



The Role of Medicare Administrative Contractors: *Enrollment to Payment*

Feb. 1, 2024

Sponsored by the Medicare Mental Health Workforce Coalition

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Meeting Details

1

Closed Captioning is enabled and attendees can turn CC on or off as they desire.

2

Interpreter Phone Number: 305-224-1968 Webinar ID: 867 1899 8284 Passcode: 702447

3

Session Evaluation / [Take Our Evaluation Survey](#) ➡ (CE credit for live attendance only)

4

Webinar will be posted on NBCC website a few days following the webinar.

5

Q&A: Please add your questions in the Q&A box at any time during the meeting.

Previous Webinars

- **Medicare 101:**
[An Introduction to the Medicare Program and Coverage of Counselors and MFTs](#)
- **Medicare 201:**
[The Implementation of Medicare Part B Coverage of Counselors and MFTs](#)
- **Medicare 301:**
[Navigating the Medicare Provider Enrollment Process and Physician Fee Schedule](#)
- **Medicare 401:**
[Assessing the Essential Features of the 2024 Medicare Physician Fee Schedule Rule and Implications for Counselors and MFTs](#)
- **Medicare 501:**
[New Engagement Opportunities for Community Behavioral Health Centers With Counselors and MFTs Under Medicare](#)
- **Medicare 601:**
[The Enrollment Process for Counselors and MFTs](#)



Medicare Mental Health Workforce Coalition Members

American Association for Marriage and Family Therapy

American Counseling Association

American Mental Health Counselors Association

Association for Behavioral Health and Wellness

California Association of Marriage and Family Therapists

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Michael J. Fox Foundation for Parkinson's Research

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National Association of Community Health Centers

National Association of County Behavioral Health
and Developmental Disability Directors

National Board for Certified Counselors

National Council for Mental Wellbeing

National Council on Aging

Network of Jewish Human Service Agencies

The Jewish Federations of North America

Learning Objectives

After this webinar, attendees will be able to:

Explain the work of MACs on Medicare enrollment, claims processing, payment, and other procedures.

Identify specific lessons for mental health counselors and marriage and family therapists.

Explain other MAC services.

Identify available resources to educate and help Medicare-enrolled providers.





Nathan L. Kennedy, Jr.

CPC, CHC, CPPM, CPC-I, CPB, CPMA

Nathan Kennedy has worked with National Government Services for over 35 years obtaining a broad knowledge base of the entire Medicare Part B program. Nathan began his Medicare career with over 3 years in claims processing, then moving on to spend over 7 years in The Appeals area.

Nathan then moved on to Provider Outreach and Education, where he has been for over 25 years now. Nathan has served as a liaison with state medical societies organizing communication directly with their organizations, the facilitator of quarterly POE Advisory Group meetings, and has worked with other Medicare partners on many occasions. Nathan has also served as a CPC Instructor of Indian Health Services staff.



Stephanie Portzline

Stephanie Portzline is the Manager of Provider Engagement for Novitas Solutions, Inc. and First Coast Service Options, the Part A and B Medicare Administrative Contractors (MAC) for Jurisdictions L, H and N. She has served in various capacities in the Medicare program for more than 10 years managing provider enrollment and contact center operations, critical and congressional provider and beneficiary inquiries, and the provider outreach and education program. Stephanie holds a master's degree in educational leadership and policy from Shippensburg University. As a former educator, Stephanie blends her passion and experience in conducting outreach with her vast knowledge of the Medicare program to facilitate engaging and informative events.

Medicare Coalition Webinar Marriage and Family Therapists (MFTs) Mental Health Counselors (MHCs)

