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2023 Medicare Part B Update – Annual Meeting of the New York Podiatric Medical Association

January 18, 2024

NY24 PODIATRIC CLINICAL CONFERENCE & EXHIBITION

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Today's Presenters

NGS PROVIDER EXPERIENCE
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- Jim Bavoso
  - Manager Provider Outreach & Education, NGS

Disclaimer

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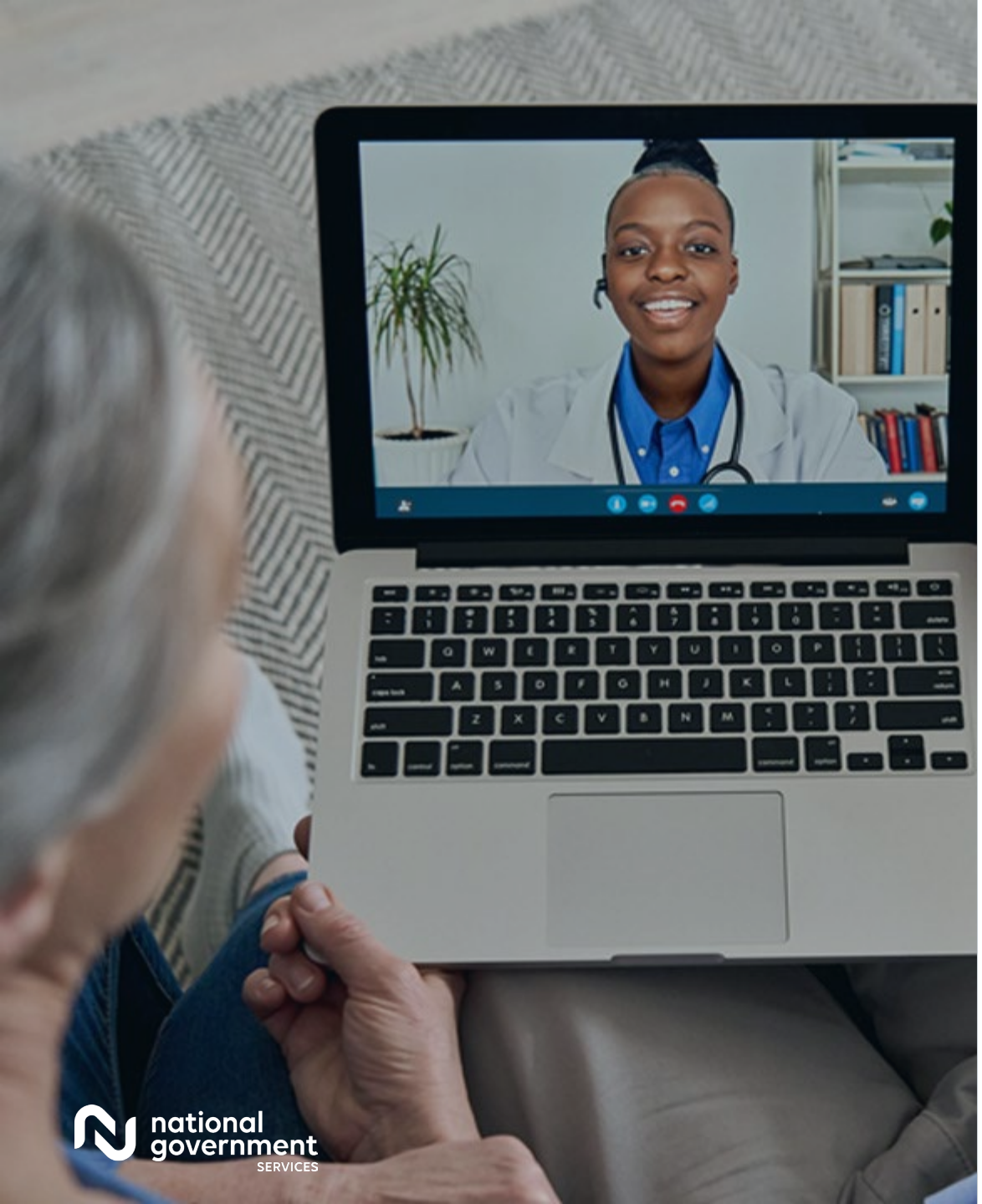

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Recording

Attendees/providers are never permitted to record (tape record or any other method) our educational events. This applies to webinars, teleconferences, live events and any other type of National Government Services educational events.

Agenda

- ✓ Staying Informed
- ✓ Calendar Year 2024 Medicare Physician Fee Schedule Final Rule Updates
- ✓ 2024 Telehealth Services
- ✓ End of the PHE FAQ's
- ✓ Claim Submission
- ✓ Local Coverage Determinations (LCDs)
- ✓ Preventive Services

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National Government Services (NGS) as the Medicare Administrative Contractor (MAC)

The Information presented here represents NGS as the MAC for J6 and JK.

- J6 - states of Illinois, Minnesota and Wisconsin
- JK - states of Connecticut, Maine, Massachusetts, New Hampshire, New York, Rhode Island and Vermont
- If you practice in a state other than these, please contact your Local MAC for specific guidance.

Calendar Year (CY) 2024 Medicare Physician Fee Schedule Final Rule Updates

2024 Medicare Premium and Deductibles

Category	Amount
Monthly Part B Premium	$174.70
Part B Deductible	$240
Part B Coinsurance	20%
Part A IH Deductible (first 60 days)	**$1,632**
Days 61 – 90 Days	$408
Lifetime Reserve Day	$816
Skilled Nursing Facilities (21-100 days)	$204

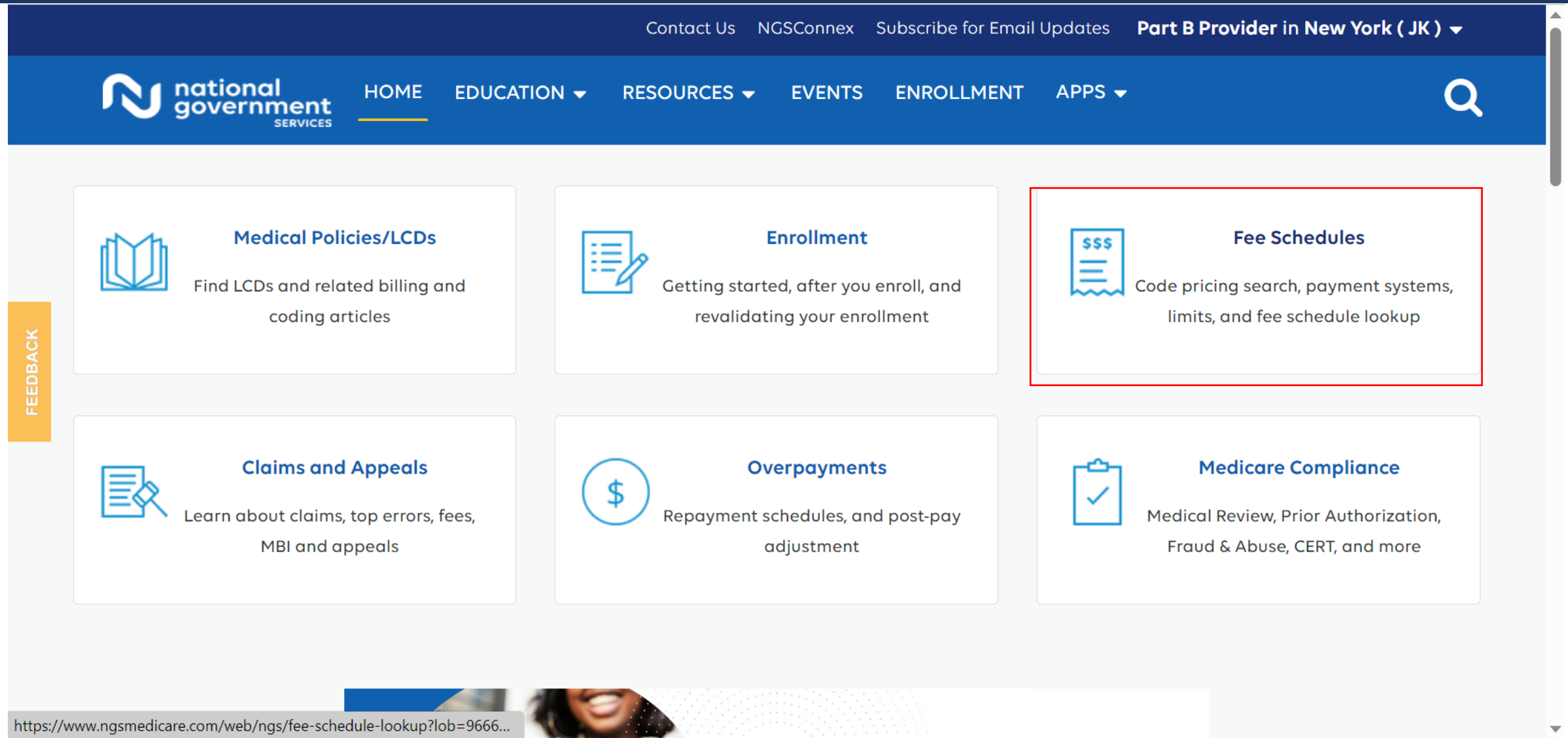
Total Medicare Part B Premiums High Income Beneficiaries for 2024

