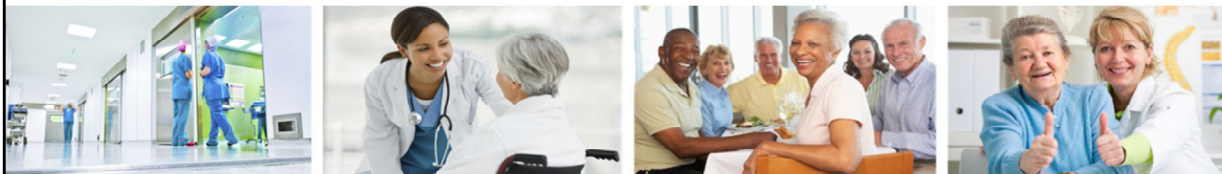# What's New for 2020

An Overview of Policy and Payment Changes to the Medicare Physician Fee Schedule for Calendar Year 2020

Kansas Medical Society and Missouri State Medical Association

January 29, 2020

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http://wpsghalearningcenter.com

CMS

We prepared this education as a tool to assist the provider community. Medicare rules change often and are contained in the relevant laws, regulations and rulings which can be found on the Centers for Medicare & Medicaid Services (CMS) website at www.cms.gov. We will provide responses to questions based on the facts given, but the Medicare rules will determine final coverage. CMS prohibits recording of the presentation for profit-making purposes.
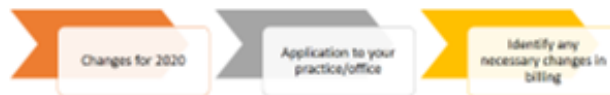
Agenda

- New Rates
- Opioid Treatment Programs
- Appropriate Use Criteria
- Patient Relationship Codes & Categories
- Care Management
- Documentation Review
- Evaluation and Management
- Opioid Use Disorder
- New Services
- Department of Justice

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Objectives

Changes for 2020 → Application to your practice/office → Identify any necessary changes in billing

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CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Acronym	Description
ADR	Additional Documentation Request
ALJ	Administrative Law Judge
AMA	American Medical Association
ASC	Ambulatory Surgical Center
AUC	Appropriate Use Criteria
AWV	Annual Wellness Visit
CARC	Claim Adjustment Reason Code
CCM	Chronic Care Management
CDSM	Clinical Decision Support Mechanism
CHIP	Children's Health Insurance Program
DG	Documentation Guidelines
DL	Demand Letter
E/M	Evaluation and Management
FAQ	Frequently Asked Questions
IDTF	Independent Diagnostic Testing Facility
IPPE	Initial Preventive Physical Exam
IVR	Interactive Voice Response
MA	Medical Assistant
MAC	Medicare Administrative Contractor
MACRA	Medicare Access CHIP Reauthorization Act
MAT	Medication-Assisted Therapy
MBI	Medicare Beneficiary Identifier
MDM	Medical Decision-Making
NPI	National Provider Identifier
NPP	Non-Physician Practitioner
OPPS	Outpatient Prospective Payment System
OTA	Occupational Therapy Assistant
OTP	Outpatient Treatment Program
OUD	Opioid Use Disorder
PAMA	Protecting Access to Medicare Act
PCM	Principal Care Management
PECOS	Provider Enrollment, Chain and Ownership System
PFS	Physician Fee Schedule
PRC	Patient Relationship Codes
PTA	Physical Therapy Assistant
QPP	Quality Payment Program
RARC	Remittance Advice Reason Code
SAMHSA	Substance Abuse and Mental Health Services Administration
SUD	Substance Abuse Disorder
TCM	Transitional Care Management

2020 Part B Deductible, Premium, Amount in Controversy Rates/Thresholds

	2019	2020
Monthly Part B Premium (based on individual taxable income of $87,000 or less or joint taxable income of $174,000 less)	$135.50	$144.60
Annual Part B Deductible	$185.00	$198.00
Amount in Controversy (Level 3 – Administrative Law Judge (ALJ) Hearing)	$160.00	$170.00
Amount in Controversy (Level 5 – U.S. District Court)	$1,630.00	$1,670.00

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Monthly Medicare Part B Premium
- Premium rates contingent on income levels
- For about 70% of Medicare beneficiaries, premiums will rise to $144.60 per month
  - 7% increase from 2019
  - 70% is based on individual taxable income of $87,000 or less or joint taxable income of $174,000 or less
  - For premiums based on other taxable income levels, refer to the CMS 2020 Medicare Parts A & B Premiums and Deductibles Fact Sheet
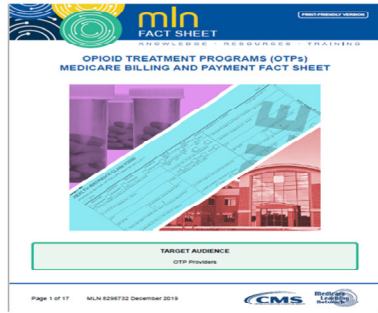
Part B Annual Deductible
- Increases by $13 to $198
  - Up 7% from $185 in 2019

