpatient Reviews
  - Purpose is to assess the hospital’s compliance with
    - Admission order requirements
    - Certification requirements
    - Two midnight benchmark

- Strategy aimed at
  - Identifying claims non-compliant with CMS-1599-F
  - Issuing denials for improper claims for payment
  - Educating providers about CMS-1599-F
Medicare Updates

- Inpatient Hospital Reviews: Updates 5-12-14
  - Medical Review activities will continue under the Probe & Educate process through **March 31, 2015**
  - Recovery Auditors are prohibited to conduct inpatient hospital patient status reviews on claims with dates of admission October 1, 2013 through **March 31, 2015**
  - As of May 12, 2014, Medicare Administrative Contractors (MACs) have completed most first probe reviews, of 10 (or 25) claims, for providers within their jurisdiction, and are beginning to provide educational information related to the first probe period findings

- For additional information
Medicare Updates

- Status of Novitas Probe and Educate Reviews
  - Phase One has been completed
  - Phase Two has begun
  - 1:1 Education calls will continue
  - Global education via teleconference will be available
## Medicare Updates

### JH Top Denial Reason

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<td>2. No records received</td>
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<td>3. Documentation did not support unforeseen circumstances interrupting stay</td>
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<td>4. Other</td>
<td>3.2%</td>
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<td>5. Order missing</td>
<td>2.8%</td>
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<tr>
<td>6. Order not validated</td>
<td>2.6%</td>
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<tr>
<td>7. Certification not present</td>
<td>2.0%</td>
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<tr>
<td>8. Certification inadequate</td>
<td>1.8%</td>
</tr>
<tr>
<td>9. Order unsigned</td>
<td>1.3%</td>
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<tr>
<td>10. Procedure not reasonable and necessary</td>
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Medicare Updates

- Documentation Did Not Support Two Midnight Expectation
  - Two midnight benchmark based on physician’s expectation of the required duration of medically necessary hospital services at the time inpatient order is written and formal admission begins
  - Physicians do not need to include a separate attestation of the expected length of stay
    ✓ Information may be inferred from the physician’s standard medical documentation such as the plan of care, treatment orders, and physician’s notes
Medicare Updates

- Missing Physician Order and Missing Signature
  - Order must clearly indicate the intent to admit as an inpatient
  - Ordering practitioner
    - Makes determination of medical necessity for inpatient care and renders admission decision
    - Not required to write the order but must sign the order reflecting decision to admit the patient
    - Not required to be physician who signs the certification
Medicare Updates

- Failure to Document Unforeseen Circumstances interrupting the stay
  - Resulting in a shorter than the physician’s expectation of at least two midnights
    - Patient may be considered to be appropriately treated on an inpatient basis and hospital inpatient payment may be made
  - Examples include unforeseen
    - Death
    - Transfer to another hospital
    - Departure against medical advice
    - Clinical improvement where stay less than expected
Medicare Updates

- ICD-10 Conversion/Coding Infrastructure Revisions/ICD-9 Updates to National Coverage Determinations (NCDs) - Maintenance CR
  - Create and updated NCD editing
  - Updated associated coding infrastructure
  - There are 29 spreadsheets attached to CR8691 that relate to 9 NCDs and provide pertinent policy/coding information necessary to implement ICD-10

Resolutions for Appeals of Patient Status Denials

- CMS offers settlement to Acute Care Hospitals and Critical Access Hospitals to resolve appeals of patient status denials
  - Any hospital willing to withdraw their pending appeals in exchange for timely partial payment (68% of the net allowable amount).
  - The administrative agreement covers admissions prior to Oct 1, 2013
  - Administrative agreement requests are due to CMS by Oct 31, 2014

- MLN Connects National Provider Call
  - Tuesday, Sept 9, 2014
  - Slides and transcript from the call are available at the following website:

- CMS Inpatient Hospital Reviews
  - [http://cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/InpatientHospitalReviews.html](http://cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/InpatientHospitalReviews.html)
Medicare Updates

- July 2014 Update of the Hospital Outpatient Prospective Payment System (OPPS)
  - Effective July 1, 2014
  - Coding updates
  - Lab billing changes and clarification
  - Reference

Medicare Updates

- Fiscal Year 2015 Policy and Payment Changes for Hospital Outpatient and Ambulatory Surgical Centers CMS Proposed Rule Fact Sheet
Medicare Updates

- Fiscal Year 2015 Policy and Payment Changes for Inpatient Stays in Acute-Care Hospitals and Long-Term Care Hospitals - CMS Final Rule Fact Sheet
Medicare Updates

- Fiscal Year 2015 Major Quality provision Updates in the Hospital Final Rule – CMS Final Rule Fact Sheet
COMPREHENSIVE ERROR RATE TESTING (CERT)
Comprehensive Error Rate Testing (CERT)

