North Carolina Health and Finance Management Association (NCHFMA)

Medicare Part A/B Updates

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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Disclaimer

The content in this presentation is intended for JJ/JM Part A/B providers and is current as of January 01, 2024. Any changes or new information superseding this information is provided in articles with publication dates after January 01, 2024, at Palmetto GBA.

This Session's Agenda

- CMS Final Rule 2024
- Claims Payment Issues Log (CPIL) Updates
- Medicare Learning Network Tutorial
- Updates and Changes

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Acronyms

ASC	Ambulatory Surgical Center
CAA	The Consolidated Appropriations Act
CMHCs	Community Mental Health Centers
CMS	Centers for Medicare & Medicaid Services
CoPs	Conditions of Participation
FQHCs	Federally Qualified Health Centers
IHS	Indian Health Systems (IHS)
IOP	Intensive Outpatient Program
LTSS	Long-Term Services and Supports Technical Assistance Center
LWBS	Left Without Being Seen
MFT	Marriage and Family Therapists
MHC	Mental Health Counselor
OTP	Opioid Treatment Program
OPPS	Hospital Outpatient Prospective Payment System
PHP	Partial Hospitalization Programs
RHCs	Rural Health Clinics Center

CMS Final Rule 2024

On November 2, 2023, the Centers for Medicare & Medicaid Services (CMS) finalized Medicare payment rates for hospital outpatient and Ambulatory Surgical Center (ASC) services for calendar year (CY) 2024

The Hospital Outpatient Prospective Payment System (OPPS) and ASC Payment System final rule is published annually

In addition to finalizing payment rates, this year's rule includes policies that align with several key goals of the Biden-Harris Administration

CMS Final Rule 2024

UPDATES TO OPPS AND ASC PAYMENT RATES

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CMS Final Rule 2024

CMS is finalizing OPPS payment rates

Hospitals

ASCs

Must meet applicable quality reporting requirements by 3.1%

This update is based on the projected hospital market basket percentage increase of 3.3%

Reduced by a 0.2 percentage point for the productivity adjustment

CMS Final Rule 2024

Scope of Benefits for IOP

CMS is setting forth the scope of benefits for IOP services as mandated by section 4124 of The Consolidated Appropriations Act (CAA), 2023.

An IOP is a distinct and organized outpatient program of psychiatric services provided for individuals who have:

An acute mental illness or substance use disorder, consisting of a specified group of behavioral health services paid on a per diem basis under the OPPS or other applicable payment system when furnished in hospital outpatient departments, CMHCs, FQHCs and RHCs

CMS Final Rule 2024

IOP Payment Rates and Policy in Hospital Outpatient Departments and CMHCs

CMS is establishing two IOP Ambulatory Payment Classifications (APCs) for each provider type; one for days with three services per day and one for days with four or more services per day.

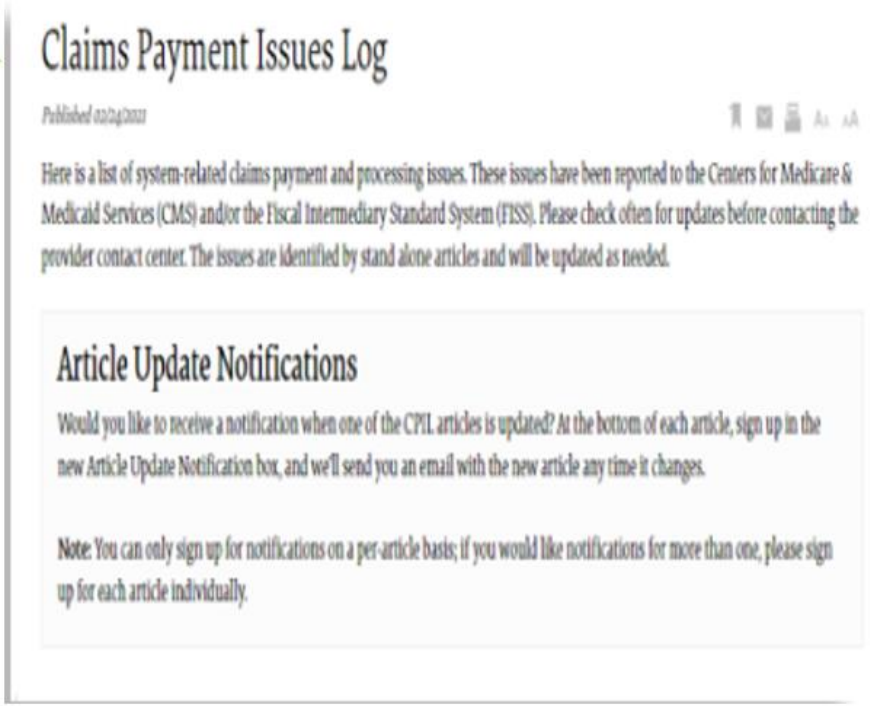
For CY 2024, CMS is finalizing hospital-based and CMHC IOP payment rates for three services per day and four or more services per day based on cost per day using a broad set of OPPS data.

- Data includes PHP days and non-PHP days for the same services they are recognizing for PHP and IOP

Currently no Medicare IOP benefit currently exists.

Medicare Claims Processing Issues Log (CPIL)Part A Updates

Part A Claims Payment Issues Log (CPIL)



Part A Open CPIL

12/5/2023	RESOLVED: End Stage Renal Disease Claim Adjustments Needed Due to Error in Date of First Dialysis *Published: 12/5/2023*
11/21/2023	RESOLVED: ESRD Claims Type of Bill 72X with Reason Code 37187 *Published: 11/21/2023*
10/17/2023	OPEN: Revision to Medically Unlikely Edit for Ranibizumab, via Intravitreal Implant *Published: 10/17/2023*
10/9/2023	RESOLVED: Part A Claims Rejected with Reason Code 7ESA1 *Published: 10/9/2023*
10/3/2023	RESOLVED: OPPS Status Indicator Change for HCPCS Code J9322 *Published: 10/3/2023*
7/14/2023	OPEN: Bypassing the Fiscal Intermediary Share System Consistency Edit to Validate the Attending Physician NPI for Claims Submitted with "AB" Modifier *Published: 7/14/2023*

Part A Claims Payment Issues Log (CPIL)

Open: Bypassing the Fiscal Intermediary Shared System (FISS) Consistency Edit to Validate the Attending Physician NPI for Claims Submitted with "AB" Modifier.

- **Issue:**
  - Centers for Medicare & Medicaid Services (CMS) is aware that since April 1, 2023, when Change Request (CR) 12889 was implemented, audiologists who furnish certain diagnostic tests without a physician order have been Returned to Provider (RTP'd) in error. CMS will update Reason Code 34963 with CR 13219 in the January 2024 quarterly release to prevent this situation
- **Status:**
  - Palmetto GBA shall override/bypass Reason Code 34963 when all lines on the claim contain the appropriate modifier until the shared system edit has been updated
- **Provider Action:**
  - Providers shall submit claims with the appropriate modifier on all lines

Part A Claims Payment Issues Log (CPIL)

Open: Revision to Medically Unlikely Edit for Ranibizumab, via Intravitreal Implant.

- **Issue :**
  - **CMS increased the National Correct Coding Initiative (NCCI) Practitioner Medically Unlikely Edit (MUE) for HCPCS code J2779 to a value of 100, effective with implementation of the October 1, 2023, MUE file. The revision will be retroactive to January 1, 2023**
- **Status:**
  - **CMS instructions require Medicare Administrative Contractors to hold new claims received for HCPCS code J2779 with units of services greater than 20 and less than or equal to 100 for dates of service on or after January 1, 2023, through October 1, 2023**
- **Provider Action:**
  - **No provider action required. Held claims will be released on October 1, 2023, when the October quarterly MUE file is implemented. Adjustments will be performed to address affected claims processed before the claim hold went into effect**

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Medicare Learning Networks (MLN) Medicare Newsletter

mlnconnects

Official CMS news from the Medicare Learning Network®

MLN Connects

- The most current newsletter is featured weekly
- The staff at CMS compiles news into a single source
- The MLN Connects® newsletter features a Provider Compliance section. If you don't already get it, subscribe now.

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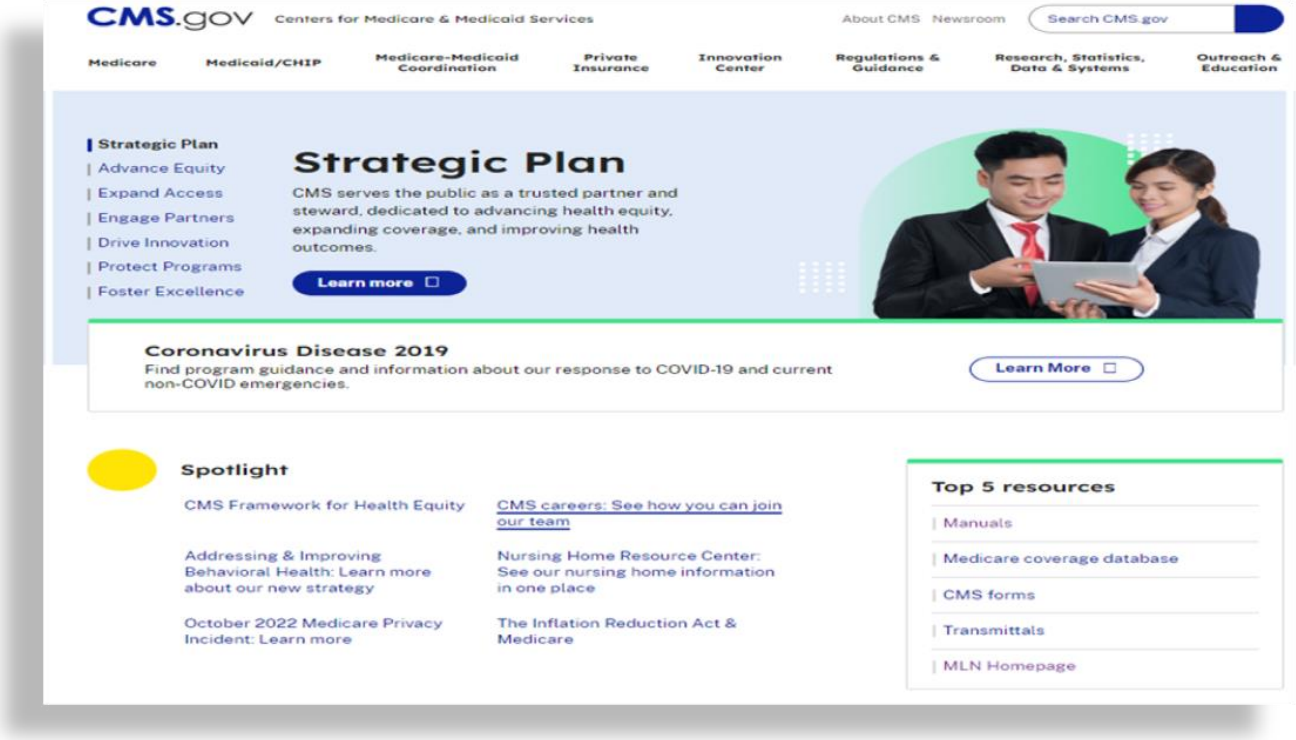
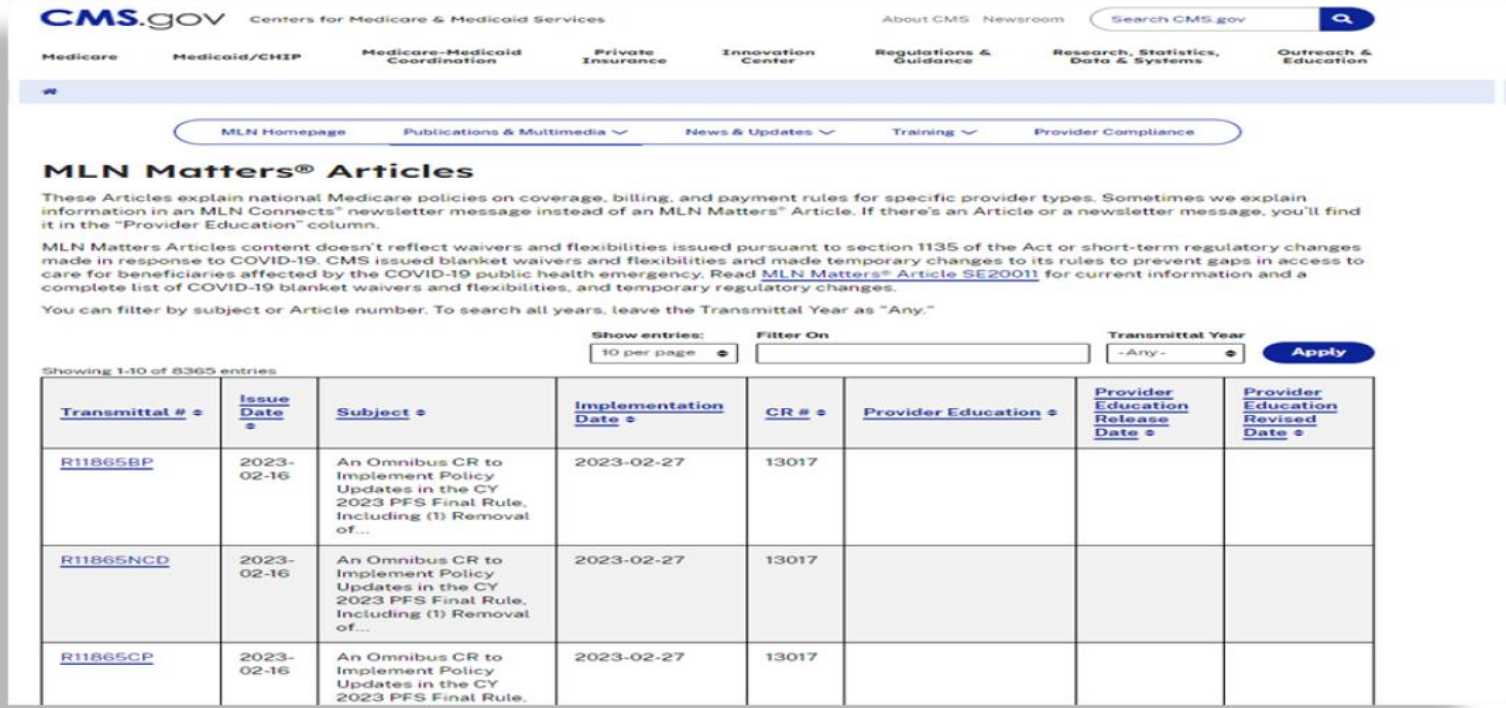


MLN Homepage

MLN Articles



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MLN Matters® Articles

These Articles explain national Medicare policies on coverage, billing, and payment rules for specific provider types. Sometimes we explain information in an MLN Connects® newsletter message instead of an MLN Matters® Article. If there's an Article or a newsletter message, you'll find it in the "Provider Education" column.

MLN Matters Articles content doesn't reflect waivers and flexibilities issued pursuant to section 1135 of the Act or short-term regulatory changes made in response to COVID-19. CMS issued blanket waivers and flexibilities and made temporary changes to its rules to prevent gaps in access to care for beneficiaries affected by the COVID-19 public health emergency. Read MLN Matters® Article SE20011 for current information and a complete list of COVID-19 blanket waivers and flexibilities, and temporary regulatory changes.

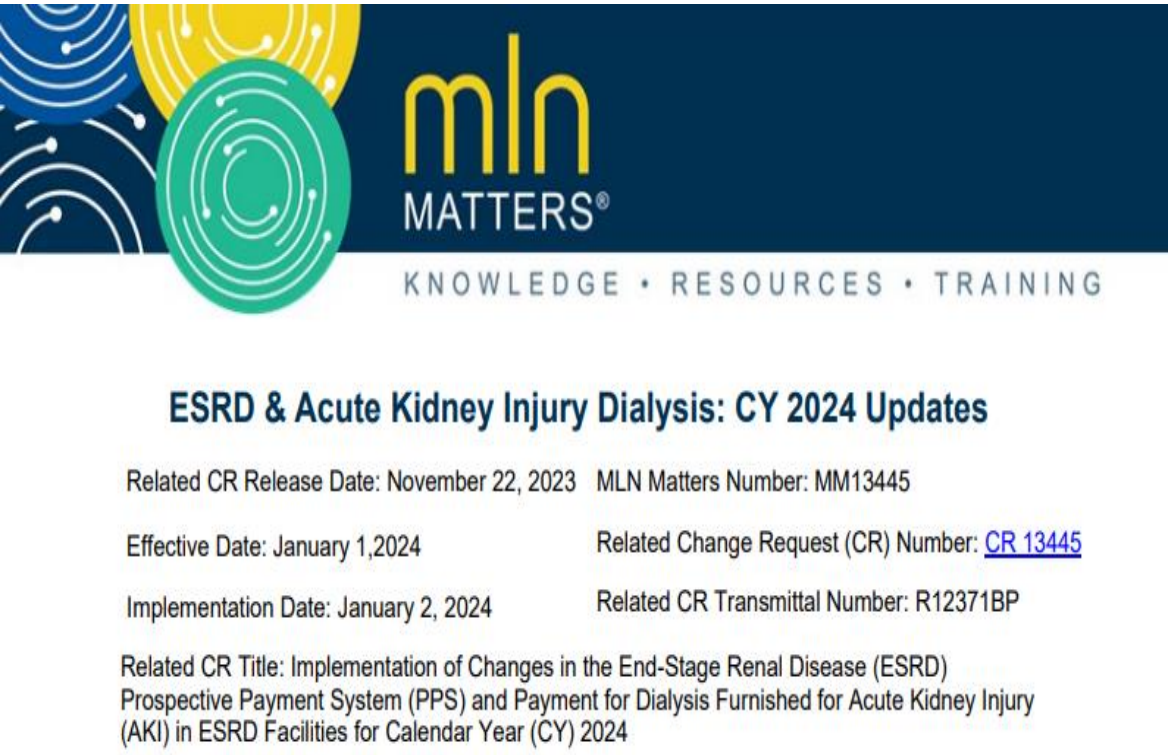
You can filter by subject or Article number. To search all years, leave the Transmittal Year as "Any."

Show entries: 10 per page | Filter On | Transmittal Year: -Any- | Apply

Showing 1-10 of 8365 entries

Transmittal #	Issue Date	Subject	Implementation Date	CR #	Provider Education	Provider Education Release Date	Provider Education Revised Date
R11865BP	2023-02-16	An Omnibus CR to Implement Policy Updates in the CY 2023 PFS Final Rule, Including (1) Removal of...	2023-02-27	13017			
R11865NCD	2023-02-16	An Omnibus CR to Implement Policy Updates in the CY 2023 PFS Final Rule, Including (1) Removal of...	2023-02-27	13017			
R11865CP	2023-02-16	An Omnibus CR to Implement Policy Updates in the CY 2023 PFS Final Rule,	2023-02-27	13017			

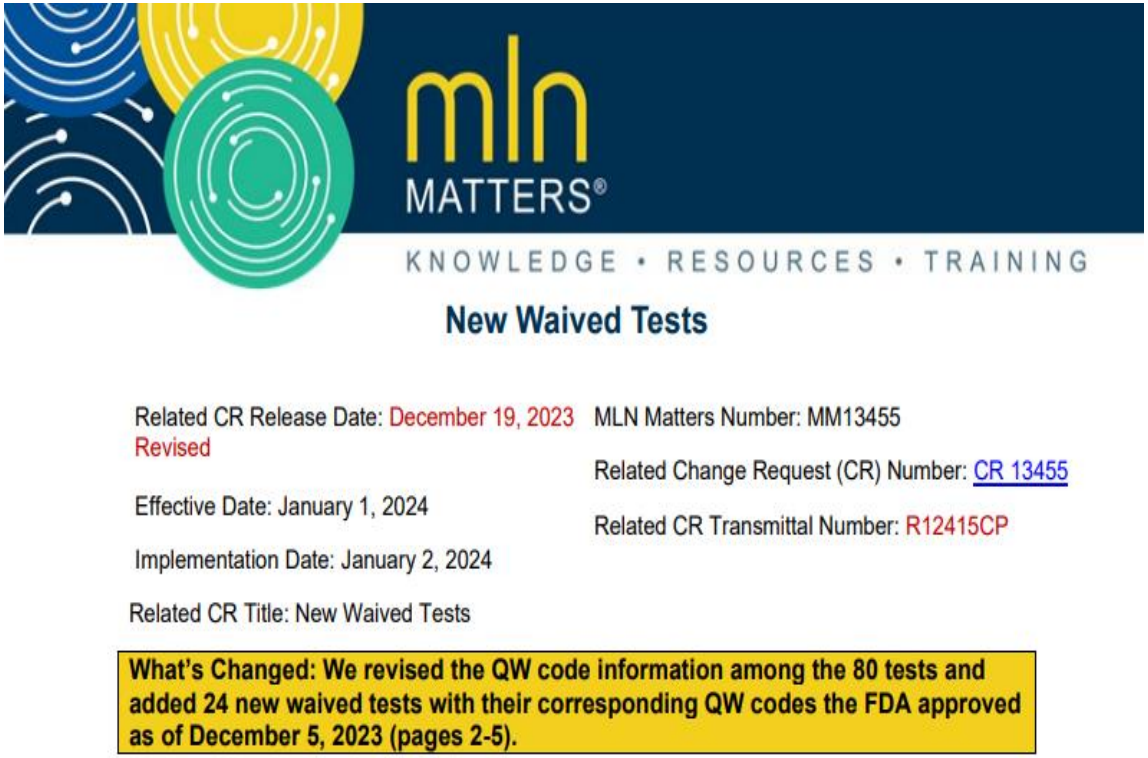
MLN Updates



Action Needed

- CY 2024 rate updates and policies for the ESRD Prospective Payment System (PPS)
- Updates to payment for renal dialysis services provided to patients with AKI in ESRD facilities

MLN Updates



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New Waived Tests

Related CR Release Date: December 19, 2023 Revised

Effective Date: January 1, 2024

Implementation Date: January 2, 2024

Related CR Title: New Waived Tests

MLN Matters Number: MM13455

Related Change Request (CR) Number: CR 13455

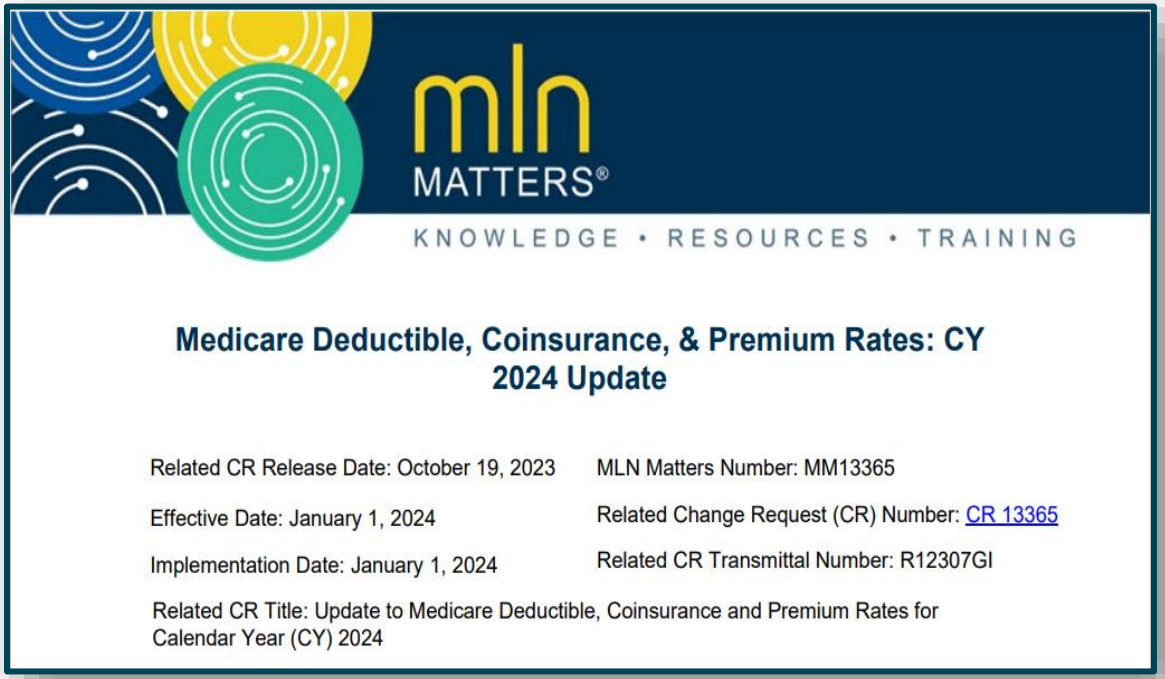
Related CR Transmittal Number: R12415CP

What's Changed: We revised the QW code information among the 80 tests and added 24 new waived tests with their corresponding QW codes the FDA approved as of December 5, 2023 (pages 2-5).