2020 Changes to Threshold Amounts for Amount in Controversy (AIC)
- Applicable to requests received on or after January 1, 2020, CMS is increasing threshold amount
  - Administrative Law Judge (ALJ) hearings – Level 3
    - $170 (compared with $160 in 2019)
  - Judicial review in U.S. District Court – Level 5
    - $1,670 (compared with $1,630 in 2019)

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Opioid Treatment Programs

Appropriate providers
- OTP accredited by a Substance Abuse and Mental Health Services Administration (SAMHSA) recognized accrediting body
- OTP certified by SAMHSA
- Enrolled with Medicare as an OTP
- Bill specific procedure codes
    - Medicare reimburses only for specific procedure codes
    - Procedure codes are not available for specialties other than OTP

CMS MLN Publication 8296732 Opioid Treatment Programs (OTPs) Medicare Billing and Fact Sheet
https://www.cms.gov/files/document/otp-billing-and-payment-fact-sheet.pdf

CMS MLN Publication 6325432 Opioid Treatment Programs (OTPs) Medicare Enrollment Fact Sheet
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/OTP-enrollment-factsheet-MLN6325432.pdf

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Protecting Access to Medicare Act (PAMA) includes provisions for Appropriate Use Criteria (AUC)

- Established AUC program to increase rate of appropriate advanced diagnostic imaging services
    - Examples of advanced imaging services include:
        - Computed tomography
        - Positron emission tomography
        - Nuclear medicine
        - Magnetic resonance imaging
- Ultimately will require prior authorization
    - For ordering providers identified as having outlier ordering patterns
- Requires ordering provider to consult a qualified Clinical Decision Support Mechanism (CDSM)
    - Interactive electronic tool
    - Assists in treatment decision
    - Provides determination
        - Ordered service does or does not adhere to AUC
        - Service is not applicable to AUC
    - CMS website lists qualified CDSMs on the CDSM web page
- Upon implementation, consultation required for:
    - Any applicable imaging service
    - Ordered by an ordering professional
    - Furnished in an applicable setting
    - Paid under an applicable payment system
- Consultation information added to furnishing provider's claim

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CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

What is "Applicable"?

Setting
- Physician's office
- Hospital outpatient department (including ED)
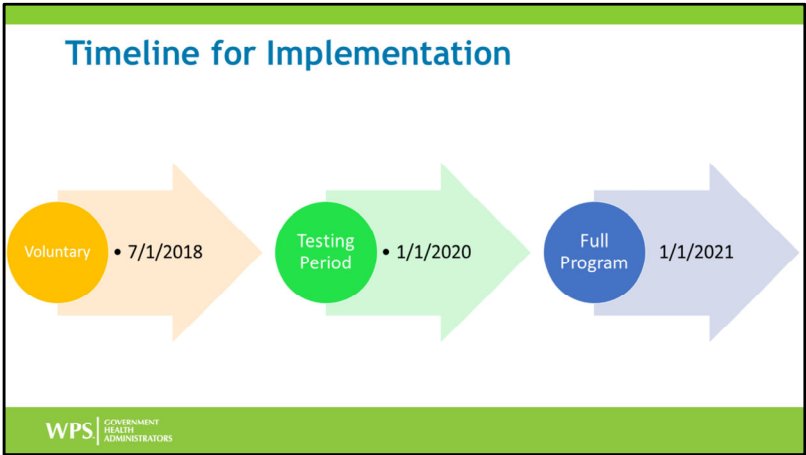- ASC
- IDTF

Payment system
- PFS
- OPPS
- ASC

What is "Applicable"?
- Setting
    - Physician's office
    - Hospital outpatient department
        - Including emergency department
    - Ambulatory Surgical Center (ASC)
    - Independent Diagnostic Testing Facility (IDTF)
- Payment system:
    - Physician Fee Schedule (PFS)
    - Hospital Outpatient Prospective Payment System (OPPS)
    - ASC payment system

Timeline for Implementation

Voluntary • 7/1/2018 → Testing Period • 1/1/2020 → Full Program 1/1/2021

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Timeline for Implementation
- Voluntary participation
    - July 1, 2018 – December 31, 2019
- Official Educational and Operations Testing Period
    - January 1 – December 31, 2020
- Full program implementation
    - January 1, 2021
- Identification of outlier providers
    - See CMS MLN Publication 11268 for list of codes and descriptions
    https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM11268.pdf

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Educational and Operations Testing Period

Educational and Operations Testing Period – Claims Processing Requirements
- Ordering professional must use a qualified CDSM
- Furnishing provider must report AUC information on claim
  - Ordering professional's NPI
  - Which CDSM consulted
    - G1000 - G1010
    - G1011 – CDSM not otherwise specified
      - Temporary code for new tool
  - CDSM determination
    - Ordered service would adhere to AUC
      - ME modifier
    - Ordered service would not adhere to AUC
      - MF modifier
    - AUC was not applicable to service
      - MG modifier
- Other modifiers for AUC exceptions
  - MA, MB, MC, MD
- When ordering professional does not provide AUC information to rendering provider
  - MH modifier
- See MM11268 for list of codes and descriptions