Beneficiaries who file an individual tax return with income:	Beneficiaries who file a joint tax return with income:	Income-related monthly adjustment amount	Total monthly premium amount
Less than or equal to $103,000	Less than or equal to $206,000	$0.00	$174.70
Greater than $103,000and less than or equal to $129,000	Greater than $206,000 and less than or equal to $258,000	$69.90	$244.60
Greater than $129,000 and less than or equal to $161,000	Greater than $258,000 and less than or equal to $322,000	$174.70	$349.40
Greater than $161,000 and less than or equal to $193,000	Greater than $322,000 and less than or equal to $386,000	$279.50	$454.20
Greater than $193,000 and less than $500,000	Greater than $386,000 and less than $750,000	$384.30	$559.00
Greater than or equal to $500,000	Greater than or equal to $750,000	$419..30	$594.00

2024 Physician Fee Schedule Conversion Factor

- The final CY 2024 PFS conversion factor is $32.74
  - A decrease of $1.15 (or 3.4%) from the current CY 2023 conversion factor of $33.89
- **The CY 2024 MPFS is now available**
- View the new fees using the Fee Schedule Lookup tool page on NGSMedicare.com

Fee Schedules



Fee Schedule Lookup

Select a Fee Schedule: *

Medicare Physician Fee Schedule Pricing

Result Type: *

- ○ Full Fee Schedule
- ◉ Specific To Fee Code

Date of Service: *

01/29/2024

Procedure Code: *

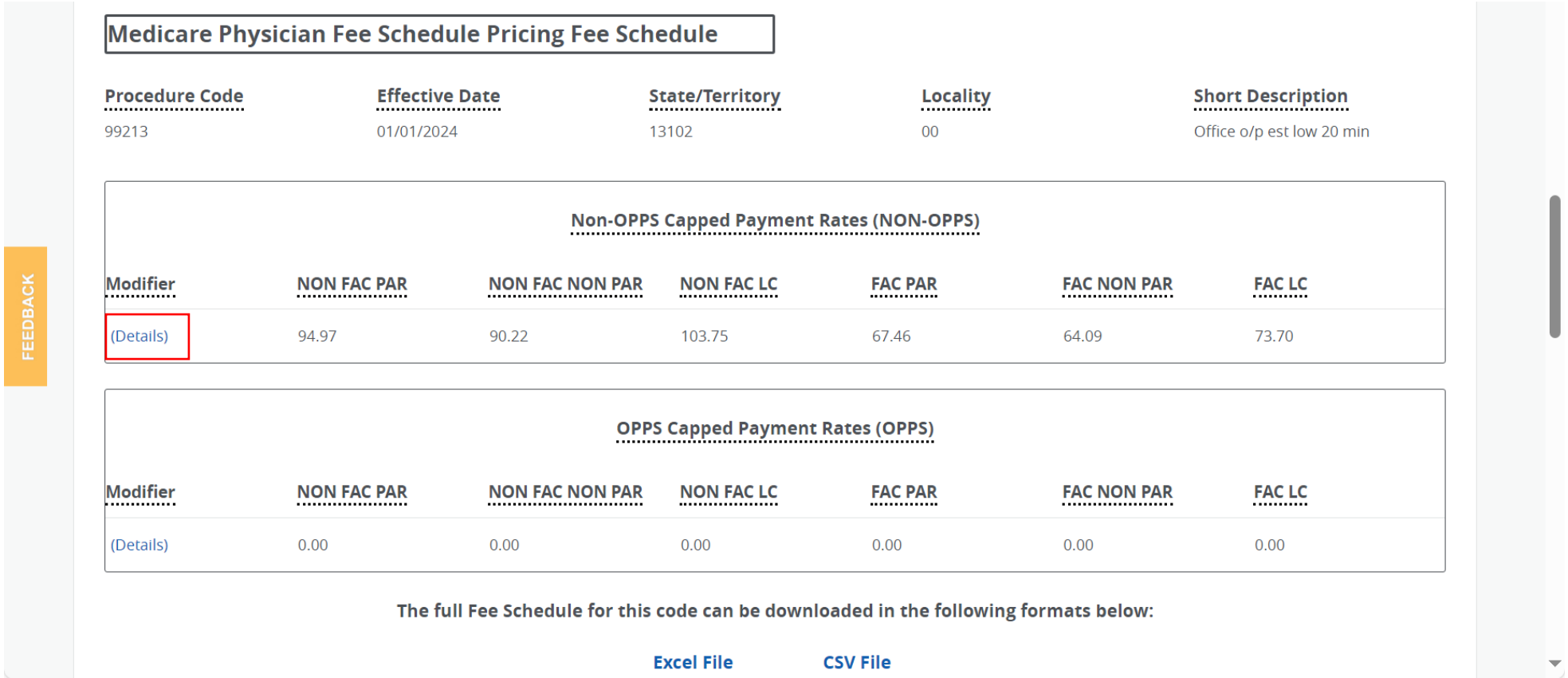
99213

Region: *

Connecticut

Search

Medicare Physician Fee Schedule Pricing



FEEDBACK

Medicare Physician Fee Schedule Pricing Fee Schedule

Procedure Code	Effective Date	State/Territory	Locality	Short Description
99213	01/01/2024	13102	00	Office o/p est low 20 min

Non-OPPS Capped Payment Rates (NON-OPPS)

Modifier	NON FAC PAR	NON FAC NON PAR	NON FAC LC	FAC PAR	FAC NON PAR	FAC LC
(Details)	94.97	90.22	103.75	67.46	64.09	73.70

OPPS Capped Payment Rates (OPPS)

Modifier	NON FAC PAR	NON FAC NON PAR	NON FAC LC	FAC PAR	FAC NON PAR	FAC LC
(Details)	0.00	0.00	0.00	0.00	0.00	0.00

The full Fee Schedule for this code can be downloaded in the following formats below:

Excel File **CSV File**

Medicare Physician Fee Schedule Pricing

Medicare Physician Fee Schedule Pricing Fee Schedule

Procedure Code	Effective Date	State/Territory	Locality	Short Description
99213	01/01/2024	13102	00	Office o/p est low 20 min

Non-OPPS Capped Payment Rates (NON-OPPS)

Modifier	NON FAC PAR	NON FAC NON PAR	NON FAC LC	FAC PAR	FAC NON PAR	FAC LC
(Details)	94.97	90.22	103.75	67.46	64.09	73.70

Modifier Selected: (blank)

Status	Conversion Factor	Update Factor	Work RVU	FAC PE RVU	NON FAC PE RVU
A	32.7442	1.0000	1.30	0.56	1.33

Malpractice RVU	Work GPCI	Practice GPCI	Malpractice GPCI	Reduced Therapy Amt	Endoscopic Base
0.10	1.022	1.091	1.207	43.35	

Global Surgery	Facility Pricing	PC/TC	Preoperative Percentage	Interoperative Percentage	Postoperative Percentage

Fee Schedules

Fee Schedule Assistance

The fee schedule assistance page provides access to information about fee schedule definitions and acronyms.

Radiopharmaceutical Reimbursement

The Radiopharmaceutical Reimbursement page provides detailed information on claim submission and reimbursement allowances for radiopharmaceuticals.