February 1, 2024

Today's Presenters

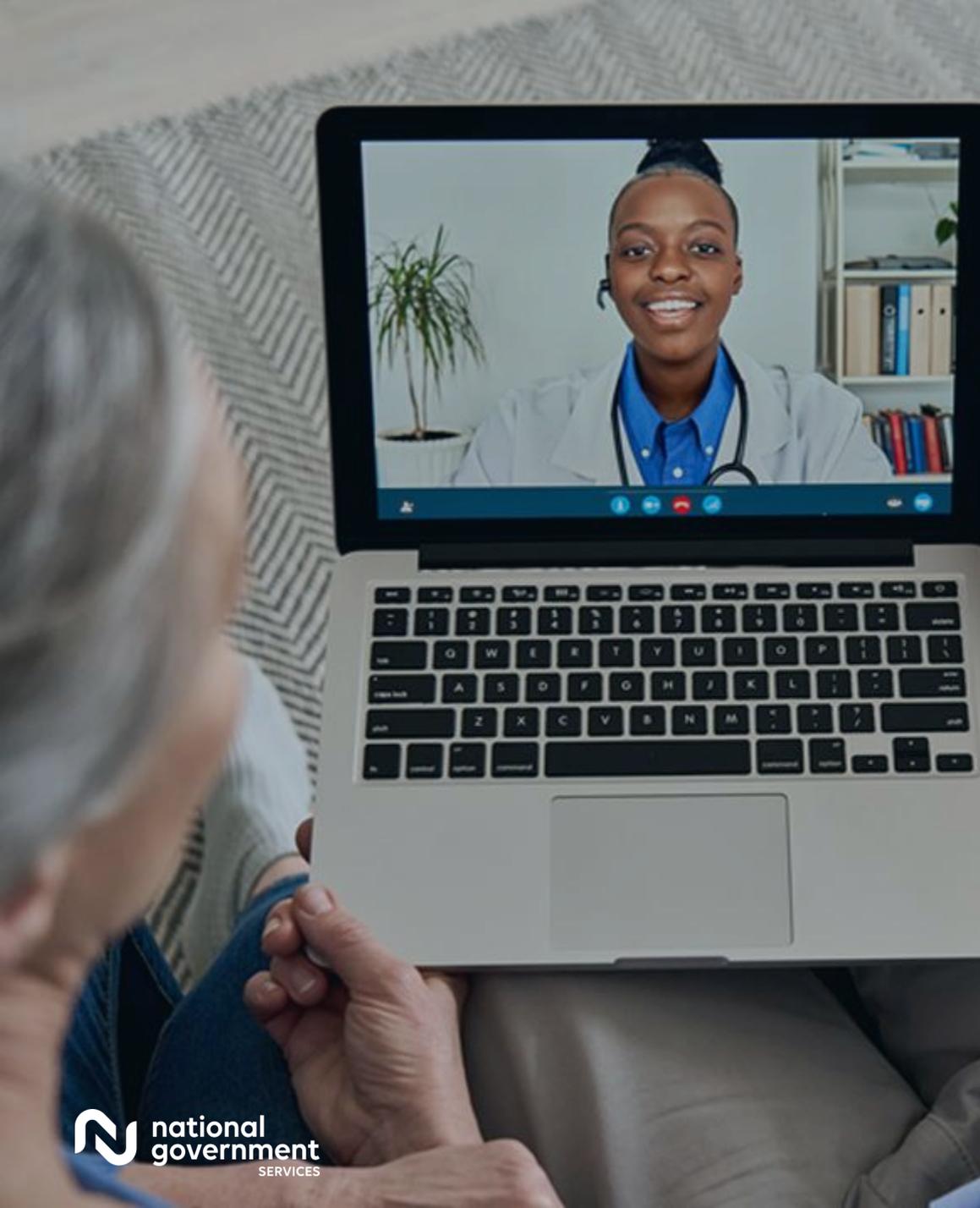


- Nathan L. Kennedy, Jr., CHC, CPC, CPC-I, CPB, CPPM, CPMA
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Objective

Sharing information on Marriage and Family Therapists (MFTs) and Mental Health Counselors (MHCs) in regard to Medicare coverage and billing while introducing the Medicare Administrative Contractors (MACs)



Agenda

Medicare Overview

Medicare Administrative Contractors (MACs)