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PRC Codes

X1 Continues/Broad Services	X2 Continuous/Focused Services	X3 Episodic/Broad Services
X4 Episodic/Focused Services	X5 Only as Ordered by Another Clinician	
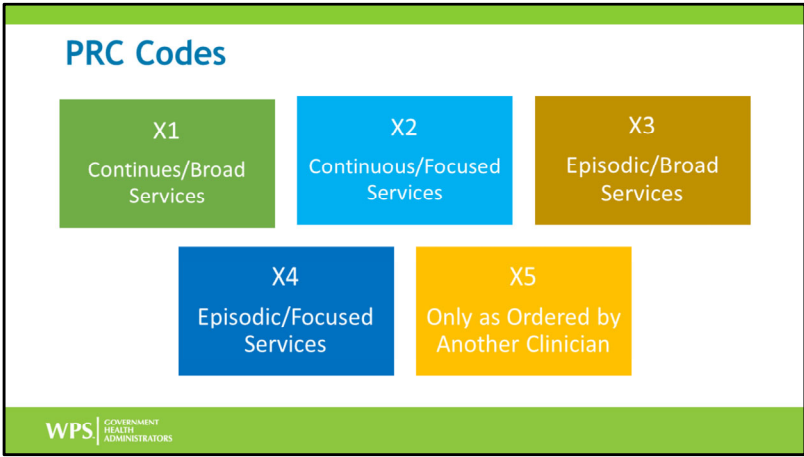
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PRC Codes
- Medicare Access CHIP Reauthorization Act of 2015 (MACRA) repealed sustainable growth rate formula
  - Authorized the Quality Payment Program (QPPs)s]
  - Section 101(f) of the MACRA amended section 1848 of the Social Security Act (the Act)
    - Requires the development of patient relationship categories and codes to facilitate the attribution of patients and episodes to one or more physician or applicable practitioners ("clinicians") for purpose of cost measurement
    - The Act requires clinicians to include the applicable patient relationship codes
    - CMS finalized five patient relationship codes for use in a voluntary reporting period beginning January 1, 2018

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CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

PRC Codes – Reporting
- Currently in a voluntary reporting period
    - CMS may adjust length of voluntary reporting period based on factors including clinicians' adoption of the codes, data analysis findings, and stakeholder feedback
    - CMS will establish mandatory reporting through rulemaking
- Physicians, physician assistants, nurse practitioners, clinical nurse specialists and certified registered nurse anesthetists may report
    - CMS may expand this list to include additional clinicians through rulemaking for future years

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CMS Efforts to Provide Clarity

- CMS Resources

X2 Continuous/Focused Services

For reporting services by clinicians whose **expertise** is needed for the **ongoing management** of a chronic disease or a condition that needs to be managed and followed for a long time.

Examples include but are not limited to:
- Endocrinologist managing diabetes
- Orthopedist managing osteoarthritis before knee replacement
- Ophthalmologist managing glaucoma or diabetic retinopathy
- Pulmonologist managing asthma
- Speech-language pathologist providing ongoing therapy for difficulty swallowing
- Infectious disease consultant managing care for a patient with HIV

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CMS Resources
- CMS resources are available their Quality Payment Program web page
    - Includes links to Patient Relationship Categories and Codes Fact Sheet, slides, transcripts, recordings, and more

Changes

Increasing payment

Allowing additional services

Increase utilization of Transitional Care Management (TCM) services
- Increasing payment
- Removing restriction of additional services paid during the same time
    - Chronic Care management
        - 99490
        - 99491
    - Complex Care management
        - 99487
        - 99489
    - Prolonged care without direct patient contact
        - 99358
        - 99359
    - International normalized ratio monitoring
        - 93792
        - 93793
    - End-Stage Renal Disease services
        - 90960
        - 90961
        - 90962
        - 90966
        - 90970
    - Analysis of date
        - 99091
    - Care Plan Oversight services
        - G0181
        - G0182

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Chronic Care Management (CCM)

- CMS changing part of description of service requirements
  - Removing
    - "Required community/social services ordered, how services of agencies/specialists unconnected will be directed/coordinated, identify the individuals responsible for each intervention."
  - Adding
    - "Interaction and coordination with outside resources and practitioners and providers."
- Additional code G2058
  - Additional time for non-complex CCM clinical time
  - Additional 20 minutes
  - Reimbursed twice in month
- Complex CCM
  - 99487
  - 99489
    - Medicare does not require substantial revision to care plan
    - Requires "established, implemented, revised, or monitored"

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Principal Care Management (PCM)

One Condition
Primary Care
Specialist
Goal

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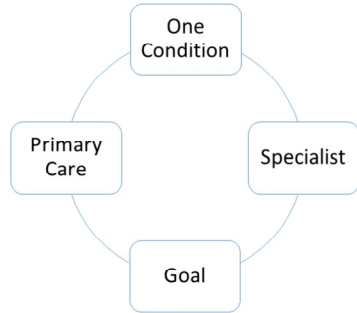
Principal Care Management
- One serious chronic condition
- Last 3 months to 1 year or until the death of the patient
- Disease resulted in recent hospitalization or there is significant risk of death, acute exacerbation, decompensation, or functional decline
- Requires substantial care management
- Generally available to specialists
- General/Primary care can also provide
- Triggered by recent hospitalization or exacerbation
- Expectation is specialist will resolve and return patient to primary care
- Patient could have more than one specialty submitting
- Primary care can continue to bill for other conditions/care coordination