National Fee Schedules

Access the CMS website to view and download the following **national fee schedules**:

- Ambulance Fee Schedule
- Ambulatory Surgical Center (ASC) Payment
- Clinical Laboratory Fee Schedule
- COVID-19: CMS Allowing Audio-Only Calls for OTP Therapy, Counseling, and Periodic Assessments
- CY 2023 Final Rule Payment Rates for Opioid Treatment Programs
- Medicare Part B Drug Average Sales Price
- DMEPOS Fee Schedule
- Vaccines and Administration Pricing
- Home Infusion Therapy (HIT) Fees

Therapy Services

2024 Annual Update of Per-Beneficiary Threshold Amounts

Effective January 1, 2024

CY 2024 KX modifier threshold amounts:

- $2,330 for PT and SLP services combined
- $2,330 for OT services

2024 Medical Record threshold amount:

- PT/SLP $3000
- OT $3000
- Will remain $3,000 until CY 2028

Evaluation and Management (E/M) Visit

- Effective January 1, 2024
- HCPCS code G2211
  - *Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to patient's single, serious condition or a complex condition. (Add-on code, list separately in addition to office/ outpatient evaluation and management visit, new or established)*
- Add on code to better recognize the resource cost associated with E/M visits for primary care and longitudinal care of complex patients
  - Applicable for office and outpatient E/M services (99202-99205 and 99211-99215) as an additional payment
  - New or established patients
  - No modifier needed
  - Relationship between the patient and the practitioner is the determining factor of when the add-on code should be billed, not based on the characteristics of a particular patient

Evaluation and Management (E/M) Visit

- G2211 will not be payable when the O/O E/M visit is reported with modifier 25
- Estimated that G2211 will be billed with 38 percent of all O/O E/M visits initially
  - 54 percent of all O/O E/M visits when fully adopted
- Likely that primary care specialties will have a higher utilization than other specialties
  - Surgical specialties will have the lowest utilization since they are less likely to establish longitudinal care

Evaluation and Management (E/M) Visit

- G2211 is not restricted to medical professionals based on a particular specialty
  - Should be used by medical professionals, regardless of specialty
- G2211 would not be considered duplicative of care management services since the inherent complexity better recognizes the professional work within the visit, while the care management codes recognize services that happen outside of the visit

FAQ – G2211

Q: Please define appropriate usage and billing for CPT G2211.

A. CMS has approved CPT G2211 for 2024 as an add-on code for complex and/or continuous office and outpatient E/M services (99202-99205 and 99211-99215). The exception is that G2211 may not be used when Modifier 25 has been added to the E/M service. Please see : **Modifier 25** additional information on Modifier 25.

- There are no medical specialty restrictions on this code; it may be added to claims for both new and established patients. The code may be appropriate in the context of providing continuous health care services and/or with medical services representing ongoing care for a single serious or complex condition.
- The practitioner's longitudinal relationship with the patient is important in considering the use of this add-on code. The practitioner may be the primary point for all needed services or may be part of a team of practitioners who are providing care for a single serious and complex condition. G2211 captures and represents the inherent complexity of an E/M service in both circumstances.

Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging Program

- Effective January 1, 2024, efforts to implement the AUC have been paused and efforts will continue to identify a workable implementation approach in the future
  - Providers and suppliers should no longer include AUC consultation information on Medicare FFS claims _ ***Computed tomography, Positron emission tomography, Nuclear medicine, Magnetic resonance imaging***
  - Additionally, CMS will no longer qualify PLEs or CDSMs and will remove this information from the AUC website
  - Claims processing instructions and guidance for the educational and operations testing period will also be removed
  - CMS has not specified a timeframe within which implementation efforts will recommence
- Appropriate Use Criteria Program

Part B Mass Adjustments Resulting in Overpayments

- In May 2023, the OIG released the final report titled “Medicare Paid Millions More for Physician Services at Higher Nonfacility Rates Rather Than at Lower Facility Rates While Enrollees Were Inpatients of Facilities” (A-04-21-04084).
- This impacts claims processed between July 2019 and July 2023. The adjustment will change **the POS from 32 (Nursing Facility) to 31 (Skilled Nursing Facility).**
- Providers whose claims are adjusted will receive overpayment letters explaining the reason further.
- Providers shall refund all improperly collected deductible and/or coinsurance amounts to the beneficiaries.

Provider Enrollment

Know Your Provider Enrollment Revalidation Due Date Today and Protect Your Bottom Line

Revalidate before your due date to avoid a hold on your Medicare payments and deactivation of your Medicare billing privileges.

There are several ways to find your revalidation due date:

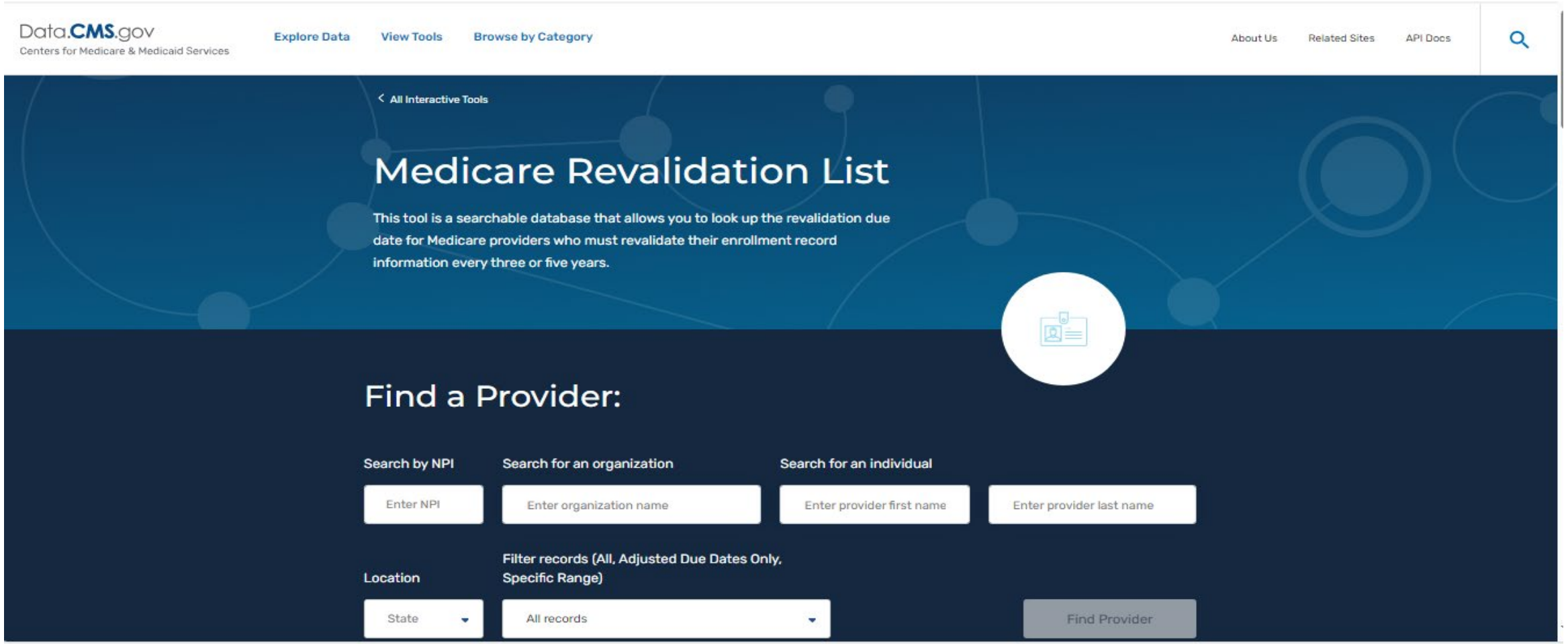
- Medicare Revalidation List Tool **- https://data.cms.gov/tools/medicare-revalidation-list**
- Instructions on how to use the tool can be found under the article titled "How to Search on the Medicare Revalidation List Tool for Due Date"

Revalidation notice mailed by National Government Services

- Mailed in yellow envelope

Internet-Based Provider Enrollment, Chain and Ownership System (PECOS)

Know Your Provider Enrollment Revalidation Due Date Today and Protect Your Bottom Line



Know Your Provider Enrollment Revalidation Due Date Today and Protect Your Bottom Line

If a current revalidation due date has not been assigned or if the due date is TBD, all unsolicited revalidation applications will be returned.

Revalidate Medicare enrollment information either electronically by using the Internet Based Provider Enrollment, Chain and Ownership System (PECOS) or by submitting the appropriate CMS-855 paper application. Find current forms on our website under Resources and then select Forms.

Already submitted your revalidation application?

Find the status of your submitted application by using our Check Provider Enrollment Application Status Tool located on our website. Select Resources and then select Tools & Calculators.