Provider Enrollment

Claims and Billing

Appeals

Overpayments

Local Coverage Determinations

Resources

Medicare Overview

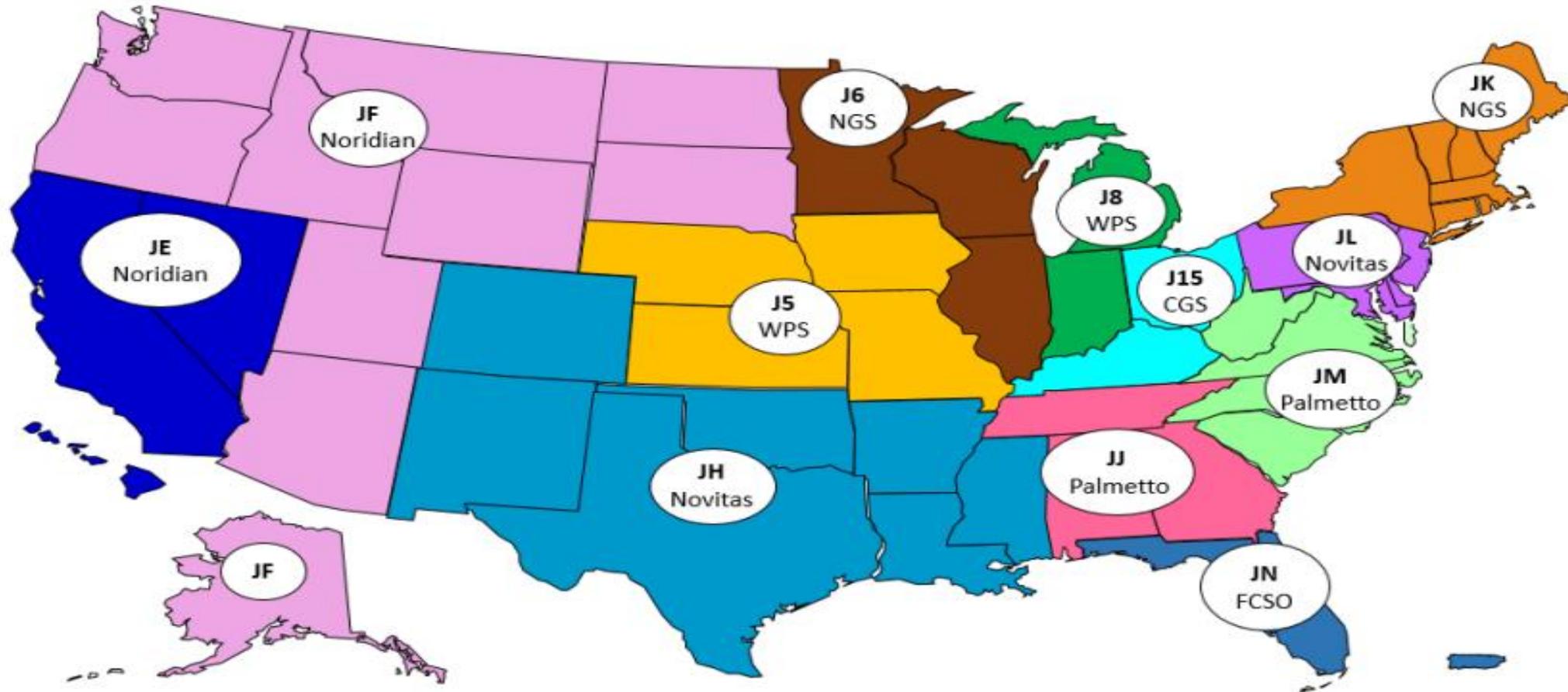
Four Parts to Medicare

- Part A Institutional Services
 - Hospital, Nursing Facility, Rehabilitation Facility, etc.
- Part B Physician Practice Services
 - Physician office, non-physician practitioners, therapists, Durable Medical Equipment
- Part C
 - Medicare Advantage private insurance companies offering private Medicare coverage
- Part D
 - Drug coverage

Medicare Administrative Contractors (MACs)

- 7 MACs administer Medicare Part A and B services across the country
- Durable Medical Equipment is broken out into its own independent set of MACs, not tied to the A/B jurisdictions
- Service location determines the MAC jurisdiction for claim submission
 - Service location is where the patient is receiving the service
- [Who are the MACs](#)

Medicare A/B MAC Jurisdictions



What the MACs Do

MACs Administer Medicare Jurisdictionally

- Each MAC is responsible for the total operation of Medicare oversight for the Jurisdiction they administer
 - Provider Enrollment
 - Claims Processing and Reimbursement
 - Determine Medical Necessity
 - Redeterminations (First Level of Appeal)
 - Overpayments
 - Customer Service
 - Provider Outreach and Education

Provider Enrollment

Provider Enrollment

- To be eligible to bill and receive direct payment for professional services under Medicare Part B, non-physician practitioner must meet all Medicare requirements
- [CY2024 CMS Physician Fee Schedule Final Rule](#)
- [CMS Marriage and Family Therapists and Mental Health Counselors Provider Enrollment Frequently Asked Questions](#)
- If all Medicare requirements are met, the practitioner will enroll in the Medicare program with the intent to submit claims on behalf of beneficiaries for all items and services provided for which Medicare payment may be made