- What is it? A program developed by Centers for Medicare & Medicaid Services (CMS) to randomly audit claims monthly to determine if they processed correctly.
- Why does it matter? To protect the Medicare trust fund and determine error rates nationally and regionally.
- Who is involved? You. A request for medical records from AdvanceMed alerts you that one of your claims has been selected as part of the monthly random sample.
- How does it work? A letter will be sent to your office requesting the medical documentation. You need to comply in a timely manner with the request.
- JH
Comprehensive Error Rate Testing (CERT)

- JH Part A Common Errors
  - Insufficient documentation
    - No valid physician’s order
    - Missing documentation to support minimum 15 hours per week of combined therapy
    - Diagnosis insufficient to support procedure or service billed
    - Skilled Nursing Facility (SNF) 3 day qualifying stay
  - Medical necessity errors
    - Need for an inpatient stay
  - Other errors
    - Diagnosis Related Group (DRG)
    - Laboratory services
WEBSITE UPDATES
Website Updates

Website Improvements

• Based on your feedback we continue to update the Novitas Solutions website to better service your needs and to allow for better navigation

• New features are available
  ✓ Website content displayed by contract and line and business
  ✓ Improved search functionality
  ✓ Enhanced left-side navigation bar
  ✓ New Search Application
Novitas Solutions, Inc. (Novitas) proudly serves as an administrative services processing company for government-sponsored health care programs on behalf of the federal government. Novitas currently administers:

- The Medicare Administrative Contract (MAC) Jurisdiction L (IL), which spans eleven states and Washington, D.C.;
- The Medicare Administrative Contract (MAC) Jurisdiction H (NH), which spans seven states, Indian Health Service (IHS) and Veterans Affairs (VA); and
- The payment processing for the Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens contract, as authorized under Section 1011 of the 2003 Medicare Modernization Act.

We are headquartered in Mechanicsburg, Pa., and employ more than 1,000 staff in the area. Nearly 1,000 other associates are located in field offices in Hunt Valley, Md.; Pittsburgh and Williamsport, Pa.; Dallas, Texas; Milwaukee, Wis.; and Jacksonville, Fla.

Career Opportunities

- Novitas job openings in Pennsylvania and Maryland
- Novitas job openings in Florida, Texas, Wisconsin and Provider Audit and work-from-home jobs in CO, NM, OK, AR, LA, MS

If you have any questions regarding your applicant profile or application status, please contact a member of our team via email or telephone.

Support Email: incapturastaffing@incapture.com
Support Hotline: 877.347.7151

If you have already applied for a job with Novitas Solutions in PA or MD, you can check your application status online by clicking the Check Your Application Status option from the job search page.

- To see career opportunities at our sister company, First Coast Service Options, please visit www.fcso.com.
- To see career opportunities at our parent company, Diversified Service Options, please visit www.dsocorp.com.
Novitas Start Center - Medicare Part A, Jurisdiction H

Mail received at the Camp Hill P.O. Boxes/Addresses will be returned effective July 25, 2014

ICD-10 Compliance Date and End-to-End Testing Updates

View active system issues.

Self-Service Features
- Address Changes
- Appeals Status Inquiry Tool
- CERT Claim ID Lookup
- Claim Triage Listing
- Contact Us
- Enrollment Forms (CMS-855)
- Enrollment Status Lookup
- Fee Schedule Downloads
- Forms Catalog
- Interactive Voice Response (IVR) - 1-855-252-8782
- Learning Center (Educational Events & Online Training)
- Medical Policy (LCD) Lookup / Search
- LCDs / Medical Policy Index

News & Popular Topics
- All Part A News & Web Site Updates
- Billing Information
- Billing
- Clinical Trials & IDE Requests
- Contractor/Payer ID's
- DDE/FS5 Forms and References
- ICD-10 Implementation
- Immediate Recoupment on a Solicited Demand
- MSP Billing Instructions
- Notifying Medicare of an Overpayment
- Recovery Auditors (RA)
- Signature Attestation (Example)
Website Updates

- Local Coverage Determinations (LCDs) Search Update
- Search current, retired, or draft policies
- Search criteria
  - Policy number
  - Healthcare Common Procedure Coding System (HCPCS)
  - Keyword
  - Local Coverage Determination (LCD) Title
- Search results based on criteria entered
- JH LCDs/Medical Policy Center
Website Updates

- Novitas Medicare Learning Center is Now Available
- Features
  - Create an individualized education account
  - Register for webinars, teleconferences, and workshops
  - Download your Continuing Education Unit (CEU) Certificates
  - Be placed on a waitlist if the educational event you register for is closed
- Benefits
  - Centralized location for all educational materials
  - Track all of the educational events you’ve attended
  - Access Medicare education 24 hours a day, 7 days a week with web-based training modules
Website Updates

- Our Education and Training Center offers a wide variety of education
- Join us for Workshops, Teleconferences, and Webinars
- To view the most current calendar of events, visit
  - JH Part A
  - JH Part B
Question & Answer Session