Physicians and Nonphysician Practitioners: Revised CMS-855I Medicare Enrollment Application Required November 1 (Combined CMS-855I and CMS-855R)

- Effective 11/1/2023, the revised version must be used (5/23)
  - Current and revised version acceptable through 10/31/2023
- Revisions include
  - Combined CMS-855I and CMS-855R paper applications
  - Discontinues CMS-855R
  - PA employer arrangements to the reassignment sections
  - Recognizes physicians and nonphysicians who provide acupuncture services
  - Identifies compact licenses
  - Adds new physician specialties
  - Expands practice location types to include telehealth
- Visit Medicare Enrollment for Providers & Suppliers for more information, including a CMS-855I instructional guide

Enrollment: Reporting Home Address

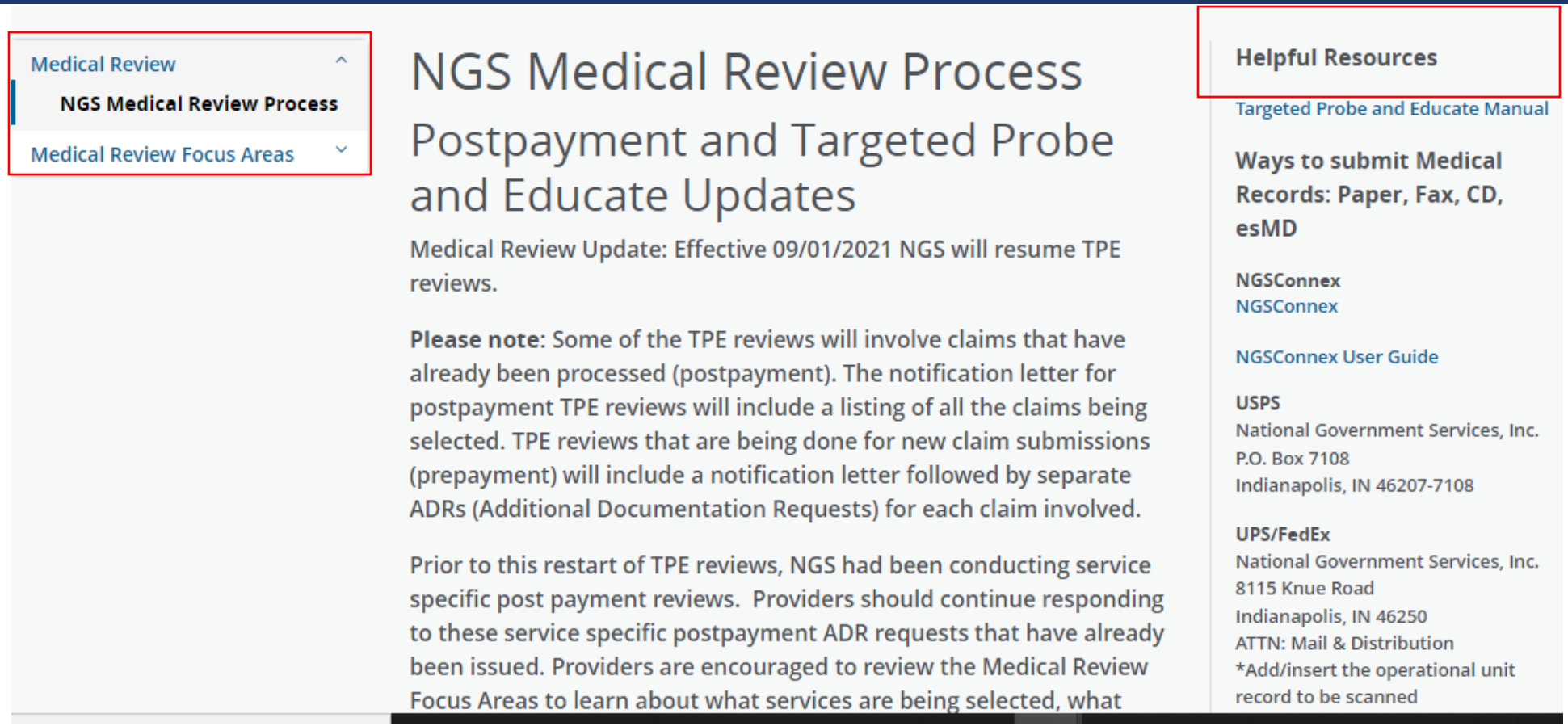
- During the PHE, CMS allowed practitioners to render telehealth services from their home without reporting their home address on their Medicare enrollment while continuing to bill from their currently enrolled location
- Waiver will continue through December 31, 2024

Medical Review – Targeted Probe & Educate (TPE)

Medical Review TPE History

- TPE process became effective 10/1/2017
  - All lines of business
- TPE History
  - Demonstration projects for inpatient services and home health
  - Proved successful in lowering providers payment error rates
  - The TPE model changed some of the process but does not affect policy and procedures

Medical Review



Medical Review Target Probe and Educate (TPE)

- Effective September 01, 2021, NGS resumed TPE reviews
- TPE reviews may involve claims that have already been processed (post payment)
  - Notification letter will include a listing of all the claims being selected
- New claim submissions (prepayment)
  - Includes a notification letter followed by separate ADRs for each claim

Currently subject to TPE

- Paring or Cutting of Benign Hyperkeratotic Lesion; - CPT 11055, 11056, 11057
- Trimming of Nondystrophic Nails and/or Nail Debridement- CPT 11719, 11720, 11721

Jurisdiction K Part B Targeted Probe and Educate: Medical Review Topics

Topic	CPT Code(s)	Common Denials	Resources
Paring or Cutting of Benign Hyperkeratotic Lesion	11055, 11056, 11057	A07 – The documentation does not support the medical necessity per policy guidelines. • The documentation does not include some or all of the required elements including the necessary class findings, the presence of a qualifying systemic illness causing a peripheral neuropathy, and/or does not include precise and specific findings including specific location of lesion(s). • The documentation does not support the class findings modifier billed. 362 – The documentation does not support the medical necessity for the level of care billed. The reviewer recoded the service to a higher or lower level of care, depending on what the documentation supported.	Local Coverage Determination (LCD): L33636-Routine Foot Care and Debridement of Nails CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15, Section 290 Title XV111 of the Social Security Act (SSA), Section 1833(e) Title XVIII of the SSA, Section 1862(a)(1)(A)
Trimming of Nondystrophic Nails and/or Nail Debridement	11719, 11720, 11721	B65 – Services not furnished directly to the patient and/or not documented. • The documentation does not support that nondystrophic nails were present and/or treated. 362 – The documentation does not support the medical necessity for the level of care billed. The reviewer recoded the service to a higher or lower level of care, depending on what the documentation supported.	Local Coverage Determination (LCD): L33636-Routine Foot Care and Debridement of Nails CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15, Section 30 Title XV111 of the SSA, Section 1833(e)

Paring or Cutting of Benign Hyperkeratotic Lesion; - CPT 11055, 11056, 11057

A07 – The documentation does not support the medical necessity per policy guidelines.

- The documentation does not include some or all of the required elements including the necessary class findings, the presence of a qualifying systemic illness causing a peripheral neuropathy, and/or does not include precise and specific findings including specific location of lesion(s).
- The documentation does not support the class findings modifier billed.

362 – The documentation does not support the medical necessity for the level of care billed. The reviewer recoded the service to a higher or lower level of care, depending on what the documentation supported.

Trimming of Nondystrophic Nails and/or Nail Debridement- CPT 11719, 11720, 11721

B65 – Services not furnished directly to the patient and/or not documented.

- The documentation does not support that nondystrophic nails were present and/or treated.

362 – The documentation does not support the medical necessity for the level of care billed. The reviewer recoded the service to a higher or lower level of care, depending on what the documentation supported.

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Local Coverage Determinations (LCDs)

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Podiatric LCDs

- Routine Foot Care and Debridement of Nails:
  - LCD# L33636
  - Article# A57759
- Debridement Services
  - LCD# L33614
  - Article# A56617

Medical Record Documentation Requirements LCD# L33636 /Article# A57759

LCD Reference Article | Billing and Coding Article

Billing and Coding: Routine Foot Care and Debridement of Nails

A57759

Expand All | Collapse All

Documentation Requirements:

The patient's medical record must contain documentation that fully supports the medical necessity for services included within the LCD. (See "Indications and Limitations of Coverage.") This documentation includes, but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures.

Documentation supporting the medical necessity, such as physical and/or clinical findings consistent with the diagnosis and indicative of severe peripheral involvement must be maintained in the patient record.

The clinical documentation must clearly show that the patient's condition warrants a provider rendering these services in accordance with the above instruction, and failure to provide such professional services would be hazardous to the beneficiary due to their underlying medical condition(s). **The billed diagnoses should be supported with clinical findings**. Failure to properly document the reasoning for the care rendered may result in denial of the claim.

There should be documentation of co-existing systemic illness. The physical examination and findings must be precise and specific, with documentation of the location, appearance, characteristics and symptoms of the nails and/or lesion(s). The procedure note must describe what, how and where the procedures were performed and correlate these treatments to the lesions documented on the physical examination. The procedure note may reference the physical examination when describing the treatment(s) given during the procedure (e.g., *left great toe, or right foot, 4th digit.*)

There must be adequate medical documentation to demonstrate the need for routine foot care services as outlined in this determination. This documentation may be office records, physician notes or diagnoses characterizing the patient's physical status as being of such severity to

National Government Services Local Coverage Determinations

Welcome to Medical Policies. Below you will find the LCDs, related billing & coding articles and additional medical policy topics. When entering criteria into the search box, the search results will be conducted within the LCDs and the Medical Policy Articles shown below. For additional Medical Policy Topics, refer to the bottom of the page.