Action Needed

- Clinical Laboratory Improvement Amendments (CLIA) requirements
- New CLIA-waived tests approved by the FDA
- Use of modifier QW for CLIA-waived tests

MLN Updates



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Medicare Deductible, Coinsurance, & Premium Rates: CY 2024 Update

Related CR Release Date: October 19, 2023

MLN Matters Number: MM13365

Effective Date: January 1, 2024

Related Change Request (CR) Number: CR 13365

Implementation Date: January 1, 2024

Related CR Transmittal Number: R12307GI

Related CR Title: Update to Medicare Deductible, Coinsurance and Premium Rates for Calendar Year (CY) 2024

Part A Deductible and Coinsurance

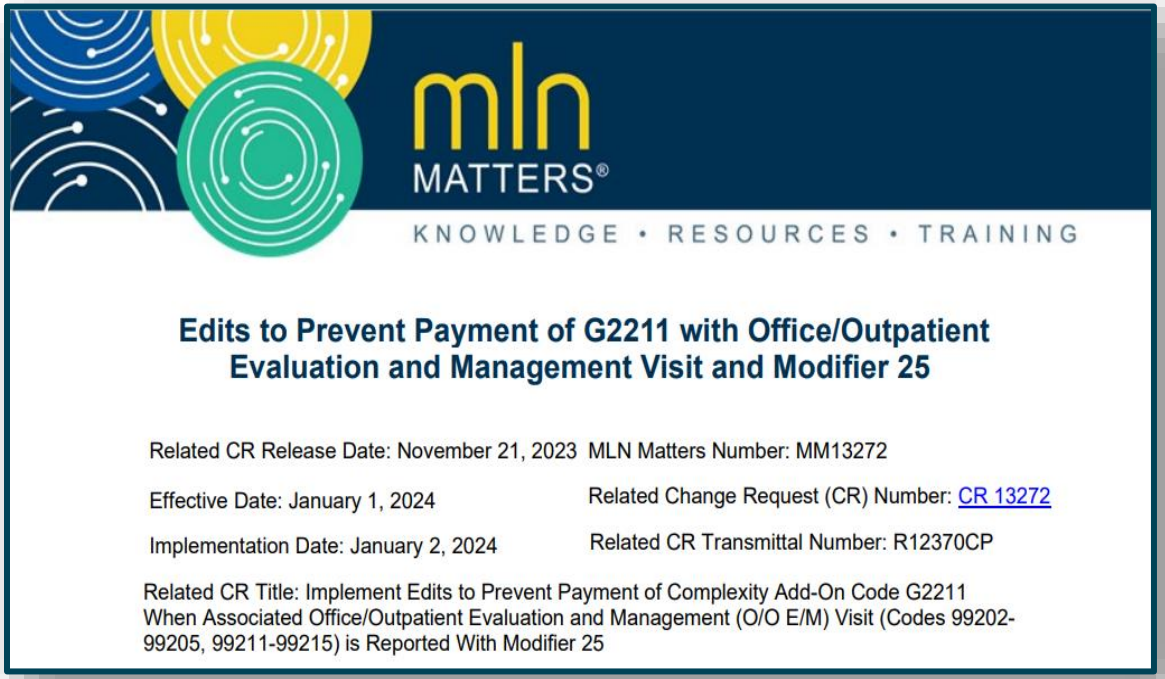
Deductible

- $1,632.00

Coinsurance:

- $408.00 a day for 61st – 90th day
- $816.00 a day for 91st – 150th day (lifetime reserve days)
- $204.00 a day for 21st – 100th day (Skilled Nursing Facility [SNF] coinsurance)

MLN Updates



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Edits to Prevent Payment of G2211 with Office/Outpatient Evaluation and Management Visit and Modifier 25

Related CR Release Date: November 21, 2023 MLN Matters Number: MM13272

Effective Date: January 1, 2024 Related Change Request (CR) Number: CR 13272

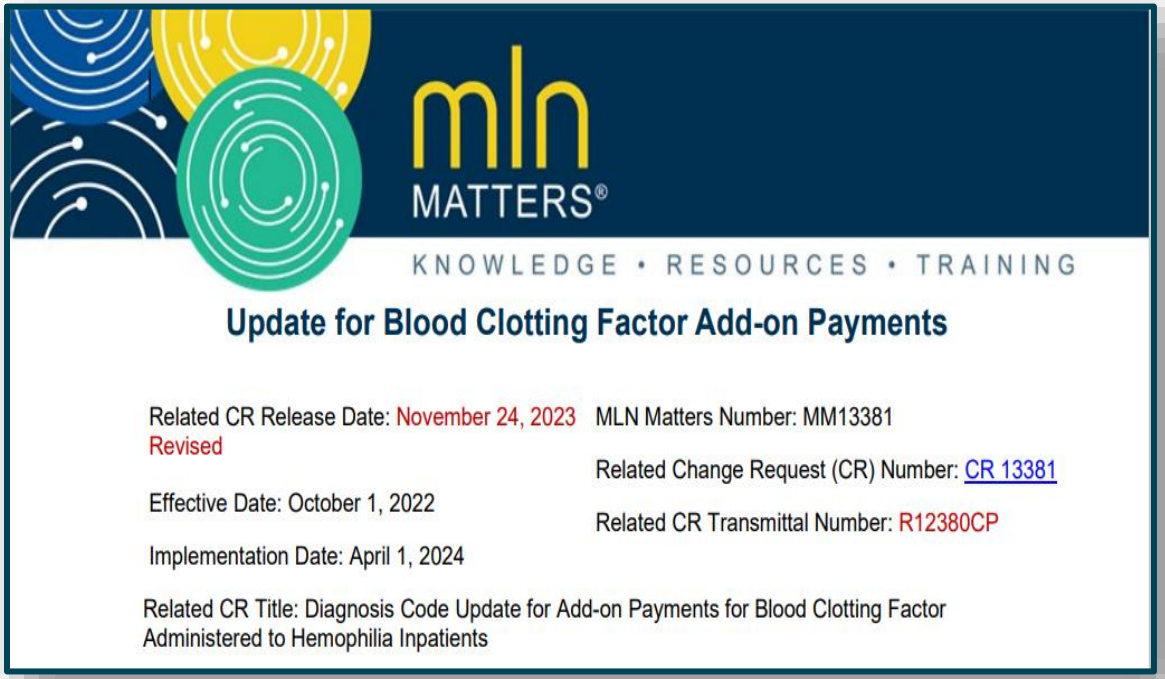
Implementation Date: January 2, 2024 Related CR Transmittal Number: R12370CP

Related CR Title: Implement Edits to Prevent Payment of Complexity Add-On Code G2211 When Associated Office/Outpatient Evaluation and Management (O/O E/M) Visit (Codes 99202-99205, 99211-99215) is Reported With Modifier 25

Key Takeaways for G2211

- Medicare pays separately starting January 1, 2024
- No payment when you report an associated O/O E/M visit with modifier 25
- Payment will not be made to Method II Critical Access Hospitals on the same encounter for type of bill 85X

MLN Updates



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Update for Blood Clotting Factor Add-on Payments

Related CR Release Date: November 24, 2023 Revised

Effective Date: October 1, 2022

Implementation Date: April 1, 2024

MLN Matters Number: MM13381

Related Change Request (CR) Number: CR 13381

Related CR Transmittal Number: R12380CP

Related CR Title: Diagnosis Code Update for Add-on Payments for Blood Clotting Factor Administered to Hemophilia Inpatients

Key Takeaways for Blood Clotting Factor Add–on Payments

- Additional diagnosis codes have become eligible for payment for blood clotting factors
- Adjustments will be made to certain claims with the added codes

MLN Updates

ICD-10-CM Codes Eligible for Add-On Payment for Blood Clotting Factors Administered to Hemophilia Inpatients

ICD-10-CM Code	Description
D68.00	Von Willebrand disease, unspecified
D68.01	Von Willebrand disease, type 1
D68.020	Von Willebrand disease, type 2A
D68.021	Von Willebrand disease, type 2B
D68.022	Von Willebrand disease, type 2M
D68.023	Von Willebrand disease, type 2N
D68.029	Von Willebrand disease, type 2, unspecified
D68.03	Von Willebrand disease, type 3
D68.04	Acquired von Willebrand disease
D68.09	Other von Willebrand disease

MLN Updates

Adjustments will be made if the claim contained one of the following HCPCS codes: J7170, J7175, **J7177, J7178**, J7179, J7180, J7181, J7182, J7183, J7185, J7186, J7187, J7188, J7189, J7190, J7192, J7193, J7194, J7195, J7198, J7200, J7201, J7202, J7203, J7204, J7205, J7207, J7208, J7209, J7210, J7211, J7212, J7213 or **J7214**.

- **PalmettoGBA will complete these adjustments by June 1, 2024.**

Updates and Changes

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DDE Users May Need to Adjust Screen Size

Effective Oct. 1, 2023, CMS recently issued Change Request 13138 “Implementation to Expand Monetary Amount Fields Related to Billing and Payment to Accommodate 10 Digits in Length ($99,999,999.99) - Phase 1.”

As a result of this expansion, National Government Services is instructing all DDE users to ensure that your DDE screen size is adjusted to 43x80 so you can continue to review and enter claims effectively.

https://www.cms.gov/files/document/r12155otn.pdf

Resubmit Telehealth Claims with Modifier CS

The following Rural Health Clinic (71X) and Federally Qualified Health Clinic (77X) telehealth claims were incorrectly returned to provider with edit W7123.

Preventive services that have cost sharing waived.

HCPCS code G2025 billed with modifier CS.

Drugs & Biologicals in **Single-Use Containers**: Using JW and JZ

- If you:
  - **Discard any of the drug, continue to: Report JW modifier on the claim**
  - **Didn't discard any of the drug: Report the JZ modifier on the claim starting no later than July 1, 2023**
- Document discarded amount in the patient's medical record
- JW and JZ modifiers used to calculate discarded drug refunds
- CMS FAQs: https://www.cms.gov/medicare/medicare-fee-for-service-payment/hospitaloutpatientpps/downloads/jw-modifier-faqs.pdf

Part B Updates

NC HFMA, January 24, 2024

Provider Outreach and Education

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Agenda

- Medicare Physician Fee Schedule Final Rule Summary: CY 2024
- Medical Review
- Initiatives
- Updates
- Resources

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Medicare Physician Fee Schedule Final Rule: CY 2024

2024 Medicare Physician Fee Schedule Final Rule

- On November 2, 2023, the Centers for Medicare & Medicaid Services (CMS) issued a final rule that announces finalized policy changes for Medicare payments under the Physician Fee Schedule (PFS), and other Medicare Part B issues, effective on or after January 1, 2024
- Calendar Year (CY) 2024 Medicare Physician Fee Schedule Final Rule | CMS
  - MM13452 — Medicare Physician Fee Schedule Final Rule Summary: CY 2024 (cms.gov)

2024 Medicare Physician Fee Schedule Final Rule

- CY 2024 PFS Ratesetting and Conversion Factor
  - By factors specified in law, overall payment rates under the PFS will be reduced by 1.25% in CY 2024 compared to CY 2023. CMS is also finalizing significant increases in payment for primary care and other kinds of direct patient care.
  - 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

Telehealth Services

- Telehealth Origination Site Facility Fee Payment Update
  - **The MEI increase for 2024 is 4.6%. Therefore, for CY 2024, the payment amount for HCPCS code Q3014 (Telehealth originating site facility fee) is 80% of the lesser of the actual charge, or $29.96. The patient is responsible for any unmet deductible amount and Medicare coinsurance.**
- Payment for Outpatient Therapy (including PT, OT, SLP), Diabetes self-management training (DSMT), and Medical Nutrition Therapy (MNT) Services when institutional staff provide the services to patients in their homes through communication technology
- Telehealth Finalized Policies for DSMT Services

Additional Final Rule Provisions

- DSMT Services Provided by Registered Dietitians (RDs) and Nutrition Professionals
- Community Health Integration (CHI) services
- Principal Illness Navigation (PIN) services

Additional Final Rule Provisions

- Social Determinants of Health (SDOH)
- Caregiver Training Services

Preventive Services

- Your MAC will use the prolonged preventive services G0513 and G0514 as an add-on to the covered preventive services list.
- Medicare PFS Preventive Services | CMS
  - **G0513 — Prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service; first 30 minutes (list separately in addition to code for the preventive service)**
  - **G0514 — Each additional 30 minutes (list separately in addition to code g0513 for additional 30 minutes of preventive service)**

E/M Complexity Add-On Code CPT® G2211

- CPT® G2211
  - **Office/Outpatient Evaluation and Management visit complexity add-on HCPCS code**
- Medicare pays separately starting January 1, 2024
- This code doesn’t pay when an associated Office/Outpatient Evaluation and Management (O/O E/M) visit is reported with modifier 25

Split (or Shared) E/M visits

- Split (or shared) E/M visits refer to visits provided in part by physicians and in part by other NPPs in hospitals and other institutional settings
- For Medicare billing purposes, the “substantive portion” means more than half of the total time spent by the physician and or nonphysician practitioner performing the split (or shared) visit, or a substantive part of the medical decision-making

Behavioral Health Services

- CPT® 90839 (Psychotherapy for crisis; first 60 minutes)
- CPT® 90840 (Psychotherapy for crisis; each additional 30 minutes — list separately in addition to code for primary service), and any succeeding codes.

Payment for Outpatient Therapy Services

The KX-modifier threshold amounts for CY 2024 are $2,330 for OT services and $2,330 for PT and SLP services combined.

Dental Services

- Dental and Oral Health Services
  - **Payment for Dental Services Related to Certain Cancer Treatments**
  - **Dentists who are interested in enrolling in Medicare to provide these services**
  - **Medicare Dental Coverage | CMS**

Medicare and Medicaid Provider and Supplier Enrollment

- All physicians, practitioners and suppliers — regardless of their Medicare participation status — must make their calendar year (CY) 2024 Medicare participation decision by December 31, 2023
- Those who want to maintain their current PAR status or non-PAR status do not need to take any action during the upcoming annual participation enrollment period
- To sign a participation agreement is to agree to accept assignment for all covered services that are provided to Medicare patients in CY 2024

Provider Enrollment Application Fee 2024

- MLN9658742 — Medicare Provider Enrollment (cms.gov)
- The application fee is $709, effective January 1, 2024
- Whether providers apply for Medicare enrollment online or use the paper application, pay the Medicare application fee online through:
  - **PECOS: During the application process, PECOS prompts you to pay the application fee**
  - **CMS Paper Application: Go to PECOS Application Fee Information to submit the application fee**

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Medical Review

Is There a Documentation Threshold?

- Is there a documentation threshold to determine if the provider should move to the next round?
  - Each MAC evaluates the TPE probe claim denial or charge denial rate against an established threshold at the conclusion of each probe round.
  - Providers with error rates that exceed the established threshold may be progressed to the next round
  - Palmetto GBA's threshold is 20 % or less will not be progressed to the next round
  - This includes both the charge denial rate (CDR) and claim denial Rate (CLDR)

Timeframe for Responding

- The Medicare Program Integrity Manual Chapter 3.2.3.2.B specifies a response must be made within **45 days** of the date of the ADR
  - **Every additional documentation request (ADR) letter will identify the timeframe to respond**
- Failure to provide the requested documentation or request an extension within 45 days may result in:
  - **Claim denial; will be adjusted to initiate overpayment recoupment actions for undocumented services**
  - **Extensions granted only in limited situations**

If no response, denies on 45th day!

ADR Process Tips for Providers

- Make sure your *correspondence* address and *medical review* address are up to date in PECOS (Provider Enrollment, Chain, and Ownership System)
- Respond to ADRs timely with all requested documentation
- Include a copy of the ADR letter
- If you utilize a clearing house, ensure that you are receiving complete messages on your 277CA report (not truncated)
- MR ADR Response Forms are available as a self-service tool function via eServices
- Identify a point of contact — name and phone number for follow up during the review if missing documentation is identified

Medicare Services under Review for Jurisdictions J&M

- Ambulance
- Drug Codes
- Cataracts
- Physical Therapy
- Surgical Debridement
- Outpatient End-Stage Renal Disease
- Echocardiography
- Presumptive Blood testing

Top Denial Categories for Medicare Part B

Denial Code	Denial Reason
WRONG	Documentation Received Contains an Incorrect, Incomplete or Illegible Patient Identification or Date of Service
NODOC	Documentation Requested for This Date of Service Was Not Received or Was Incomplete; Therefore, We Are Unable to Make A Reasonable and Necessary Determination as Defined Under Section 1862(A) (1) (A) of The ACT for the Service Billed and This Service Has Been Denied
DNSRP	Documentation Not Signed By the Rendering Provider
BILER	Claim Billed in Error per Provider
NOTMN	Payer Deems the Information Submitted Does Not Support the Medical Necessity of the Services Billed

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Initiatives

CMS Medicare Behavioral Health Initiatives

The CMS Behavioral Health Strategy covers multiple elements

- **Access to prevention and treatment services**
- **Medicare coverage for services beneficial to the mental well-being of Medicare beneficiaries**
- **Covered services supporting these initiatives include**
  - Psychotherapy for Crisis | CMS
  - Behavioral Health Integration Services MLN909432 Booklet (cms.gov) including the Collaborative Care Model
  - Opioid Use Disorder Screening & Treatment | CMS

CMS Medicare Behavioral Health Initiatives Education

- Dear Physicians and Nonphysician Practitioner letter mailed in October
- Webinars
  - **Behavioral Health Initiatives Overview**
  - **Behavioral Health Integration Services**
  - **Psychotherapy for Crisis**
  - **Opioid Use Disorder Screening & Treatment**

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Updates

2024 Part B Premium and Deductible

- The Medicare Part B premium, deductible, and coinsurance rates are determined according to provisions of the Social Security Act.
- The standard monthly premium for Medicare Part B enrollees is $174.70 for 2024.
- The annual deductible for all Medicare Part B beneficiaries is $240 in 2024.

New Provider Types

- CMS will implement marriage and family therapist and mental health counselor provider types on January 1, 2024.
- You must enroll in Medicare to submit claims and get paid for covered items or services.

New Provider Types

- Prepare to enroll
  - **Review the application: electronic version in PECOS or paper CMS-855I**
  - **Gather your supporting documents**
  - **PalmettoGBA.com website**
- More Information
  - **Provider Enrollment and Certification | CMS**
  - **Marriage and Family Therapists and Mental Health Counselors FAQ (cms.gov)**

Medicare Beneficiary Identifier (MBI)

- CMS sent letters to people with Medicare who may have been affected by a recent data breach. They are mailing approximately 47,000 new Medicare cards with a new MBI to those affected. Learn what to do if your patient's MBI changes.
  - **MLN8816413: Checking Medicare Eligibility (cms.gov)**
    https://www.cms.gov/files/document/checking-medicare-eligibility.pdf
  - **Welcome to Palmetto GBA eServices (onlineproviderservices.com)**
    https://www.onlineproviderservices.com/ecx_improvev2/

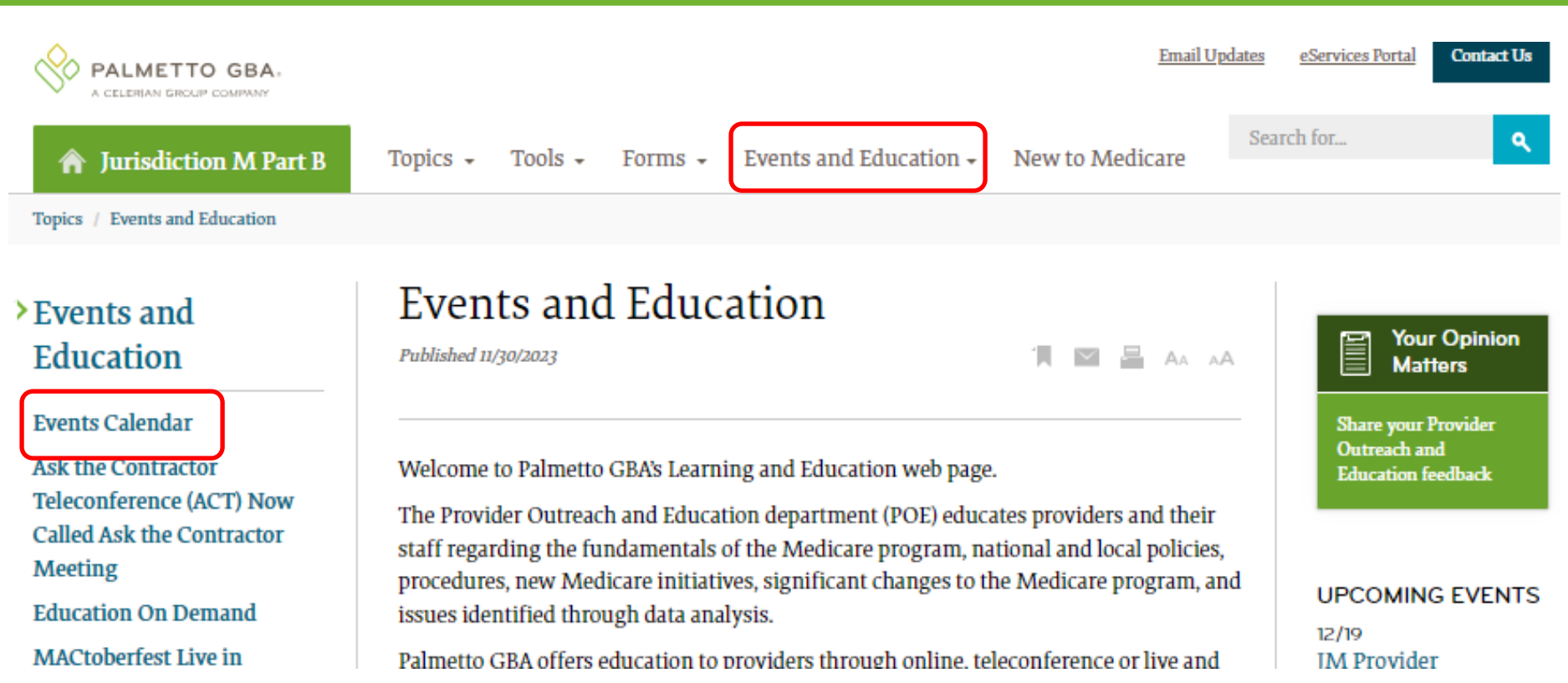
2024 Appeal Amount in Controversy

- Jurisdiction J Part B — Notification of the 2024 Dollar Amount in Controversy Required to Sustain Appeal Rights for an Administrative Law Judge (ALJ) Hearing or Federal District Court Review (palmettogba.com)
- Jurisdiction J Part B — Notification of the 2024 Dollar Amount in Controversy Required to Sustain Appeal Rights for an Administrative Law Judge (ALJ) Hearing or Federal District Court Review (palmettogba.com)

2024 Appeal Amount in Controversy

	CY 2023	CY 2024
Administrative Law Judge (ALJ) Hearing	$180	$180
Judicial Review	$1850	$1840

Education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Topics
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Events and Education
Events Calendar
Ask the Contractor Teleconference (ACT) Now Called Ask the Contractor Meeting
Education On Demand
MACtoberfest Live in
Events and Education
Published 11/30/2023
Welcome to Palmetto GBA's Learning and Education web page.
The Provider Outreach and Education department (POE) educates providers and their staff regarding the fundamentals of the Medicare program, national and local policies, procedures, new Medicare initiatives, significant changes to the Medicare program, and issues identified through data analysis.
Palmetto GBA offers education to providers through online, teleconference or live and
Your Opinion Matters
Share your Provider Outreach and Education feedback
UPCOMING EVENTS
12/19
IM Provider

Educational Opportunities

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LINKEDIN

LinkedIn is your source for the latest Palmetto GBA news

Resources

CMS IOM 100-02 Medicare Benefit Policy Manual	https://tinyurl.com/mwx7hdj
CMS IOM 100-08 Medicare Program Integrity Manual Chapter 3, Section 3.3.2.4 & 7	https://tinyurl.com/bddje7n8
Palmetto GBA Website	https://www.palmettogba.com

Resources

- MM13452 — Medicare Physician Fee Schedule Final Rule Summary: CY 2024 (cms.gov)
- Jurisdiction M Part B (palmettogba.com)
- Home — Centers for Medicare & Medicaid Services | CMS

Customer Experience Survey

FEEDBACK

Your Opinion Matters!

Don’t forget to complete the feedback survey!

http://tinyurl.com/5ckwjbfp

Thank You!

THANKS
FOR ATTENDING!

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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Electronic Data Interchange Updates

A Guide through EDI Enrollment and Services

Kim Campbell
Manager, EDI Operations

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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Disclaimer

The content in this presentation is intended for JJ/JM Part A/B providers and is current as of January 01, 2024. Any changes or new information superseding this information is provided in articles with publication dates after January 01, 2024, at Palmetto GBA.

Agenda for Today

- Acronyms Used by EDI
- EDI Enrollment Options
- How to Enroll
- eServices Registration Requirements
- EDI Tools
- Security Reminders
- When to Contact EDI
- How to Contact EDI

Acronyms Used by EDI

- **EDI** – Electronic Data Interchange – sending and receiving data files electronically: claims, remittances, reports
- **Submitter/Receiver ID** – Unique id used by providers and clearinghouses to submit and receive data files directly from us
- **GPNet** – Palmetto GBA's front end system for sending and receiving data files
- **837** file – claims batched together into one file and submitted
- **277CA Report** – Claim Acknowledgement Report generated through GPNet that provides claim rejections or acceptance
- **835/ERA** – Electronic Remittance Advice: electronic file of remittances
- **DDE ID** – Direct Data Entry ID – unique id assigned to an individual to access the standard processing system to key and correct Part A claims
- **eServices** – Palmetto GBA's provider portal
- **PCC** – Provider Contact Center or Customer Service

EDI Options

- Submit claims electronically directly or through a clearinghouse
- Receive 277CA Reports showing acceptance or rejections
- Receive remittances electronically
- Part A providers may key and correct claims directly into the processing system using DDE IDs
- Part B providers(only) may submit claims through eServices
- Claim Status and Eligibility may be checked using the eServices portal among many other eServices options

Requirements Prior to Enrolling with EDI

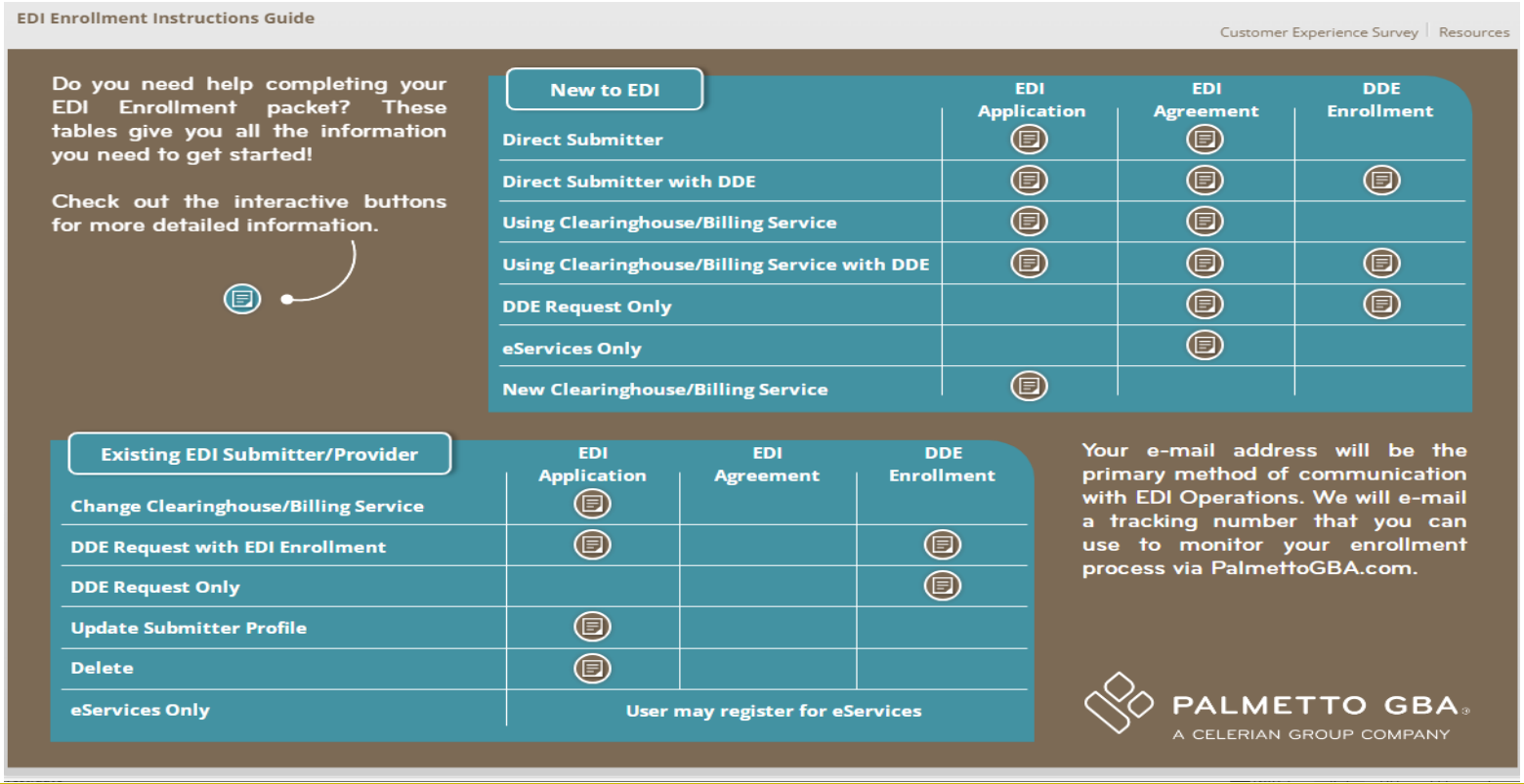
- For JJ and JM Providers:
  - **You must receive your Welcome to Medicare acknowledgement from Provider Enrollment which indicates your PTAN/NPI combination is set up in the standard system for processing**
  - **Please use the address on file with Provider Enrollment when enrolling – either physical or mailing address**
- For RR Providers:
  - **You must be assigned a Railroad PTAN from RR Provider Enrollment which indicates your RR PTAN/NPI combination is set up in the standard system to process railroad claims**
  - **Please use the address on file with your local MAC when enrolling – either physical or mailing address**

NOTE: All updates made with Provider Enrollment require three business days to update EDI Systems

Enrolling in EDI

- Select contract and line of business from Palmettogba.com/medicare homepage
- View the EDI Enrollment Instructions Guide Tool and decide how you want to submit your claims to Palmetto GBA
- On the home page, select New to Medicare at the top of the page and follow the EDI Instructions
- For established providers needing to make updates, please visit the EDI Enrollment section for your specific contract on the Palmettogba.com/medicare website
- For additional assistance with completing forms view the Forms Assistance webinar

EDI Enrollment Instructions Guide Tool



Providers New to Medicare

Steps to Becoming a Successful Medicare Provider

Welcome to Medicare! Our goal is to provide a step-by-step process for you to become a Medicare provider, obtain access to all appropriate systems and be well on your way to becoming a Medicare expert. For general information about the Medicare program view our Medicare Made Easy Module.

