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North Carolina Health Insurance Institute Medicare Part A and B Updates

April 26, 2023

Disclaimer

The content in this presentation is intended for Jurisdictions M Part A and B providers and is current as of April 1, 2023. Any changes or new information superseding this information is provided in articles with publication dates after April 1, 2023, at Palmetto GBA.

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Agenda

- Comparative Billing Reports (CBRs)
- Comprehensive Error Rate Testing (CERT)
- Medicare Part A and B Targeted Probe and Educate (TPE) Updates
- Medicare Part B Updates
- Resources

Electronic Comparative Billing Reports (eCBRs)

What Is an eCBR?

- Electronic Comparative Billing Report (eCBR)
- Educational tool that Palmetto GBA utilizes
- Targets specific providers
- Provides billing and payment insight
- Proactive tool to help providers identify and correct errors
- Not intended to be punitive or indicative of fraudulent activity

https://pepper.cbrpepper.org/

How Are Topics Selected?

- Comprehensive Error Rate Testing (CERT) Reports
  - CERT Reports | CMS
  - **Top improper payments by provider type**
- Office of Inspector General (OIG)
  - Home | Office of Inspector General (dhs.gov)
  - **False claim reports**
  - **Cases related to fraud and abuse**

How Are Providers Notified?

Letter via U.S. Postal Service

- Attend webcast
- Webcast link to register
- eServices link
- Resources for additional information

PO BOX 100238 | COLUMBIA, SC 29202 | PALMETTOGBA.COM/JMA | ISO 9001

A/B MAC JURISDICTION M
North Carolina, South Carolina, Virginia, West Virginia, Home Health and Hospice

******* *, 2022

PROVIDER NUMBER:

Your Attendance Is Requested

Dear Medicare Provider:

The Palmetto GBA Provider Outreach and Education department, along with MCG Health, will be conducting a webinar on your recent electronic Comparative Billing Report (eCBR) for Urinary Tract Infections (UTIs). The topics of discussion will include understanding your eCBR, MCG Health care guidelines, and documentation guidelines. We highly encourage you to attend our webinar on February 23, 2022 at 11:00 AM ET. Additional details are provided below.

To view your organization's Reducing Urinary Tract Infection Readmission results, log on to the Palmetto GBA eServices web page at https://tinyurl.com/ewmhmd3j. You may also find more information on this subject at https://tinyurl.com/4vj4yu5c.

Webinar Title: Urinary Tract Infections eCBR - Part A
Webinar Date: Wednesday, February 23, 2022 at 11:00 AM ET
Webinar Link: **https://tinyurl.com/2p8faukx**

Thank you for your prompt attention to this matter. We look forward to your attendance.

Sincerely,

Palmetto GBA Provider Outreach and Education Team

Where to View eCBR

- Palmetto GBA website eServices Portal
- Electronic Data Interchange (EDI) Enrollment Agreement
  - **Must complete prior to access to eServices**
- Register in eServices
  - **Can register after EDI approval**

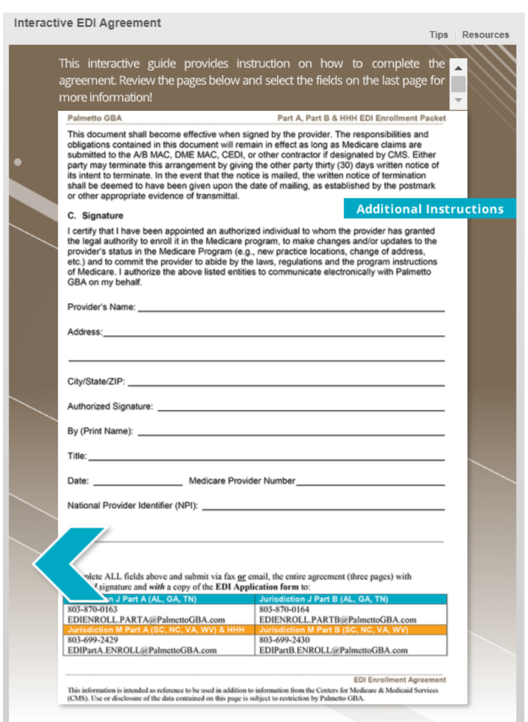
Where to Find EDI Enrollment Agreement

EDI Help

- EDI Enrollment Instructions Guide (palmettogba.com)

Interactive EDI Enrollment Agreement

- Interactive EDI Agreement (palmettogba.com)


Interactive EDI Agreement

Tips | Resources

This interactive guide provides instruction on how to complete the agreement. Review the pages below and select the fields on the last page for more information!

Palmetto GBA — Part A, Part B & HHH EDI Enrollment Packet

This document shall become effective when signed by the provider. The responsibilities and obligations contained in this document will remain in effect as long as Medicare claims are submitted to the A/B MAC, DME MAC, CEDI, or other contractor if designated by CMS. Either party may terminate this arrangement by giving the other party thirty (30) days written notice of its intent to terminate. In the event that the notice is mailed, the written notice of termination shall be deemed to have been given upon the date of mailing, as established by the postmark or other appropriate evidence of transmittal.

Additional Instructions

C. Signature

I certify that I have been appointed an authorized individual to whom the provider has granted the legal authority to enroll it in the Medicare program, to make changes and/or updates to the provider's status in the Medicare Program (e.g., new practice locations, change of address, etc.) and to commit the provider to abide by the laws, regulations and the program instructions of Medicare. I authorize the above listed entities to communicate electronically with Palmetto GBA on my behalf.

Provider's Name: ____________________

Address: ____________________

____

City/State/ZIP: ____________________

Authorized Signature: ____________________

By (Print Name): ____________________

Title: ____________________

Date: __________ Medicare Provider Number __________

National Provider Identifier (NPI): ____________________

…plete ALL fields above and submit via fax <u>or</u> email, the entire agreement (three pages) with …l signature and ***with*** a copy of the **EDI Application form** to:

…n J Part A (AL, GA, TN)	Jurisdiction J Part B (AL, GA, TN)
803-870-0163 EDIENROLL.PARTA@PalmettoGBA.com	803-870-0164 EDIENROLL.PARTB@PalmettoGBA.com
Jurisdiction M Part A (SC, NC, VA, WV) & HHH	**Jurisdiction M Part B (SC, NC, VA, WV)**
803-699-2429 EDIPartA.ENROLL@PalmettoGBA.com	803-699-2430 EDIPartB.ENROLL@PalmettoGBA.com

EDI Enrollment Agreement

This information is intended as reference to be used in addition to information from the Centers for Medicare & Medicaid Services (CMS). Use or disclosure of the data contained on this page is subject to restriction by Palmetto GBA.