Marriage and Family Therapist

- Qualifications and requirements
 - Possess a master's or doctor's degree which qualifies for licensure or certification as a marriage and family therapist pursuant to State law of the State in which the individual furnishes the services defined as marriage and family therapist services
 - Performed at least 2 years or 3,000 hours of post master's degree clinical supervised experience in marriage and family therapy in an appropriate setting such as a hospital, SNF, private practice, or clinic
 - Are licensed or certified as a marriage and family therapist by the State in which you perform services

Mental Health Counselor

- Qualifications and requirements

- Possess a master's or doctor's degree which qualifies for licensure or certification as a mental health counselor, clinical professional counselor, professional counselor under the State law of the State in which the individual furnishes the services defined as mental health counselor services
- Performed at least 2 years or 3,000 hours of post master's degree clinical supervised experience in mental health counseling in an appropriate setting such as a hospital, SNF, private practice, or clinic
- Are licensed or certified as a mental health counselor, clinical professional counselor or professional counselor by the State in which you perform services

Additionally, addiction counselors and alcohol and drug counselors who meet all the applicable requirements of an MHC may enroll in Medicare as MHCs and bill Medicare for MHC services.

Provider Enrollment

- CMS website information
 - [Marriage and Family Therapists & Mental Health Counselors](#)
- Definition of the NPI Type 1 and 2 profile established within the NPPES (hhs.gov) system:
 - NPI Type 1 is an Individual provider
 - NPI Type 2 is an Organization (clinics/group practices) entity that has a TIN
- Paper Application
 - [CMS 855I](#)
 - [CMS 855B](#)
 - [CMS 588](#)
 - [CMS 460](#)
- [PECOS](#)

Provider Enrollment

- First time enrolling, understand how you will be billing Medicare to enroll correctly.
 - An individual provider billing as a sole proprietor will need to either enroll in PECOS or submit the paper CMS-855I and CMS-588. The CMS-460 is optional.
 - An individual provider billing as a sole owner will need to either enroll in PECOS or submit the paper CMS-855I and CMS-588. The CMS-460 is optional.
 - An individual provider reassigning benefits to an organization (clinic/group practice), will need to either enroll in PECOS or submit the paper CMS-855I for the individual Medicare Provider Enrollment but also verify that the organization (clinic/group practice) has a Medicare Provider Enrollment that the individual provider will be associated as a reassignment.
 - ✓ Reminder: If reassigning benefits to an organization (clinic/group practice), the individual provider assumes the participation status of the enrolled group
 - An organization (clinic/group practice) owned by more than one individual will need to either enroll in PECOS or submit the paper CMS-855B and CMS-588, the CMS-460 (optional) and will need to verify the individuals reassigning benefits to the organization (clinic/group practice) are established with a Medicare Provider Enrollment and submit the paper CMS-855I to associate each as a reassignment.

Opting Out of Medicare

- When an eligible practitioner opts out of Medicare, Medicare covers no services provided by that individual and no Medicare payment can be made to that eligible practitioner directly or on a capitated basis
 - Additionally, no Medicare payment may be made to a beneficiary for items or services provided directly by an eligible practitioner who has opted out of the program
- Eligible practitioner who chooses to opt-out of Medicare may provide covered care to Medicare beneficiaries only through private agreements/contracts
 - A private contract is a contract between a Medicare beneficiary and an eligible practitioner who has opted out of Medicare for two years for all covered items and services the eligible practitioner furnishes to Medicare beneficiaries
 - In a private contract, the Medicare beneficiary agrees to give up Medicare payment for services furnished by the eligible practitioner and to pay the eligible practitioner without regard to any limits that would otherwise apply to what the eligible practitioner could charge
- Once an eligible practitioner files an affidavit notifying the Medicare contractor that the he/she has opted out of Medicare, the eligible practitioner is out of Medicare for two years from the date the affidavit is signed

Submitting an Opt Out Affidavit

- Each MAC's provider website will provide a template or requirements for what to submit for an Opt Out affidavit and instructions on how to submit it
- Affidavits must be filed within 10-days of entering into the first private contract with a Medicare beneficiary
- Opt out statuses are granted in two-year increments
 - Providers must notify the MAC in writing within 30 days of the next two-year opt out period of intent to cancel if the provider no longer wishes to opt out of the program
- Once the affidavit is processed by the MAC, the provider's status is made public on the [CMS Opt-Out Dataset](#)