Our Jurisdiction M Part A website provides information about the Medicare program, training modules and videos, upcoming educational events and much more. Sign up to receive Palmetto GBA's email updates to keep abreast of any program changes.

If you have any questions or need assistance please contact us

1

Enroll in Medicare

Complete your enrollment application and apply for your Medicare provider numbers.

Enroll Now Check Enrollment Status

2

Enroll in Electronic Claims Submission

Electronic submissions are quick and easy.

Enroll Now

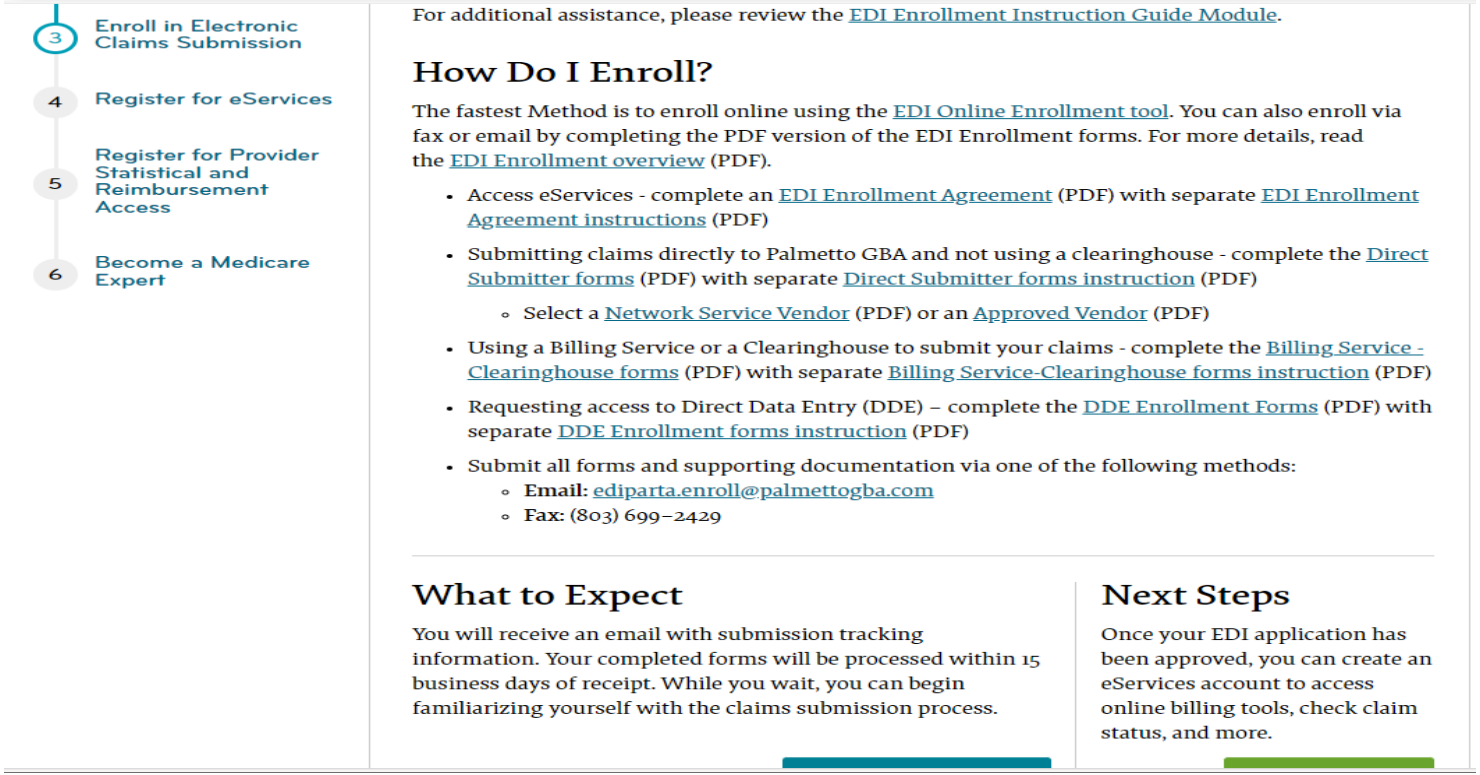
3

Register for eServices

The eServices portal is a secure, internet-based application that allows access to beneficiary and claim information. You may obtain eligibility, claims status, financial information and many other features.

Register Today

Specific Instructions for Enrolling



3 Enroll in Electronic Claims Submission

4 Register for eServices

5 Register for Provider Statistical and Reimbursement Access

6 Become a Medicare Expert

For additional assistance, please review the EDI Enrollment Instruction Guide Module.

How Do I Enroll?

The fastest Method is to enroll online using the EDI Online Enrollment tool. You can also enroll via fax or email by completing the PDF version of the EDI Enrollment forms. For more details, read the EDI Enrollment overview (PDF).

- Access eServices - complete an EDI Enrollment Agreement (PDF) with separate EDI Enrollment Agreement instructions (PDF)
- Submitting claims directly to Palmetto GBA and not using a clearinghouse - complete the Direct Submitter forms (PDF) with separate Direct Submitter forms instruction (PDF)
  - Select a Network Service Vendor (PDF) or an Approved Vendor (PDF)
- Using a Billing Service or a Clearinghouse to submit your claims - complete the Billing Service - Clearinghouse forms (PDF) with separate Billing Service-Clearinghouse forms instruction (PDF)
- Requesting access to Direct Data Entry (DDE) – complete the DDE Enrollment Forms (PDF) with separate DDE Enrollment forms instruction (PDF)
- Submit all forms and supporting documentation via one of the following methods:
  - **Email:** ediparta.enroll@palmettogba.com
  - **Fax:** (803) 699–2429

What to Expect

You will receive an email with submission tracking information. Your completed forms will be processed within 15 business days of receipt. While you wait, you can begin familiarizing yourself with the claims submission process.

Next Steps

Once your EDI application has been approved, you can create an eServices account to access online billing tools, check claim status, and more.

Tips for Completing Forms

- Use the Provider Name and Address on file with Provider Enrollment – either physical or mailing address
- Part B & Railroad – Enroll with Group information only – PTAN, Provider Name & Address; member of group does not need to enroll
- Railroad Providers enroll with your Railroad PTAN on file with Railroad Provider Enrollment and address on file with your local MAC
- Complete all fields on the Enrollment Forms

Tips Continued

- If using a clearinghouse, contact them prior to submitting any forms – use current pdf forms from the Palmetto GBA web site
- If submitting directly or through eServices – complete the Online Enrollment Forms
- If requesting a Direct Data Entry(DDE) ID – include DDE ID if person previously had an ID, new ID will not be assigned if ID already exists

NOTE: DDE IDs are assigned to individuals and should NOT be shared with anyone

Completion of Enrollment Forms

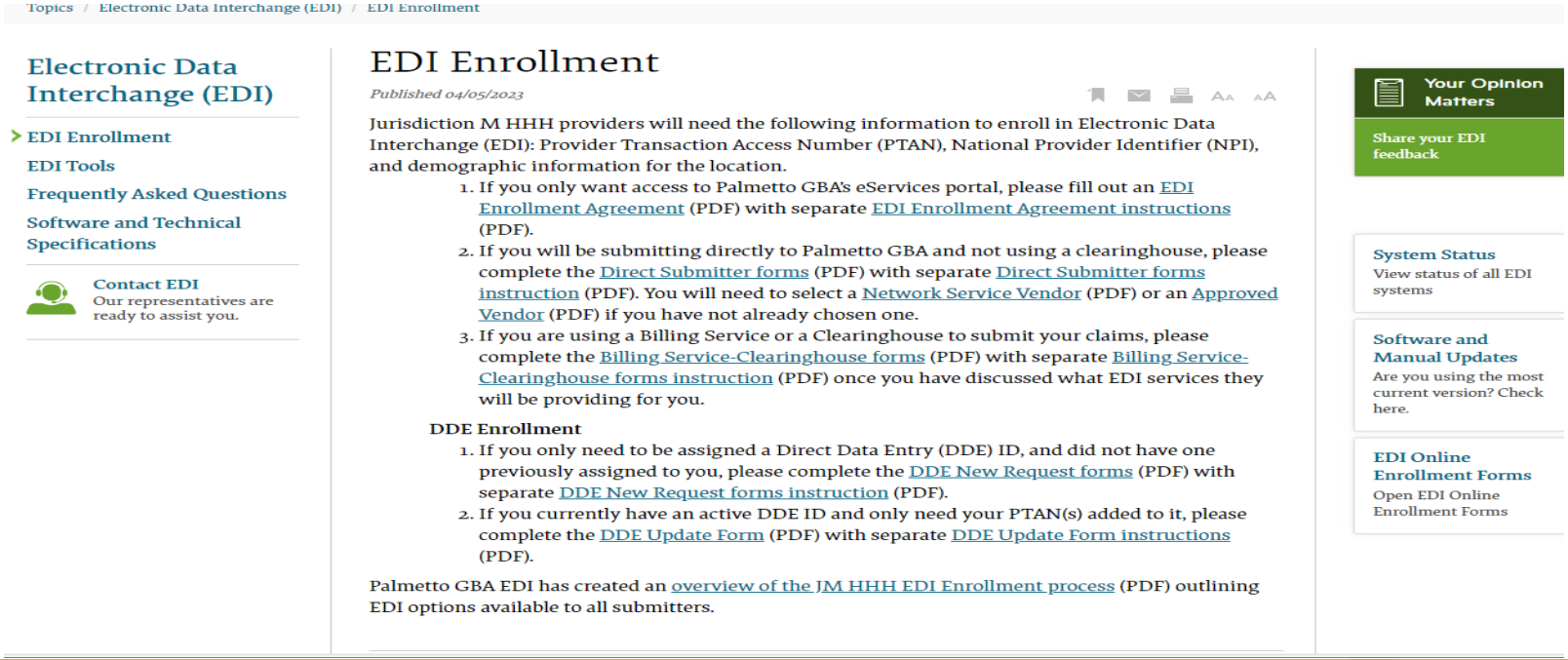
- Email notification will be sent out to email address listed on the forms
- If forms are rejected a description of the rejection will be provided on the notification
- Status of forms may also be checked using the EDI Enrollment Status Tool located under the EDI Tools section for each contract on the Palmetto GBA website

eServices Registration Requirements

- EDI Enrollment Agreement on file
- Access Code will be sent to the email listed on the EDI Enrollment Agreement
- Person who is going to be Administrator needs to be the person setting up the account
- Should have a backup Administrator
- Administrators set up their user ids and profiles

EDI Updates for Existing Providers

- The EDI Enrollment section of each contract has been streamlined to assist with completing the correct forms



Topics / Electronic Data Interchange (EDI) / EDI Enrollment

Electronic Data Interchange (EDI)

- EDI Enrollment
- EDI Tools
- Frequently Asked Questions
- Software and Technical Specifications

Contact EDI
Our representatives are ready to assist you.

EDI Enrollment

Published 04/05/2023

Jurisdiction M HHH providers will need the following information to enroll in Electronic Data Interchange (EDI): Provider Transaction Access Number (PTAN), National Provider Identifier (NPI), and demographic information for the location.

1. If you only want access to Palmetto GBA's eServices portal, please fill out an EDI Enrollment Agreement (PDF) with separate EDI Enrollment Agreement instructions (PDF).
2. If you will be submitting directly to Palmetto GBA and not using a clearinghouse, please complete the Direct Submitter forms (PDF) with separate Direct Submitter forms instruction (PDF). You will need to select a Network Service Vendor (PDF) or an Approved Vendor (PDF) if you have not already chosen one.
3. If you are using a Billing Service or a Clearinghouse to submit your claims, please complete the Billing Service-Clearinghouse forms (PDF) with separate Billing Service-Clearinghouse forms instruction (PDF) once you have discussed what EDI services they will be providing for you.

DDE Enrollment

1. If you only need to be assigned a Direct Data Entry (DDE) ID, and did not have one previously assigned to you, please complete the DDE New Request forms (PDF) with separate DDE New Request forms instruction (PDF).
2. If you currently have an active DDE ID and only need your PTAN(s) added to it, please complete the DDE Update Form (PDF) with separate DDE Update Form instructions (PDF).

Palmetto GBA EDI has created an overview of the JM HHH EDI Enrollment process (PDF) outlining EDI options available to all submitters.

Your Opinion Matters
Share your EDI feedback

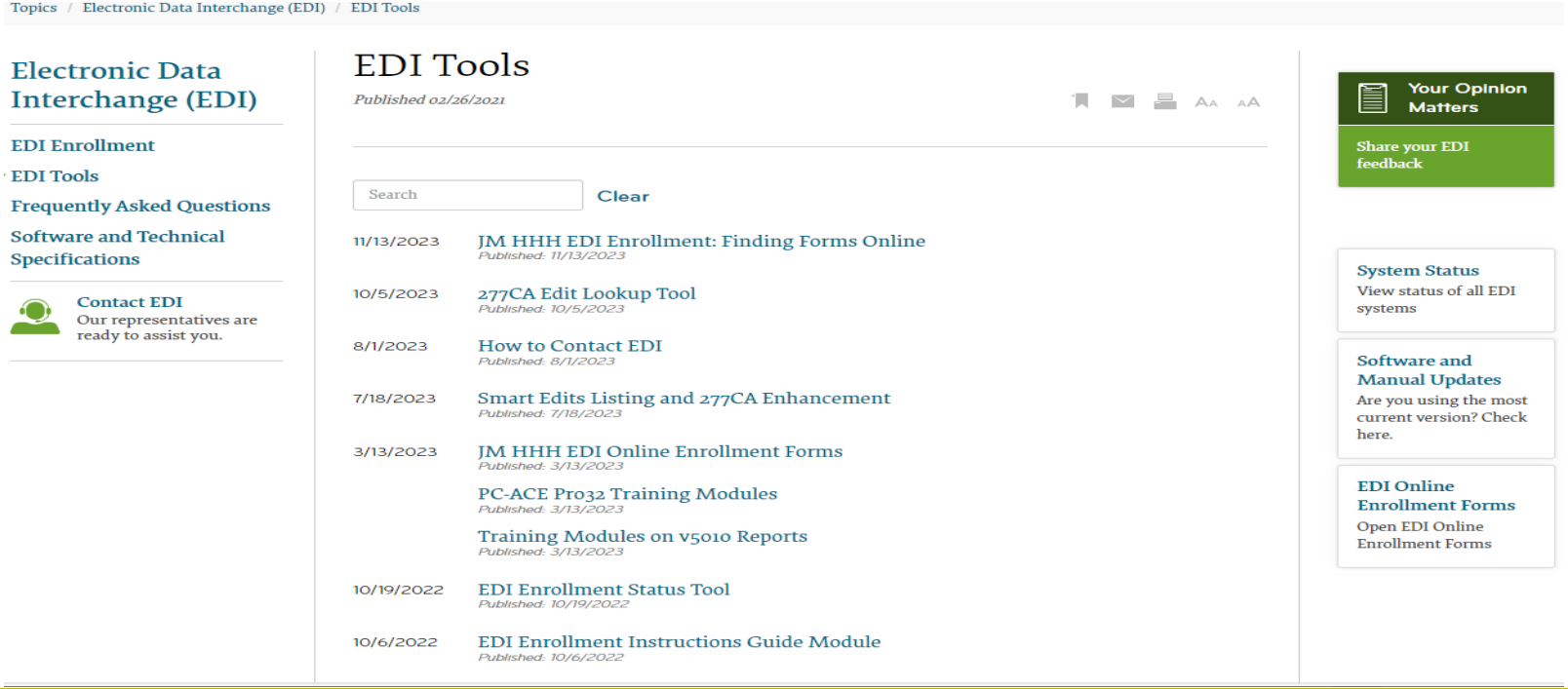
System Status
View status of all EDI systems

Software and Manual Updates
Are you using the most current version? Check here.

EDI Online Enrollment Forms
Open EDI Online Enrollment Forms

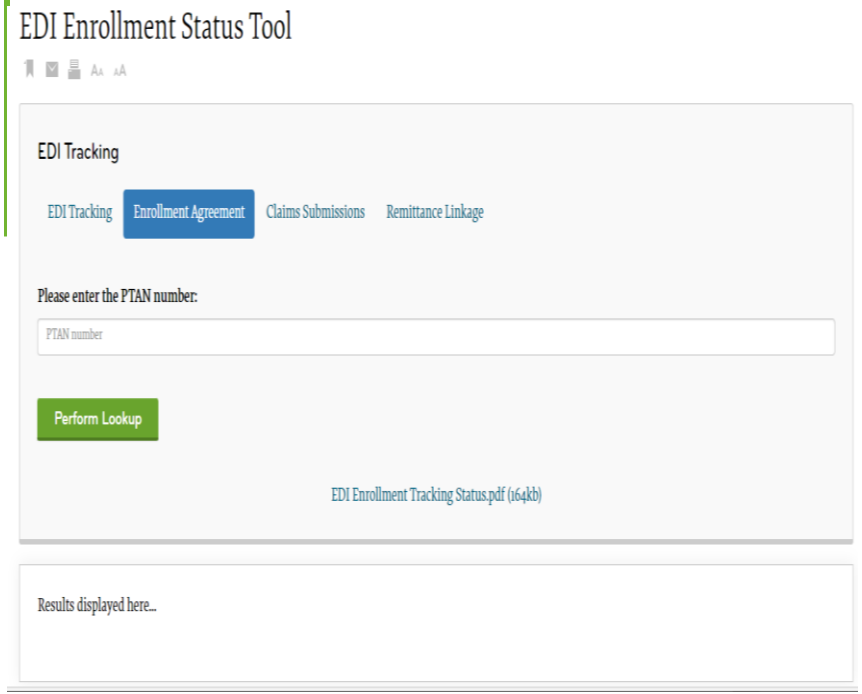
EDI Tools

- Under the EDI Tools section are various tools to assist with all aspects of EDI

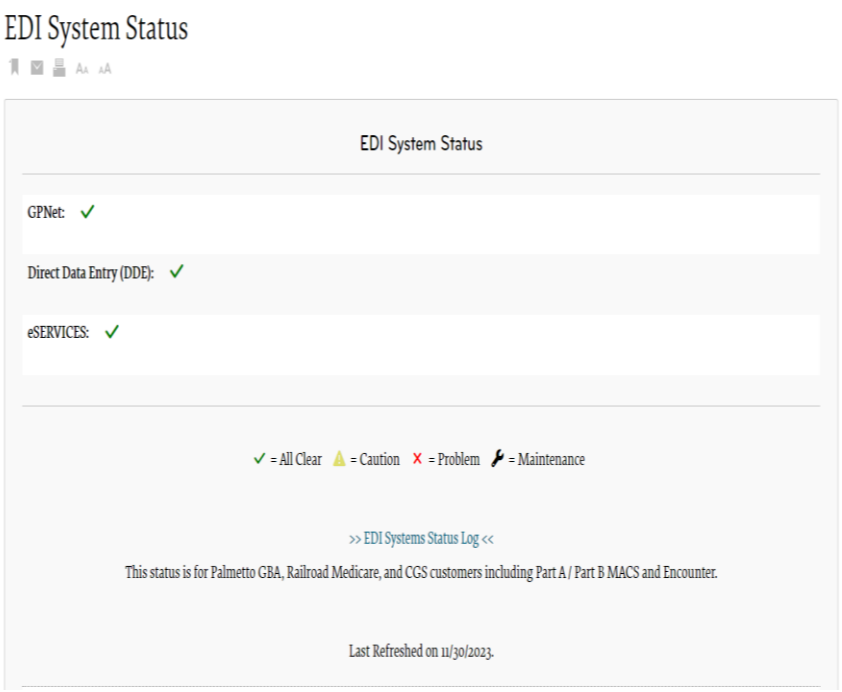


Examples of Tools

EDI ENROLLMENT STATUS TOOL

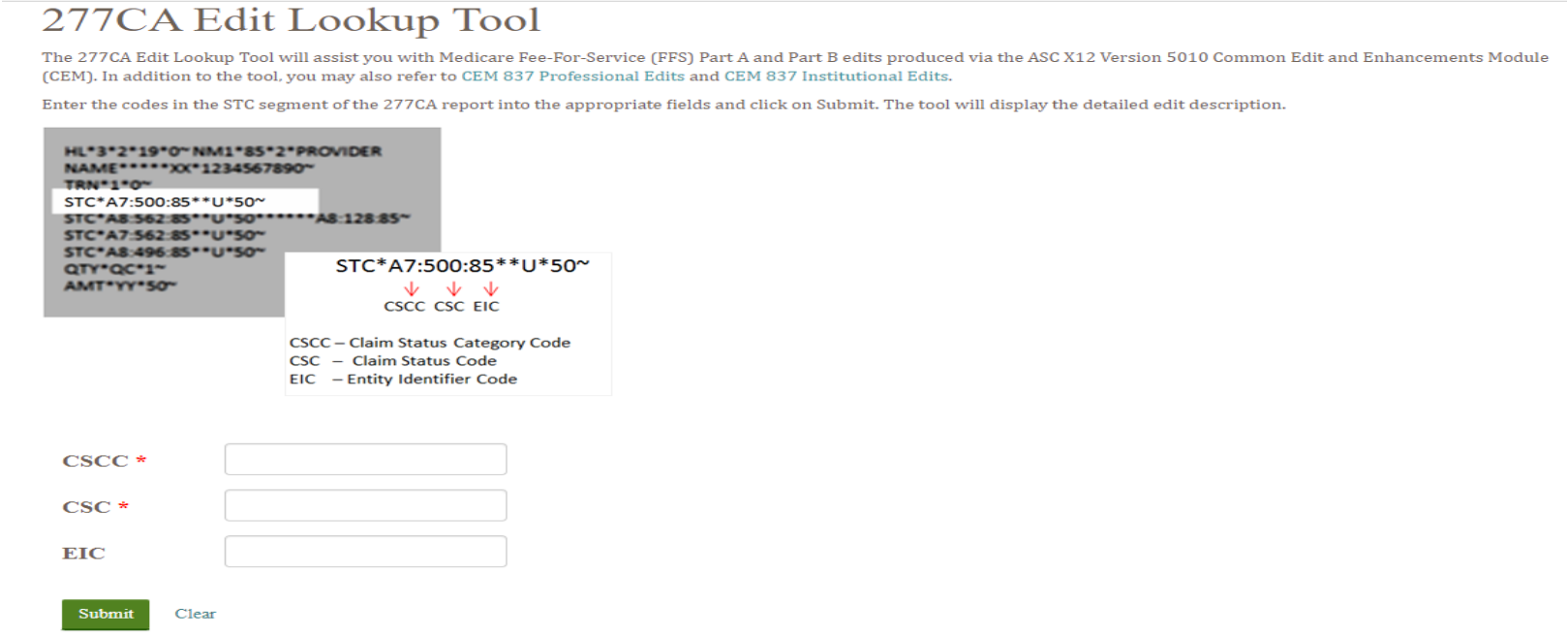


EDI SYSTEM STATUS TOOL



277CA Edit Lookup Tool

- Key in the rejection code from the 277CA Report and a detailed message about the error will display



Security Reminders

- All DDE and eServices IDs are assigned to individuals and cannot be shared with other people
- If an ID is shared it will be deleted
- All IDs are required to be certified and if they are not, they will be deleted
- Individuals must respond to emails from the Palmetto GBA security team to avoid their id being deleted

When to Contact EDI for Assistance

- ✓ Change Clearinghouses
- ✓ Update your DDE ID
- ✓ Update the EDI Contact
- ✓ Check the status of an EDI Application
- ✓ Get assistance with understanding GPNet errors
- ✓ Look up a GPNet error message
- ✓ Look up a Smart Edit error message
- ✓ Get a missing 277CA Report restored
- ✓ Get an 835 remit file restored
- ✓ Know if all systems are available and running on time – GPNet, eServices, DDE

How to Contact EDI

- Call our PCC EDI telephone number and follow the prompts:
  - **JJ877–567–7271**
  - **JM 855–696–0705**
  - **RR 888–355–9165**
- Chat with EDI staff 8 a.m. to 4 p.m. ET M-F — secure and can respond to PHI
- Email at medicare.edi@Palmettogba.com — not secure and cannot send PHI information

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Customer Experience Survey

YOUR FEEDBACK IS IMPORTANT!

Don’t forget to complete the feedback survey!

http://tinyurl.com/tvej6jhx

The Ways of A&R

An Overview of Cost Report Audit and Reimbursement

Arteya Robinson
Audit and Reimbursement Director

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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Disclaimer

- The content in this presentation is intended for JM Part A providers and is current as of January 2, 2024. Any changes or new information superseding this information is provided in articles with publication dates after January 2, 2024, at www.palmettogba.com.

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Audit and Reimbursement Processes

Audit and Reimbursement Process

- Cost reports are accepted or rejected within 30 days of receipt
- Tentative settlements are determined with 90 days of acceptance
- Desk reviews are started and completed according to CMS instructions
- Audits are selected for review each year based on various criteria

Worksheet S-10 Audit Process

Current cycle related to cost reports that begin during FFY 2021

Starts in January or early February with staggered issuance of information request letters

Response requested within two weeks, if needed an extension may be requested by the provider

Failure to respond timely to request can result in sampling of data and errors found that could have been resolve by communicating with the MAC

Worksheet S-10 Audit Process

01

Additional requests or follow-up questions may be required to complete the review

02

Providers receive a minimum of two weeks to review proposed adjustments prior to the exit conference

03

Providers should submit responses or rebuttals regarding proposed adjustments before the exit conference

04

No additional support will be accepted after the exit conference

Desk Review Process

Amended cost reports should be submitted before a desk review is started and must have the applicable wage index and S-10 adjustments in the amended file submitted for acceptance.