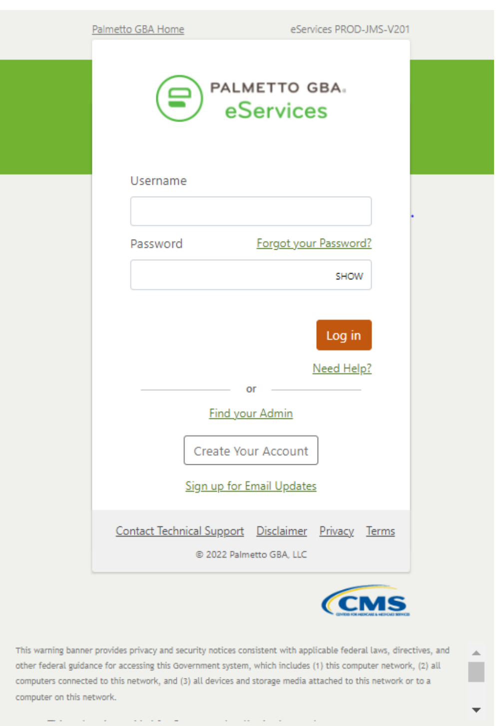
How to Register in eServices

Register at: www.PalmettoGBA.com/eServices

- Username
- Password

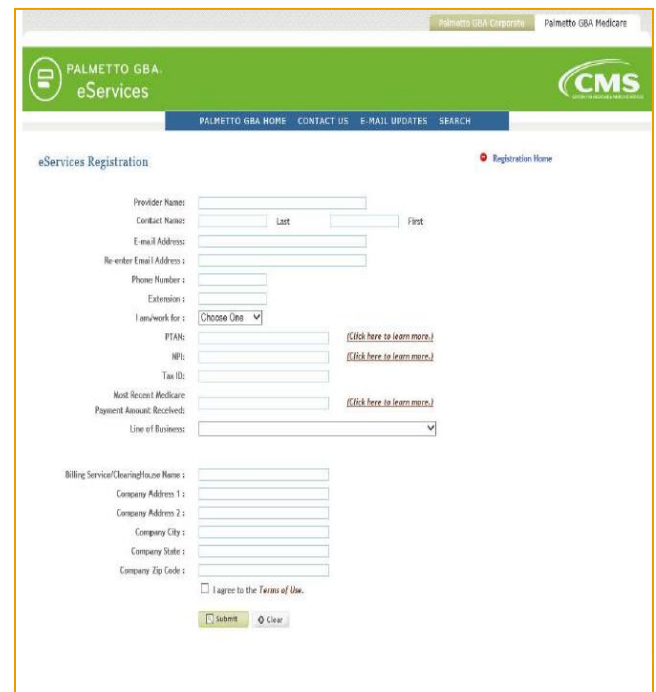
OR Select

- Find Your Admin
- Create Your Account
- Sign up for Email Updates



What Is Needed to Register in eServices?

- Provider name
- Contact name (person assigned to this user ID)
- Email address, phone number, extension
- Provider, billing service or clearinghouse indicator
- PTAN, NPI, Tax ID
- Most recent Medicare payment amount received
- If you have several payments received in one day, use the amount related to the highest check number
- Line of business: choose from dropdown selections



Comprehensive Error Rate Testing (CERT) Program

Claim Selection → Medical Records → Medical Review → Calculation of the Improper Payment Rate → Reporting

Medicare FFS Claims Universe
- FISS – Part A
- MCS – Part B
- VMS - DME

Request

Receipt

Providers

Effectuation of appeals
Finalization of expenditure data
Cutoff Date: Mid-Oct. of year reporting

Comprehensive Error Rate Testing Contractor

The CERT program was developed to:

- Measure the accuracy of Medicare's payments on a national level for each MAC region
- Assist CMS in understanding the educational needs of the provider community and their contractors
- Prevent improper payments

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CERT Initial Documentation Request

Day 0	**CERT sends an Initial letter to request documentation**
Day 25	Phone contact is made by CERT to follow-up on their initial request and to offer assistance
Day 30	A second letter is sent by CERT (**15 days are left to fulfill CERT's request timely**)
Day 40	Phone contact is made by CERT to follow-up on their initial request and to offer assistance
Day 45	A third letter is sent by CERT, and around this date a call is also made by Palmetto GBA's MR staff to encourage submission of records (response is due)
Day 55	Phone contact is made by CERT to follow-up on their initial request and to offer assistance (response is overdue)
Day 60	Phone contact is made by CERT to follow-up on their initial request and to offer assistance (response is overdue)

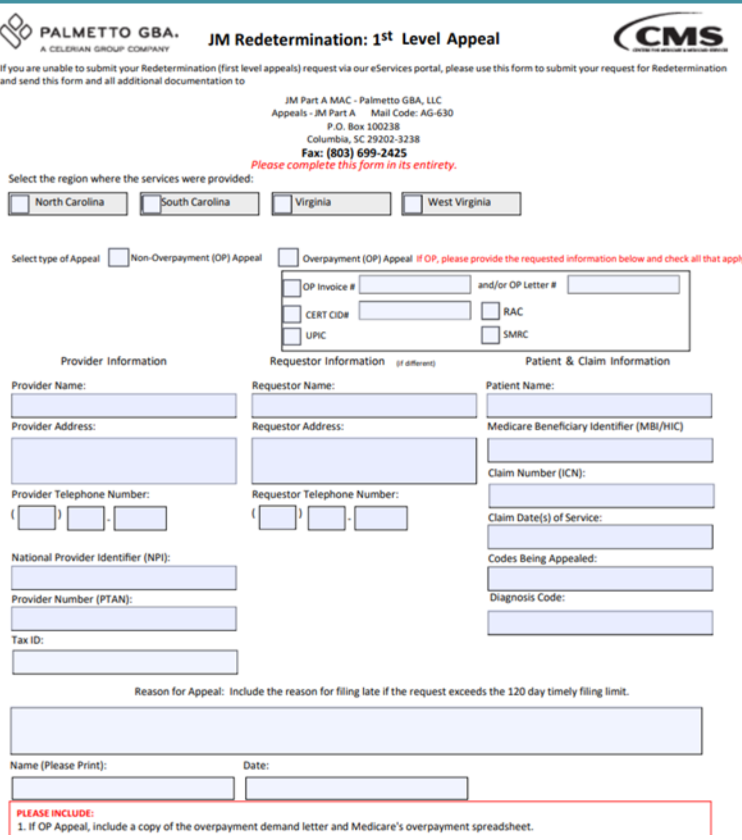
Finalizing CERT's Process

Day 76

- Claims are counted as a non-response error if requested documentation isn't received
- Funds are subject to overpayment recovery
- Palmetto GBA's MR staff will contact providers to encourage the filing of a Redetermination Comprehensive Error Rate Testing Appeal

Post-Day 76

- Palmetto GBA's MR staff sends a Teaching and Instruction Paragraph Letter or "TIP Letter"



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JM Redetermination: 1st Level Appeal

CMS

If you are unable to submit your Redetermination (first level appeals) request via our eServices portal, please use this form to submit your request for Redetermination and send this form and all additional documentation to

JM Part A MAC - Palmetto GBA, LLC
Appeals - JM Part A Mail Code: AG-630
P.O. Box 100238
Columbia, SC 29202-3238
Fax: (803) 699-2425
Please complete this form in its entirety.