Provider Enrollment Articles

- Resource articles:
 - [Medicare Learning Network \(MLN\) Educational Tool: Medicare provider Enrollment](#)
 - [Medicare Learning Network \(MLN\) Matters Article MM13331 “Provider Enrollment Changes to the Medicare Program Integrity Manual”](#)
- Refer to your MAC website for additional resources

Claims and Billing

Claim Submission

- Claims may be submitted electronically, or via paper CMS-1500 if ASCA waiver requirements are met
 - Demonstrated HIPAA standard does not permit submission of a particular type of claim
 - Disability of all members of a provider's staff prevents use of a computer for electronic submission
 - Other, rare situations that cannot be anticipated by CMS where provider can establish due to conditions outside their control it would be against equity and good conscience for CMS to enforce the requirement
- To ensure timely reporting of services to Medicare, claims must be submitted no later than 12 months, or one calendar year, after the date the services were furnished
- [CMS IOM Publication 100-04, Chapter 1 – General Billing, Section 70 “Timely Filing Period”](#)
- ASCA waiver information found in [IOM 100-04, Chapter 24, Section 90](#)
- CMS-1500 completion instructions [IOM 100-04, Chapter 26, Section 10](#)
- CMS-1500 Electronic instructions [NUCC 1500 Claim Form Map to 837P](#)

Claims Processing

- Claims are processed by each MAC for their jurisdiction
- Electronic claims submitted with no need for development will process and be subject to a 14-day payment floor prior to payment being issued
- Paper claims submitted with no need for development will process and be subject to a 29-day payment floor prior to payment being issued
- Any development or additional information needed for processing may delay these time frames
 - Additional development request (ADR) is generated when documentation is necessary to support a Medicare claim
 - Request is sent to provider's practice address on file with Medicare
 - ✓ Keep your Medical Review Correspondence Address in PECOS current
 - Attach copy of the ADR letter as the first page to ensure documentation is matched to appropriate patient and claim
 - Submit information pertaining to the request, not an entire medical chart, to the MAC using the response options and timeframe specified in the ADR

Additional Development Request (ADR)

- ADR is generated when documentation is necessary to support a Medicare claim
- Request is sent to provider's practice address on file with Medicare
 - Keep your Medical Review Correspondence Address in PECOS current
- Attach copy of the ADR letter as the first page to ensure documentation is matched to appropriate patient and claim
- Submit information pertaining to the request, not an entire medical chart
- Documentation may be sent via US Mail, your MAC provider portal, electronically (if available), on CD, DVD, or USB drive
- Please review the letter carefully to determine the deadline for response

Remittance Advice

- May be either an Electronic Remittance Advice (ERA) or Standard Paper Remittance (SPR)
- Explains the payment and or denial/rejection reason(s)
- Provides
 - Payment details
 - Deductible and co-pays
 - Adjustments
 - Denials
 - Missing or incorrect data
 - Refunds
 - Medicare Secondary Payer (MSP) withholding
 - Penalty situations withholding

Remittance Advice

- Detailed claim information
- Claim Adjustment Reason Codes (CARCs)
- Remittance Advice Remark Codes (RARCs)
- Group Codes
- Reason Codes
- [Understanding Your Remittance Advice Reports](#)
- [Code Set Listings](#)

Appeals

Appeal Definition

- Appeal definition:
 - Allowance of a new and independent review of an initial determination of a claim
- An initial determination must be made on the claim prior to starting the appeals process
 - The appeals process always starts at the first level: redetermination
 - [Medicare Claims Processing Manual, Pub. 100-04, Chapter 29 – Appeals of Claims Decisions, Section 200 B “Initial Determinations”](#)
 - The appeals process will continue to progress from one level to the next as long as procedural requirements are met including but not limited to:
 - ✓ Adherence to the timeframe for submission to the appropriate contractor
 - ✓ Associated costs with the appealed claim(s) meet the amount in controversy (AIC)

Appeal Levels

Level of Appeal	Time Limit for Filing a Request	Monetary Threshold to be Met/Amount in Controversy (AIC)
Redetermination by the Medicare Administrative Contractor (MAC)	120 days from the initial claim determination	None
Reconsideration by a Qualified Independent Contactor (QIC)	180 days from the date of the Redetermination Decision	None
Administrative Law Judge (ALJ)	60 days from the date of receipt of the Reconsideration Decision	\$180.00
Review by the Medicare Appeals Council (MAC) of the Departmental Appeals Board (DAB)	60 days from the date of receipt of the ALJ decision	None
Judicial Review in US Federal District Court	60 days from the date of receipt of the MAC decision	\$1,840.00