When a desk review is started, if documentation is requested the provider only has a maximum of three weeks to provide information.

Once the Pending Settlement Letter (PSL) is sent you will have 2 weeks to respond to the proposed adjustments* with supporting documentation.

Audit Process

- If a cost report is selected for audit, they will be added to our audit plan
  - **4–6 weeks before the start of the audit an engagement letter is sent to the provider**
  - **An entrance conference is held at the start of the audit**
  - **A pre-exit conference is held after completion of the audit work**
  - **The provider has four weeks from pre exit to respond to the adjustments and provide additional information**
  - **If the provider does not submit the documentation within the four-week time frame the adjustments are considered final**

Audit Process

Exit conference is held within 12 weeks from the pre-exit

Cost report is settled within 60 days of exit conference

Adjustments made for lack of documentation are not a basis to request a reopening

Wage Index Review Process

- FY 2025 Wage Index: cost reporting periods beginning on or after October 1, 2020, through September 30, 2021
- Round 1 of wage is September through mid-November 2023
  - **September 1, 2023: deadline for hospital revision request**
  - **November 3, 2023: deadline for Macs to notify state hospital associations regarding hospital that fail to respond to issues raised during the desk review**
  - **November 15, 2023: Deadline for MACs to complete all desk reviews and transmit revised Worksheet S-3 wage data and occupational mix date to DAC**

Wage Index Review Process

- January 31, 2024 — Release of revised FY 2025 wage index and occupational mix files as PUFs on CMS website
- February 16, 2024 — Deadline for hospitals to submit requests (including 100 percent supporting documentation) for:
  - **Corrections to errors in the January PUFs due to CMS or MAC mishandling of the wage index data; or**
  - **Revisions of desk review adjustments to their wage index and occupational mix data as included in the January PUFs (and to provide documentation to support the request)**

Wage Index Review Process

- March 20, 2024 — Deadline for the following:
  - **MACs to transmit final revised wage index data**
  - **MACs to send written notification to hospitals regarding the status of the hospitals February 16, 2024, correction/revision requests**
- April 3, 2024 — Deadline for hospitals to appeal MAC determinations and request CMS' intervention in cases where the hospital disagrees with the MACs determination
- April 29, 2024 — Release of final FY 2025 wage index and occupational mix data on PUFs on CMS web page

Wage Index Review Process

- **Correction of Errors to CMS and MAC**
  - May 29, 2024 — Deadline for hospitals to submit correction requests to both CMS and their MAC to correct errors due to CMS or MAC mishandling of the final wage and occupational mix data as posted in the April 29, 2024, PUF
  - Changes to data will be limited to situations involving errors by CMS or the MAC that the hospital could not have known about before review of the final April PUFs. CMS and the MACs must receive all requests by this date.
  - Hospitals must submit corrections with all supporting documentation for the FY 2025 wage index cycle via the Wage Index Appeals (WIA) module in the Medicare Electronic Application Request Information System (MEARIS) at https://mearis.cms.gov
  - To ensure compatibility with MEARIS, supporting documentation shall preferably be PDF or Word files and spreadsheets shall be in Excel
  - If a hospital is unable to submit an appeal via MEARIS, for FY 2025 the hospital may submit via email to wageindexreview@cms.hhs.gov

Wage Index Review Process

- **Dispute of Data Corrections**
  - May 29, 2024 — Deadline for hospitals to dispute data corrections made by CMS of which the hospital is notified on or after 13 calendar days prior to April 3, 2024 (i.e., March 21, 2024), and at least 14 calendar days prior to May 29, 2024 (i.e., May 15, 2024), that do not arise from a hospital's request for revisions
  - Data corrections made by CMS of which a hospital is notified on or after 13 calendar days prior to May 29, 2024 (i.e., May 16, 2024) may be appealed to the Provider Reimbursement Review Board (PRRB)
  - CMS and the MACs must receive requests with complete documentation by this date via email wageindexreview@cms.hhs.gov. Do not submit a request via MEARIS for this dispute.
- **August 1, 2024 —** Approximate date for publication of the FY 2025 final rule; wage index includes final wage index data corrections
- **October 1, 2024 —** Effective date of FY 2025 wage index

Cost Report Reopening Process

- Reopening Requests should be sent to JMaudit.reopening@palmettogba.com
- Each request should include the provider's name, provider number and FYE — the original NPR date
- Supporting documentation should be sent with the reopening request
- Must be received within three years of the original NPR
- Must be greater than $10,000 unless related to a payment error by the MAC

Cost Report Reopening Process

- The reimbursement impact of the reopening should be included in the request
- The request should be related to new information or a clear and obvious error
- PHI and PII should be encrypted when sent with the reopening request
- Once a cost report is finalized you may not amend the report but can reopen
- Once received and accepted, the provider will receive correspondence within 90 days to indicate if approved, denied, or additional information is needed

Cost Report Reopening Process

- Currently DSH related reopenings are on hold prior to FYE 9/30/2014. We are waiting on guidance from CMS on the release and timeline for processing these reopenings.
- You may reopen a reopened NPR within three years of that RNPR; however, the issue must be the same and additional items are not accepted
  - **For example, if the original NPR was 6/1/2019 and you had a reopening on bad debts settled 6/1/2022 you may only request a reopening based on those specific items originally requested in that bad debt request**
  - **You cannot add additional bad debts not originally requested**
  - **If you find an error with the 6/1/2022 settlement we can reopen to correct the error if within three years**

Filing an Appeal

An appeal must be requested within 180 days from the date of the final determination. 42 CFR § 405.1835 (c). from the date of the final determination. 42 CFR § 405.1835 (c).

- Final determinations include:
  - NPRs (Notice of Program Reimbursement)
  - Revised NPRs
  - Federal Registers
  - The MAC's Failure to Timely Issue an NPR
  - Notice of Hospice Cap Determinations
  - Denial of Quality Reporting Reconsideration (2% reduction)

Final Determination

Revised NPR

- **A revised NPR is a result of a correction to the cost report, which may result from a provider requested reopening, an appeal, CMS instruction, etc.**
- **When determining appeal jurisdiction, 42 CFR § 405.1889(b) states:**

  "Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.

  "Any matter that is not specifically revised (including any matter that was reopened, but not revised) may not be considered in any appeal of the revised determination or decision."

Final Determination

- This means that if a RNPR is issued and the traditional bad debts were adjusted, only the traditional bad debts that were reviewed can be subsequently appealed
- A **new population** of bad debts **cannot** be appealed
  - **For example, provider requests a reopening for $100,000 of traditional bad debts and a RNPR is issued with adjustments to allow only $80,000 of the traditional bad debts**
  - **Only the $100,000 of adjusted bad debts may be appealed as a result of this reopening**
  - **The provider could not include another type of bad debts (for example, crossover bad debts) that were not included in the reopening, as part of an appeal**
- The provider cannot appeal a MAC's refusal to reopen a cost report

Provider Reimbursement Review Board Rules

- Board Rules, Version 3.1 were published on June 16, 2021, and became effective Monday, November 1, 2021
  - **Effective November 1, 2021, all filings must be submitted to the Provider Reimbursement Review Board (PRRB) electronically through the Office of Hearings Case and Document Management System (OH CDMS) unless an exemption granted under PRRB Rule 2.1.2 applies**
    - Submissions through OH CDMS will be accepted as timely filed until 11:59 p.m. Eastern Time on the filing due date
  - **For any system or access questions, please contact the OH CDMS Help Desk at 833–783–8255 or Helpdesk_OHCDMS@cms.hhs.gov**

Filing an Individual Appeal

An individual appeal request must meet the following filing requirements:

- Amount in Controversy of at least $10,000 at the time of filing
- Add a New Issue to an Individual Case
  - **The Board will add issues to an open appeal no later than 60 days after the expiration of the applicable 180-day period for filing the initial appeal (for example, if the provider files an appeal for bad debts on the 150th day, the provider has 90 days to add another issue**
  - **If the provider does not file the initial appeal until the 180th day, the provider only has 60 days to add an additional issue)**

Filing a Group Appeal

A group case must meet the following filing requirements:

- The amount in controversy must be $50,000 or more in aggregate and must be met by the full formation of the group
- The issue being appealed must involve a single issue for at least two providers
- Common Issue Related Party (CIRP) — two providers by full formation
  - **Providers under common ownership or control that appeal a specific matter that is common to the providers for fiscal years ending in the same calendar year must file a CIRP appeal**

Group Appeal

- Optional — two providers, both at inception and full formation
  - **Providers not under common ownership or control may choose to join together to file an optional group appeal for a specific issue that is common to the providers for fiscal years ending in the same calendar year**
  - **Filing in an optional group is not mandatory**
- Provider can be added by transfer or direct add

Group Appeal

- Types of Group Cases:
  - **Mandatory Common Issue Related Party (CIRP) Group**
    - Providers under common ownership or control that appeal a specific matter that is common to the providers for fiscal years ending in the same calendar year must file a CIRP appeal
    - Provider not under common ownership or control may choose to join together to file an optional group appeal for a specific issue that is common to the providers for fiscal years ending in the same calendar year
    - This is not a requirement

Within 60 days of the full formation of the group, the rep must prepare the final schedule of providers, including all supporting jurisdictional documentation.

No Duplicate Filings

A provider may not appeal and pursue the same issue from a single final determination in more than one appeal (individual or group).

Once an issue is dismissed or withdrawn, the provider may not appeal or pursue that issue in any other case covering the same time period.

Transfer of Issue to Groups (Optional or CIRP)

The Board expects transfers of issues from individual appeals to group appeals will be effectuated prior to submission of the preliminary paper.

PRRB Acknowledgement & Critical Due Dates Letter

- The PRRB will acknowledge receipt of an appeal request and assign it a case number. This acknowledgement is sent via email through OHCDMS within 30 days of receipt.
- The PRRB acknowledgement typically establishes the critical due dates for position papers
  - **The exception is for Mandatory (CIRP) group appeals (cases designated as "GC")**
  - **These group appeals will receive an acknowledgment when filed and a separate critical due dates letter when the group is complete**

Provider Case Representative

A party may be represented by legal counsel or by any other person appointed to act as its case representative at any proceedings before the Board.

- A representation letter is required to be submitted with the appeal request
  - **All actions taken by the representative are considered to be those of the provider**
  - **There is only one representative per appeal**
  - **The Board will only accept correspondence from the representative's organization**
    - The representative must:
      - Ensure contact information is current
      - Meet the Board's deadlines
      - Respond timely to Board correspondence or requests

Jurisdictional Review

- Only a provider or group of providers is entitled to appeal to the PRRB.
- A home office is not a provider and cannot file an appeal.
- Allocations to a provider from the home office cost statement can be appealed by a provider only from an adjustment made to the provider's claimed home office costs on the provider's Medicare cost report.
- A provider may not appeal an issue from the same final determination in more than one appeal.
- Once an issue is dismissed or withdrawn, the issue may not be appealed in another case.
- Appeals that fail to meet jurisdictional requirements will be dismissed.

Jurisdictional Review

Some appeal issues include “flow-through effects,” meaning that if you adjust something in one year, it could impact one or more subsequent years (ex: IME and GME FTE counts, IME Resident to Bed Ratio, capitalized interest, NAH Add-On payments, etc.).

In order for the provider to have jurisdiction on those “flow-through” items, the provider must specifically appeal the flow-through on each cost report that it affects.

Non-Appealable Issues

By statute or regulation, some issues are not appealable.

- The following are a few examples:
  - **Rural Floor Budget Neutrality Adjustment (42 CFR § 405.1804)**
  - **DSH Uncompensated Care Payments (SSA § 1886(r)(3))**
  - **Inpatient Rehab Facility Low Income Payment (IRF LIP) (42 U.S.C. 1395ww(j)(3)(A)(v))**

Notice of Hearing

- The Board will issue a Notice of Hearing scheduling the hearing date and the final position paper due dates for both parties
- The hearing dates in this notice governs the deadlines for discovery, subpoenas, witness lists and other deadlines under these rules
- A case will be dismissed if the provider fails to appear at a hearing (unless there is good cause beyond the provider's control)
- The provider may request a consolidated hearing for multiple cases that have identical legal issues
  - **For example, if a provider has multiple fiscal years for the same issue(s) and there are no differences in the issue(s), one case will be designated as the Lead case, and the decision reached will be applied to all cases involved**

MAC Appeals

Regulations applicable to MAC Appeals — 42 CFR §§ 405.1809-405.1834

- MAC appeals are similar to PRRB appeals, except that the amount in controversy is greater than $1,000 and normally less than $10,000
- Cases are heard by a MAC Hearing Officer or panel of officers
  - **The MAC Hearing Officer(s) is an employee of the Appeals Support Contractor (ASC). Currently the ASC is Federal Specialized Services (FSS)**
- The parties to a MAC appeal are the provider and its related parties, not the MAC or CMS. The provider remains the moving party
- The determination of the MAC Hearing Officer shall be final and binding on the parties to the hearing and the MAC, unless the hearing decision is reviewed by CMS

MAC Appeals

- Differences between a MAC appeal and a PRRB appeal:
  - **There are only final position papers, no preliminaries**
  - **The MAC does not have the ASC to assist in writing its paper or jurisdictional reviews**
  - **The MAC does not have the ASC to assist in writing its paper or jurisdictional reviews**
  - **MAC Appeals do not utilize OHCDMS**

Return to Normal Operations for Appeals

Effective Wednesday, December 7, 2022, the Board returned to normal operations, ceasing suspension of deadlines and will hold parties to the deadline specified in:

- **Any Board rule or instruction**
- **Any Board notice or correspondence issued on or after December 7, 2022**

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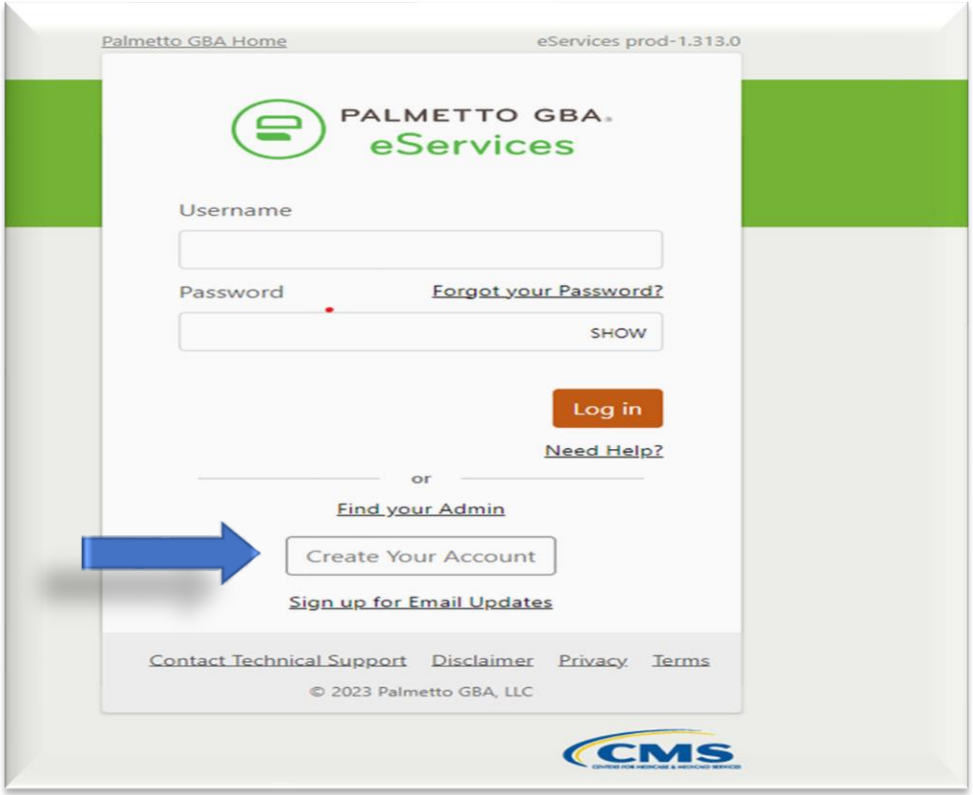

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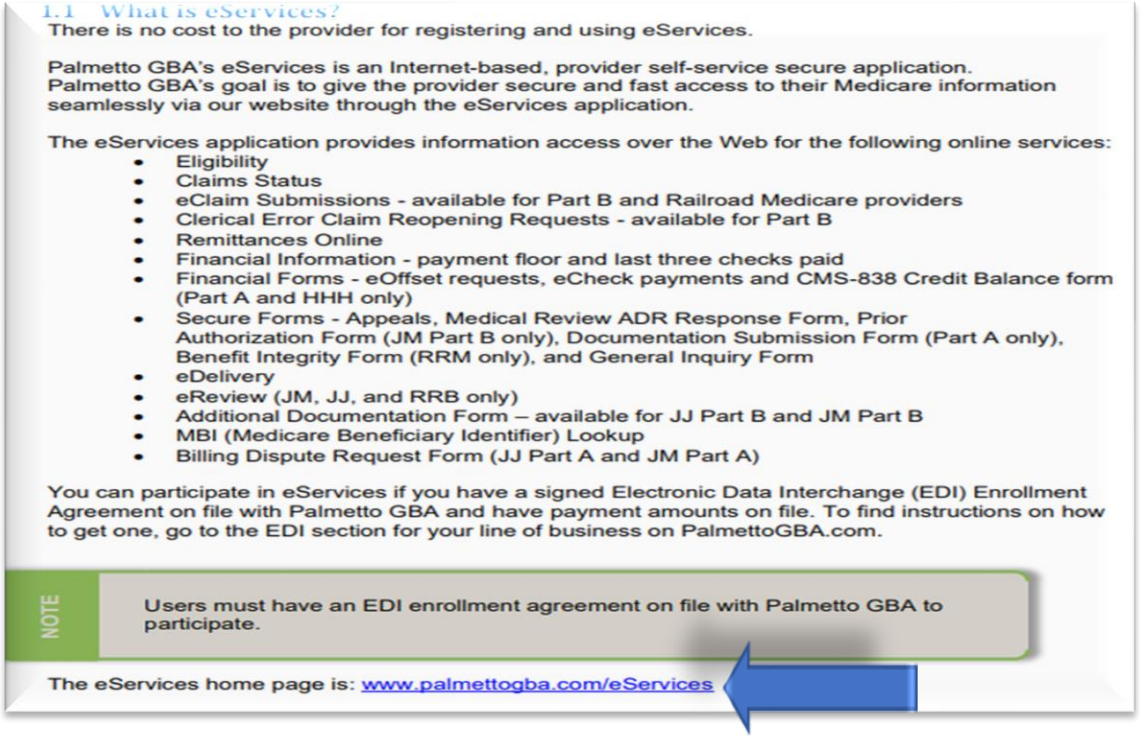

1.1 What is eServices?

There is no cost to the provider for registering and using eServices.

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 application provides information access over the Web for the following online services:

- Eligibility
- Claims Status
- eClaim Submissions - available for Part B and Railroad Medicare providers
- Clerical Error Claim Reopening Requests - available for Part B
- Remittances Online
- Financial Information - payment floor and last three checks paid
- Financial Forms - eOffset requests, eCheck payments and CMS-838 Credit Balance form (Part A and HHH only)
- Secure Forms - Appeals, Medical Review ADR Response Form, Prior Authorization Form (JM Part B only), Documentation Submission Form (Part A only), Benefit Integrity Form (RRM only), and General Inquiry Form
- eDelivery
- eReview (JM, JJ, and RRB only)
- Additional Documentation Form – available for JJ Part B and JM Part B
- MBI (Medicare Beneficiary Identifier) Lookup
- Billing Dispute Request Form (JJ Part A and JM Part A)

You can participate in eServices if you have a signed Electronic Data Interchange (EDI) Enrollment Agreement on file with Palmetto GBA and have payment amounts on file. To find instructions on how to get one, go to the EDI section for your line of business on PalmettoGBA.com.

NOTE

Users must have an EDI enrollment agreement on file with Palmetto GBA to participate.

The eServices home page is: www.palmettogba.com/eServices

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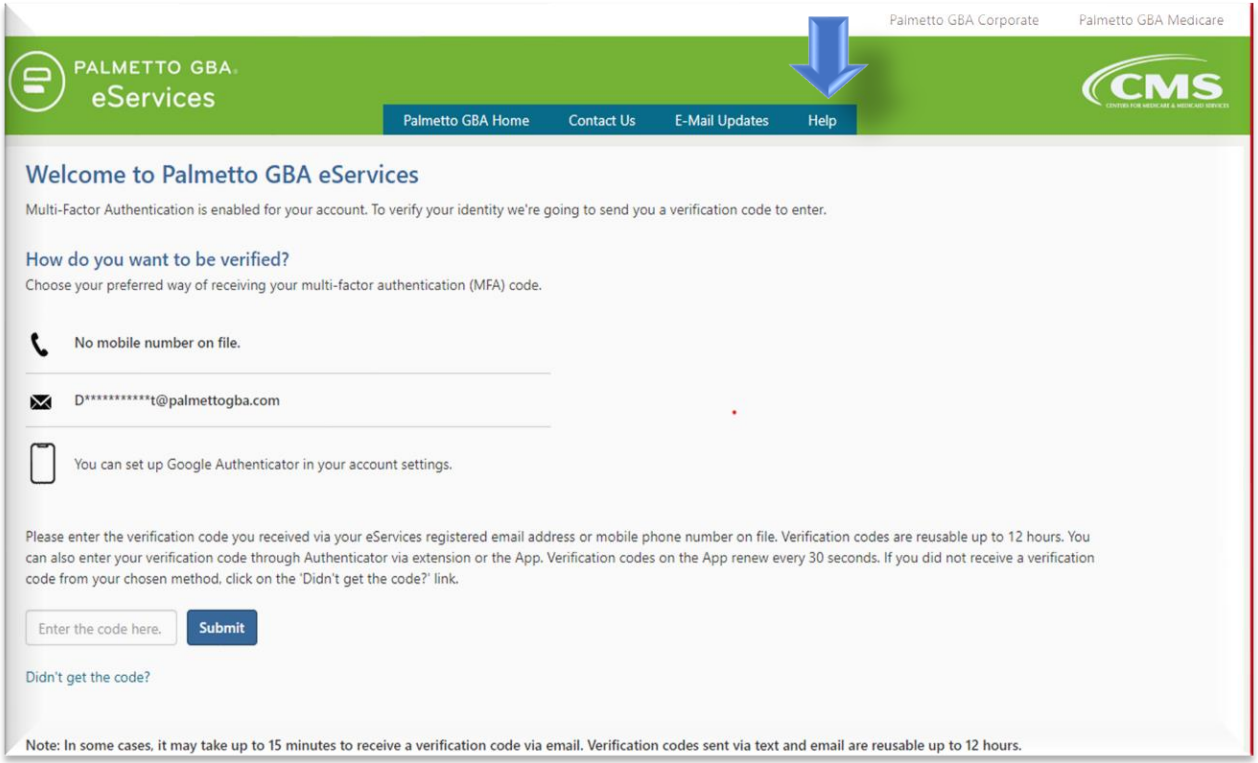
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Multi-Factor Authentication is enabled for your account. To verify your identity we're going to send you a verification code to enter.
How do you want to be verified?
Choose your preferred way of receiving your multi-factor authentication (MFA) code.
No mobile number on file.
D**********t@palmettogba.com
You can set up Google Authenticator in your account settings.
Please enter the verification code you received via your eServices registered email address or mobile phone number on file. Verification codes are reusable up to 12 hours. You can also enter your verification code through Authenticator via extension or the App. Verification codes on the App renew every 30 seconds. If you did not receive a verification code from your chosen method, click on the 'Didn't get the code?' link.
Enter the code here.
Submit
Didn't get the code?
Note: In some cases, it may take up to 15 minutes to receive a verification code via email. Verification codes sent via text and email are reusable up to 12 hours.

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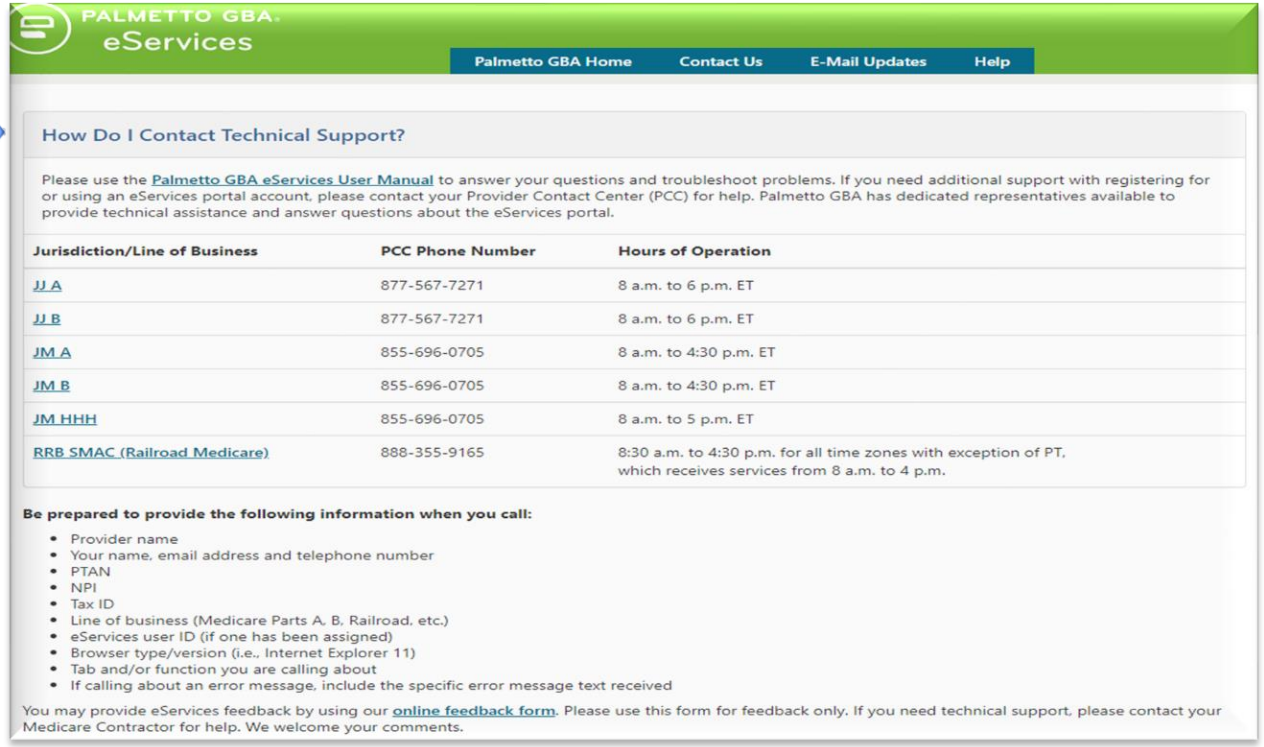
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How Do I Contact Technical Support?
Please use the Palmetto GBA eServices User Manual to answer your questions and troubleshoot problems. If you need additional support with registering for or using an eServices portal account, please contact your Provider Contact Center (PCC) for help. Palmetto GBA has dedicated representatives available to provide technical assistance and answer questions about the eServices portal.
Jurisdiction/Line of Business
PCC Phone Number
Hours of Operation
JJ A
877-567-7271
8 a.m. to 6 p.m. ET
JJ B
877-567-7271
8 a.m. to 6 p.m. ET
JM A
855-696-0705
8 a.m. to 4:30 p.m. ET
JM B
855-696-0705
8 a.m. to 4:30 p.m. ET
JM HHH
855-696-0705
8 a.m. to 5 p.m. ET
RRB SMAC (Railroad Medicare)
888-355-9165
8:30 a.m. to 4:30 p.m. for all time zones with exception of PT, which receives services from 8 a.m. to 4 p.m.
Be prepared to provide the following information when you call:
Provider name
Your name, email address and telephone number
PTAN
NPI
Tax ID
Line of business (Medicare Parts A, B, Railroad, etc.)
eServices user ID (if one has been assigned)
Browser type/version (i.e., Internet Explorer 11)
Tab and/or function you are calling about
If calling about an error message, include the specific error message text received
You may provide eServices feedback by using our online feedback form. Please use this form for feedback only. If you need technical support, please contact your Medicare Contractor for help. We welcome your comments.