Procedure codes
G2064 – Practitioner Services
- Single high risk disease
- At least 30 minutes
G2065 – Clinical Staff
- Single high risk disease
- At least 30 minutes

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Remote Psychological Monitoring

Care Management		
General Supervision	99457	99458

Part of Care Management designation
- Services provided under general supervision
- 99457 – first 20 minutes
- 99458 – additional 20 minutes

Beneficiary Consent

Communication technology services
- New services for 2019
- Services
  - Non-face-to-face
  - Without patient involvement
  - Intraprofessional consultations

Beneficiary consent
- CMS requires consent prior to submitting charges
- Patient has cost-sharing
- Consent can now cover multiple services
- Consent valid for one year
  - Unless patient revokes
- New consent after one year

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2020 Services

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┌──────────────────┐  ┌──────────────────┐
│ 1995/1997        │  │ Time             │
│ Documentation    │  │ Counseling/      │
│ Guidelines       │  │ Coordination     │
│                  │  │ of Care          │
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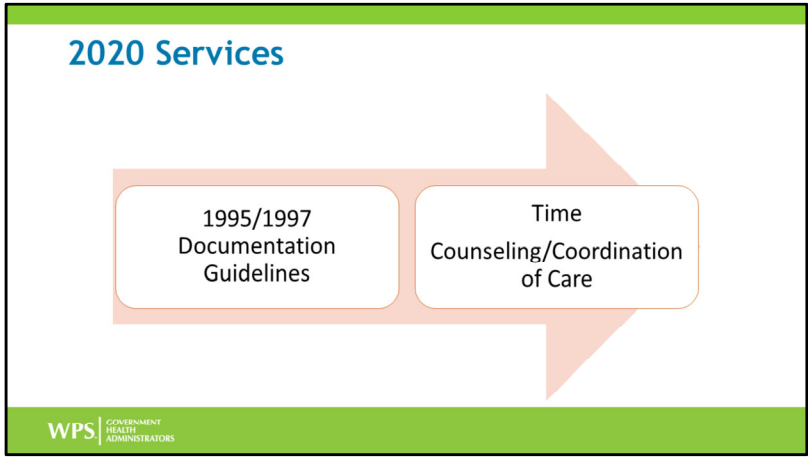
Evaluation and Management (E/M) Services are not changing for 2020
- Choose your procedure based on
  - 1995 Documentation Guidelines (DG)
  - 1997 DG
    - History
    - Exam
    - Medical Decision-Making (MDM)
  - Time
    - When counseling/coordination of care reflects more than 50% of the practitioner/patient face-to-face time (facility can include floor or unit time)

Medical Necessity

Medical Necessity is the Overarching Criterion for Payment

Diagnosis or Treatment of Illness or Injury Improve Functioning of Malformed Body Part

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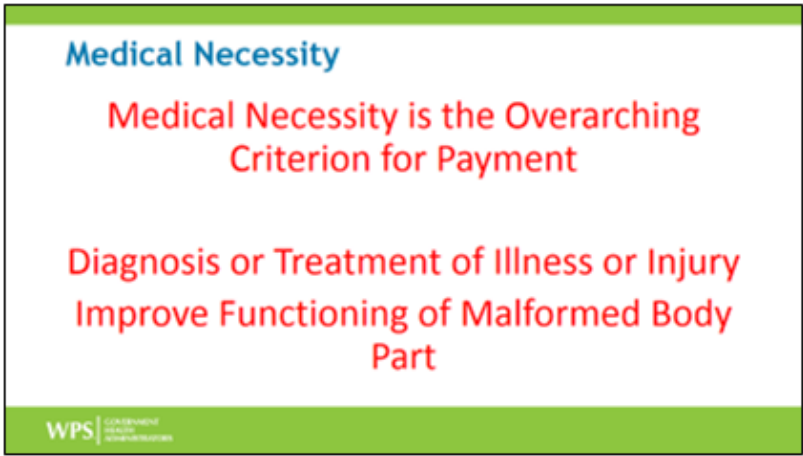
Changes for 2021

Blended Rate
- Submit appropriate level
- CPT deleting 99201

Choice
- Medical Decision-Making
- Time

2019 Final Rule for Office or Other Outpatient Services
- Blended rate for level 2 – 4
- Separate payment for level 5
- Choice of procedure code based on
    - 1995 DG
    - 1997 DG
    - Time
    - MDM

2020 Final Rule
- Separate allowance for level of service
- CPT deleting procedure code 99201
- Choice of procedure code based on
    - Time
        - Billing practitioner
        - Date of service
        - Face-to-face
        - Non-face-to-face
    - MDM
        - American Medical Association (AMA) changes for MDM
- Procedure codes 99358 and 99359 not used for office/outpatient visits
- CPT will add a code for extended visits
    - Used when billing based on time and exceed time for 99205 or 99215 by at least 15 minutes or more