Select the region where the services were provided:

☐ North Carolina ☐ South Carolina ☐ Virginia ☐ West Virginia

Select type of Appeal ☐ Non-Overpayment (OP) Appeal ☐ Overpayment (OP) Appeal If OP, please provide the requested information below and check all that apply

☐ OP Invoice # ______ and/or OP Letter # ______
☐ CERT CID# ______ ☐ RAC
☐ UPIC ☐ SMRC

Provider Information	Requestor Information (if different)	Patient & Claim Information
Provider Name:	Requestor Name:	Patient Name:
Provider Address:	Requestor Address:	Medicare Beneficiary Identifier (MBI/HIC)
		Claim Number (ICN):
Provider Telephone Number: ( ) -	Requestor Telephone Number: ( ) -	Claim Date(s) of Service:
National Provider Identifier (NPI):		Codes Being Appealed:
Provider Number (PTAN):		Diagnosis Code:
Tax ID:		

Reason for Appeal: Include the reason for filing late if the request exceeds the 120 day timely filing limit.

Name (Please Print): ______ Date: ______

PLEASE INCLUDE:
1. If OP Appeal, include a copy of the overpayment demand letter and Medicare's overpayment spreadsheet.

CERT Subsequent Documentation Request

Provider Name
Address 1
Address 2
City ST 00000

Date: 1/1/1900
Reference ID: CID #: 1555555
NPI/Provider #:
Phone:
Fax:

Request Type & Purpose: ADR to Third Party Provider
Subject: Additional Documentation - This is not a duplicate request

Dear Medicare Ordering/Referring Provider:

The Centers for Medicare & Medicaid Services (CMS), through the Comprehensive Error Rate Testing (CERT) program, carries out the task of requesting, receiving, and reviewing medical records.[1] The CERT program reviews selected Medicare A, B and DME claims and produces annual improper payment rates. For more information regarding the CERT program, please visit www.cms.gov/CERT

Reason for Selection
The CMS' CERT program has randomly selected a claim for review from a billing provider or supplier for which you were the ordering/referring provider. The CERT Documentation Office is contacting you to request additional documentation to support the necessity and payment for service(s)/item(s) billed to Medicare.

Action: Medical Records Required
Federal law requires that providers/suppliers submit medical record documentation to support claims for Medicare services upon request. Providers/suppliers are required to send supporting medical records to the CERT program. Please provide the requested documentation as identified on the attached barcoded cover sheet, in connection with the billing provider's date of service of 1/1/1900 - 1/1/1900 , to the CERT Documentation Office as soon as possible. Note that supporting documentation may be prior to or after the billing provider's date of service. Please ensure that all records are legible. **Providing medical records of Medicare patients to the CERT program does not violate the Health Insurance Portability and Accountability Act (HIPAA).** Patient authorization is not required to respond to this request. The CMS is not authorized to reimburse providers/suppliers for the cost of medical record duplication or mailing. If you use a photocopy service, please ensure that the service does not invoice the CERT program.

When: 1/1/1900
Please provide the supporting documentation by 1/1/1900 . In the event you are unable to locate the requested information, please contact the CERT Documentation Office, as a response is still required.

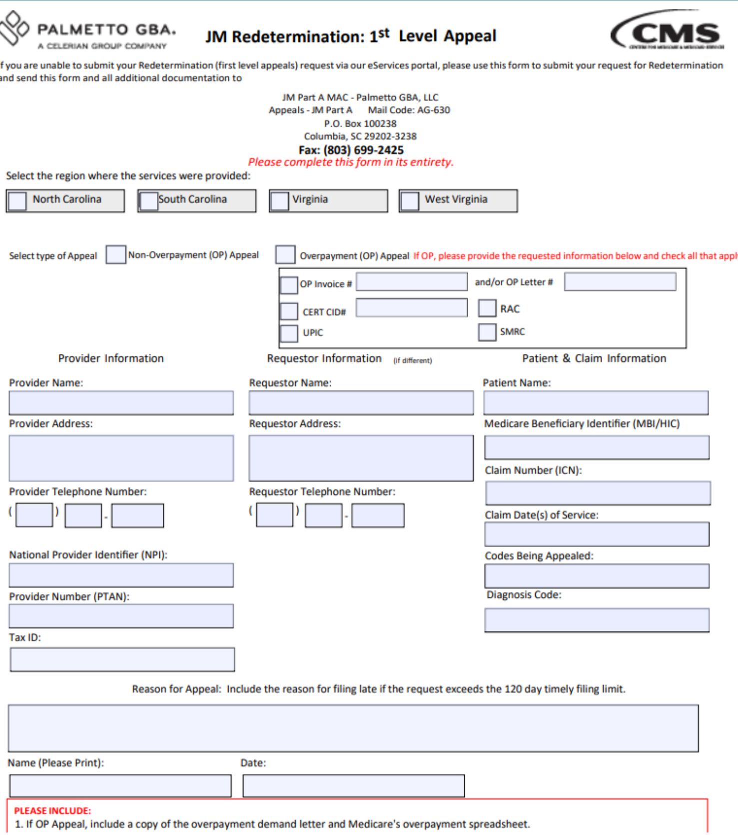
Consequences
If the provider/supplier fails to send the requested documentation or contact CMS by 1/1/1900 , the provider's/supplier's Medicare contractor will initiate claims adjustments or overpayment recoupment actions for these undocumented services.

If, during CERT's initial medical review, the need for additional info is identified, a subsequent documentation request will be issued as follows:

- Day 1 — CERT sends an initial subsequent request letter, and a phone call is made by CERT to the provider to follow-up on the request and to help
- Day 10 — CERT sends a second subsequent request letter, and a phone call is made by CERT and Palmetto GBA POE to the provider to follow-up on the request and to help
- Day 16 — Claim is back in the review process

Finalizing CERT's Process

- Claims are counted as an error if requested documentation isn't received timely
- Funds are subject to overpayment recovery
- Palmetto GBA's MR staff will contact providers to encourage the filing of an Appeal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Fax: (803) 699-2425
Please complete this form in its entirety.