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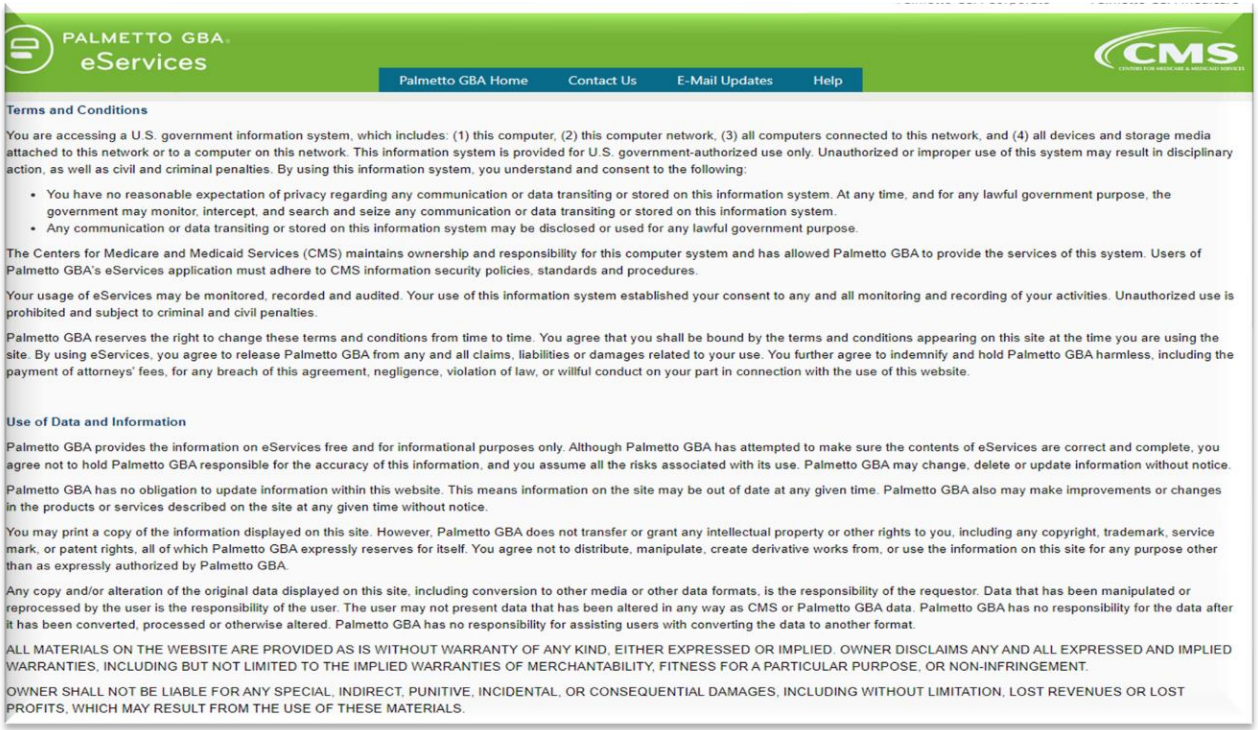
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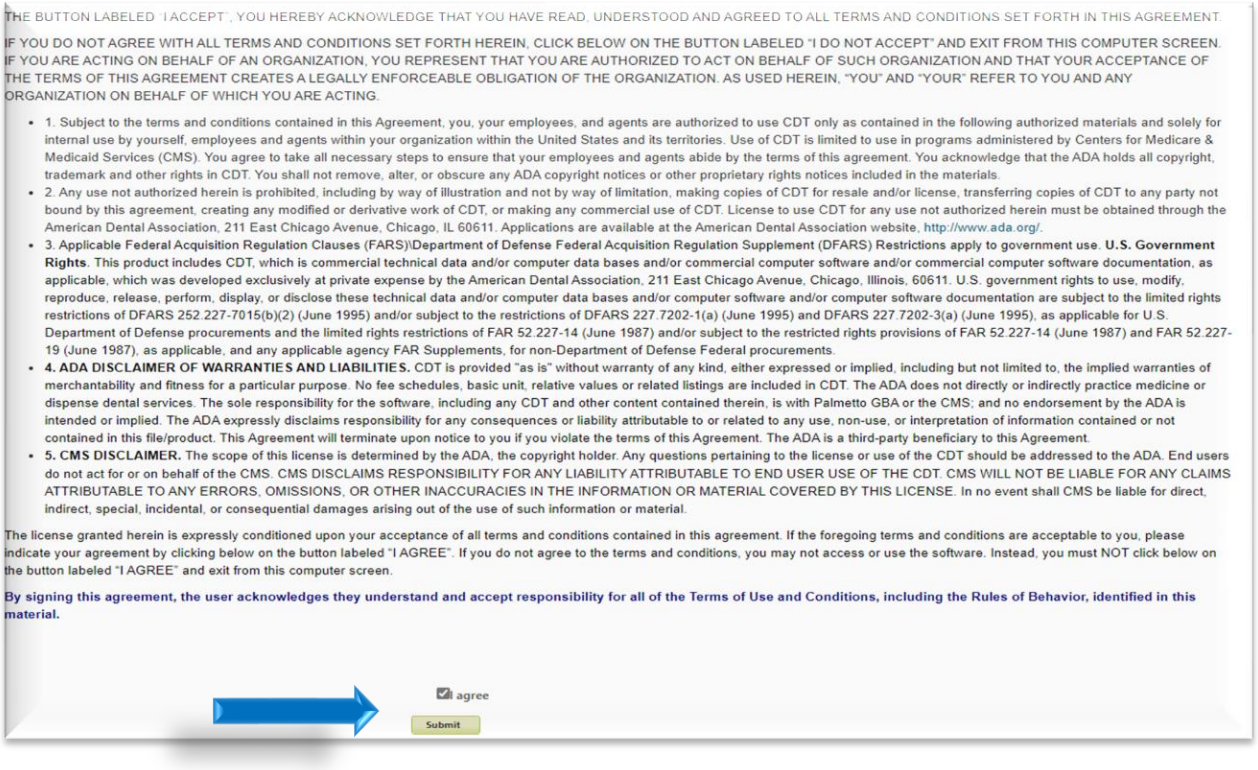

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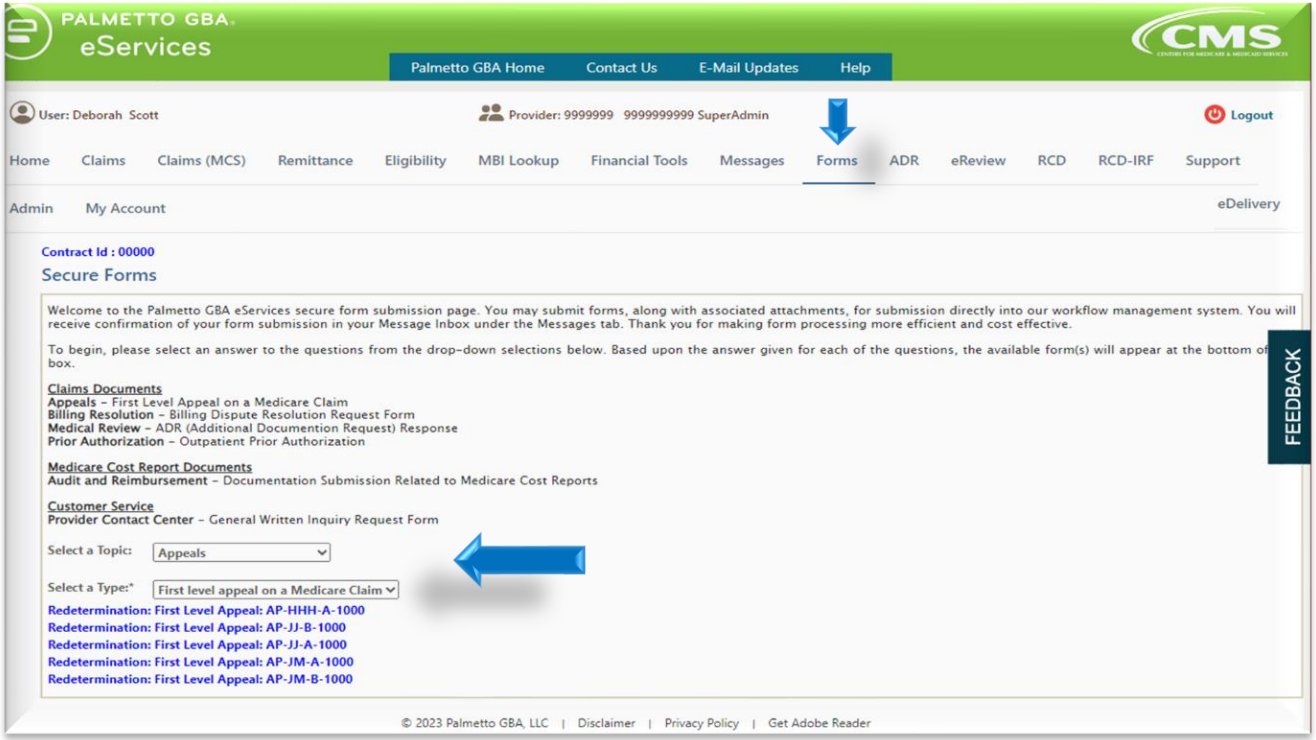
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Billing Resolution – Billing Dispute Resolution Request Form
Medical Review – ADR (Additional Documention Request) Response
Prior Authorization – Outpatient Prior Authorization
Medicare Cost Report Documents
Audit and Reimbursement – Documentation Submission Related to Medicare Cost Reports
Customer Service
Provider Contact Center – General Written Inquiry Request Form
Select a Topic:
Appeals
Select a Type:*
First level appeal on a Medicare Claim
Redetermination: First Level Appeal: AP-HHH-A-1000
Redetermination: First Level Appeal: AP-JJ-B-1000
Redetermination: First Level Appeal: AP-JJ-A-1000
Redetermination: First Level Appeal: AP-JM-A-1000
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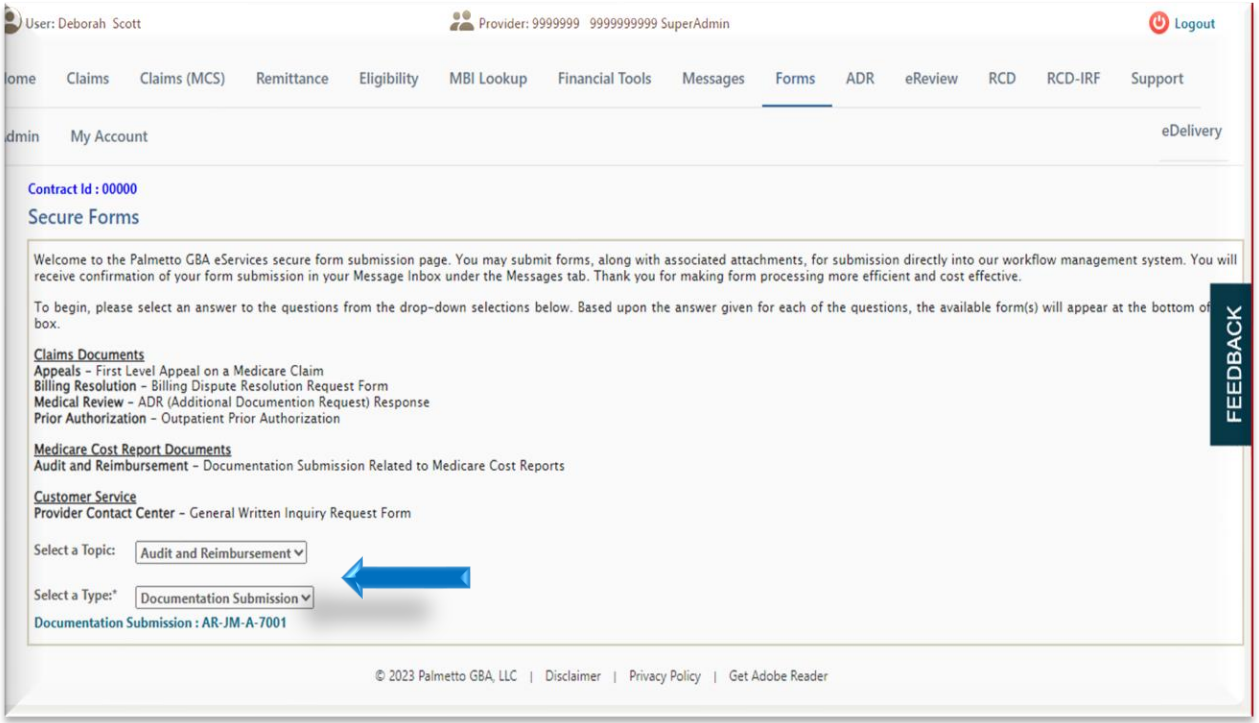
User: Deborah Scott
Provider: 9999999 9999999999 SuperAdmin
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Claims (MCS)
Remittance
Eligibility
MBI Lookup
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Messages
Forms
ADR
eReview
RCD
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Medical Review – ADR (Additional Documention Request) Response
Prior Authorization – Outpatient Prior Authorization
Medicare Cost Report Documents
Audit and Reimbursement – Documentation Submission Related to Medicare Cost Reports
Customer Service
Provider Contact Center – General Written Inquiry Request Form
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Audit and Reimbursement
Select a Type:*
Documentation Submission
Documentation Submission : AR-JM-A-7001
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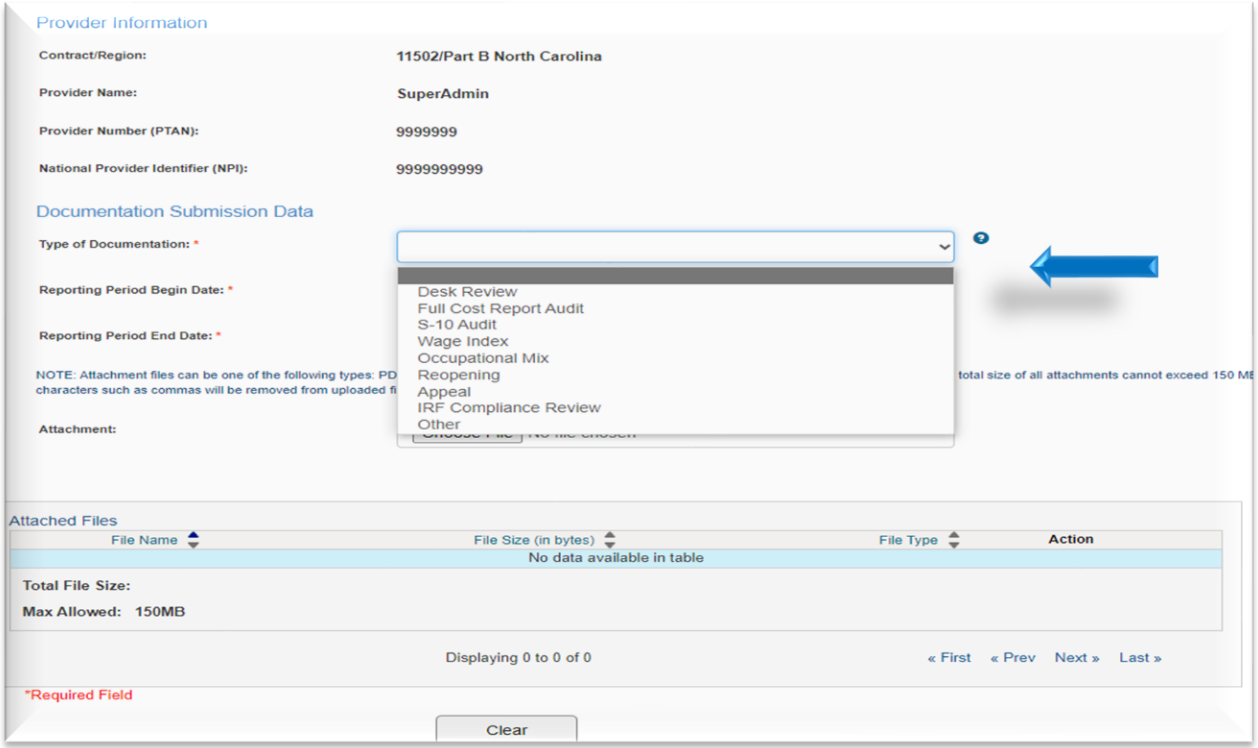
Provider Information
Contract/Region:
11502/Part B North Carolina
Provider Name:
SuperAdmin
Provider Number (PTAN):
9999999
National Provider Identifier (NPI):
9999999999
Documentation Submission Data
Type of Documentation: *
Reporting Period Begin Date: *
Reporting Period End Date: *
Desk Review
Full Cost Report Audit
S-10 Audit
Wage Index
Occupational Mix
Reopening
Appeal
IRF Compliance Review
Other
NOTE: Attachment files can be one of the following types: PD
characters such as commas will be removed from uploaded fi
total size of all attachments cannot exceed 150 MB
Attachment:
Attached Files
File Name
File Size (in bytes)
File Type
Action
No data available in table
Total File Size:
Max Allowed: 150MB
Displaying 0 to 0 of 0
« First
« Prev
Next »
Last »
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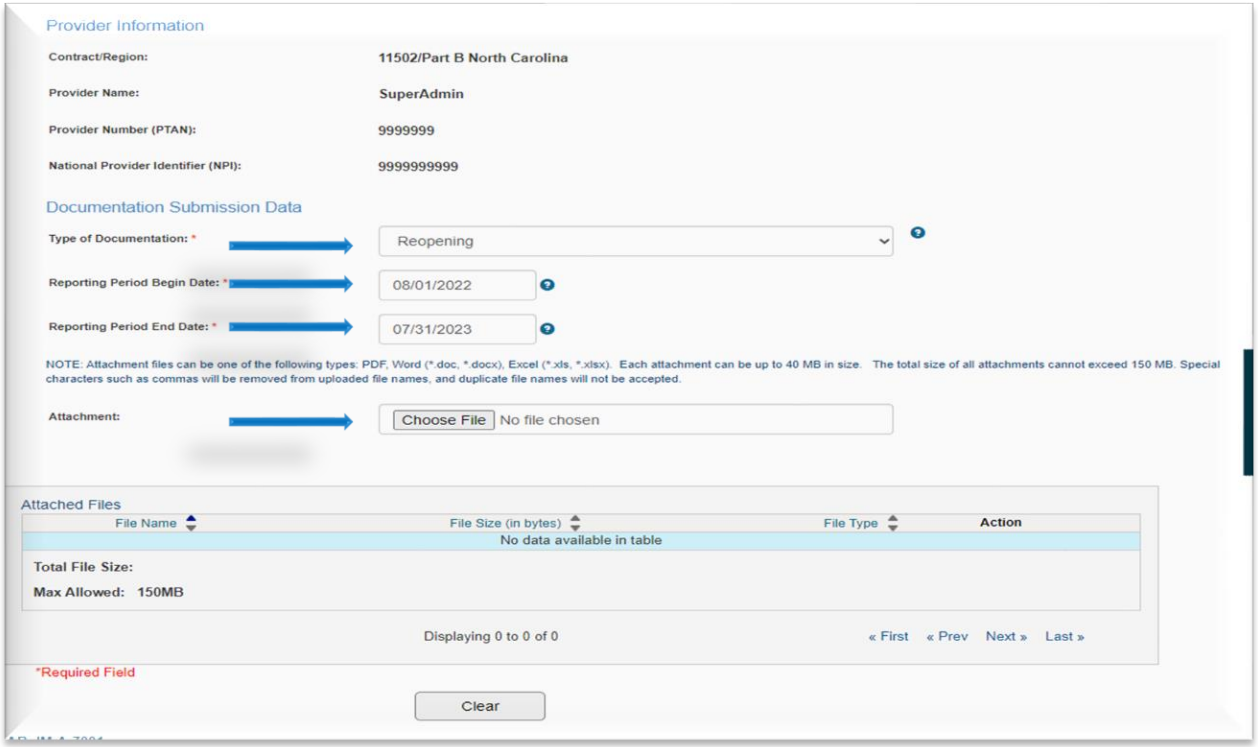
Provider Information
Contract/Region:
11502/Part B North Carolina
Provider Name:
SuperAdmin
Provider Number (PTAN):
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National Provider Identifier (NPI):
9999999999
Documentation Submission Data
Type of Documentation: *
Reopening
Reporting Period Begin Date: *
08/01/2022
Reporting Period End Date: *
07/31/2023
NOTE: Attachment files can be one of the following types: PDF, Word (*.doc, *.docx), Excel (*.xls, *.xlsx). Each attachment can be up to 40 MB in size. The total size of all attachments cannot exceed 150 MB. Special characters such as commas will be removed from uploaded file names, and duplicate file names will not be accepted.
Attachment:
Choose File
No file chosen
Attached Files
File Name
File Size (in bytes)
File Type
Action
No data available in table
Total File Size:
Max Allowed: 150MB
Displaying 0 to 0 of 0
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Next »
Last »
*Required Field
Clear

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Medicare Cost Report e-Filing (MCReF)

Medicare Cost Report Filing

- The cost report is due within five months of the cost reporting fiscal year end (e.g., provider's FYE is 12/31/2021, the cost report is due 5/31/2022)
- MACs will issue a reminder letter, two months prior to the cost report due date
- Reconcile subunit number(s) within the subject portion of this letter with those entered on your report, prior to filing your cost report. If there are discrepancies, contact your MAC immediately
- Cost report due dates can be affected by pending CHOW, FYE changes, voluntary termination, etc.
- Cost report submissions must be received by the due date to be considered timely

Medicare Cost Report Filing

- In the event that you fail to timely file an acceptable cost report with all required information, Medicare payments will be suspended until a cost report is filed and determined to be acceptable (see 42 CFR, Section 405.371[c])
- Acceptance review process can take up to 30 days
- Failure to file a cost report will result in a referral to the Department of Treasury for collection, as well as possible termination from the Medicare program
- If the cost report is rejected, it is deemed unacceptable and treated as if it were never filed. A suspension of payments will be implemented under the provisions of 42 CFR, Section 405.371(c)

Medicare Cost Report Filing Tips

- Develop a plan and timetable
- Know CMS Regulations
- Keep IDM accounts in good standing. This includes password updates and timely replacement of Security Officials.
- Pull together required records including Provider Statistical & Reimbursement Reports (PS&R)
- File before due date! If correction is needed for the cost report to be accepted, a grace period will go into effect before payments are suspended.

Note: File your cost report via MCReF – Medicare Cost Report Electronic Filing.

MCReF

The Medicare Cost Report e-Filing (MCReF) is an application that allows Part A providers to electronically transmit (e-File) their Medicare cost report package.

It was designed to automate and streamline the providers submission of the cost. Report.

One process for all providers via one submission portal.

Available to all Part A providers regardless of MAC.

MCReF

- Access is controlled by IDM
- Accessible by the IDM PS&R Security Official (SO), Backup Security Official (BSO) and the MCReF Approved Cost Report Filer
- Any organization without access to PS&R must register a PS&R SO with IDM
- If you want to use MCReF, keep your IDM accounts in good standing
  - **Includes password updates and timely replacement of SOs**
  - **IDM credential issues are not a valid reason for late MCR filing**

MCReF Benefits

- Efficient for both the provider and MACs
  - **Front-end (Level 1) edits alerting providers of errors preventing successful transmission**
    - Insufficient/missing IRIS
    - Insufficient/missing proper form
    - Incorrect Cost Report Period
  - **Immediate acknowledgment of successful transmission, i.e., removing concerns of potential payment suspensions**
  - **Removes manual processing for Cost Report Receipt process, which reduces risk of human error**

MCReF Benefits

- Effective April 2020, MCRef was enhanced to allow providers to see their cost report status
  - **FYE Not Elapsed (The selected provider has an FYE that has not passed yet.)**
  - **Pending Receipt (An acceptable submission has not yet been received.)**
  - **Processing (Everything from the initial receipt of a submission undergoing an acceptability check by the MAC, through all subsequent processes undertaken by the MAC to reach finalization falls into this category. This includes tentative settlements, rate reviews and audits, in a state of pending, in progress or complete.)**
  - **Complete (All currently planned work for the provider and FYE is complete. This includes issued NPRs, years closed without an NPRS and years where any/all reopenings and appeals are closed.)**
  - **Reopening/Appeal (Indicates that at least one reopening or appeal is currently open/in progress for an otherwise complete FYE.)**

MCReF Benefits

- Effective June 2023, MACs are required upload NPRs, Interim Rate Reviews and Tentative Settlement documentation into STAR
  - **If provider submits cost report electronically, they will have access to these records for download**
- Currently electronic filing is optional, but it is both a CMS and MAC goal to increase the use of this system

Questions?

Customer Experience Survey

YOUR FEEDBACK IS IMPORTANT!

Don’t forget to complete the feedback survey!

http://tinyurl.com/423e7e3j

UPIC – OIG – SMRC Overpayments

Julia Knapper
Accounting Supervisor

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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UPIC – OIG – SMRC Overpayments

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Disclaimer

The content in this presentation is intended for JJ/JM Part A, Part B and HHH providers and is current as of January 15, 2024. Any changes or new information superseding this information is provided in articles with publication dates after January 15, 2024, at: www.palmettogba.com.

Who Are the UPIC, OIG and SMRC??

- UPIC – Unified Program Integrity Contractor
  - **Contracted by the government (CMS)**
  - **Primary goal is to identify cases of suspected fraud, waste and abuse.**
- OIG – Office of Inspector General
  - **Government Agency**
  - **OIG is at the forefront of the nation's efforts to fight waste, fraud and abuse and to improve the efficiency of Medicare.**

- SMRC – Supplemental Medical Review Contractor
  - **Contracted by the government (CMS)**
  - **SMRC main tasks are to perform and/or provide support for a variety of tasks aimed at lowering the improper payment rates and increasing efficiencies of the medical review functions of the Medicare and Medicaid program.**
- Although different, the agencies have the same common goal. Their goal is to ensure compliance with Medicare regulations and to protect the Medicare Trust Fund.