[View Draft Policies | View Future Effective LCDs | View Future Effective Billing & Coding Articles | National Coverage Determinations]

11042

Local Coverage Determinations | Medical Policy Articles

Local Coverage Determinations

LCD	LCD #	Billing and Coding #	Response to Comments	Related CPT/HCPCS Codes
Debridement Services *Related terms: N/A*	L33614	A56617		11000, 11001, 11042, 11043, 11044, 11045, 11046, 11047, 97597, 97598

1 to 1 of 1 records (filtered from 80 total entries)

< 1 >

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National Government Services Local Coverage Determinations

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[View Draft Policies | View Future Effective LCDs | View Future Effective Billing & Coding Articles | National Coverage Determinations]

11721

Local Coverage Determinations | Medical Policy Articles

Local Coverage Determinations

LCD	LCD #	Billing and Coding #	Response to Comments	Related CPT/HCPCS Codes
Debridement Services *Related terms: N/A*	L33614	A56617		11000, 11001, 11042, 11043, 11044, 11045, 11046, 11047, 97597, 97598

2024 Telehealth Services

Modifiers CR and CS

- Modifier CR (catastrophe/disaster related)
- Modifier CS (modifier waived cost sharing requirements)
  - Effective 5/12/2023, these modifiers are no longer used

2024 CMS List of Telehealth Services

- List of Telehealth Services

List of Telehealth Services

List of services payable under the Medicare Physician Fee Schedule when furnished via telehealth.

List of Telehealth Services for Calendar Year 2024 (ZIP) - Updated 11/13/2023

Medicare Telehealth Originating Site Facility Fee, Q3014

Time Period	MEI (%)	Facility Fee for Q3014
2024	4.6%	$29.96

Telehealth Originating Site Facility Fee Payment Amount

- HCPCS code Q3014
  - 2024 fee is $29.96
    - ✓ MEI increase for 2024 is 4.6%
  - Applies to traditional telehealth services
  - By submitting Q3014, the originating site authenticates they are located in either a rural HPSA or non-MSA county
  - Q3014 is **not** billable for telehealth services when the patient is located in their home

Major Medicare Telehealth Flexibilities Not Affected

- Flexibilities will remain in place through December 2024 due to the bipartisan Consolidated Appropriations Act (CCA), 2023
  - Medicare beneficiaries can
    - ✓ Access telehealth services in any geographic area in the U.S., rather than only those in rural areas
    - ✓ Stay in their homes for telehealth visits that Medicare pays for rather than traveling to a health care facility
  - Certain telehealth visits can be delivered audio-only if someone is unable to use both audio and video
- Category column showing on the list of telehealth services
  - CMS added 11/1/2023
  - Provisional- will remain on the list for CY 2024
  - Permanent- will remain on the list after 12/31/2024

Originating Sites

- An originating site is the location where a patient is located and receives medical services via telehealth
- Through 12/31/2024
  - Patients can get telehealth wherever they are located
  - No geographic location restrictions
- After 12/31/2024
  - For non-behavioral telehealth services, there may be originating site requirements and geographic location restrictions
  - For behavioral or mental telehealth services, all patients can continue to get telehealth wherever they are located, with no originating site requirements or geographic location restrictions

Distant Sites

- A distant site is the location where a physician or practitioner provides telehealth
- Through 12/31/2024
  - All providers who are eligible to bill Medicare for professional services can provide distant site telehealth

Place of Service Codes

- Effective 1/1/2024
  - Use POS 02-To indicate you provided the service via telehealth and the originating site is other than the patient's home
    - ✓ **To be paid at the facility rate**
  - Use POS 10-For telehealth services when the patient is in their home
    - ✓ Beginning in CY 2024, telehealth services furnished to people in their home will **be paid at the non-facility PFS rate (higher rate on fee schedule)**
      - This is to protect access to mental health and other telehealth services by aligning with telehealth-related flexibilities that were extended via the CAA, 2023

Reporting Home Address

- Reporting Home Address
  - Through 12/31/2024, CMS will allow practitioners to render telehealth services from their home without reporting their home address on their Medicare enrollment, while continuing to bill from their currently enrolled location
- Reference: Physicians and Other Clinicians: CMS Flexibilities to Fight COVID (updated 11/6/2023)

Physician Supervision Requirements

- For CY 2024, CMS will permit the presence and immediate availability of the supervising practitioner through real-time audio and video interactive telecommunications through 12/31/2024
  - CMS believes that extending this definition of direct supervision through 12/31/2024, aligns the timeframe of this policy with many of the previously discussed PHE-related telehealth policies that were extended under provisions of the CAA, 2023

Removal of Frequency Limitations on Certain Telehealth Services to Continue

- CMS removed frequency restrictions for the following listed codes furnished via telehealth
  - A subsequent inpatient visit could be furnished via telehealth, without the limitation that the visit is once every three days (CPT codes 99231-99233)
  - A subsequent skilled nursing facility visit could be furnished via telehealth, without the limitation that the telehealth visit is once every 14 days (CPT codes 99307–99310)
  - Critical care consult codes could be furnished to a Medicare beneficiary via telehealth beyond the once per day limitation (HCPCS codes G0508–G0509)
- CMS removed these frequency limitations until 12/31/2024

Telephone Services

- 99441–99443
  - Telephone E/M service by a practitioner or qualified health care professional
  - Use modifier 95 for the remainder of CY 2023
    - ✓ **Note:** Medicare payment for CPT codes 99441–99443 is equivalent to the Medicare payment for office/outpatient visits with established patients effective 3/1/2020
  - Physicians (including Osteopaths, Podiatrists, and Optometrists), Dentists, Nonphysician Practitioners (including Nurse Practitioner, Clinical Nurse Specialist, Physician Assistant, Certified Nurse Midwife) and Maxillofacial Surgeon
  - The Consolidated Appropriations Act, 2023 provides for an extension for this flexibility through 12/31/2024
- 98966–98968
  - Telephone assessment and management service
  - **5/9/2023 –** added to the CMS list of telehealth codes
    - ✓ Use modifier 95 for the remainder of CY 2023
  - **11/2/2023 –** listed on the 2024 CMS list of telehealth codes as permanent codes
  - Clinical Psychologists, PT/OT/SLP, Optometrists, Nonphysician practitioners (including Nurse Practitioner, Clinical Nurse Specialist, Physician Assistant, Certified Nurse Midwife), LCSWs, RDs and NPs

Telehealth Documentation

- Same as any face-to-face patient encounter, except a statement needed indicating service was telehealth, along with
  - Patient location
  - Provider location
  - Names of all persons participating in the telemedicine service and their role in the encounter
- Time-based services, document start/stop time or total time
- Teaching physician may use audio/video telecommunications during key portions of service

End of the PHE FAQs

FAQ Three

- Is the GT modifier not accepted for telehealth services after the PHE or at the end of December?
  - The GT modifier is not used for professional services submitted to Medicare. Medicare Part B recognizes modifier 95 for telehealth services billed with the place of service that would have been billed if the service were provided face-to-face.

FAQ Four

- With the end of the PHE, will HIPAA compliant telehealth platforms only be allowed, or can we continue to use any platform?
  - The Department of Health and Human Services HIPAA regulations require a HIPAA compliant platform be used. The PHE allowed for enforcement discretion during the PHE and that was extended through 8/9/2023. The Notification of Enforcement Discretion for Telehealth contains information regarding a compliant HIPAA platform.

FAQ Seven

- I thought CMS was permanently allowing the beneficiary to have telehealth sessions in their homes. Is there an end date to this?
  - CMS has indicated on their website that based on the Consolidated Appropriations Act of 2023, Medicare beneficiaries can continue to receive telehealth services from their home through 12/31/2024. However, if the beneficiary is receiving the service at their home the physician may not bill for an originating site fee (Q3014).