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Content of Service

History → Exam → Medical Decision-Making
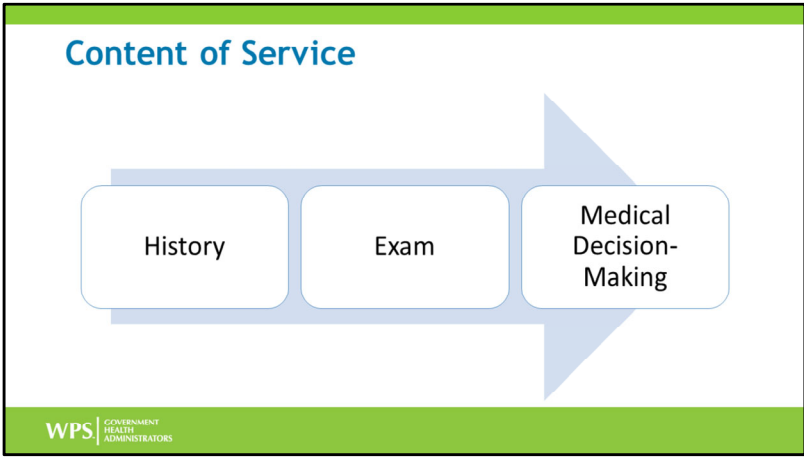
Office or other outpatient services
Components of E/M
- History
- Exam
- MDM

For 2021
Documentation
- History
- Exam
    - When medically appropriate and performed
- MDM
    - Based on AMA new interpretive guidelines
- Time
    - Time spent with practitioner
    - Will not require counseling/coordination of care
    - Includes non-face-to-face on the same date

Changes do not apply to other E/M categories

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Additional Codes

Add-On Code

Extended Service

Global Surgery
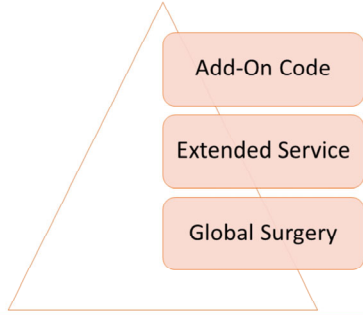
2019 Final Rule
- Separate add-on codes
    - Primary care
    - Specialty
- Prolonged service
    - Separate G code

2020 Final Rule
- One add-on G code
    - Applies to all specialties including primary care
    - Single, serious, or complex chronic condition
- Extended service
    - CPT adding procedure code
    - Will reflect each additional 15 minutes
    - Apply when using time to choose procedure code
    - Use when 99205 or 99215 time exceeded

Global Surgery
- Not making changes
    - Pricing for surgical procedures
    - Global surgery package instructions

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Documentation by Others

Physician and Practitioners – office or other outpatient services
- Can use information in the medical record entered by others
    - Patient
    - Medical Assistant (MA)
    - Previous entries
    - Non-Physician Practitioners (NPP)
    - Physicians
    - Clinical Staff
    - Students
    - Other members of the medical team
- Provider of service must
    - Show his/her review of information
    - Verification and update/changes as necessary

Student Documentation
- Do not need to document again
- Show review and verification of information
- Applies to non-physician practitioners

NPPs and teaching physicians may NOT submit charges for service provided by the students

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Bundled Payment

G2086

G2087

G2088

.Procedure Codes
- G2086
    - Services in the first month of treatment
    - Requires at least 70 minutes of time documented
    - Requires at least one psychotherapy service
- G2087
    - Services in a subsequent month of treatment
    - Requires at least 60 minutes of time documented
    - Requires at least one psychotherapy service
- G2088
    - Additional therapy services
    - Requires at least 120 minutes documented
- Requires an initiating encounter
    - Within one year from start of care
        - Evaluation and management
        - Welcome to Medicare Visit
        - Annual Wellness Visit
        - Transitional Care Management
- Incident to applied
    - General supervision
    - Scope of practice
- Must have patient consent

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Ambulatory Blood Pressure Monitoring

Ambulatory Blood Pressure Monitoring
- National Coverage Determination 20.19
  - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part1.pdf
  - Covered when patient has suspected "white coat hypertension"
  - 24 hours continual monitoring
  - Procedure codes
    - 93784, scanning analysis, recording, interpretation and report
    - 93786, recording only
    - 93789, scanning analysis with report
    - 93790, review with interpretation and report
- Decision Memo CAG-000067Rs
  - https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=294&NCDId=254&ncdver=2&SearchType=Advanced&CoverageSelection=Both&NCSelection=NCA%7cCAL%7cNCD%7cMEDCAC%7cTA%7cMCD&ArticleType=BC%7cSAD%7cRTC%7cReg&PolicyType=Both&s=All&KeyWord=Ambulatory+Blood+Pressure&KeyWordLookUp=Doc&KeyWordSearchType=Exact&kq=true&IsPopup=y&bc=AAAAAAAAQAAA&
  - Additional coverage proposed for suspected masked hypertension
  - Watch for NCD update

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Patient Reporting Blood Pressure

Two procedure codes
99473
- Device calibration
- Patient education/training

99474
- Patient self-measurement
- Twice daily over 30 day period
  - Minimum 12 readings
- Physician or other health care professional
- Report of average diastolic and systolic
- Communication of treatment plan

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Coverage of Services

Online Digital Evaluation Service
- Requires clinical decision-making
- Cumulative time during 7-day period
- Physician and non-physician practitioners (NPP)
- Patient is established patient
- Included in E/M provided 7-days prior or 7-days after
- Included in other services such as Care Plan Oversight, Transitional Care Management, and Care Management
- Procedure codes (MD/DO, NPP)
  - 99421 – 5 to 10 minutes
  - 99422- 11 to 20 minutes
  - 99423 – 21 minutes or more
- Procedure code clinical staff
  - G2061 – 5 to 10 minutes
  - G2062 – 11 to 20 minutes
  - G2063 – 21 minutes or more
- Services are not appointments, providing test results, etc.