Overpayments

- Overpayment Types
  - **Actual overpayment – Previously paid claim adjusted to pay less than the original claim amount**
  - **Extrapolated Overpayment – Use of statistical sample to estimate the overpayment amount (Not currently used by the SMRC)**
  - **Both Overpayment types are 935 eligible**

Overpayment Processing

- Although OIG, SMRC and UPIC are separate entities, the audits and overpayment determinations are handled similarly.
- Each entity will notify the provider of the upcoming audit. This is typically done by an audit engagement letter and/or an Additional Documentation Request (ADR). Please adhere to the instructions and deadlines outline in this notification. (STAY ENGAGED)
- Once the review is complete, the provider will be notified by letter or report.

Overpayment Processing

- Each entity will notify your MAC of the overpayment determination. At this time the MAC will establish the overpayment and issue the demand per the instructions received.
- The MAC will review the overpayment request and documentation to ensure there are no clerical errors related to the overpayment amount. However, documentation will not be reviewed to validate the findings.
- All post-pay overpayments determined by OIG, UPIC and SMRC are eligible for appeal

Tips

- Always stay engaged in the audit process. You can possibly prevent an overpayment
- Be patient with the process. The MACs are typically notified of the overpayment after the provider.
- Wait until you receive your demand letter before filing an appeal.

FAQ

- I received an overpayment letter from the UPIC/SMRC/OIG, but I haven't received a demand letter yet."
  - **Providers are typically notified of the overpayment first. There is always a time lapse before the MAC receives the overpayment request. Also, demand letters cannot be issued until the claims have been adjudicated. Once the claims finalize, the demands will be issued systematically.**
- "I received a payment suspension termination letter from the UPIC, when will my funds be released?
  - **Providers are notified of the termination first. There is always a time lapse before the MAC receives the termination request. If there is a related overpayment request, the termination cannot be completed until the overpayments have been established.**
- "Why didn't I receive any of the payments held during suspension?"
  - **There are a couple of reasons a provider may not receive suspended funds. 1. The provider has a UPIC debt or other outstanding Medicare debt to which the funds were applied. 2. When there is no outstanding debt, the UPIC instructs the MAC to return the funds back to the Medicare Trust Fund instead of the provider.**

FAQ

- "I have claims identified by the OIG in their draft report; can I go ahead and adjust them before the final report comes out?"
  - **We advise against adjusting claims identified in the draft report. Adjusting the claims will not reduce the overpayment amount in the final report.**
- "Why is Palmetto recouping early? I have not received the demand letter yet."
  - **When a claim is adjusted, it will appear on your remittance advice. This is a notification of the adjustment not a withholding/recoupment.**

Overpayment Appeal Process

- What is an overpayment?
  - Medicare payments to a provider or beneficiary in excess of amounts due and payable under the statue and regulations (IOM 100-06 – Chapter 3 § 10)
- Types of overpayments
  - System Adjustments
  - Voluntary Refunds
  - Post Pay Audits

Post-Pay Audits

- Post Pay Audits can result in an overpayment
  - **SMRC**
  - **RAC**
  - **UPIC**
  - **RCD Post Pay Review**
  - **CERT**
  - **OIG**
  - **Medical Review**

935 Overpayments

- Post Payment Audits can result in a 935 overpayment
- A 935 overpayment is subject to a limitation of recoupment (IOM 100-06 § 200)
  - **As a provider you have the right to stop the recoupment process**
    - Redetermination 1st Level Appeal
    - Reconsideration 2nd Level Appeal

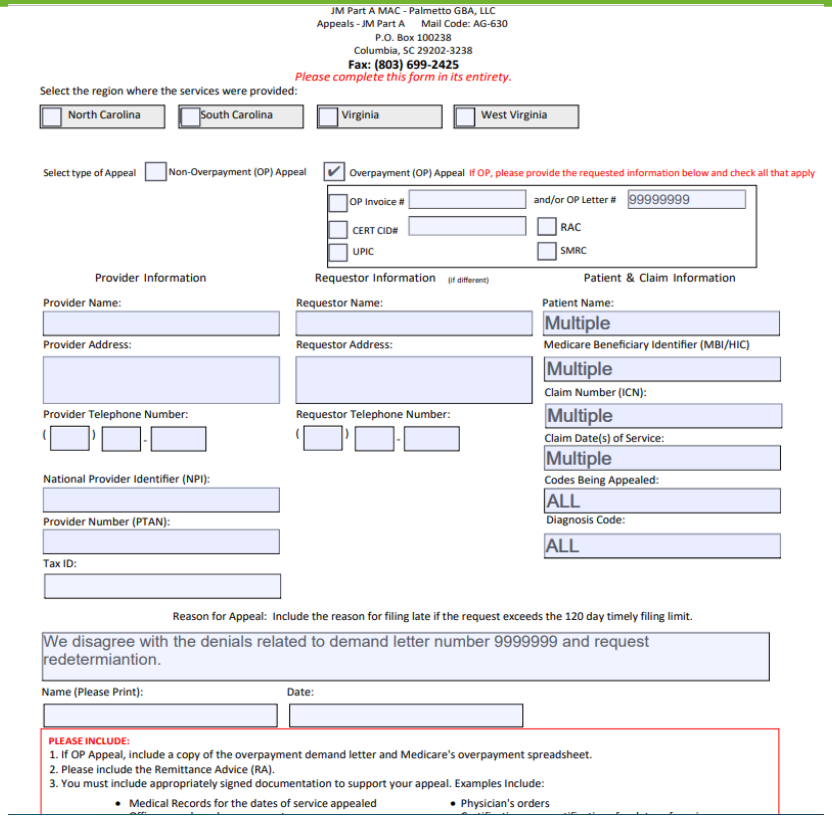
Timeline of a 935 Overpayment

- Pre-Demand
  - **Audit Process and Additional Documentation Requests**
- **Day 1 —** Initial Demand – Demand letters are issued based the results sent to the MAC or review of the medical documentation
- **Day 1 to 15 —** Rebuttal Process
- **Day 30 —** Appeal needs to be received at MAC to stop recoupment
- **Day 41 —** Recoupment begins
- **Day 125 —** Redetermination Appeal rights lapse

Tips for Filing an Appeal

- Wait for your demand letter (sign up for electronic delivery)
- Submitting a Request for Redetermination
  - **Requests can be submitted via a paper form by mail or fax**
  - **eServices portal**
- Submit as soon as possible to stop recoupment
- Use the demand letter

Appeal Request



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 # 99999999
☐ CERT CID# ____ ☐ RAC
☐ UPIC ☐ SMRC

Provider Information

Provider Name:
Provider Address:
Provider Telephone Number: ( ) -
National Provider Identifier (NPI):
Provider Number (PTAN):
Tax ID:

Requestor Information (if different)

Requestor Name:
Requestor Address:
Requestor Telephone Number: ( ) -

Patient & Claim Information

Patient Name: Multiple
Medicare Beneficiary Identifier (MBI/HIC): Multiple
Claim Number (ICN): Multiple
Claim Date(s) of Service: Multiple
Codes Being Appealed: ALL
Diagnosis Code: ALL

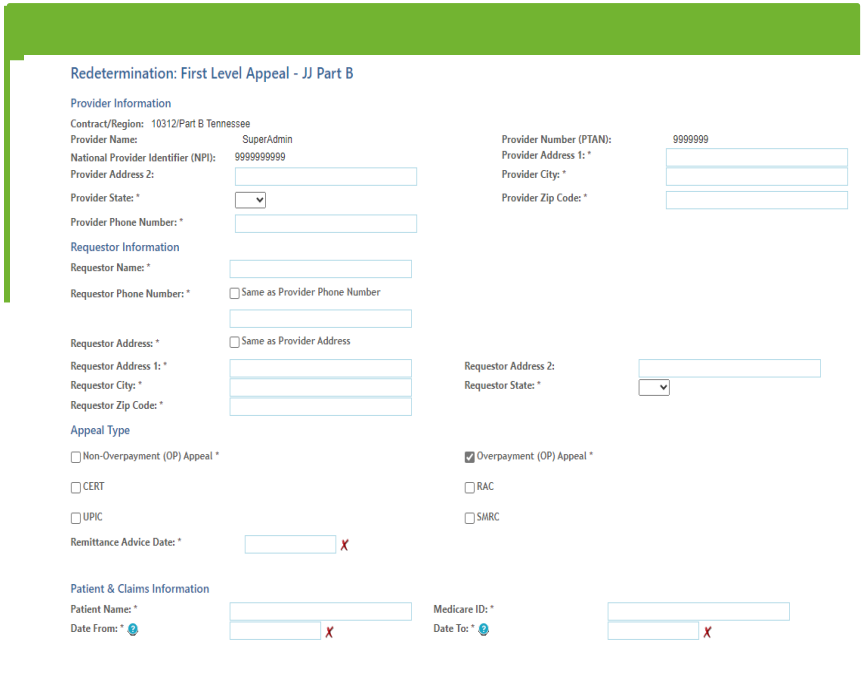
Reason for Appeal: Include the reason for filing late if the request exceeds the 120 day timely filing limit.

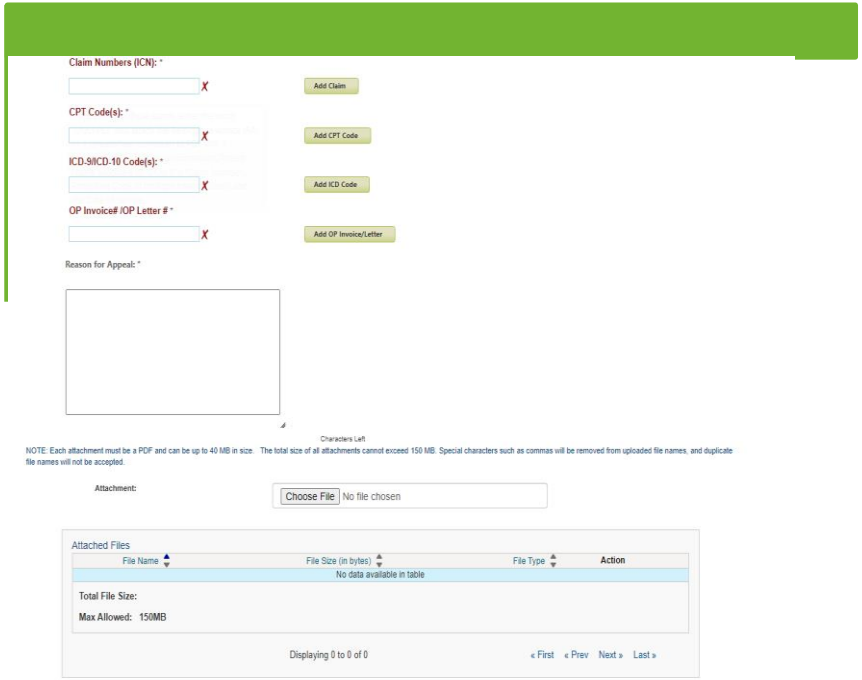
We disagree with the denials related to demand letter number 9999999 and request redetermiantion.

Name (Please Print): Date:

PLEASE INCLUDE:
1. If OP Appeal, include a copy of the overpayment demand letter and Medicare's overpayment spreadsheet.
2. Please include the Remittance Advice (RA).
3. You must include appropriately signed documentation to support your appeal. Examples Include:
   - Medical Records for the dates of service appealed
   - Physician's orders

Appeal Request (eServices)





Once a Decision Has Been Issued

- Unfavorable/Affirmed Decisions
  - **If a balance remains – Balance due letter will be mailed**
  - **If no balance (overpayment has collected) – No balance due letter will be mailed**
- Fully Favorable Decisions
  - **You will not receive a decision letter**
  - **Review your remittance**
- Partially Favorable Decisions
  - **Review your remittance**
  - **A letter will be mailed to you to state the new overpayment/remaining overpayment amount even if the overpayment has been collected in full**

Steps for a Provider after Redetermination

- Unfavorable/Affirmed
  - **Appeal to the 2nd Level or Reconsideration**
- Fully Favorable
  - **No action is needed by the provider**
- Partially Favorable
  - **Once you receive your updated overpayment amount, you can appeal to the reconsideration (60 days to stop recoupment or 180 total days to file an appeal)**

Key Timeframes Post Appeal Decisions

- 60 Days after Redetermination Balance Due
  - **Recoupment will begin**
- Up to 180 Days after Redetermination to request Reconsideration
- 30 Days after Reconsideration Balance Due
  - **Recoupment will begin**
- Up to 60 Days after Reconsideration to request 3rd level or Administrative Law Judge (ALJ) Appeal

Questions?

Connect With Us

FACEBOOK

Follow us on Facebook to learn about upcoming events and ask us general questions

X (TWITTER)

#StayConnected on Twitter for quick access to news and information

YOUTUBE

Go to YouTube for educational videos, tips and strategies

LINKEDIN

LinkedIn is your source for the latest Palmetto GBA news

Customer Experience Survey

YOUR FEEDBACK IS IMPORTANT!

Don’t forget to complete the feedback survey!

http://tinyurl.com/4ux35e96

North Carolina Health and Finance Management Association (NCHFMA)

Medicare Part A/B CERT Updates

Charles Cannan
Senior Provider Education Consultant

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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Disclaimer

The content in this presentation is intended for JJ/JM Part A/B providers and is current as of January 01, 2024. Any changes or new information superseding this information is provided in articles with publication dates after January 01, 2024, at Palmetto GBA.

Frequently Used Acronyms

Acronym	Description
ADR	Additional Documentation Request
CERT	Comprehensive Error Rate Testing
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
MCD	Medicare Coverage Database
LCD/NCD	Local/National Coverage Determination
MAC	Medicare Administrative Contractor
IOM	Internet Only Manual
MLN	Medicare Learning Network
MR	Medical Review

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Comprehensive Error Rate Testing (CERT) Program

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

$$i_e^{di} = \sum_{k=1}^{a} \frac{N_k}{n_k} \sum_{j=1}^{n_k^{di}} e_{kj} - \sum_{k=1}^{a} W_k \sum_{j=1}^{n_k^{di}} e_{kj}$$

$$i_p^{di} = \sum_{k=1}^{a} \frac{N_k}{n_k} \sum_{j=1}^{n_k^{di}} p_{kj} - \sum_{k=1}^{a} W_k \sum_{j=1}^{n_k^{di}} p_{kj}$$

$

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

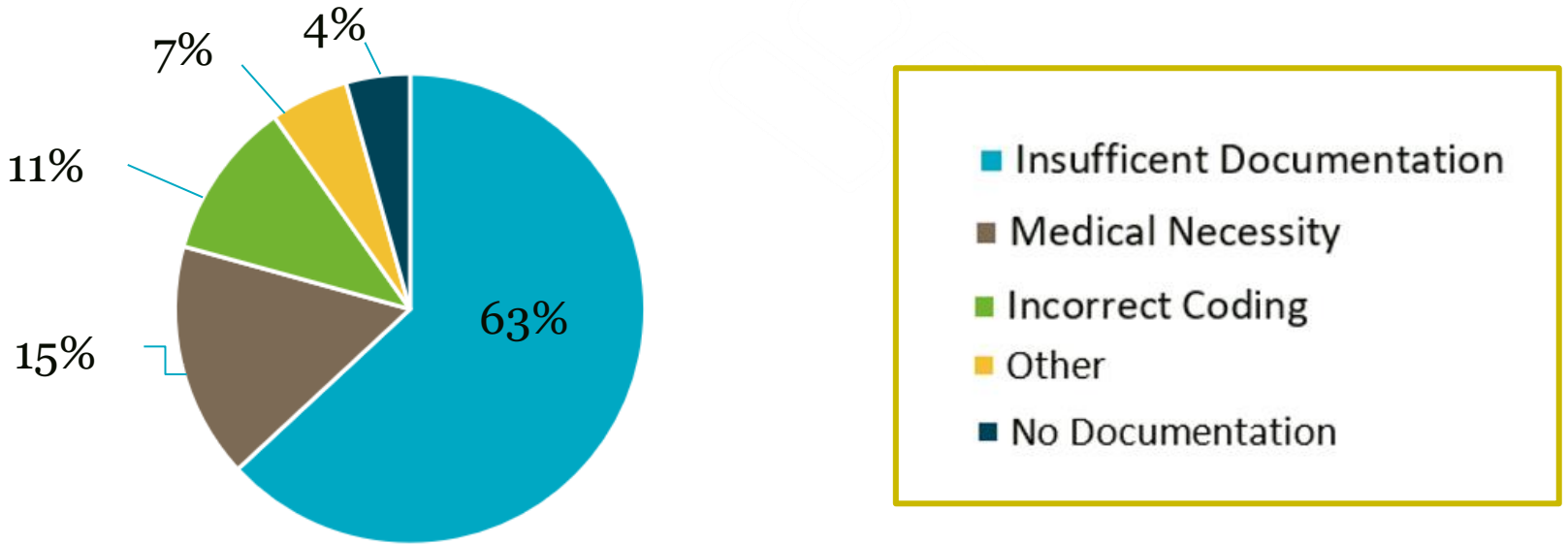
Comprehensive Error Rate Testing Contractor

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

Five Major CERT Error Categories

Comprehensive Error Rate Testing Contractor's 2023 National Improper Payment Rate Errors Defined by Category



All data analysis includes reviewed claims data from the sampling period of July 2021 — June 2022, as of November 15, 2023.

HHS Corrective Actions

Corrective Action/Audits	Description
MAC Medical Review/Targeted Probe and Educate (TPE)	MACs continued the Targeted Probe and Educate process and offered extensions due to ongoing COVID-19 effects. 29 This process entails three rounds, each reviewing 20–40 claims and offering one-on-one education after each round. HHS conducted medical reviews in various service areas, including hospital outpatient, IRF, SNF, home health, hospice, and DMEPOS. MACs reviewed 3,888 hospital outpatient providers, 193 IRF providers, 1,356 SNF providers, 1,033 home health agencies, 762 hospice providers, and 5,073 DME suppliers.
Supplemental Medical Review Contractor (SMRC) Reviews	SMRC conducted post payment Medicare FFS reviews for hospital outpatient, IRF, SNF, hospice, and DMEPOS claims. After completing reviews, SMRC shares results with MACs for claim adjustments. Providers receive detailed SMRC review result letters and MAC demand letters for overpayment recovery, including educational information on billing errors. SMRC conducted postpayment reviews for 7,936 hospital outpatient claims, 4,588 SNF claims, 7,184 IRF claims, 38,604 hospice claims, 5,897 DME claims, and more.
Recovery Audit Contractor (RAC) Reviews	Medicare FFS RACs identified and recovered improper payments in IRF, SNF, professional services, home health, and DMEPOS claims. The majority of Medicare FFS RAC recoveries, 30 percent, came from hospital outpatient overpayments, with an additional 5 percent originating from SNF overpayments.

CERT Initial Documentation Request

For an initial documentation request, provider contact is made as follows:	
Day 1	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

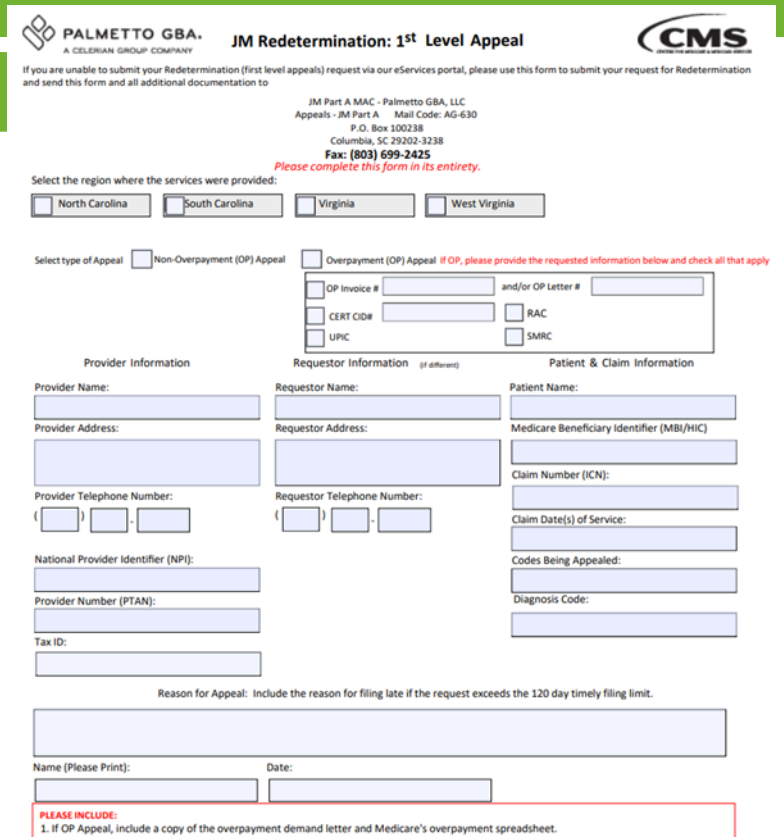
CERT's Process for concluding a request:

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 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

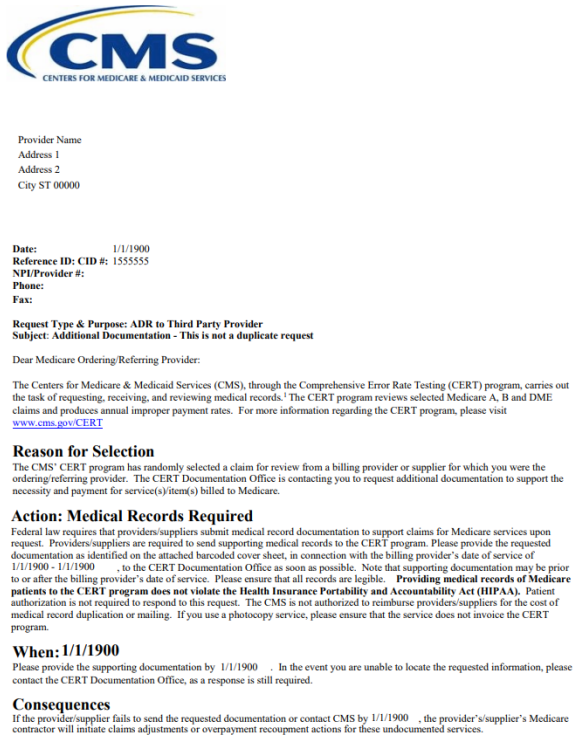
Provider Information	Requestor Information (if different)	Patient & Claim Information
Provider Name:	Requestor Name:	Patient Name:
Provider Address:	Requestor Address:	Medicare Beneficiary Identifier (MBI/HIC)
Provider Telephone Number: ( ) -	Requestor Telephone Number: ( ) -	Claim Number (ICN):
National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

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



CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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.

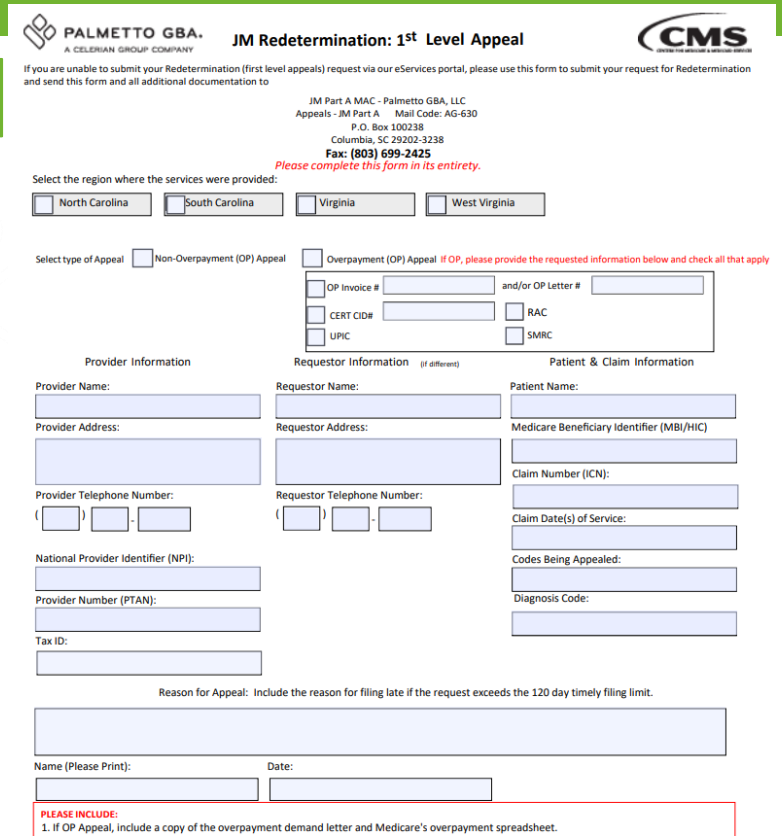
If, during CERT's initial medical review, the need for additional info is identified, a subsequent documentation request will be issued as follows:

- 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 offer assistance
- Day 10 — CERT sends a second subsequent request letter, and a phone call is made by CERT to follow-up on the request and to offer assistance
- Day 16 — Claim is back in the review process

Finalizing CERT's Process

CERT's Process for concluding a request:

- Claims are counted as an 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 an Appeal



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JM Redetermination: 1st Level Appeal

CMS

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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)
Provider Telephone Number: ( ) -	Requestor Telephone Number: ( ) -	Claim Number (ICN):
National Provider Identifier (NPI):		Claim Date(s) of Service:
Provider Number (PTAN):		Codes Being Appealed:
Tax ID:		Diagnosis Code:

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 Request

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


CENTERS FOR MEDICARE AND MEDICAID SERVICES
CERT DOCUMENTATION CENTER
1510 E. Parham Road
Henrico, VA 23228

Important Dated Information Enclosed

Immediate Response Required

Medicare Record Request

If no addressee name is shown, forward to Medical Records Department.