Medicare and You Handbook 2024

- Medicare and You Handbook 2024
- Share the 2024 with your patients and their caregivers
- Encourage them to switch to the electronic versions of the Handbook and Medicare Summary Notices

Claim Submission

Duplicate Claims

- May delay payment
- Increases administrative costs to the Medicare Program
- Could be identified as an abusive biller; or
- May result in an investigation for fraud if a pattern of duplicate billing is identified

Tip to Avoiding Denials

- Check your remittance advice for previously posted claim
- Verify reason initial claim was denied
- Don’t just resubmit to correct a denial
- Use the IVR or NGSConnex to check on current claim status
- Allow 30 days from the receipt date
- Make sure your billing service/clearing house is waiting the appropriate time frame

Unprocessable

- Incomplete, invalid or missing information
- Claim rejections
- Remittance advice with a MA130
- Additional remark code identifying what must be corrected
- Resubmit new claim
- Unprocessable claims do not have appeal rights

Unprocessable Rejections

- Methods used:
  - Remittance advice rejected with MA130
  - Paper claims are mailed back with a form letter
  - Electronic claims will be returned via the acceptance report

Top Reasons for Return to Provider (RTP)

- Missing or invalid insured Medicare ID number
- Missing diagnosis code
- Missing place of service code
- Missing service facility location
- Missing or invalid NPI format

Time Limitations for Filing Part B Claims

- As part of the Patient Protection and Affordable Care Act of 2010
  - Timely filing limit was amended to one calendar year after the date of service
    - ✓ Claims submitted beyond the timely filing limit will be denied
    - ✓ Claims not filed timely do not have appeal rights
  - For Part B services the start date for determining the 12-month timely filing period is date of service or the "From" date on the claim
    - ✓ If the "From" date is not timely but the "To" date is timely, line items will be split

How to Request a Waiver to Extend the Timely Filing Requirement

- Post-Claim
  - Claim has been submitted
  - Claim denied for timely filing
- Complete a Part B Reopening Form
- Attach documentation to establish good cause
- Mail to address indicated on the bottom of the Part B Reopening Form

How to Request a Waiver to Extend the Timely Filing Requirement

- Pre-Claim
  - No claim has been submitted
- Meet the qualifications for “good cause”
- Complete a CMS-1500 claim form
- A letter explaining the reason for late filing
  - Documentation to prove “good cause” for late filing

Pre-Claim Request Submission

State(s)	Address
Connecticut	National Government Services, Inc. Attn: Claims Manager P.O. Box 6185 Indianapolis, IN 46206-6185
Massachusetts, Maine, New Hampshire, New York (downstate counties), Rhode Island, Vermont	National Government Services, Inc. Attn: Claims Manager P.O. Box 6178 Indianapolis, IN 46206-6178
New York (Queens only)	National Government Services, Inc. Attn: Claims Manager P.O. Box 6239 Indianapolis, IN 46206-6239
New York (upstate counties)	National Government Services, Inc. Attn: Claims Manager P.O. Box 6189 Indianapolis, IN 46206-6189
Illinois, Minnesota, Wisconsin	National Government Services, Inc. Attn: Claims Manager P.O. Box 6475 Indianapolis, IN 46206-6475

2024 ICD-10-CM

ICD-10 codes

Latest News

CMS Regional Offices

2024 ICD-10-PCS

ICD-10 Resources

2024 ICD-10-CM

2024 ICD-10-CM

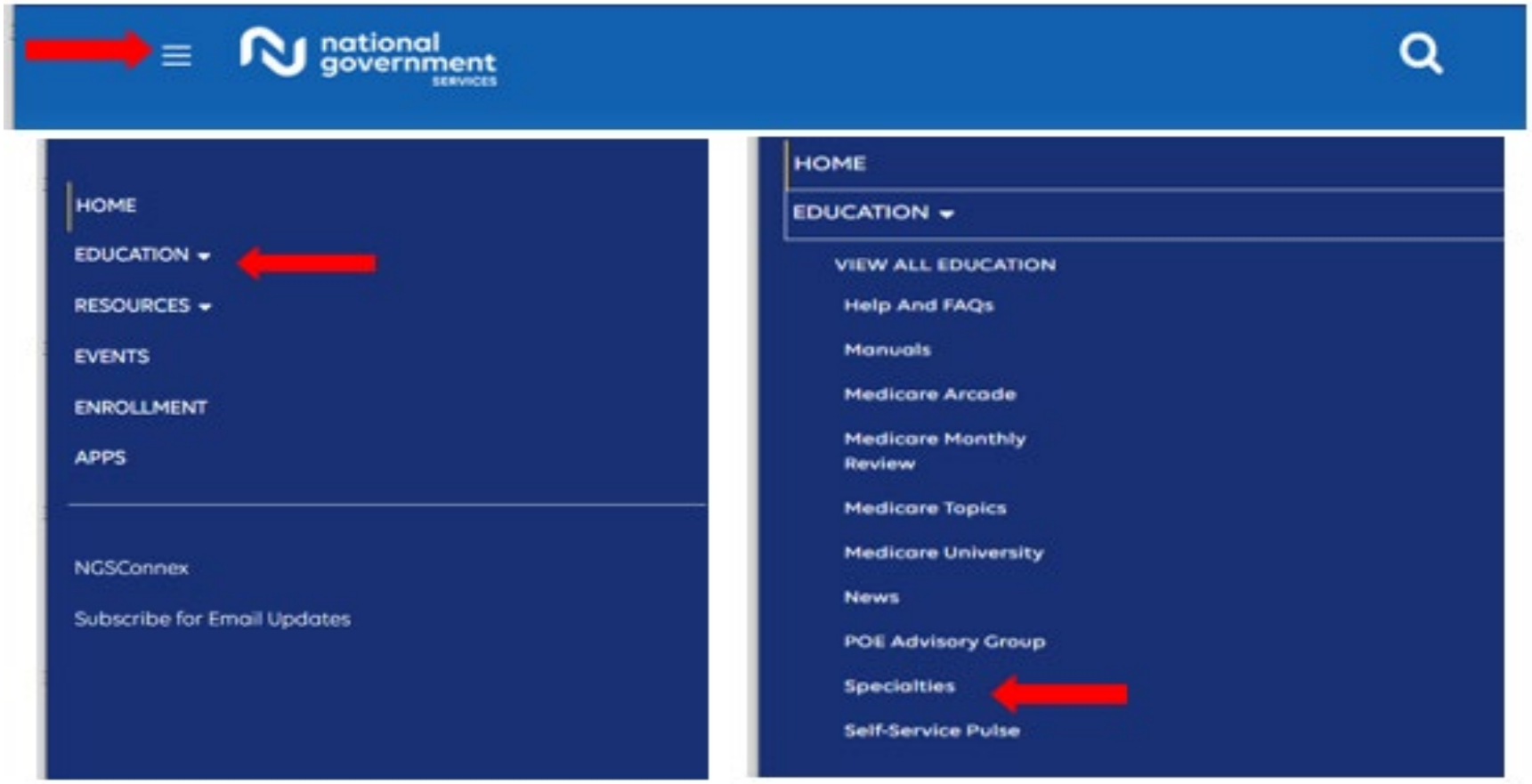
The 2024 ICD-10-CM files below contain information on the ICD-10-CM updates for FY 2024. These 2024 ICD-10-CM codes are to be used for discharges occurring from October 1, 2023 through September 30, 2024 and for patient encounters occurring from October 1, 2023 through September 30, 2024.

Note:

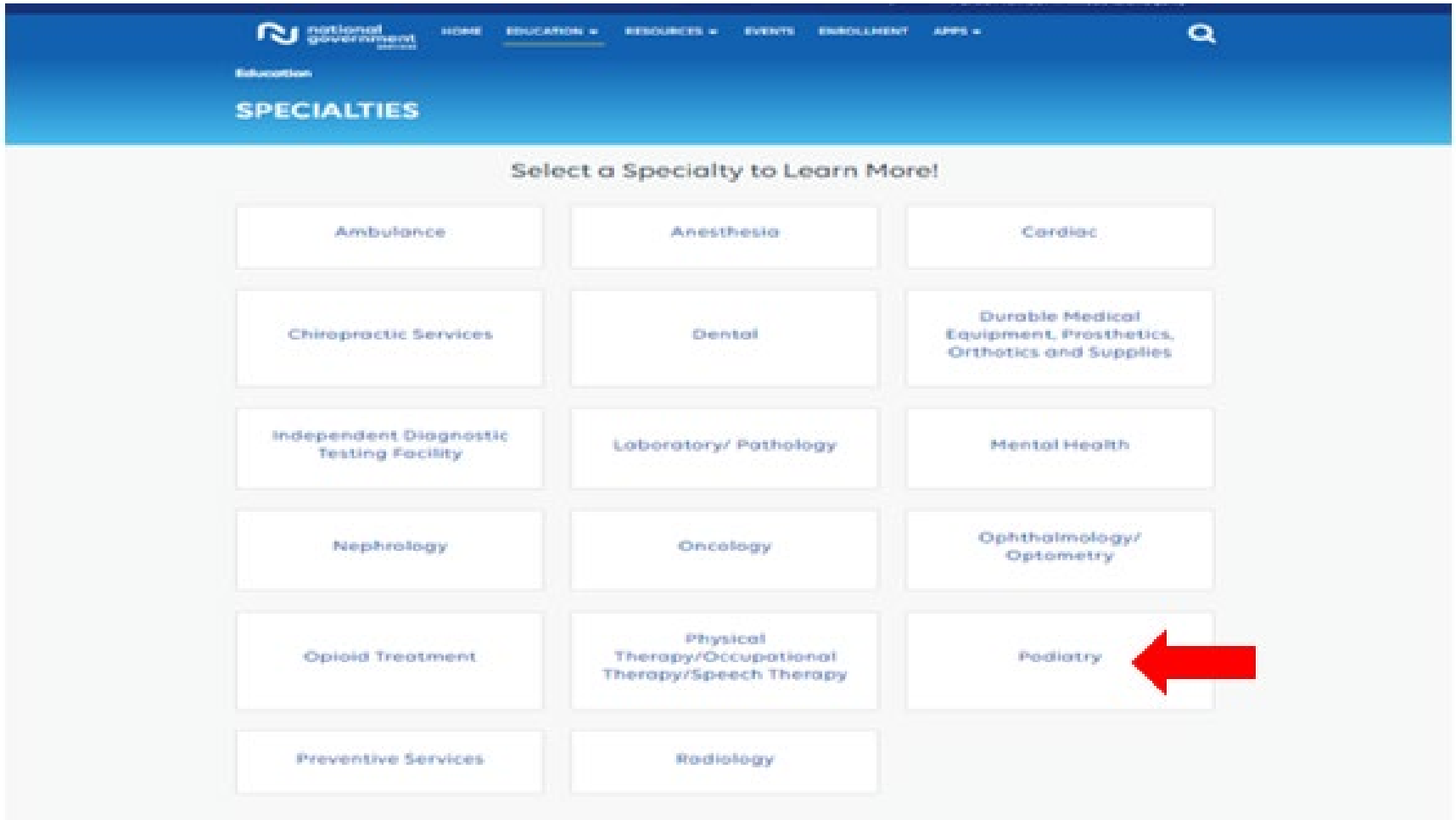
There is no FY 2024 GEMs file. As stated in the FY 2016 IPPS/LTCH PPS final rule (80 FR 49388), the GEMs have been updated on an annual basis as part of the ICD-10 Coordination and Maintenance Committee meetings process and will continue to be updated for approximately 3 years after ICD-10 is implemented.

Podiatry Billing Guide on www.NGSMedicare.com

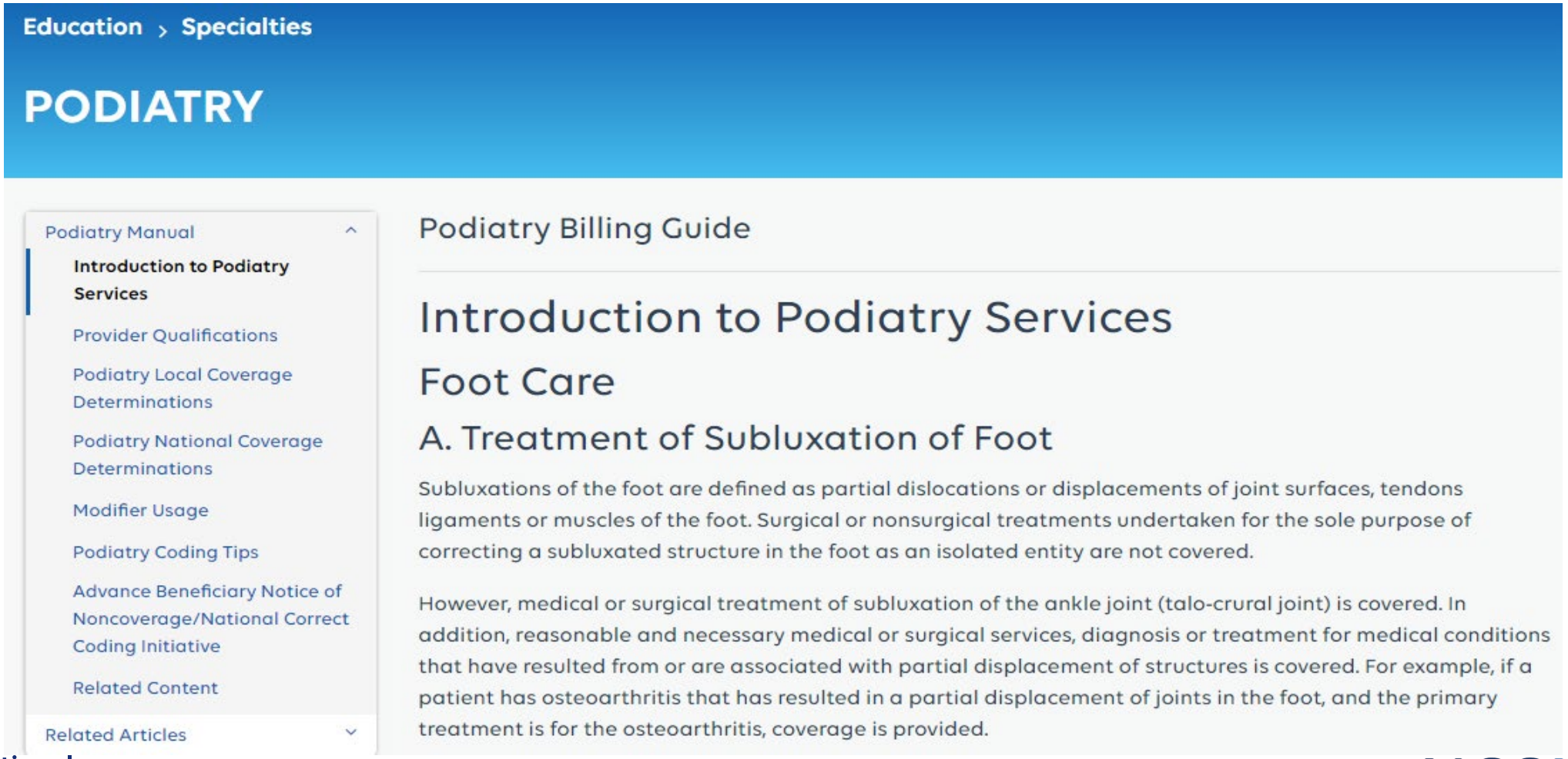
Podiatry Billing Guide



Podiatry Billing Guide



Podiatry Billing Guide



Local Coverage Determinations (LCDs)

Additional Medical Policy Topics

Additional Medical Policy Topics

- Conflict of Interest Disclosure
- Contractor Advisory Committee (CAC)
- Investigational Device Exemption Request
- LCD Open Meetings
- LCD Reconsideration Process
- Medical Policy Contact Information
- New LCD Request Process

New LCD Request Process (A56198)

- Request considered in our jurisdiction from:
  - Beneficiaries residing or receiving care
  - Healthcare professionals
  - Any interested party
- Request should include:
  - Language that requestor wants included in the new LCD
  - Justification supported by peer-reviewed evidence
  - Full copies of published evidence to be considered
  - Information that addresses the relevance, usefulness, clinical health outcomes or medical benefits
  - Information that fully explains the design, purpose and/or method
- An informal meeting may be requested for discussion of the potential LCD
  - Submit via e-mail

New LCD Request Process (A56198)

- Request can be sent via e-mail, facsimile or written letter
  - Email: NGSnewlcdrequest@anthem.com
  - Fax: (317) 595-4334
    - ✓ Attention: New LCD Request
  - Mail:
    - ✓ National Government Services, Inc.
      Medical Policy Unit
      Attention: **New LCD Request**

    P.O. Box 7108
    Indianapolis, IN 46207-7108

Article for LCD Reconsideration Process (A52842)

- Requesting a revision to a **final** LCD
- Submit written request
- Identify language that requestor wants added/deleted from LCD
- Copies of published authoritative evidence
  - Scientific data or research studies published in peer-reviewed medical journals not previously reviewed or listed in sources of information
  - Consensus of expert medical opinion (recognized authorities in the field)
  - Medical opinion derived from consultations with medical associations or other healthcare experts

Reconsideration Process

- **Submission of electronic request is preferred**
  - Email: NGS.lcd.reconsideration@anthem.com
  - Fax: (317) 595-4334
- **Mail to:**
  - National Government Services, Inc.
    Medical Policy Unit
    Attention: LCD Reconsideration Request

    P.O. Box 7108
    Indianapolis, IN 46207-7108

Requesting Addition of ICD-10 Code

- Providers may request that an LCD be **revised** to **add coverage for additional diagnosis codes**
- Does not qualify as a reconsideration
- Can send a request to
  - ✓ Email: NGS.lcd.reconsideration@anthem.com
- Include clinical rationale if no peer-reviewed literature is available
  - Remember no PHI or PII can be sent electronically