Select the region where the services were provided:
☐ North Carolina ☐ South Carolina ☐ Virginia ☐ West Virginia

Select type of Appeal ☐ Non-Overpayment (OP) Appeal ☐ Overpayment (OP) Appeal If OP, please provide the requested information below and check all that apply

☐ OP Invoice # ____ and/or OP Letter # ____
☐ CERT CID# ____ ☐ RAC
☐ UPIC ☐ SMRC

Provider Information	Requestor Information (if different)	Patient & Claim Information
Provider Name:	Requestor Name:	Patient Name:
Provider Address:	Requestor Address:	Medicare Beneficiary Identifier (MBI/HIC)
		Claim Number (ICN):
Provider Telephone Number: ( ) -	Requestor Telephone Number: ( ) -	Claim Date(s) of Service:
National Provider Identifier (NPI):		Codes Being Appealed:
Provider Number (PTAN):		Diagnosis Code:
Tax ID:		

Reason for Appeal: Include the reason for filing late if the request exceeds the 120 day timely filing limit.

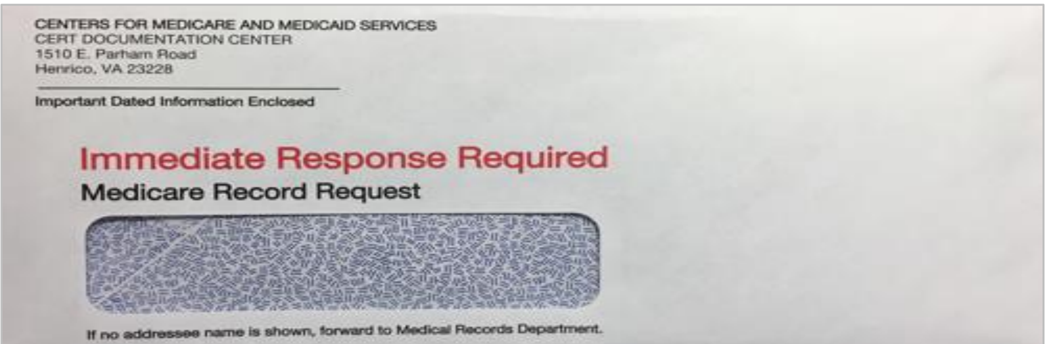
Name (Please Print): Date:

PLEASE INCLUDE:
1. If OP Appeal, include a copy of the overpayment demand letter and Medicare's overpayment spreadsheet.

Responding to CERT Requests

Responding to a CERT request is not optional, it's imperative!

- A reply is still required if records can not be located
- This is not a HIPPA violation
- Patient authorization is not required to respond
- Contact the CERT Documentation Center at 888–779–7477, if you have questions regarding requested documentation



Things to Know to Avoid CERT Errors

Avoid general payment errors by ensuring that:

- You are aware of CERT requests
- Updates are made to your contact information when necessary
- The original barcoded cover sheet is used when responding to request

PLACE THIS BARCODED COVER SHEET IN FRONT OF THE RECORD

Medicare CERT Review Contractor
GS-00F-263CA CERT

CID: 1555555

Due Date: 1/1/1900 Medicare Part B Provider

Patient Name: Patient Name

Date of Birth: 1/1/1900 **Date of Service: 1/1/1900 - 1/1/1900**

Claim Control Number: CCN0000000000

Universe Date: 1/1/1900 Request Date: 1/1/1900

Contractor Number: 99999 Contractor Type: B

Billing Provider NPI: 0000000000

Letter Sequence: ADR to Billing Provider (First Request)

Please send documentation to:
Fax #: 804-261-8100 or
Mail: CERT Documentation Office - Attn: CID # 1555555, 1510 East Parham Road, Henrico, VA 23228
Phone #: 888-779-7477 or 443-663-2699

The documents listed below may be required in support of a medical claim review. Please provide all of the **pertinent** medical records/ documentation listed **below and any additional documentation** to support the above listed claim for the specified date(s) of service. Please copy both sides of each page and please DO NOT cut off page edges when copying.

Note: If the medical record documentation is not signed or if the signature is illegible, submit an attestation statement or a signature log for those medical record entries. In order to be considered valid for Medicare medical review purposes, an attestation statement must be signed and dated by the author of the medical record entry and must contain sufficient information to identify the beneficiary. An attestation statement cannot be used when an order is not signed.

CERT's Chain Address Program

Providers that have at least 10 PTAN numbers can elect a single point of contact (POC).

Providers Must:

- Call the CERT office or their local MAC CERT Coordinator with a list of PTAN numbers and their designated POC information
- This information should be provided to CERT within 45 days from the initial notification of CERT's request for documentation

CERT's Response:

- CERT will email/call the POC with a list of outstanding CID numbers
- When requested, the CERT CSR will forward a copy of documentation request letters to the POC

Five Major CERT Error Categories

IMPROPER PAYMENT RATE ERROR CATEGORIES BY PERCENTAGE OF 2022 NATIONAL IMPROPER PAYMENTS

Insufficient Documentation | Medical Necessity | Incorrect Coding | Other | No Documentation

3.8%
8.3%
10.5%
13.8%
63.6%

[Comprehensive Error Rate Testing Contractor's 2022 National Improper Payment Rate Errors Defined by Category]

All data analysis includes reviewed claims data from the sampling period of July 2020 — June 2021, as of November 2022.

Example — No Documentation

- Provider indicated that a record could not be found for the specified date of service
  - **Received note that states, "Unable to locate physician documentation for date of service requested error. Please initiate overpayment recoupment”**

  Or

  - **Received note that states, "Please submit HIPPA release authorization form for records"**

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Examples — Insufficient Documentation

- No clinical note provided: no physician note, or note is vague or not relevant, or no clinical documentation provided
- No physician orders provided or evidence of intent to order
- No documentation to support that services ordered were performed or that units of service billed were rendered
- Chart only notes diagnosis code, no other notations made
- No relevant treatment or clinical history provided
- Documentation missing important facts
- Includes documentation with invalid or missing signatures
- Illegible medical records

Signature Tips

Signatures may be handwritten or electronically signed

- Exceptions for stamped signatures are described in MLN Matters article MM8219
  - ✓ https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8219.pdf

Do not add late signatures to a medical record

- Consider using the signature authentication process outlined in MLN Matters article MM6698
  - ✓ https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6698.pdf

Things to Know to Avoid CERT Errors

Are you familiar with signature attestation statements?

- CMS does not require or instruct providers to use a certain form or format for attestation forms
- CERT has a downloadable PDF available for providers
- CERT C3Hub/Attestation Letters
  - ✓ [C3HUB (cms.gov)]

Medical Record Signature Attestation Statement

NOTE: This form provides a suggested format for a signature attestation statement. Submission of a signature attestation statement and use of this form is optional.

Name of Patient:	
Medicare Number:	

I, ______________________________ (*Print full name of the physician/practitioner*), hereby attest that the medical record entry for ______________________ (*Date of Service*) accurately reflects signatures/notations that I made in my capacity as a(n) ____________________ (*Insert credentials, e.g., M.D.*) when I treated/diagnosed the above listed Medicare beneficiary. I do hereby attest that this information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or, criminal liability.