CERT's Chain Address Program

Providers that have at least five 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:

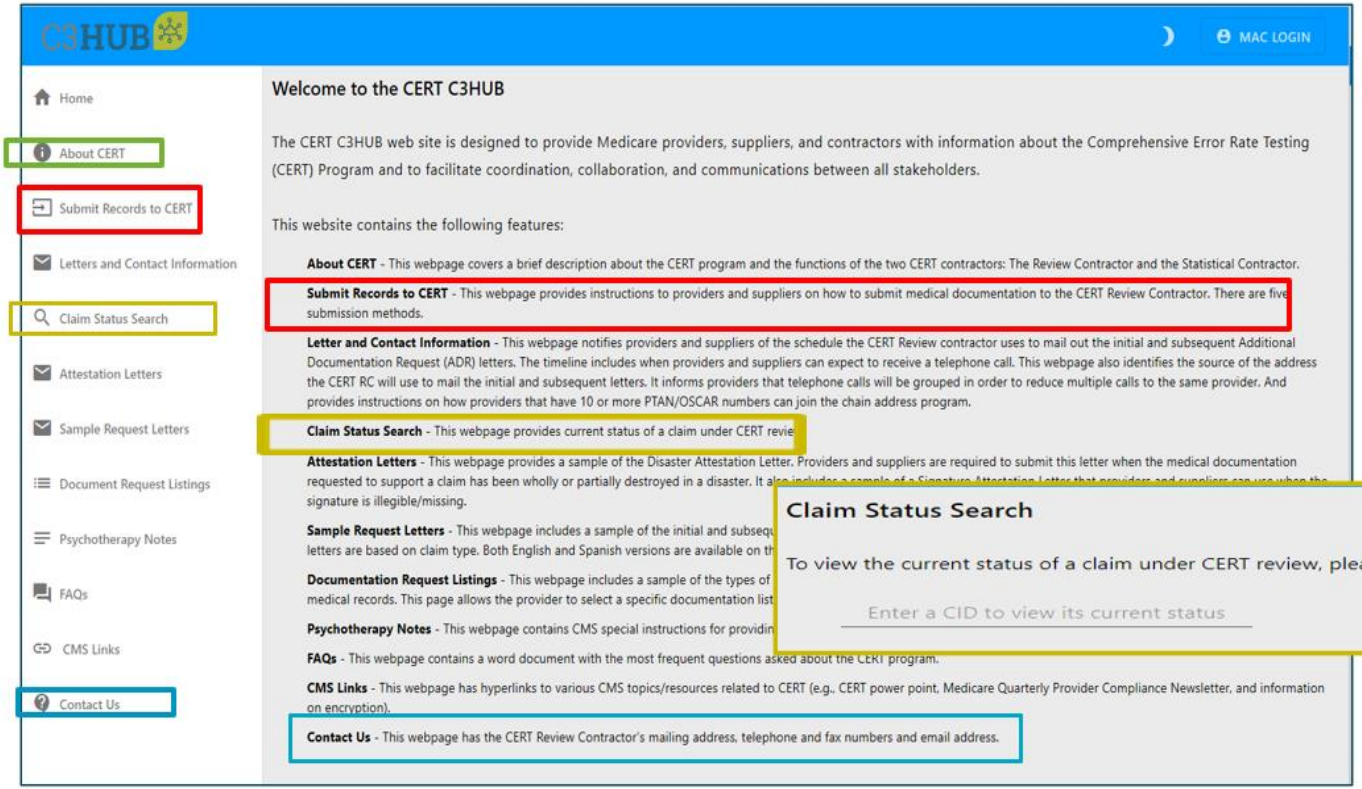
- CERT will email/call the POC with a list of outstanding CID numbers
- When requested, the CERT CSR will forward a copy of documentation request letters to the POC

Methods for Submitting Documentation to CERT

U.S. Mail	CERT Documentation Center 1510 East Parham Road Henrico, Virginia 23228
Fax	Send a separate fax for each individual claim to (804) 261–8100
Electronic Submission of Medical Documentation (esMD)	Include a CID# or Claim number
Compact Disc (CD)	• Should be encrypted per HIPAA security rules • Password and CID# must be provided via email to CERTMail@nciinc.com or via fax to (804) 261–8100 • Only images in TIFF or PDF are acceptable formats
Email Attachment	• Should be encrypted per HIPAA security rules • Password and CID# must be provided via phone to 888–779–7477 or via fax to (804) 261–8100 • Only attachments in TIFF or PDF are acceptable formats

The original barcoded cover sheet should be included with all submissions.

CERT C3HUB



Contact Us

CERT Documentation Center
1510 East Parham Road
Henrico, VA 23228
Fax: 804-261-8100
Customer Service: 443-663-2699
Toll Free: 888-779-7477
Email: certprovider@nciinc.com

https://c3hub.certrc.cms.gov/

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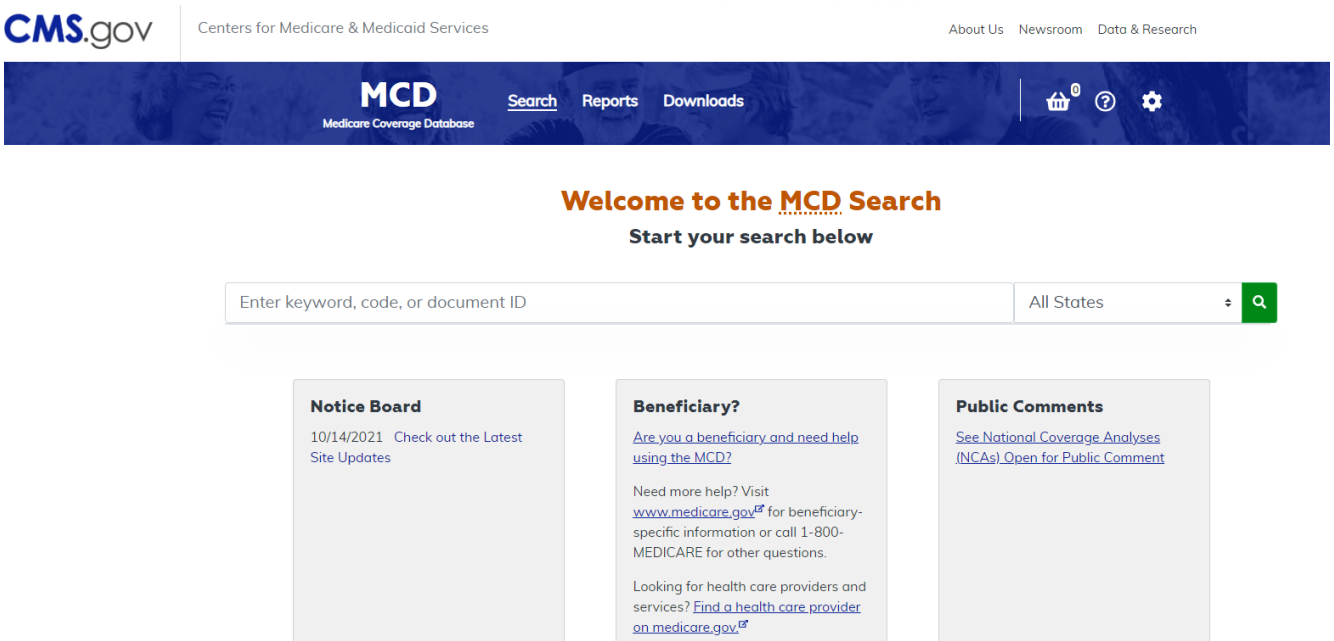
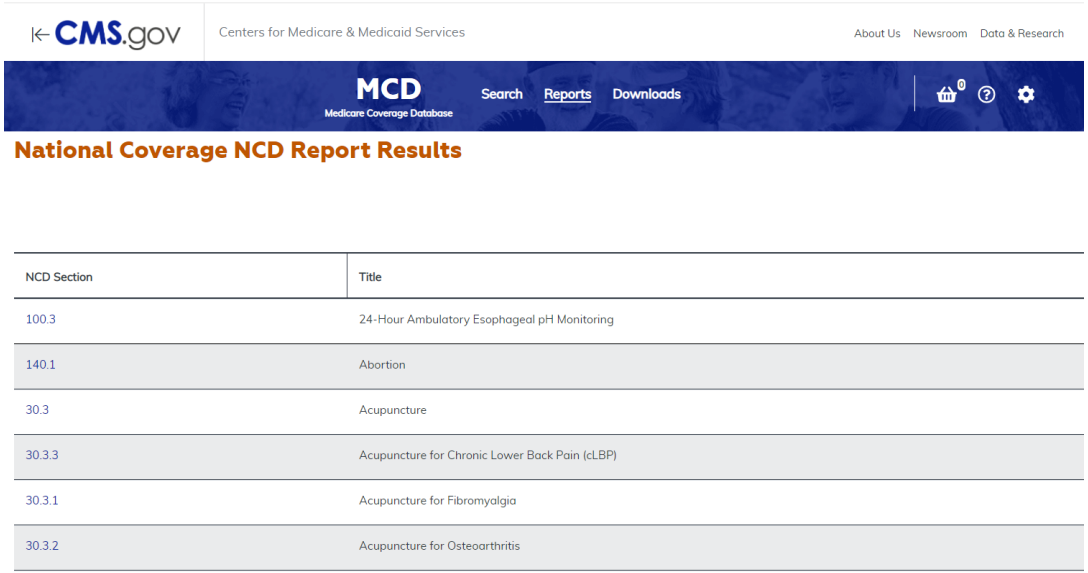
CMS Medicare Coverage Database (MCD) Navigation



Medicare Coverage Database

MCD Reports

Select National Coverage Report



Medicare National Coverage Determinations Manual

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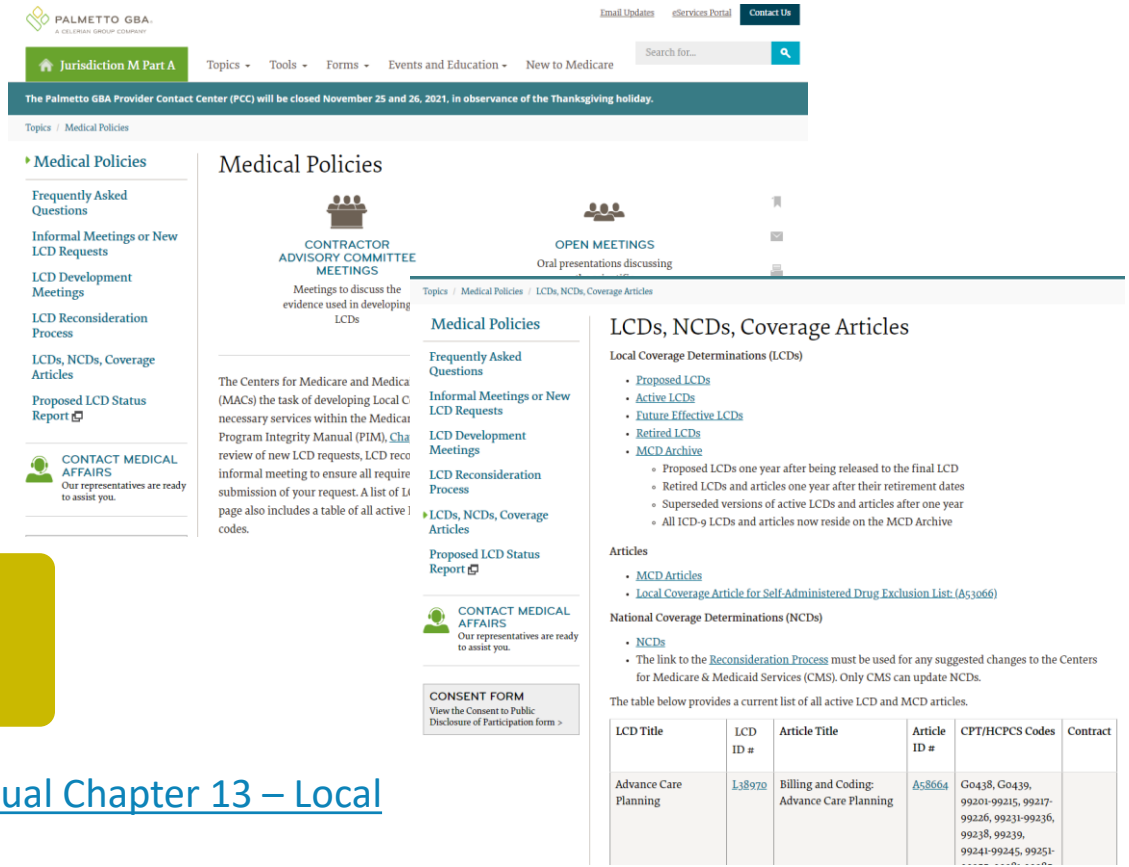
Topics

Medical Policies



Medicare Program Integrity Manual Chapter 13 – Local Coverage Determinations

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Five Major Error Categories

- No Documentation (Error 99)
- Insufficient Documentation (Error 16)
- Medical Necessity (Error 25)
- Incorrect Coding (Error 31)
- Other (Error 60)

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.

Things to Know to Avoid CERT Errors

Avoid documentation payment errors by ensuring that:

- Comprehensive documentation is submitted timely
- The code billed best reflects rendered services
- An order or an intent to order is obtained when necessary
- Documentation and signatures are legible (signature logs and attestation statements should be used when necessary)

Things to Know to Avoid CERT Errors

Avoid documentation payment errors by ensuring that:

- Comprehensive documentation is submitted timely
- The code billed best reflects rendered services
- An order or an intent to order is obtained when necessary
- Documentation and signatures are legible (signature logs and attestation statements should be used when necessary)

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 to support the service, billing error. Please initiate overpayment recoupment."

Examples of 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

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Part A Documentation Tips

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

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 nonphysician practitioner (meaning a physician assistant, nurse practitioner or clinical nurse specialist) using an evidence-based decision tool on ICDs prior to initial ICD implantation

Dialysis

- Treatment records for each visit
- POC documenting education and training
- Home dialysis order/home treatment logs
- Progress notes
- Assessment report
- Authenticated physician/NPP's visit/progress notes
- Signed order or protocol orders

Inpatient Rehabilitation Facility (IRF)

- Team conference notes with legible signatures
- Pre-admission screening
- Admission and all other orders
- Overall individualized plan of care/update plan of care
- H&P/post-admission physician evaluation (PAPE no longer required)
- MD progress notes and DC summary
- PT, OT evaluations, treatment notes, POCs and DC notes
- Team conference, nursing, and case management notes
- IRF-PAI
- MAR/Diagnostic testing results

Inpatient Psychiatric Facilities (IPF)

CERTIFICATION/RECERTIFICATION

There is a difference in the content of the certification and recertification statements. The required physician's statement should certify that the IPF admission was medically necessary for either.

- Treatment which could reasonably be expected to improve the patient's condition
- Diagnostic study

The physician's recertification should state each of the following:

That inpatient psychiatric hospital services furnished since the previous certification or recertification were, and continue to be, medically necessary for either

- treatment which could reasonably be expected to improve the patient's condition; or
- diagnostic study

The hospital records indicate that the services furnished were either intensive treatment services, admission and related services necessary for diagnostic study, or equivalent services

LCD — PSYCHIATRIC INPATIENT HOSPITALIZATION (L34570) (CMS.GOV)

Inpatient Psychiatric Facilities (IPF)

- Initial Psychiatric Evaluation
- Physician Orders
- Plan of Treatment
- Progress Notes
- Physician Progress Notes
- Individual and Group Psychotherapy and Patient Education and Training Progress Notes
- Discharge Plan

Hyperbaric Oxygen Therapy (HBOT)

COVERAGE REQUIREMENTS

HCPC: G0277

Revenue Code: 0413

TOB: 13x (Hospital Outpatient)

Billed in 30-minute intervals

- ✓ 30 minutes = 1 unit
- ✓ 2 hours = 4 units
- Hyperbaric chambers are medical devices that require FDA clearance
- FDA: [Hyperbaric Oxygen Therapy: Get the Facts | FDA]

Physician Responsibilities

PRIMARY PHYSICIAN

Must:

- Provide direct supervision per CMS requirements as an outpatient service
- Must be readily available to provide immediate physical presence for assistance and direction through out the procedure
- Personally see the patient periodically to assess
- Treatment course
- Patient's progress
- Make any necessary changes to the treatment regimen

- ✓ Provide a signed and dated order for therapy to be administered
- ✓ Progress notes
- ✓ History & Physical (HP) and any other pertinent clinical documentation
- ✓ Diagnostic testing to confirm the diagnosis and support medical necessity

NCD — Hyperbaric Oxygen Therapy (20.29) (cms.gov)

Covered Diagnoses

Acute carbon monoxide intoxication	Gas embolism	Actinomycosis	Cyanide poisoning	Acute peripheral arterial insufficiency
Gas gangrene	Diabetic wounds of the lower extremities	Preparation and preservation of compromised skin grafts	Soft tissue radionecrosis	Osteoradionecrosis
Chronic refractory osteomyelitis	Decompression illness	Progressive necrotizing infections (necrotizing fasciitis)	Acute traumatic peripheral ischemia	Crush injuries and suturing of severed limbs

Covered Diagnoses

Some of the covered diagnoses have specific requirements that must be met per NCD 20.29 before they can be covered:

- Compromised Skin Grafts
- Chronic Refractory Osteomyelitis
- Actinomycosis
- Diabetic Wounds
- Acute Traumatic Peripheral Ischemia, Crush Injuries, Sutured Severed Limbs
- Osteoradionecrosis, Soft Tissue Radionecrosis
- Acute Peripheral Arterial Insufficieny

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)

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**

Documentation Tips

- Ensure correct assignment of all principal and secondary diagnosis and procedures codes
  - Correct coding and DRG assignments for these cases requires scrutiny of operative reports and a deep understanding by clinical coders
- Identify CCs and MCCS and ensure all codes are sequenced correctly
- Confirm that all diagnoses are supported by clinical documentation that is complete and legible and query providers if documentation is unclear
- Avoid relying solely on the coding applications or electronic health record for final code assignment
  - Especially for any CC/MCC secondary diagnoses that meet the definition of a reportable diagnosis

Documentation Tips

- Stay current on coding guidelines
  - Updated yearly
- Replacement, revision, repositioning, insertions, and upgrades are all variables that can affect DRG assignments
- Correct coding and DRG assignments for these cases requires scrutiny of operative reports and a deep understanding by clinical coders
- Coders must also understand the devices and procedures performed
  - Pacemakers versus defibrillators
  - Placement of devices

Documentation Tips

- Details of the patient's medical history
- Inpatient admission orders
- Description of the patient's current condition and treatment plan
- Progress note(s) that supports medical necessity documenting the patient's medical need
  - Visits will be prior to procedure being performed
- Procedure(s) performed, medical device implanted and rationale/expected outcome for treatment
- Documentation of the clinical evidence supporting the treatment plan including comorbidities

Documentation Tips

- Detail the patient's diagnosis and course of treatment
  - Adverse outcomes or lack of improvement from prior therapies
  - This will include office visit notes prior to the performance of procedure
- Describe the procedure in detail
- Operative report
- Nurse's notes
- Case management, social work, or discharge planning notes
- Describe any medical device and its benefits as they relate to the patient's condition
- Copy of the FDA approval letter (if applicable)

Prevention Tips

- Submit signed, dated orders and dated progress or treatment notes on and prior to the date of service to ensure documentation reflects medical necessity
- If progress/treatments notes are not signed, obtain an attestation from the physician, if illegible, obtain a signature log
- If using standing orders, make sure they are up-to-date
- If electronic orders, include electronic signature use policy and procedure
  - Use a checklist to ensure all the essential pieces are included in the record
  - Make sure that both sides of double-sided documents are submitted
  - Remember it is the billing provider's responsibility to obtain any necessary information required for the record review, regardless of the location of the documentation

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Part B Documentation Tips

Errors: Evaluation and Management (E/M)

- Documentation does not support the level of service billed — Incorrect coding
- Documentation did not support medical necessity
- Insufficient documentation
- No documentation received
- Unsigned medical record encounter

Medical necessity is the primary reason Medicare pays for a service. It is not medically necessary or appropriate to bill a higher level of E/M service when a lower level of service is more appropriate.

E/M Documentation Tips

- Should identify the patient, date of service and provider of service
- Should be clear, concise and reflect the patient's condition
- Documentation should substantiate the service performed/billed
- Documentation should substantiate the diagnosis code billed
- Document time
  - In and out time
  - Total time

If billing based on time, include documentation that reflects the entire visit with a clear explanation of what occurred during the visit and the plan

Errors: ESRD — Monthly Outpatient ESRD — Related Services

- Missing comprehensive assessment/reassessment of the beneficiary relative to the DOS developed by Interdisciplinary team
- No Plan of Care for home dialysis relative to the DOS developed and signed by at least one team member and the beneficiary or their designee
- Documentation did not support a face-to-face visit
- Not submitting the monthly comprehensive note from the billing provider
- Incorrectly billed ESRD MCP claim prior to the end of the month

Errors: Drugs of Abuse Testing

- Documentation did not support medical necessity of the service
- Documentation did not support the frequency of the billed service
  - Local Coverage Determination L35724
- Documentation did not include a risk assessment
- Incorrect date of service (DOS)

Remember that the DOS refers to the date of the sample collection, not the date the test was run. To receive reimbursement for controlled substance and drugs of abuse testing, the service reported on the claim must match the service ordered by the physician.

Drugs of Abuse Testing Documentation Tips

- Adhere to requirements outlined in Local Coverage Determination: L35724
- Document the covered indication
- Document medical necessity
- Documented risk assessment
  - The patient's risk category must be clearly defined in the medical record is essential in determining the number of UDTs billed over time and medical necessity

Errors: Drugs and Biologicals

- Missing order or plan/intent to order
- Documentation submitted did not support the service(s) billed
  - No documentation to support drug administration
- Documentation was for the incorrect date of service/patient
- Documentation does not support medical necessity of the billed service
- Utilization does not meet guidelines and regulations
  - Does not meet applicable LCD requirements (i.e. not an approved diagnosis)
- Documentation submitted does not support the ordered protocol was followed
- Missing signatures

Drugs and Biologicals Documentation Tips

- Include relevant history and physical to support the **medical necessity** of administration and/or dose of the drug (including any testing to support diagnosis)
  - **Relevant clinical signs and symptoms related to the medical condition for which the drug is indicated**
- Include a physician certified diagnosis that supports the need for the drug
- Signed physician order for drug/biological
- Order for protocol, if applicable
- Diagnostic test results that support medical necessity, when applicable
- Documentation of medication administration
- Document discarded amount (when applicable)
- Include documentation/signature of supervising provider

Documentation Tips

Audit-Proof Your Documentation

- Design an internal quality control record review
- Establish protocols and procedures
- Identify key personnel
- Implement the process
- Develop a checklist for documentation based on the information in this session
- Design and fix bad habits
- Keep records of the results of the audits
- Educate staff on what to look for when submitting medical records
- Educate professional medical staff on proper elements of documentation, especially signatures

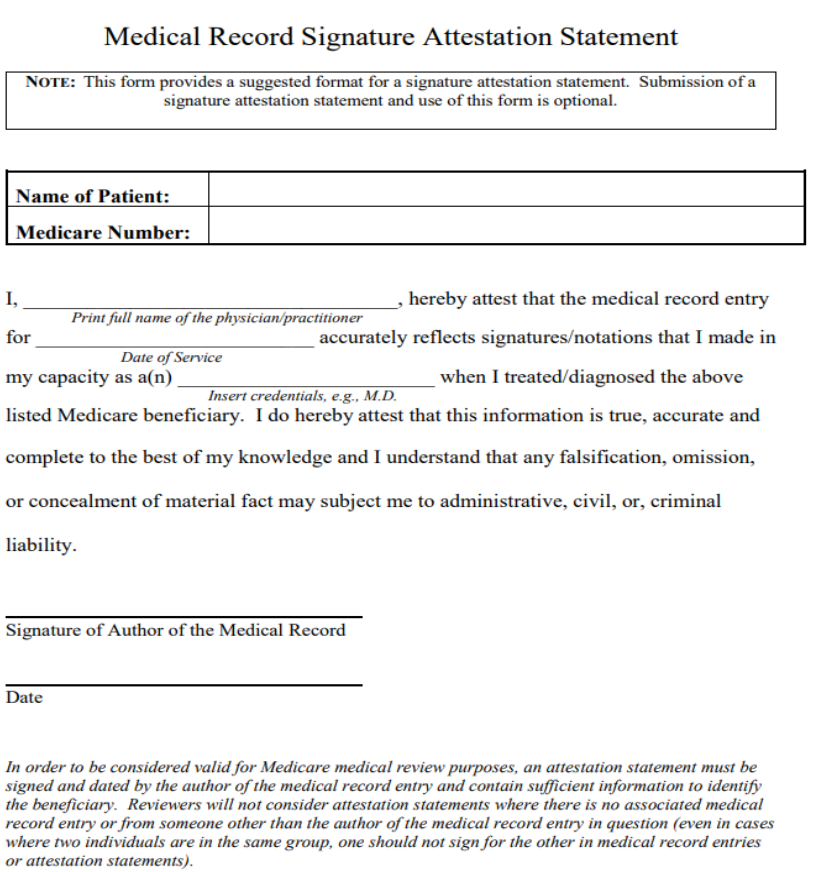
Signature Tips

- 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, _____, hereby attest that the medical record entry
Print full name of the physician/practitioner
for _____ accurately reflects signatures/notations that I made in
Date of Service
my capacity as a(n) _____ when I treated/diagnosed the above
Insert credentials, e.g., M.D.
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).

CMS Medicare Behavioral Health Initiatives

CMS Behavioral Health Strategy covers multiple elements

- Access to prevention and treatment services
- Medicare coverage for services beneficial to the mental well-being of Medicare beneficiaries
- Covered services supporting these initiatives include
  - Psychotherapy for Crisis
  - Behavioral Health Integration including the Collaborative Care Model
  - Opioid Use Disorder screening and treatment

Education

- Dear Physicians and Nonphysician Practitioner letter mailed in October
- Upcoming webinars
  - Behavioral Health Initiatives Overview
  - Behavioral Health Integration Services
  - Psychotherapy for Crisis
  - Opioid Use Disorder Screening & Treatment

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Appeals

What to Do When a Claim Is Denied

- CERT denials can be appealed
  - Please do not resubmit the claim(s)

- Denial decision was based on review of medical records the CERT contractor received; therefore, claims for these services may not be resubmitted, but may be appealed

- Documentation can be resubmitted if the claim denial is for insufficient documentation or no response to documentation requests

Appeals

First level of appeal — Redetermination

Timeframe — 120 days from the date of the initial determination. Services that are "returned to provider" with remark code MA130 must be corrected and resubmitted, not appealed.

Second level of appeal — Reconsideration

Timeframe — 180 days from receipt of redetermination. Submit this form to the Qualified Independent Contractor (C2C)

Redetermination Submissions

- **Use Palmetto GBA's eServices tool at:**
  https://www.onlineproviderservices.com/ecx_improvev2/
  - Most efficient and effective method of submission
  - Free and easy to use
  - You control the data entered
  - Reduces the potential for keying errors and misrouted mail

Redetermination Submissions

- **Via fax:**
  - JJ Part A: (803) 870–0138
  - JJ Part B: (803) 870–0139
  - JM Part A: (803) 699–2425
  - JM Part B: (803) 699–2427
- **Via mail:**
  - JJ Appeals Part A, Mail Code: AG-630, P.O. Box 100305, Columbia, SC 29202-3305
  - JJ Appeals Part B, Mail Code: AG-655, P.O. Box 100306, Columbia, SC 29202-3306
  - JM Appeals Part A, Mail Code: AG-630, P.O. Box 100238, Columbia, SC 29202-3238
  - JM Appeals Part B, Mail Code: AG-655, P.O. Box 100190, Columbia, SC 29202-3190

Redetermination — Helpful Information

- Please only submit your request via one method. Like requests are considered duplicates and must be consolidated.
  - This requires additional research that may delay processing
- If you are only appealing specific lines on the claim, clearly indicate which procedure code(s) you are appealing
- When submitting an appeal for denied service(s) on multiple claims, write “multiple claims” on the redetermination request form and include a list of all claims being appealed
  - You may also attach a spreadsheet or remittance advice (RAs) for the claims being appealed
- If appealing an overpayment, include a copy of the complete overpayment demand letter
- Clearly identify which claims are being appealed or if you wish to appeal all claims in the overpayment, clearly state this on your request.