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- Subscribe to the Newsletter
    - Receive information on recent activity
- Annual Work Plan
- Recent results of criminal activity
- Office of Inspector General
- https://oig.hhs.gov/
- Travel Allowance for Phlebotomy and/or Specimen Collection
- https://www.wpsgha.com/wps/portal/mac/site/claims/guides-and-resources/travel-allowance-for-phlebotomy-and-specimen-collection/

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CTBS

Remote Check-In

Remote Evaluation of Recorded images

Communication Technology Based Services
- Virtual Check-in
    - G2012
    - Patient initiated
    - Requires patient consent
    - Patient cost-sharing
- Remote evaluation of recorded images
    - G2010
    - Patient initiated
    - Requires patient consent
    - Patient cost-sharing
    - Documentation of image, evaluation, and patient contact
- Interprofessional consultations
    - Procedure codes 99446-99452
    - Requires patient consent for both parties
    - One code – 99452 for requesting
    - Remainder for consulting
        - Documentation
        - Time
        - Written report

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Customer Service Closure

- Third Friday of each month
  - 7:30 AM – 3:30 PM
- Impacting:
  - General Inquiries
  - Appeals
  - Reopenings
  - EDI
  - Provider Enrollment

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Customer Service Closures
- Customer Service Training
  - Third Friday of each month
    - 7:30 AM - 3:30 PM CT
    - 8:30 AM – 4:30 PM ET
- Impacting:
  - General Inquiries
  - Appeals
  - Reopenings
  - EDI
  - Provider Enrollment
- Goal of call center closure training:
  - Improve the consistency and accuracy of answers to provider questions
  - Increase understanding of issues
  - Facilitate fact retention of training by increasing its frequency

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Tips and Reminders

WPS GHA Learning Center Reminders
Paying with check or credit card?

- You may choose to pay with check or credit card
    - May "purchase" free events in separate transaction
    - Seats not guaranteed until check is received
        - Send copy of invoice to expedite processing
    - Assign seats to yourself or others
        - Must have Learning Center account
    - If seat(s) not assigned
        - Event will not appear on Dashboard
        - No dial-in, webinar link or access to handouts
            - Handouts in Additional References
    - Details on how to join the event are available in module for the live event
    - Handouts are available in Additional References
    - FAQs available for help
    - Other questions? surveymail@wpsic.com

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Order Confirmation

Thank you for your purchase!

Assign Courses
If you haven't already, assign the seat for your course to either yourself or another WPS GHA Learning Center. You can assign seats now or come back later and assign the seats from your "Orders" page (find it by hovering on your name at the top right of the menu above).

View Your Courses
You can view your courses by clicking on the "My Courses" link above. This link will be available anytime you are logged into the WPS GHA Learning Center.

Purchase Date: 11/20/2019	Invoice #: LITMOS-17150	
Order Details		
Course	Seats	Price
Webinar - 2019 11/21 Medicare Secondary Payer: Billing MSP Claims (Part A)	2	$0.00
	Total	$0.00

Course Assignments

Course		
Live Event - 11/21/19 Medicare Secondary Payer: Billing MSP Claims (Part A)	Seat 1	Assign to me / Assign to other
	Seat 2	Assign to other

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Due 12/02/2019

Webinar - 2019 11/21 Medicare Secondary Payer: Billing MSP Claims (Part A)

The training is intended for our J5/J8 Part A providers billing on a UB-04 or electronic equivalent.

Medicare secondary payer (MSP) is a term used when Medicare is not the beneficiary's primary health insurer. Providers are responsible to determine whether Medicare is the primary payer or not, as well as billing appropriately for the services and/or supplies provided to Medicare beneficiaries. Part A billing can be confusing at times, whether billing an MSP claim or an MSP conditional claim.

This event is the sixth in a series of webcasts designed in collaboration with the A/B Medicare Administrative Contractors (MACs) to educate Medicare providers on correctly billing Medicare when another payer is the primary insurer.

Topics for this webcast will include:
• Provider responsibilities
• Part A billing codes
• Preparing and submitting MSP/conditional claims
• Responding to claims that have been returned
• MSP Resources

Join us for this informative educational session.

Time of Event:
Call/Sign-in: 12:45 - 1:00 PM CT (1:45 - 2:00 PM ET)
Event: 1:00 - 2:30 PM CT (2:00 - 3:30 PM ET)

To cancel your registration, open the module titled "Live Event - 11/21/19 Medicare Secondary Payer: Billing MSP Claims (Part A)", and click on Unregister.

Continuing Education Units (CEUs)
CEUs can be obtained from professional organizations. WPS GHA will provide a Certificate of Achievement once you successfully complete a course in the Learning Center. For a live event, this includes participation from start to finish of the live session. If a biography of the presenter is needed, please contact us at surveymail@wpsic.com.