____
Signature of Author of the Medical Record

____
Date

In order to be considered valid for Medicare medical review purposes, an attestation statement must be signed and dated by the author of the medical record entry and contain sufficient information to identify the beneficiary. Reviewers will not consider attestation statements where there is no associated medical record entry or from someone other than the author of the medical record entry in question (even in cases where two individuals are in the same group, one should not sign for the other in medical record entries or attestation statements).

Top CERT Errors for Medicare Parts A&B

CERT Errors Part A — Inpatient Hospital Stay

- Authenticated history and physical
- Authenticated M.D. inpatient admit order
- MD progress notes
- Labs/MAR
- Operative report
- Provider emergency records
- Case management, discharge planning, or social worker notes
- Consult records (signed preoperative provider office notes, diagnostic/X-ray or imaging reports that support the medical necessity for billed surgery)

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Inpatient Hospital Stay

Most common denial related to this service:

- The documentation submitted for review did not support the medical necessity of the services provided

Submit documentation to support that all services were medically necessary on an inpatient basis instead of a less intensive setting.

- Include documentation of services, medication and medical interventions performed in the emergency department

Cardiac Procedures

Percutaneous and Other Intracardiac Procedures (LAAC)

- NCD 20.34, Percutaneous Left Atrial Appendage Closure (LAAC)
  - **The interventional cardiologist and cardiothoracic surgeon must jointly participate in the intra-operative technical aspects of TAVR**
  - **A formal shared decision-making encounter must occur between the patient and an independent non-interventional physician using an evidence-based decision tool on oral anticoagulation in patients with NVAF prior to LAAC**

Cardiac Procedures

Transcatheter Edge-to-Edge Repair (TEER) for Mitral Valve Regurgitation

- NCD 20.33, Transcatheter Edge-to-Edge Repair (TEER) for Mitral Valve Regurgitation
  - **An interventional cardiologist or cardiac surgeon from the heart team must perform the mitral valve TEER and an interventional echocardiographer from the heart team must perform transesophageal echocardiography during the procedure. The interventional echocardiographer may not also furnish anesthesiology during the same procedure. The interventional cardiologist and cardiac surgeon may jointly participate in the intra-operative technical aspects of TEER as appropriate. All physicians who participate in the procedure must have device-specific training as required by the manufacturer.**

Cardiac Procedures

Endovascular Cardiac Valve Replacement (TAVR)

- NCD 20.32, Transcatheter Aortic Valve Replacement (TAVR)
  - **The interventional cardiologist and cardiothoracic surgeon must jointly participate in the intra-operative technical aspects of TAVR**

Implantable Cardioverter Defibrillator (ICD)

- NCD 20.4, Implantable Automatic Defibrillators
  - **A formal shared decision-making encounter must occur between the patient and a physician or qualified non-physician practitioner (meaning a physician assistant, nurse practitioner or clinical nurse specialist) using an evidence-based decision tool on ICDs prior to initial ICD implantation**

CERT Errors Part B — Insufficient Documentation

- No clinical note provided: no physician note, or note is vague or not relevant, or no clinical documentation provided
- No physician orders provided or evidence of intent to order
- No documentation to support that services ordered were performed or that units of service billed were rendered
- Chart only notes diagnosis code, no other notations made

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Services under Medical Review for Parts A&B

Provider-Specific Medical Reviews Part A

Line of Business	Code Type	Specific Code	Edit Topic	Edit Description
Part A JM	CPT®	97140	Manual Therapy	Review of outpatient claims for CPT® 97140 — Manual Therapy
Part A JM	HCPCS	J9271	Drugs/Biologics	Review of outpatient claims for HCPCS J9271 — Pembrolizumab (Keytruda®)
Part A JM	HCPCS	G0277	Hyperbaric Oxygen Therapy (HBO)	Review of inpatient claims for Hyperbaric Oxygen Therapy (HBO)
Part A JM	HCPCS	J2505, J2506	Drugs/Biologics excludes biosimilar, 0.5mg	Review of outpatient claims for HCPCS J2505; this code was retired as of 1/1/22. HCPCS J2506 is effective 1/1/22 for providers to bill

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Provider-Specific Medical Reviews Part A

Line of Business	Code Type	Specific Code	Edit Topic	Edit Description
Part A JM	HCPCS	J9035	Drugs/Biologics	Review of outpatient claims for HCPCS J9035 — Bevacizumab (Avastin®), 10mg
Part A JM	HCPCS	J1745	Drugs/Biologics	Review of outpatient claims for HCPCS J1745 — Infliximab (Remicade®)
Part A JM	CPT®	97110	Therapeutic Exercise	Review of outpatient claims for CPT® 97110 — Therapeutic Exercise
Part A JM	HCPCS	J9311, J9312	Drugs/Biologics	Review of outpatient claims for HCPCS J9311 & J9312 — Rituximab (Rituxan®) 10 mg and Hyaluronidase/Rituximab, 10 mg
Part A JM	HCPCS	J0897	Drugs/Biologics	Review of outpatient claims for HCPCS J0897 — Denosumab (Prolia®)

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Provider-Specific Medical Reviews Part A

Line of Business	Code Type	Specific Code	Edit Topic	Edit Description
Part A JM	DRG	885	Psychoses	Review of Inpatient Claims for DRG 885 – Psychoses
Part A JM	IRF	0604	Inpatient Rehabilitation Services	Review of Inpatient Rehabilitation Services (IRF): 0604 — Neurological M<25.85
Part A JM	CPT®	97112	Neuromuscular Reeducation	Review of outpatient claims for Rehabilitation Services: CPT® 97112 — Neuromuscular Reeducation
Part A JM	IRF	0106	Inpatient Rehabilitation Services	Review of Inpatient Rehabilitation Services (IRF): Stroke M<41.50 & A<84.50

Provider-Specific Medical Reviews Part A

Line of Business	Code Type	Specific Code	Edit Topic	Edit Description
Part A JM	IRF	2004	Inpatient Rehabilitation Services	Review of Inpatient Rehabilitation Services (IRF): misc. codes
Part A JM	CPT®	77301	Intensity Modulated Radiotherapy (IMRT) Planning	Review of outpatient claims for diagnostic imaging: CPT® Codes 77301 — Intensity Modulated Radiotherapy (IMRT) Planning
Part A JM	CPT®	77338	MLC Device(s) for IMRT	Review of outpatient claims for diagnostic imaging: CPT® Code 77338 — MLC Device(s) for IMRT
Part A JM	DRG	470	Major Joint Replacement	Joint Replacement, Review of claims submitted for DRG 470 — Major Joint Replacement
Part A JM	CPT®	97110, 97112, 97140	Therapy Cap Review with KX HCPCS Modifier	Review of Outpatient claims for Therapy Services billed with a KX HCPCS Modifier