LCD Open Meetings

- Held for each LCD development cycle
- Notice of meeting is posted with location and time of meetings about one month in advance
- Medical Policy Section of our website
- Open to the public
- In person or teleconference participation available

Medical Policy Unit Contact

- Clinical issues related to Medicare coverage
  - Submit to our Contractor Medical Director
    - ✓Email: NGSCMD@elevancehealth.com
- General inquiries related to Medicare coverage, local and national coverage determinations, billing and reimbursement must be directed to our Provider Contact Center
  - JK: 866-837-0241
  - J6: 866-234-7340

Preventive Services

MLN Educational Tool – Preventive Services Chart (ICN 006559)

Resources

Helpful Resources

- Fact Sheet - CMS Waivers, Flexibilities, and the Transition Forward from the COVID-19 Public Health Emergency
- HHS Fact Sheet: COVID-19 Public Health Emergency Transition Roadmap
- Creating a Roadmap for the End of the COVID-19 Public Health Emergency
- CMS Coronavirus waivers & flexibilities
  - Includes updated provider specific fact sheets
- MLN® Fact Sheet: *Telehealth Services* (Updated June 2023)
- MM13452 Medicare PFS Final Rule Summary (CY2024)
- 2024 PFS Final Rule Fact Sheet
- 2024 CMS PFS Final Rule

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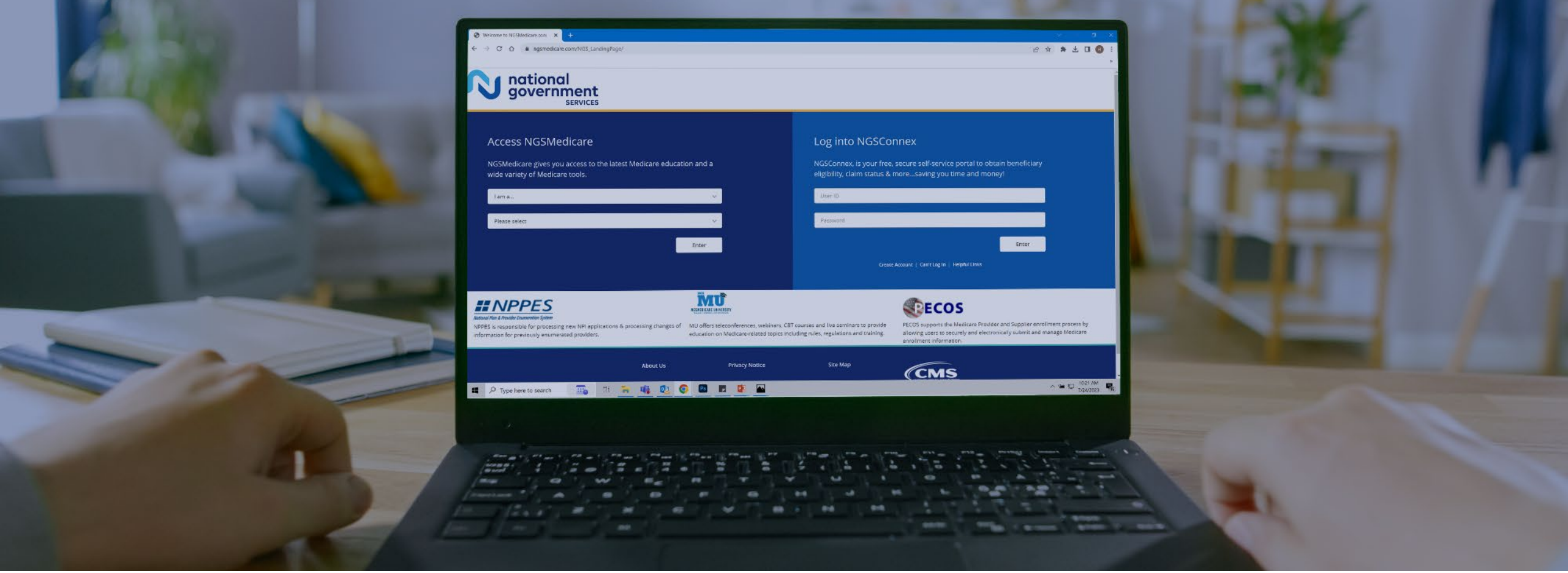
YouTube Channel
Educational Videos

medicare mobile
Text NEWS to 37702; Text GAMES to 37702

www.MedicareUniversity.com
Self-paced online learning

LinkedIn
Educational Content


national government SERVICES
Access NGSMedicare
NGSMedicare gives you access to the latest Medicare education and a wide variety of Medicare tools.
I am a...
Please select
Enter
Log into NGSConnex
NGSConnex, is your free, secure self-service portal to obtain beneficiary eligibility, claim status & more...saving you time and money!
User ID
Password
Enter
Create Account | Can't Log In | Helpful Links
NPPES
NPPES is responsible for processing new NPI applications & processing changes of information for previously enumerated providers.
MU
MU offers teleconferences, webinars, CBT courses and live seminars to provide education on Medicare-related topics including rules, regulations and training.
PECOS
PECOS supports the Medicare Provider and Supplier enrollment process by allowing users to securely and electronically submit and manage Medicare enrollment information.
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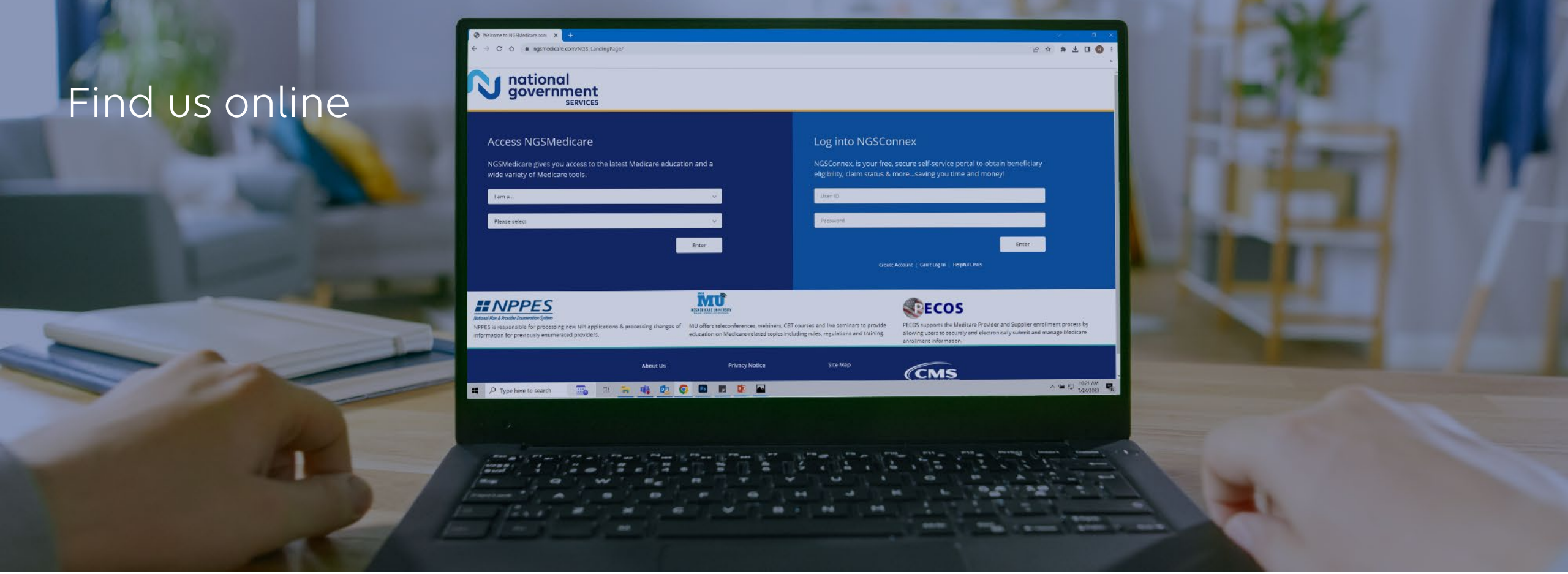
CMS

Find us online



www.NGSMedicare.com
Online resources, event calendar, LCD/NCD, and tools

IVR System
The interactive voice response system (IVR) is available 24-hours a day, seven days a week to answer general inquiries

NGSConnex
Web portal for claim information

Sign up for Email Updates
Subscribe for Email updates at the top of any NGSMedicare.com webpage to stay informed of news

Questions?