Start this course

≡ Modules | 📄 Additional References

The modules in this course must be completed in the order listed.

▷ Pre Assessment - 112119MSPA ⓘ

▷ Live Event - 11/21 Medicare Secondary Payer: Billing MSP Claims (Part A) ⓘ

△ Who Attended - 112119MSPA Locked ⓘ
Optional

△ Follow up Questions - 112119MSPA Locked ⓘ
Optional

△ Survey - 112119MSPA Locked ⓘ

≡ Modules | 📄 **Additional References**

📄 20191121PartAMSPClaimSubmissionsHandout.pdf — download

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WPS GHA YouTube Channel
- POE committed to providing interactive education and resources in various formats
- Feedback and suggestions are welcome
- Please subscribe
    - Go to YouTube.com and search for WPS GHA
        - Select the red "Subscribe" box

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Medicare Beneficiary Identifier

MBI Compliance and Utilization
- Effective January 1, 2020
- All initial claims must be billed using the MBI
    - Regardless of dates of service

If you do not use MBIs on claims after January 1, you will get:
- Electronic claims reject codes: Claims Status Category Code of A7 (acknowledgment rejected for invalid information), a Claims Status Code of 164 (entity's contract/member number), and an Entity Code of IL (subscriber)
- Paper claims notices: Claim Adjustment Reason Code (CARC) 16 "Claim/service lacks information or has submission/billing error(s)" and Remittance Advice Remark Code (RARC) N382 "Missing/incomplete/invalid patient identifier"

For more information, refer to MLN Matters Article SE18006
- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE18006.pdf

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When an MBI Changes

- CMS may issue new number/card
  - Lost, stolen or otherwise compromised
- Eligibility transaction error code
  - AAA 72 - "invalid member ID"
- Historic eligibility search
  - Get termination date of old MBI
- MBI look-up tool
  - Get new MBI

When an MBI Changes
- CMS may terminate an MBI and issue a new one
  - Beneficiary or representative request
  - Lost, stolen or compromised
- Eligibility queries using "old" MBI
  - After effective date of "new" MBI
    - Transaction error code AAA 72
      - Invalid member ID
  - Request date or range overlaps active period
    - Eligibility data returned
    - Termination date of "old" MBI also returned
- Use MBI Look-up Tool
  - Beneficiary can't or won't give MBI
  - Required elements:
    - First name
    - Last name
    - Suffix (if applicable)
    - Date of birth
    - Social Security Number
      - For beneficiary
      - Not their HICN
- Beneficiary can access and print copy of current card
  - Register at medicare.gov
  - Torn, faded, illegible
    - Went through washing machine
    - "My dog ate it"

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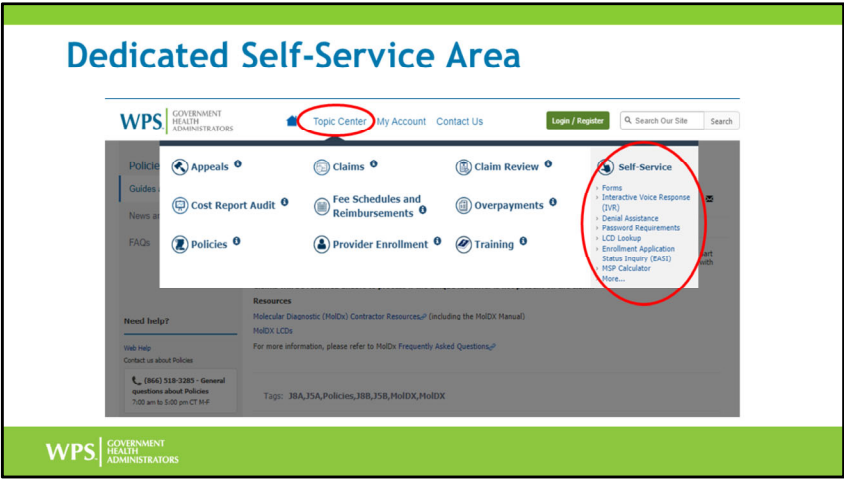
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Dedicated Self-Service Area
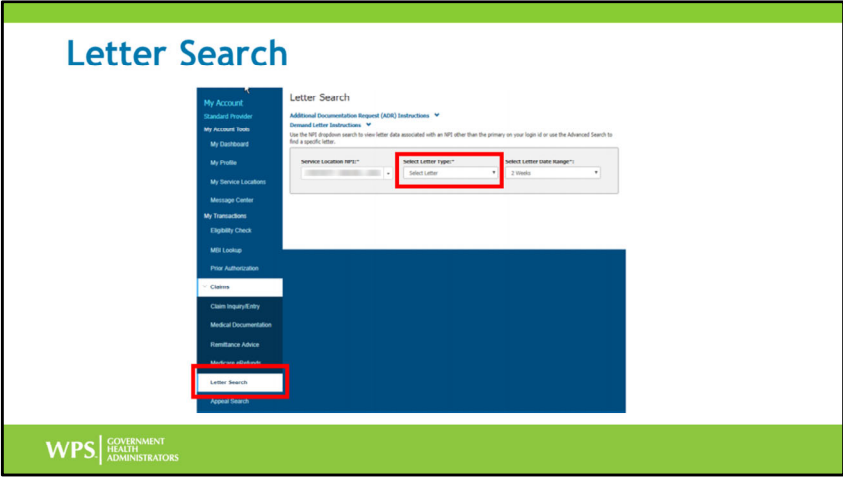
Letter Search