Provider-Specific Medical Reviews Part B

CPT®	66984	CPT® 66984 — Extracapsular Cataract Removal with Insertion	Review of outpatient claims for CPT® 66984 — Extracapsular Cataract Removal with Insertion
CPT®	97110	CPT® 97110 — Therapeutic Exercise	Review of outpatient claims for CPT® 97110 — Therapeutic Exercise
CPT®	90960–90967	CPT® 90960–90967 — ESRD —Monthly Outpatient ESRD —Related Services	Review of outpatient ESRD claims with CPT® 90960–90967
CPT®	82542	CPT® 82542 — Column Chromatography/Mass Spectrometry	Review of Outpatient claims for Drugs of Abuse Laboratory Tests: CPT® 82542 — Column Chromatography/Mass Spectrometry

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Provider-Specific Medical Reviews Part B

HCPCS	J0897	HCPCS J0897 — Denosumab (Prolia®)	Review of outpatient claims for HCPCS J0897 — Denosumab (Prolia®)
HCPCS	J2778	HCPCS J2778 — Ranibizumab (Lucentis®)	Review of outpatient claims for HCPCS J2778 — Ranibizumab (Lucentis®)
HCPCS	J1745	HCPCS J1745 — Infliximab (Remicade®)	Review of outpatient claims for HCPCS J1745 — Infliximab (Remicade®)
HCPCS	80305–80307, G0480–G0483	HCPCS 80305–80307/G0480–G0483 — Diagnostic Services: Clinical Labs	Review of outpatient claims for Drugs of Abuse Laboratory Tests: HCPCS 80305–80307/G0480–G0483
HCPCS	Q4174	Q4174 — Palingen	Review of Q4174 — Palingen

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Provider-Specific Medical Reviews Part B

HCPCS	Q4177	Q4177 — Floweramnioflo	Review of Q4177 — Floweramnioflo
CPT®	11042–11047	CPT® 1104–11047 — Surgical Debridement	Review of outpatient claims for surgical services: CPT® 11042–11047 — Surgical Debridement
CPT®	93306	CPT®93306 — Echocardiography with Contrast	Review of outpatient claims for CPT® 93306 — Echocardiography with Contrast
HCPCS	J0178	HCPCS J0178 — Aflibercept (Eylea®)	Review of outpatient claims for HCPCS J0178 — Aflibercept (Eylea®)
HCPCS	J9311, J9312	HCPCS J9311 & J9312 — Rituximab (Rituxan®)	Review of outpatient claims for HCPCS J9311 and J9312 — Rituximab (Rituxan®)

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Provider-Specific Medical Reviews Part B

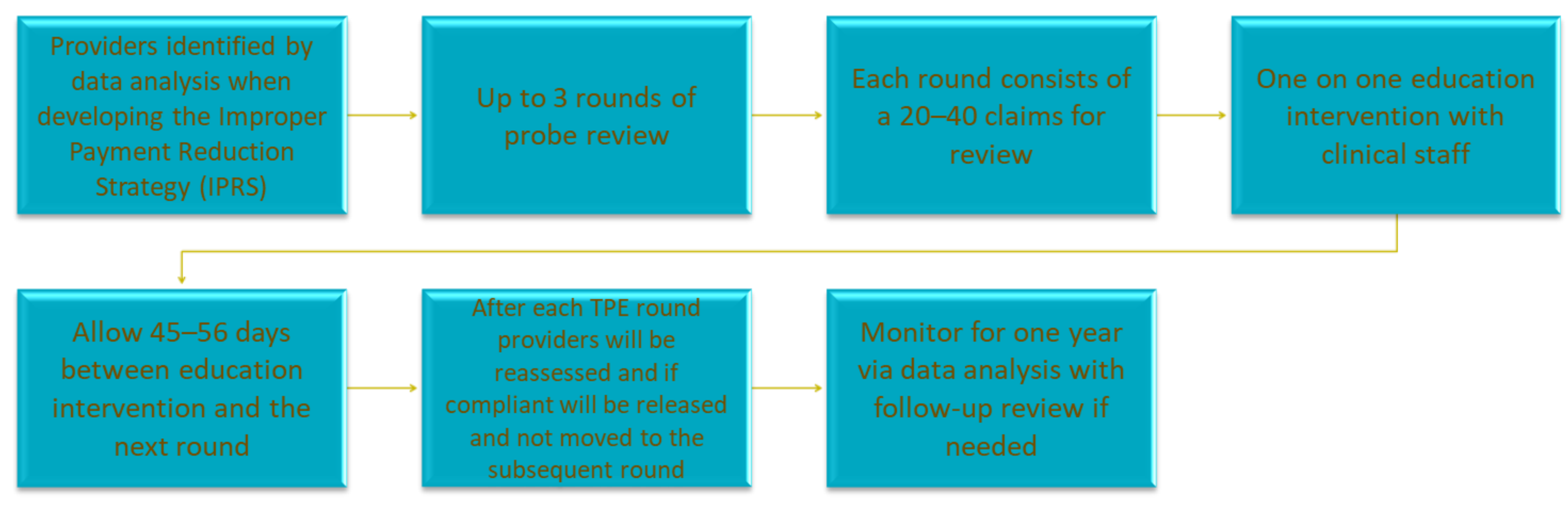
HCPCS	J0717	HCPCS J0717 — Certolizumab (Cimzia®)	Review of outpatient claims for HCPCS J0717 — Certolizumab (Cimzia®)
HCPCS	J0129	HCPCS J0129 — Abatacept (Orencia®)	Review of outpatient claims for HCPCS J0129 — Abatacept (Orencia®)
HCPCS	A0427, A0429, A0425	Ambulance Service, Advanced Life Support , Emergency Transport/Ambulance Service , Basic Life Support, Emergency Transport/Ground Mileage	Review of Ambulance claims for Ambulance Service, Advanced Life Support, Emergency Transport/Ambulance Service, Basic Life Support, Emergency Transport/Ground Mileage

Targeted Probe and Educate Overview
Palmetto GBA Medical Review Program

Designed to reduce/prevent improper payments by preventing payment of claims that do not comply with Medicare's coverage, coding, payment and billing policies.

Beginning September 1, 2021, the MACs resumed Targeted Probe and Educate, (TPE) an intensive education to assess provider compliance through up to three rounds of review.

Targeted Probe and Educate Process



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Reason for Selection

ADR

- You will receive a Notice of Review – Targeted Probe and Education letter
- In addition, you will receive the ADR for claims selected which will outline the information specific to the service and claim selected for review

Your letters will be addressed to the Medicare Provider or Compliance Officer.