Appeals Process

- [Medicare Part A & B Appeals Process](#)
- Learn how to file appeal request
- File requests on time with the appropriate entity
- Include a copy of the decision letter or claim information at prior level
- If appealing an overpayment include the demand letter
- Include all relevant supporting documentation with your first appeal
- Include an Appointment of Representative form if necessary
- Respond promptly to document requests
- Be aware of time limits for each step of the Appeals process

Overpayments

Overpayments

- [Medicare Overpayments](#)
- Overpayments occur when the provider or CMS (or an entity acting on their behalf) identifies a service was paid and should not have been, or was paid above the normal amount
- Overpayments are debts owed to the federal government
- Laws and regulations require recovery of overpayments
- Common Causes
 - Incorrect coding
 - Insufficient documentation
 - Medical necessity errors
 - Processing and administrative errors

Overpayments

- SSA 1128J (d) requires a provider to report and return overpayment that is self-identified to the MAC within 60 days
- Methods of repayment options
 - Immediate recoupment – may make one time request or set up for all overpayments
 - Standard recoupment – A MAC automatically begins collection and interest may accrue
 - Extended Repayment Schedule (ERS) – If full payment cannot be made in the required timeframe, ERS may be requested per instructions in demand letter
- Rebuttal process is available as is Appeals process
- If overpayment is not met within appropriate timeline the debt will be referred to the Department of Treasury and correspondence will come from them

Local Coverage Determinations (LCDs) Process

Introducing LCDs

- According to Section 1862(a)(1) of the Social Security Act, the CMS and its contractors may develop standards outlining what is “reasonable and necessary” for coverage under Medicare
- Purpose
 - LCDs are MAC developed administrative and educational tools to assist providers in submitting correct claims
- Information contained in LCDs may include:
 - Contractor Information
 - LCD Information
 - CMS National Coverage Policy
 - Coverage Guidance
 - Coding Information
 - General Information
 - Revision History Information
 - Associated Documents

Introducing Local Coverage Articles

- Serve as a complimentary resource to published LCDs
- Purpose:
 - Convey billing and coding information/guidelines
 - Communicate any non-reasonable and necessary language
 - Companion to LCD or stand alone
 - Includes ICD-10 diagnosis codes, CPT and HCPCS codes
 - Communicate responses to comments submitted on proposed LCDs

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 MAC website
- Open to the public

Introducing National Coverage Determinations (NCDs)

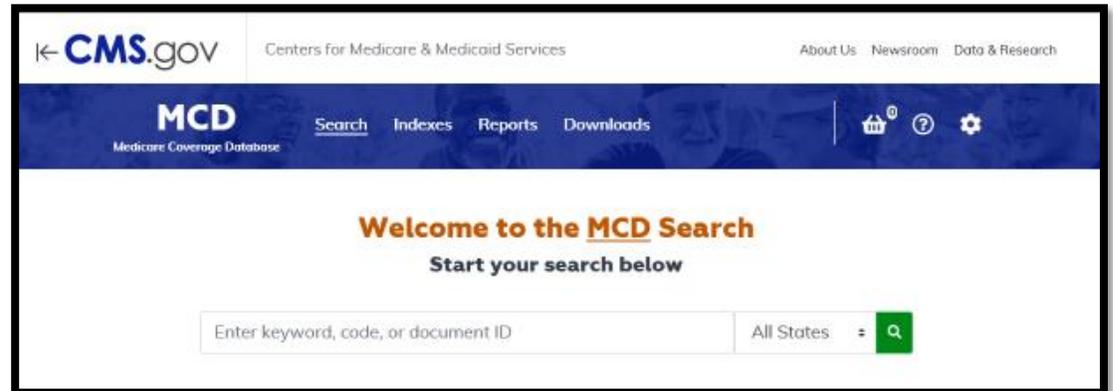
- Developed by CMS to describe circumstances for Medicare coverage nationwide for an item or service
- Purpose
 - Generally outline the conditions for which an item or service is considered to be covered (or not covered) under §1862(a) (1) of the Social Security Act or other applicable provisions of the Act
 - NCD can be initiated by CMS if they find
 - ✓ Inconsistent local coverage policies exist
 - ✓ Service represents a significant medical advance and no similar service is currently covered by Medicare
 - ✓ Service is the subject of substantial controversy
 - ✓ Potential for rapid diffusion or overuse exists
 - NCDs can be found on the CMS Website
 - ✓ [Alphabetical index](#)