Letter Search
- View and respond to Additional Documentation Requests (ADRs) and Demand Letters (DLs)
- Email alert to notify a letter is available
    - One email even if multiple letters issued
        - For one or more associated NPIs
- Also an alert on Dashboard after logging in
- Select "Letter Search" in left navigation
- NPI defaults to primary for your account
    - Only displays letters for the NPI selected
- Choose letter type from drop-down

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Additional Documentation Request (ADR)
- May search for letters by date range
  - Between 2 weeks and 3 months
  - Displays the ADR
  - Greyed out if letter not available yet
- allows you to respond
- Claim number is hyperlink to claim
- Alert received, but can't find letter
  - Select "Include Pending ADRs without Available Letters"
    - May take a day or so to be viewable

Demand Letter

- Notification of overpayment
    - Identifies beneficiary and claim
    - Reason for the overpayment

- view letter

-   view claim

-   complete and print Immediate Recoupment form

-   send refund electronically via portal

Portal Feedback
- Submit comments via fillable form/survey
    - From footer, select "Feedback"
- Rate the page you are on and add comments
    - Bottom of any page in Guides and Resources
    - Like/dislike/ways to improve
- Quickly return to jurisdictional home page:
    - Click on any WPS GHA logo
    - Click icon that resembles a house
        - Top of page
- Easily navigate to CMS.gov:
    - Click on CMS logo

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Interactive Voice Response

- Merged with Customer Service phone line
- Enhanced options
- May transfer to Customer Service
  - After authentication

(866) 518-3285

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Interactive Voice Response
- IVR merged with Customer Service phone line
  - J5 - (866) 518-3285
  - J8 - (866) 234-7331
- Enhanced options provide even more information
- Upfront message
  - "Are you calling about patient eligibility, claim status or payment information?"
    - "Yes" – transfer to the IVR
    - "No" – direct to appropriate agent
- You may transfer to Customer Service from IVR
  - After authentication
  - Previously required to hang up and call back

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Thank you for attending!

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CMS 2020 Medicare Parts A & B Premiums and Deductibles Fact Sheet

https://www.cms.gov/newsroom/fact-sheets/2020-medicare-parts-b-premiums-and-deductibles

CMS Decision Memo CAG-000067Rs

https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=294&NCDId=254&ncdver=2&SearchType=Advanced&CoverageSelection=Both&NCSelection=NCA%7cCAL%7cNCD%7cMEDCAC%7cTA%7cMCD&ArticleType=BC%7cSAD%7cRTC%7cReg&PolicyType=Both&s=All&KeyWord=Ambulatory+Blood+Pressure&KeyWordLookUp=Doc&KeyWordSearchType=Exact&kq=true&IsPopup=y&bc=AAAAAAAAQAAA&

CMS Finalized Policy, Payment and Quality Provisions Changes to the Medicare Physician Fee Schedule for Calendar Year 2020 Fact Sheet

https://www.cms.gov/newsroom/fact-sheets/finalized-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar

CMS List of Approved Clinical Decision Support Mechanisms

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Appropriate-Use-Criteria-Program/CDSM

CMS MLN Publication 11268

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM11268.pdf

CMS MLN Publication 11532

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM11532.pdf

Resources

CMS MLN Publication 6325432 Opioid Treatment Programs (OTPs) Medicare Enrollment Fact Sheet
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/OTP-enrollment-factsheet-MLN6325432.pdf

CMS MLN Publication 8296732 Opioid Treatment Programs (OTPs) Medicare Billing and Fact Sheet
https://www.cms.gov/files/document/otp-billing-and-payment-fact-sheet.pdf

CMS National Coverage Determination 20.19
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part1.pdf

CMS Patient Relationship Categories and Codes Fact Sheet
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/CMS-Patient-Relationship-Categories-and-Codes.pdf

CMS Quality Payment Program Web Page
https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program

CMS Website
https://www.cms.gov/

Medicare Access CHIP Reauthorization Act of 2015 (MACRA)
https://www.congress.gov/bill/114th-congress/house-bill/2/text

Medicare Provider Enrollment, Chain, and Ownership System (PECOS) Online Medicare Enrollment for Providers and Suppliers
https://pecos.cms.hhs.gov/pecos/login.do#headingLv1

Office of Inspector General
https://oig.hhs.gov/

Travel Allowance for Phlebotomy and/or Specimen Collection
https://www.wpsgha.com/wps/portal/mac/site/claims/guides-and-resources/travel-allowance-for-phlebotomy-and-specimen-collection/

Social Security Act – Title XVIII
https://www.congress.gov/bill/114th-congress/house-bill/2/text

WPS GHA Learning Center
http://wpsghalearningcenter.com/store-catalog

WPS GHA Web Portal
https://www.wpsgha.com

YouTube
https://www.youtube.com/