NOTIFICATION

As an A/B MAC, Palmetto GBA is tasked with preventing inappropriate Medicare payments. This is accomplished through provider education, training and the medical review of claims. This section in the ADR will include why the claim was selected for review.

How to Respond to an ADR

ADR RESPONSE

The timeframe to submit additional documentation is ***45 days from the date of the request***, located in the upper right-hand corner of the ADR letter.

Submit the ADR cover letter with **EACH** claim separately and the associated attached documentation.

Ensure each packet submitted has

- Records for identified beneficiary on the ADR letter
- The Correct Dates of Service (DOS) specified on the ADR letter
- The Point of Contact form filled out in its entirety which is contained within the ADR

NPI	
PTAN	
Group/Practice Name	
Provider Name	
Contact Name	
Title	
Contact Number	
Hours of Availability	

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Results and Education — Part A

Some examples of missing documentation most frequently requiring contact, may include (but not limited to):

For Drugs:

- Missing history and physical
- Missing documentation of medication administration
- Missing administration code requiring UB correction
- Missing documentation of wastage (for applicable drug review)

For Therapy:

- Not submitting evaluation, POC and certification of POC (note often providers look at the dates of service in review and only submit the treatment notes for those dates and not everything else the ADR requests; for example, the dates in review are 1001–103121 but the eval was 090821 then need to include the eval, POC and certification of POC)
- Illegible signatures with no typed name under signature or signature log or attestation, providers can refer to MLN MM6698 "signature guidelines")
- Not submitting the plan of care which cover all the DOS: sometimes the dates of service in review may span across two POC timeframes, the reviewer needs both POC and both certification of POC to cover all the dates of service in review

Results and Education — Part A

Some examples of missing documentation most frequently requiring contact, may include (but not limited to):

For HBO:

- Missing treatment notes
- Missing documentation to support medical necessity of HBO treatment (example: missing documentation to support radiation therapy for soft tissue radio necrosis or osteoradionecrosis)
- For diabetic wounds: missing Wagner Grade Classification, documentation of prior failed treatment, documentation of measurable signs of healing for at least 30 consecutive days of treatment when using standard wound therapy, missing evaluation of wound at least every 30 days during administration of HBO.
- Incorrect units billed requiring UB correction
- Missing progress reports every 30 days after HBO starts (if appliable for diagnoses)
- Missing X-Ray, MRI, Bone Scan, etc. for chronic refractory osteomyelitis as well as proof that the patient was receiving antibiotic for at least 4 weeks

For Inpatient Psych:

- Missing medical evaluation
- Signature verifications (progress notes not signed or illegible signature)

Results and Education Part B

Surgical Edits

- **Operative note**: Need to submit provider signed documentation of the surgical procedure that was performed/billed. Documentation should reflect the code billed.
- **Medical necessity documentation**: Need to submit any medical necessity documentation to support the reason for the procedure. This should not be only the pre-op eval on the date of the surgical procedure. This documentation should include the evaluation of the patient at the time the decision for surgery was made.
- **Post operative evaluation**: Documentation should also include in follow up the patient received post procedure
- For Cataract 66984, refer to Local Coverage Determination (LCD) L34413

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Results and Education Part B

Emergent Ambulance Transport

- Documentation of the transport must be submitted (run sheet)
- All appropriate signatures are clearly indicated and captured (if electronic)
- All documentation of crew signatures, credentials, and responsibilities during transport should be clearly indicated and captured (if electronic)

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Results and Education Part B

End Stage Renal Disease Monthly Capitation 90960–90966

- All face-to-face encounters are documented. These encounters should support the interaction of the provider with the beneficiary. This can be demonstrated by documentation of a discussion, education, or a portion of a physical exam by the provider with the patient.
- Documentation of the comprehensive note
- Make sure claim is billed on the correct date of service
  - The correct date of service needs to include the date at which services were completed
    - A date range of the first of the month as the start of services and an end date of the end of the month is the most common way to show the completion of monthly capitation

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Results and Education Part B

Injectable Edits

- An order or documentation where the intent to order was clearly expressed
- Documentation of the actual administration of the injectable: route, amount, any waste, and other details of the administration
- Documentation to support the medical necessity
  - This may be the evaluation at which time the injectable was decided upon
  - Any testing to support the medical necessity of the injectable
  - Any documentation to support the continued need of the injectable
- The billing provider documented as the supervising physician on the date of administration

Results and Education Part B

Laboratory Services

- Things to include for documentation submission:
  - Order/intent to order for the testing
  - The evaluation from the ordering provider at which time the testing was decided upon for this beneficiary. (Regardless if the billing provider is a lab facility only.)
  - Documentation that supports the medical necessity for testing
    - Needs to show how this study is going to be integrated in the management of the beneficiary
    - Needs to support why a lower-level testing would not meet the needs in the management of the beneficiary
  - Include the actual results of the testing
  - Refer to Local Coverage Determination (LCDs) for Palmetto GBA: A54799 and L35724

Results and Education Part B

Physical Therapy(97110–97530)

- DOCUMENTATION REQUIREMENTS
  - Initial evaluation
  - Plan of care
  - Certification
  - Treatment note
  - Progress note (if required)
  - Recertification (if required)
  - Re-evaluation (if required)
  - **Referrals are not required

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Results and Education Part B

Echocardiogram 93306

- To support the medical necessity of this testing should be one of the following:
  - Documentation of an ongoing or new diagnosis that is listed in the PalmettoGBA LCD: 37379 Echocardiography and A56625 Billing and Coding: Echocardiography.
  - Documentation of the evaluation at which time the need for testing was determined with the rationale for the testing documented
- Documentation of the actual study
- Documentation of the interpretation by the billing provider. This must be signed by the billing provider.
  - The provider must be a physician with appropriate background to read the study (radiologist or cardiologist)
  - Please note, “General Study” per the LCD is not an appropriate reason for an Echocardiogram. These claims would be denied.

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Auto Denial/No Response Errors Requested Records Not Submitted

To Prevent:

- Monitor your claim status on Direct Data Entry (DDE). If the claim is in status/location SB6001, the claim has been selected for review and records must be submitted. **(Part A and HHH only)**.
- To ensure you are receiving Additional Documentation Requests (ADR), please ensure you update enrollment with any address changes promptly
- For your convenience, all providers enrolled in **eServices** will automatically receive the ADR by eDelivery
  - Palmetto GBA's eServices is an internet-based, provider self-service secure application
  - Palmetto GBA's goal is to give the provider secure and fast access to their Medicare information seamlessly via our website through the eServices application
  - The eServices **User Guide** can be accessed at https://www.palmettogba.com/eServicesUserGuide

Auto Denial/No Response Errors
Requested Records Not Submitted (continued)

- Aim to submit medical records within 30 days of the ADR date. The ADR date is in the upper left corner of the ADR request. The claim will auto deny by the system on day 46.
- Gather all information needed for the claim and submit it all at one time.
- Attach a copy of the ADR request to each individual claim.
- If responding to multiple ADRs, separate each response and attach a copy of the ADR to each individual set of medical records.
  - *Ensure each set of medical records is bound securely so the submitted documentation is not detached or lost.*
- If mailing, please return the medical records to the address on the ADR. Be sure to include the appropriate mail code. This ensures your responses are promptly routed to the Medical Review department.