Information Contained in NCDs

- Information that may be contained in an NCD includes:
 - Description Information:
 - ✓ Benefit Category
 - ✓ Item/Service Description
 - ✓ Indications and limitations of coverage and/or medical necessity
 - ✓ Claims processing instructions
 - National Coverage Analyses
 - Transmittal Information
 - Revision History
 - Additional Information
 - Procedure codes
 - Covered and/or non-covered diagnosis codes
- CPT/HCPCS, ICD-10 codes are not listed within the NCD

Medicare Coverage Database (MCD) Search

- [Welcome to the MCD Search](#)
- Keyword or document ID of LCD or NCD:
 - Starts with
 - All words
 - Any words
- All document types:
 - Local coverage
 - National coverage
- Select your state
- Select your contractor
- More:
 - CPT/HCPC
 - ICD-10 diagnosis code
 - Date of service



Resources

Resources

- [Marriage and Family Therapists & Mental Health Counselors](#)
- [Important New Changes to Improve Access to Behavioral Health in Medicare](#)
- [Change Request \(CR\) 13469 Updates to Medicare Benefit Policy Manual and Medicare Claims Processing Manual for Marriage and Family Therapists \(MFTs\) and Mental Health Counselors \(MHCs\)](#)



Questions and Answers

Resources





Critical Resources on Medicare Part B Coverage of Counselors and MFTs

Legislation Mandating Medicare Part B Coverage of Counselors and Marriage and Family Therapists

<https://www.congress.gov/117/bills/hr2617/BILLS-117hr2617enr.pdf>

How to Enroll in the Medicare Program

- **Medicare Enrollment for Providers and Suppliers**
<https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/chain-ownership-system-pecos>
- **New Provider Type: Marriage and Family Therapists (MFTs) and Mental Health Counselors (MHCs) FAQs (36 questions answered) Published Sept 2023**
<https://www.cms.gov/files/document/marriage-and-family-therapists-and-mental-health-counselors-faq-09052023.pdf>
- **The Medicare Learning Network:**
<https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnngeninfo>
- **Web-based Training:**
<https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/webbasedtraining>
- **Becoming a Medicare Provider (World of Medicare):**
<https://www.cms.gov/Outreach-and-Education/MLN/WBT/MLN9329634-WOM/WOM/index.html>
- **Weekly Email Newsletter for Medicare Providers:**
<https://www.cms.gov/outreach-and-education/outreach/ffsprovpartprog/provider-partnership-email-archive>





Critical Resources on Medicare Part B Coverage of Counselors and MFTs continued

Role of the Centers for Medicare and Medicaid Services (CMS)

- <https://www.investopedia.com/terms/u/us-centers-medicare-and-medicaid-services-cms.asp>
- <https://www.cms.gov/outreach-and-education/outreach/ffsprovpartprog/provider-partnership-email-archive>

Medicare Mental Health Benefits for Beneficiaries

Medicare and Your Mental Health Benefits:

<https://www.medicare.gov/Pubs/pdf/10184-Medicare-and-Your-Mental-Health-Benefits.pdf>

Medicare Mental Health:

<https://www.cms.gov/files/document/mln1986542-medicare-mental-health.pdf>

Medicare Beneficiary Handbook:

<https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf>





Critical Resources on Medicare Part B Coverage of Counselors and MFTs continued

Medicare Administrative Contractors (MACs)

<https://www.cms.gov/medicare/medicare-contracting/medicare-administrative-contractors/what-is-a-mac>

Medicare Physician Fee Schedule

<https://www.federalregister.gov/documents/2023/08/07/2023-14624/medicare-and-medicaid-programs-cy-2024-payment-policies-under-the-physician-fee-schedule-and-other>

Key Steps to Becoming a Medicare Provider

1. Register in the [I&A](#) System
2. Get an [NPI](#)
3. Enter information into [PECOS](#)
4. Decide if you want to be a participating provider

[Form CMS-855I: Physicians and non-physician practitioners \(PDF link\)](#)





**Thank you
for attending!**



**Medicare Mental Health
Workforce Coalition**