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How to Avoid Denials

1

Read ADR regarding documentation requirements.

2

Use the ADR as a checklist so that all the required documentation can be submitted.

3

Refer to the LCD if available (for example: inpatient psych, outpatient therapy).

4

Refer to the NCD or LCD, if available (example: HBO, LAAC, outpatient therapy).

Instructions for Document Submission

The ADR will include a list of recommended documentation to submit in response to the ADR.

- Providers are responsible for obtaining supporting documentation from third parties (hospitals, nursing homes, suppliers, etc.)
- Patient identification, date of service and provider of the service should be clearly identified on the submitted documentation

We recommend you include the original ADR with your response.

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Submission Methods

Via eServices portal:

- Visit our website at www.PalmettoGBA.com/eServices for more information

Via Electronic Submission of Medical Documentation (esMD):

- Include a copy of the ADR with your documents
- More information on esMD can be found at www.cms.gov/esMD

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CMS /Palmetto GBA Resources

mln
FACT SHEET
KNOWLEDGE • RESOURCES • TRAINING
PRINT-FRIENDLY VERSION

Medical Record Maintenance & Access Requirements

Introduction

This fact sheet educates Medicare physicians, nonphysician practitioners, hospitals, other providers, and suppliers on the updated regulations at 42 Code of Federal Regulations (CFR) Section 424.516(f). It gives information on updated documentation maintenance and access requirements for billing services to Medicare patients. It also tells you how long to keep the documentation and who is responsible for providing access.

Who does the updated regulation impact?

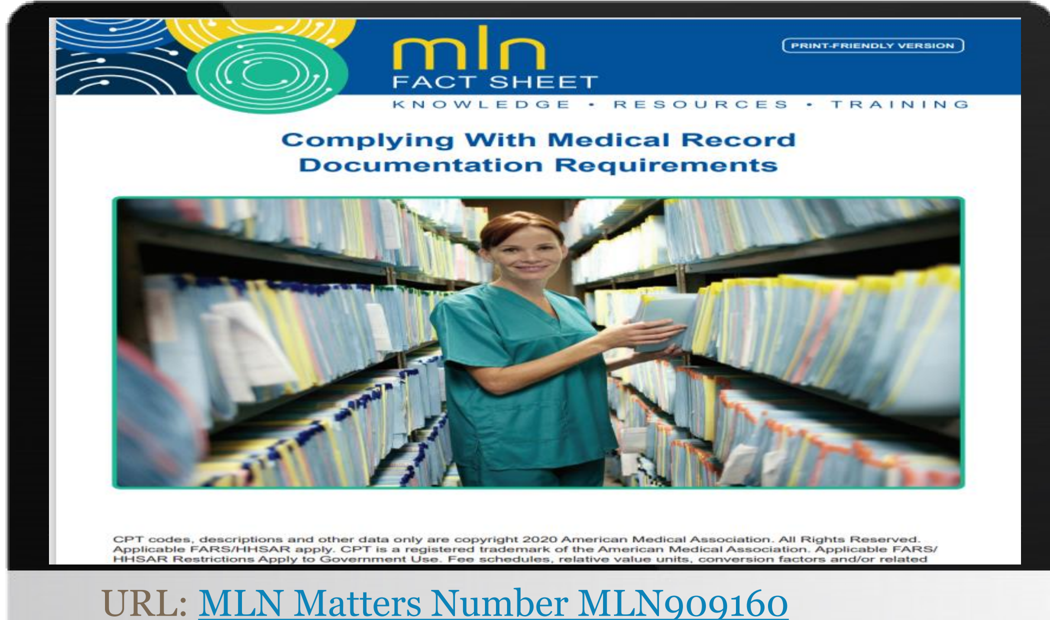
- A Medicare provider or supplier that furnishes covered ordered, certified, referred, or prescribed Part A or B services, items, including laboratory and imaging services, or drugs.

> Example:
> 123 Medical Supply is a Durable Medical Equipment (DME) supplier that furnished walkers and wheelchairs that Dr. John Doe ordered for patients. 123 Medical Supply must maintain and provide access to medical records for DME items Dr. John Doe ordered.

- A physician or, when permitted, an eligible professional who orders, certifies, refers, or prescribes Part A or B services, items, or drugs.

URL: MLN Matters Number MLN4840534

Resources



URL: MLN Matters Number MLN909160

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References and Resources

Medicare Program Integrity Manual

- https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf

MLN Connects: CMS Resumes Targeted Probe and Educate Program

- https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2021-08-12-mlnc#_Toc79579748

Palmetto GBA.com

- Jurisdiction M Part A — Targeted Probe and Educate (palmettogba.com)
- Jurisdiction M Part A — JJ Part A and Part B Targeted Probe and Educate (TPE) Active Medical Review List (palmettogba.com)

Targeted Probe and Education Overview

- https://www.youtube.com/watch?v=IOlXztBmcEM

Resources

- CMS Medicare Fee for Service Improper Payment Data 2022
  - **https://www.cms.gov/files/document/2022-medicare-fee-service-supplemental-improper-payment-data.pdf**
  - CERT C3Hub Provider portal
- End Stage Renal Disease (ESRD) Center
- CMS IOM Medicare National Coverage Determinations (NCD) (Pub. 100-03), Chapter 1, Part 1 Sections 20.4/20.32/20.34
- CMS IOM Medicare Claims Processing Manual (Pub. 100-04), Chapter 32, Section 270/290

Contact Us — JM Part A and B

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Palmetto GBA Part A Medical Review Mail Code: AG-230 P.O. Box 100238 Columbia, SC 29202-3238	Palmetto GBA Part A Medical Review Mail Code: AG-230 2300 Springdale Drive, Bldg. 1 Camden, SC 29020

JMA Fax: (803) 699–2432

JMB Fax: (803) 699–2434

U.S. MAIL	OVERNIGHT MAIL
Palmetto GBA Part B Medical Review Mail Code: AG-230 P.O. Box 100190 Columbia, SC 29202-3190	Palmetto GBA Part B Medical Review Mail Code: AG-230 2300 Springdale Drive, Bldg. 1 Camden, SC 29020

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YOUTUBE

Go to YouTube for educational videos, tips and strategies

LINKEDIN

LinkedIn is your source for the latest Palmetto GBA news

Thank You!

THANKS
FOR ATTENDING!