Decisions will be rendered within 60 days of receipt of the written request.

Initial Determinations

- Initial determinations regarding claim benefits under Medicare Part A and B are made by the Medicare Administrative Contractors (MACs)
- Requests for payments that do not meet the requirements for a Medicare claim are not considered an initial determination, and as such are not appealable. Correct claim and resubmit.
- A Redetermination is an independent review of an initial determination on a claim by the A/B Medicare Administrative Contractor (MAC) and made by reviewers who were not involved in the initial claim determination

Appeal Decision Outcomes

Full Reversal

- You will receive a revised Medicare Remittance Advice (RA) showing the paid service/claim. You will not receive a Medicare Redetermination Notice (MRN). Medicare contractors may need to adjust the overpayment or amount of interest charged (may apply these funds to any other debt that you might owe and then release any excess to you).

Partial Reversal (Partially Favorable)

- In this instance, you will receive both a Medicare RA showing the paid service/claim portion allowed on appeal and a MRN letter explaining our decision; portion payable and what portion remain denied. The MRN will also provide further appeal rights.

Full Affirmation of the Initial Decision

- With an “unfavorable” decision that upholds the initial determination, you will receive a MRN letter explaining our decision. The MRN will also provide further appeal rights.

Resources

- **Medicare Benefit Policy Manual, Chapter 15**
  - https://tinyurl.com/4sfpkw5t
- **Medicare Claims Processing Manual**
  - https://tinyurl.com/4krad4b8
- **Palmetto GBA Jurisdiction M Part B Website**
  - https://tinyurl.com/3y5m3e5n

Customer Experience Survey

FEEDBACK

Don’t forget to complete the feedback survey!

http://tinyurl.com/bdfk6e43

Medical Review and Data Strategy

What should you know about Targeted Probe and Educate (TPE)?

MaKisha Pressley-Callaham, Ed.D
Clinical Reporting Supervisor

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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Disclaimer

The content in this presentation is intended for JM providers and is current as of the date of this presentation. Any changes or new information superseding this information is provided in articles with publication dates after the date of this presentation, at www.palmettogba.com .

Agenda

- The Medical Review Program
  - **Targeted Probe and Educate (TPE)**
  - **Data Strategy and Edit Effectiveness**
  - **How to respond to an Additional Documentation Request (ADR)**
  - **Top Denial Reasons and Common Errors**
  - **CERT**
  - **Provider Survey: Your Opinion Matters**

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.

Medical review involves the collection and clinical review of medical records and related information to ensure that payment is made only for services that meet all Medicare requirements.

Medical review identity's errors through claims analysis and/or medical record review activities

Source: [Medical Review and Education | CMS]

The Goal of TPE

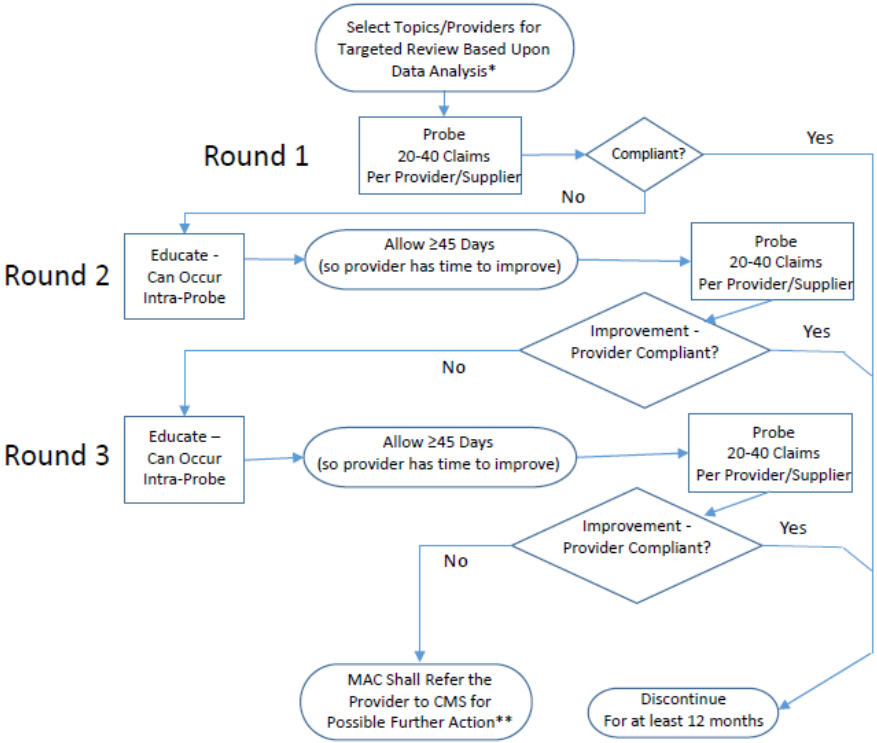
Reduce	Reduce appeals
Decrease	Decrease provider burden
Improve	Improve the Medical Review education process

TPE Background

- Targeted Probe and Educate (TPE) began as a pilot program in June of 2016
  - Paused April 2020
  - Restarted September 2021
- Developed from the Inpatient as well as Home Health Probe and Educate models
  - Prior models included participation of all providers with smaller review samples
  - Current TPE model providers are selected based on data analysis and probe reviews are conducted for 20-40 claims

Targeted Probe and Educate Process

The Cycle of TPE



What Is Data Strategy and Edit Effectiveness?

Defining Risks and Analysis

Analysis of data

Evaluation from independent resources

Validation/Analyze/Improve

Measure

Analyze

Improve/Control

Defining Risks and Analysis

- Analysis of Data:
  - Provider, service and beneficiary specific
  - Historical Claims Data
    - National, regional and state
  - Utilization trending and patterns
    - High volume/cost
    - Change in frequency

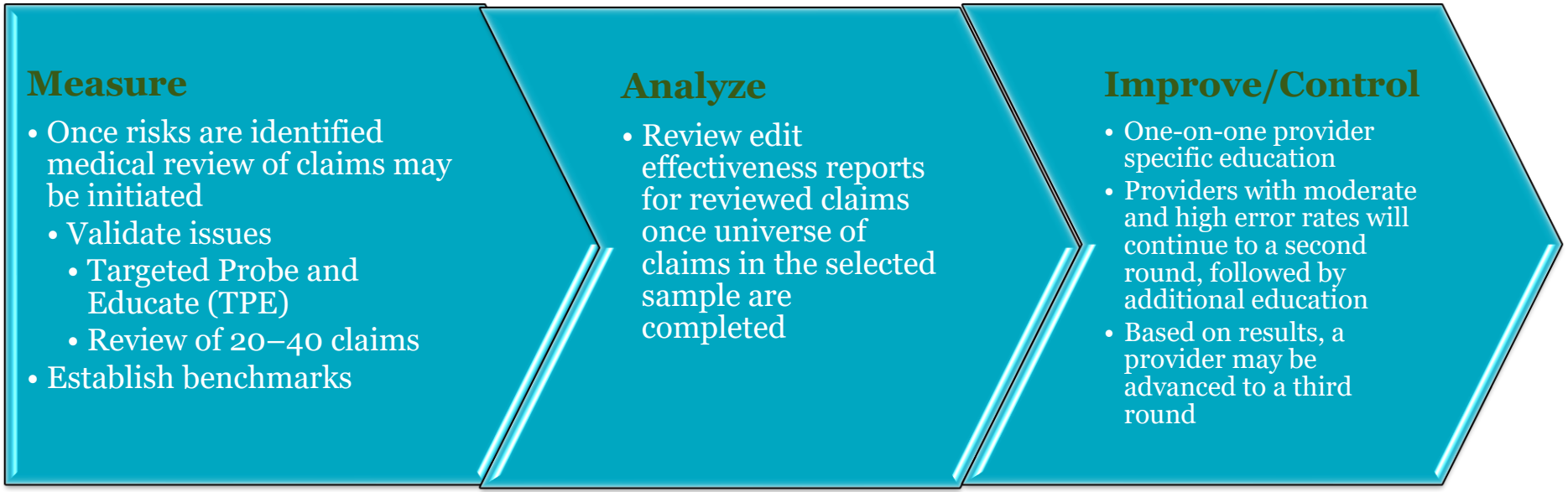
Defining Risks and Analysis (cont.)

Evaluation from independent resources

- Reports from CMS and other Government Agencies
  - Office of Inspector General (OIG)
  - Government Accountability Office (GAO)
- Reports from other Contractors
  - Comprehensive Error Rate Testing (CERT)
  - Recovery Auditor

Jurisdiction Specific Prioritization Reports

Validation/Analyze/Improve



Statistics & Error Reporting for Edits

Navigate	Navigate to Palmetto GBA website • www.Palmetto GBA.com
Select	Select the jurisdiction and line of business
Access	Access the Medical Review Topics list
Populate	Articles will populate on the landing page

What Is an Additional Documentation Request (ADR)?

According to the Social Security Act, Sections 1815(a), 1833€ and 1962 (a)(1)(A), providers are required to submit medical record documentation to support claims for Medicare services to the Medicare Administrative Contractor (MAC) upon request

This type of request is referred to an Additional Documentation Request (ADR)

The ADR outlines the information specific to the service and claim selected for review

How to Respond to an ADR

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 separate claim and the associated attached documentation
- Ensure each packet submitted has:
  - **1-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		Time Zone	☐ Pacific ☐ Mountain ☐ Central ☐ Eastern

Non-Response = Consequences

Per the Social Security Act, Sections 1815(a), 1833(e), and 1862(a)(1)(A), if the provider fails to send the requested documentation or extension request within 45 days, the claim review determination will be denied as not reasonable and necessary.

Instructions for Document Submission

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

The records should be submitted to Palmetto GBA Medical Review via one of the methods listed at the end of presentation

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

Submitting Medical Records

Medicare requires that medical record entries for services provided/ordered be authenticated by the author.

The method used shall be a handwritten or electronic signature.

If you question the legibility of your signature, you may submit an attestation statement in your ADR response	If the signature requirements are not met, the reviewer will conduct the review without considering the documentation with the missing or illegible signature	This could lead the reviewer to determine that the medical necessity for the service billed has not been substantiated	Electronic Submissions are the preferred method as they can be received within a short time frame	Stamped signatures are not acceptable

Results and Education

During the probe review, the reviewer may contact the designated POC for any missing information or to provide education on a specific claim or issue identified.

If you have submitted a complete documentation package or no education requirement was identified during the probe, the reviewer will not contact you during the probe.

Providers will receive an education letter at the conclusion of each reviewed claim with the individual claim specific results and any applicable education.

At the conclusion of the 20–40 claim review, cumulative results for the 20–40 claims reviewed will be issued and the clinician will contact the provider POC to schedule a 1:1 education session.

Top Denial Reasons

Auto-Denial/No Response Errors 56900/ 296/ 936

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
  - **eServices User Guide can be access at https://www.palmettogba.com/eServicesUserGuide**

Common TPE Questions

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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What Is the Process to Appeal a TPE Denial?

- The appeals process has not changed due to TPE
- If you have a review determination during TPE that results in a claim denial, we encourage you to review the medical records you submitted, and if you disagree with that determination, you should follow the established appeal's process

Examples of Data Analysis that May Trigger Selection for TPE?

Data is analyzed to identify services that have a high payment error probability and/or present the greatest risk

These services may be identified via previous review activity conducted by the MAC, the CERT contractor, the OIG and other CMS contractors

Once the services are identified, additional data analysis includes (but is not limited to) establishing a baseline to identify unusual trends such as provider's rank against peers and changes in utilization over time

When Were the First TPE Notification Letters Mailed?

- Initial TPE notification letters were mailed in September 2021 (TPE Restart)
- Initial TPE notification letters were mailed in September 2021 (TPE Restart)
- TPE probes and rounds are specific to a provider and each provider is treated independently

Is There a Documented Threshold to Determine if the Provider Should Move to the Next Round?

Each MAC evaluates the TPE probe claim denial or charge denial rate against an established threshold at the conclusion of each probe round.

Providers with error rates that exceed the established threshold may be progressed to the next round.

- *This information is communicated to the provider via the probe results information that all providers are issued at the conclusion of the 20–40 claim review for each probe*

Prior to the start of the next TPE probe round, all completed appeals and reopens are considered prior to transitioning a provider to the next probe.

If the new claim and charge denial rates are 20% or less, a new TPE results letter will be issued, and the provider will be removed from progressing to the next probe.

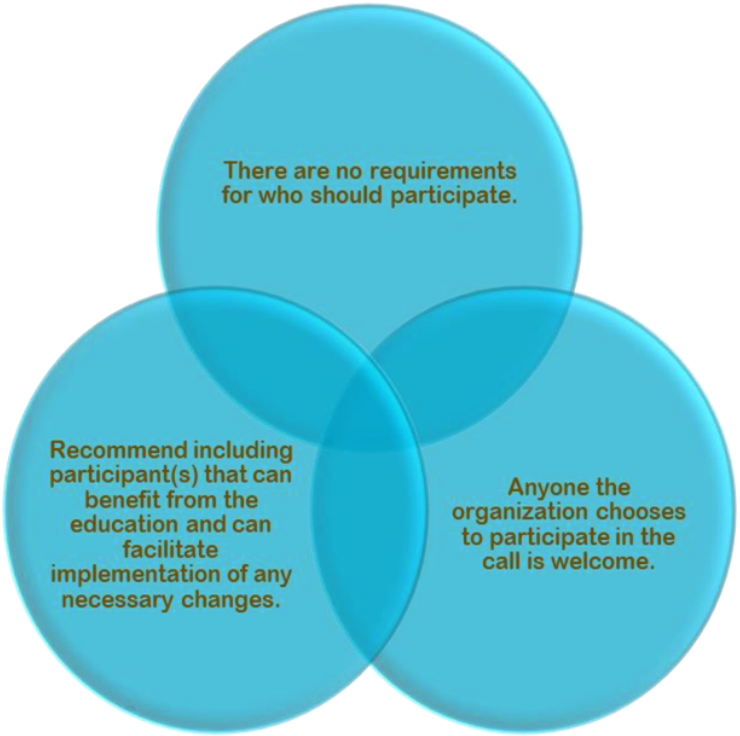
Who Conducts the TPE Reviews?

Registered Nurses

Certified Coders

Physical Therapists

Who Should Participate In the 1:1 Education?



PCC Contact Information

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

Part A

JJA Fax: (803) 870–0131

U.S. MAIL	OVERNIGHT MAIL
Palmetto GBA Part A Medical Review Mail Code AG-230 PO Box 100305 Columbia, SC 29202-3305	Palmetto GBA Part A Medical Review Mail Code AG-230 2300 Springdale Dr. Bldg. 1 Camden, SC 29020

JMA Fax: (803) 699–2432

U.S. MAIL	OVERNIGHT MAIL
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

Part B

JJB Fax: (803) 870–0135

U.S. MAIL	OVERNIGHT MAIL
Palmetto GBA Part B Medical Review Mail Code: AG-230 P.O. Box 100306 Columbia, SC 29202-3306	Palmetto GBA Part B Medical Review Mail Code: AG-230 2300 Springdale Drive, Bldg. 1 Camden, SC 29020

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

Home Health and Hospice

Fax: (803) 699–2436

U.S. MAIL	OVERNIGHT MAIL
Palmetto GBA HHH Medical Review Mail Code: AG-230 P.O. Box 100238 Columbia, SC 29202-3238	Palmetto GBA HHH Medical Review Mail Code: AG-230 2300 Springdale Drive, Bldg. 1 Camden, SC 29020

References

CMS IOM : https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html

100-02 Medicare Benefit Policy Manual

100-08 Medicare Program Integrity Manual

- Chapter 3
- Chapter 7

TPE Flowchart: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Downloads/TPE-Pilot-Flow-chart06-20-17v9-final.pdf

CMS TPE Strategy Article: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Targeted-Probe-and-EducateTPE.html

Connect With Us

FACEBOOK

Follow us on Facebook to learn about upcoming events and ask us general questions

X (TWITTER)

#StayConnected on Twitter for quick access to news and information

YOUTUBE

Go to YouTube for educational videos, tips and strategies

LINKEDIN

LinkedIn is your source for the latest Palmetto GBA news

Customer Experience Survey

FEEDBACK

Don’t forget to complete the feedback survey!

http://tinyurl.com/yf2dxpj6

Advance Care Planning

Presentation Sub-Title Goes Here

Charles Canaan
Senior Provider Education Consultant

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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Disclaimer

The content in this presentation is intended for JM providers and is current as of the date of this presentation. Any changes or new information superseding this information is provided in articles with publication dates after the date of this presentation, at www.palmettogba.com .

What Is Advance Care Planning?

Advance care planning involves discussing and preparing for future decisions about the beneficiary's medical care if the beneficiary becomes seriously ill or is unable to communicate his/her wishes.

Advance Care Planning: Advance Directives for Health Care | National Institute on Aging (nih.gov)

What Are Advance Directives?

- Advance directives are legal documents that provide instructions for medical care and only go into effect if the beneficiary cannot communicate his/her own wishes
- The two most common advance directives for health care:
  - **Living will**
  - **Durable power of attorney for health care**

Living Will

- A living will is a legal document that tells medical staff how the beneficiary wants to be treated if he/she cannot make his/her own decisions about emergency treatment.
- In a living will, the beneficiary dictates:
  - **Which common medical treatments or care he/she would want**
  - **Which ones he/she would want to avoid**
  - **Under which conditions each of these choices apply**

Advance Care Planning: Advance Directives for Health Care | National Institute on Aging (nih.gov)

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Advance Care Planning Forms and Orders

Do Not Resuscitate (DNR)

- A DNR becomes part of your medical chart to inform medical staff in a hospital or nursing facility that the beneficiary does not want CPR or other life-support measures to be attempted if your heartbeat and breathing stop
- Sometimes this document is referred to as a DNR order or an Allow Natural Death (AND) order

Do Not Intubate (DNI)

A DNI informs medical staff in a hospital or nursing facility that the beneficiary does not want to be on a ventilator.

Do Not Hospitalize (DNH)

A DNH indicates to long-term care providers, such as nursing home staff, that the beneficiary does not prefer not to be sent to a hospital for treatment at the end of life.

Out-of-Hospital DNR Order

An out-of-hospital DNR alerts emergency medical personnel to your wishes regarding measures to restore your heartbeat or breathing if you are not in a hospital.

POLST/MOLST

- Physician orders for life-sustaining treatment (POLST) and medical orders for life-sustaining treatment (MOLST) forms
- These forms provide guidance about your medical care that health care professionals can act on immediately in an emergency
- MOLST and POLST are the same thing, but in different states they call them by those two different names

Advance Care Planning: Advance Directives for Health Care | National Institute on Aging (nih.gov)

Advance Directives

Name of Document	What It Records	When It Is Used	Signed by a Doctor?	Witnesses Needed
Medical Power of Attorney (also called Durable Power of Attorney for Health Care)	Who will speak for the beneficiary regarding decisions about medical care	If beneficiary is unable to speak for him/herself to make decisions about medical care	No	Two witnesses or notary
Living Will (Also called Directive to Physicians and Family or Surrogates)	What the beneficiary wants in regarding decisions about medical care	If beneficiary is unable to speak for him/herself to make decisions about medical care	No	Two witnesses or notary

Advance Care Planning Workbook (mdanderson.org)

Advance Directives

Name of Document	What It Records	When It Is Used	Signed by a Doctor?	Witnesses Needed
Out-of-Hospital Do-Not Resuscitate (DNR) Order	Beneficiary does not wish to have CPR	If the heart or heart and lungs stop working when beneficiary is outside of the hospital (at home, in the community)	Yes (This is a medical order and advance directive)	None
Appointment of Disposition of Remains	Who will make decisions about beneficiary after death	After death	No	Two witnesses and notary
In-Hospital Do-Not Resuscitate (DNR) Order	Beneficiary does not wish to have CPR	If the heart or heart and lungs stop working when beneficiary is in the hospital	Yes (This is a medical order)	None

Medical Power of Attorney

- This advance directive names someone to make decisions for the beneficiary if the beneficiary is unable to speak for himself/herself, whether permanent or temporary. If the beneficiary cannot make decisions, this person will make decisions
- The responsibility of being a medical power of attorney can be emotionally difficult

Advance Care Planning Workbook (mdanderson.org)

Medical Power of Attorney

The beneficiary should choose someone who will honor, respect and follow the beneficiary's wishes. The medical power of attorney should be someone who:

- Is willing to speak on the beneficiary's behalf
- Is willing to act according to the beneficiary's wishes
- Can be there when needed
- Understands what is important to the beneficiary
- Is willing to ask important questions and understand the possible outcomes of medical decisions
- Is willing to talk about sensitive or difficult issues
- Can handle conflicting opinions among family, friends and medical providers

North Carolina State Law

N.C.G.S. § 90-21.13 provides the framework for a provider to determine who has the authority to make the health care decisions for the incapable patient.

Health Care Decisions in North Carolina — Who Decides? | The National Law Review (natlawreview.com)

N.C. Next of Kin for Informed Consent to Health Care Treatment or Procedure

The following persons, in the order indicated, are authorized to consent to medical treatment on behalf of a patient who is comatose or otherwise lacks capacity to make or communicate health care decisions:

1. A guardian of the patient's person, or a general guardian with powers over the patient's person, appointed by a court of competent jurisdiction pursuant to Article 5 of Chapter 35A of the General Statutes; provided that, if the patient has a health care agent appointed pursuant to a valid health care power of attorney, the health care agent shall have the right to exercise the authority to the extent granted in the health care power of attorney and to the extent provided in G.S. 32A-19(a) unless the Clerk has suspended the authority of that health care agent in accordance with G.S. 35A-1208(a).
2. A health care agent appointed pursuant to a valid health care power of attorney, to the extent of the authority granted
3. An agent, with powers to make health care decisions for the patient, appointed by the patient, to the extent of the authority granted
4. The patient's spouse
5. A majority of the patient's reasonably available parents and children who are at least 18 years of age
6. A majority of the patient's reasonably available siblings who are at least 18 years of age
7. An individual who has an established relationship with the patient, who is acting in good faith on behalf of the patient, and who can reliably convey the patient's wishes

If none of the persons listed under subsection (c) of this section is reasonably available, then the patient's attending physician, in the attending physician's discretion, may provide health care treatment without the consent of the patient or other person authorized to consent for the patient if there is confirmation by a physician other than the patient's attending physician of the patient's condition and the necessity for treatment; provided, however, that confirmation of the patient's condition and the necessity for treatment are not required if the delay in obtaining the confirmation would endanger the life or seriously worsen the condition of the patient

gs_90-21.13.pdf (ncleg.net)

No Code and Do Not Attempt Resuscitation Orders

- In addition to recognizing a Declaration for a Natural Death, North Carolina law further provides for a Health Care Power of Attorney, Portable Do Not Resuscitate Orders and a Medical Orders for Scope of Treatment
- Immunity protects persons and institutions that honor these documents in good faith

No Code and Do Not Attempt Resuscitation Orders — North Carolina Medical Society (ncmedsoc.org)

N.C. General Guidelines Applicable to All “No Code Blue” or DNR Orders

- Orders shall be entered only on the authority of the patient’s physician. A second physician’s opinion or signature is not required
- The orders shall be in writing and placed in the physician’s order section of the medical record
- The physician shall state in a progress note of the patient’s medical record the basis for entering the DNR order. The entry should include the patient’s medical status and prognosis and should indicate that the order is in keeping with the patient’s rights, known wishes or values and best interest
- Further supporting documentation also may summarize conversations with family members or the patient’s representative(s). In the event the patient has an advance directive, a copy should be included in the patient’s record
- The acceptability of telephone or oral DNR orders shall be established in individual health care institutions or agencies by policies jointly developed by the medical staff and the administration
- Orders to limit, withhold or discontinue life-prolonging measures, including a DNR order, shall be regularly reviewed and renewed in writing in a timely manner under policies established by the medical staff and the administration of the institution or agency
- DNR orders shall also be reviewed whenever there is: (a) a change in the patient’s condition or prognosis, including decisional capacity; (b) a change in the patient’s, family’s or surrogate’s wishes; (c) a change in the patient’s physician; or (d) a transfer to another care setting

No Code and Do Not Attempt Resuscitation Orders — North Carolina Medical Society (ncmedsoc.org)

N.C. Portable Do Not Resuscitate Order and Medical Order for Scope of Treatment

- § 90-21.17
- A physician may issue a portable DNR order or MOST for a patient:
  1. With the consent of the patient
  2. If the patient is a minor, with the consent of the patient's parent or guardian
  3. If the patient is not a minor but is incapable of making an informed decision regarding consent for the order, with the consent of the patient's representative

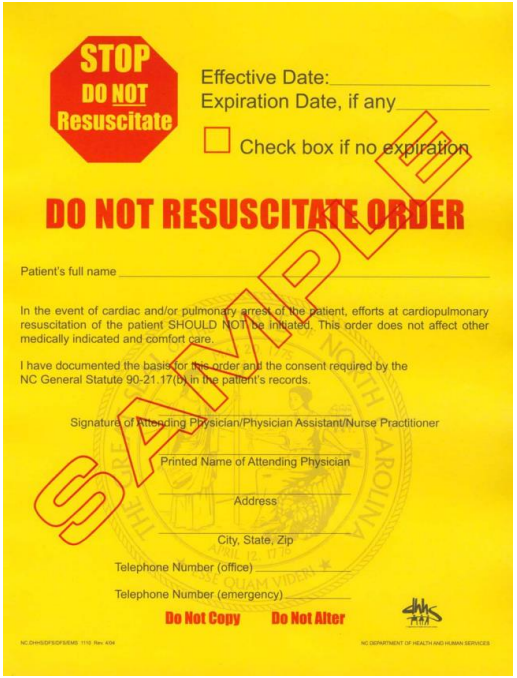
GS_90-21.17.pdf (ncleg.net)

N.C. Portable Do Not Resuscitate Order and Medical Order for Scope of Treatment

- The physician shall document the basis for the DNR order or MOST in the patient's medical record
- When the order is a MOST, the patient or the patient's representative must sign the form, provided, however, that if it is not practicable for the patient's representative to sign the original MOST form, the patient's representative shall sign a copy of the completed form and return it to the health care professional completing the form
- The copy of the form with the signature of the patient's representative, whether in paper or electronic form, shall be placed in the patient's medical record

GS_90-21.17.pdf (ncleg.net)

N.C. DNR Order Form


STOP
DO NOT
Resuscitate

Effective Date:
Expiration Date, if any
Check box if no expiration

DO NOT RESUSCITATE ORDER

SAMPLE

Patient's full name

In the event of cardiac and/or pulmonary arrest of the patient, efforts at cardiopulmonary resuscitation of the patient SHOULD NOT be initiated. This order does not affect other medically indicated and comfort care.

I have documented the basis for this order and the consent required by the NC General Statute 90-21.17(b) in the patient's records.

Signature of Attending Physician/Physician Assistant/Nurse Practitioner

Printed Name of Attending Physician

Address

City, State, Zip

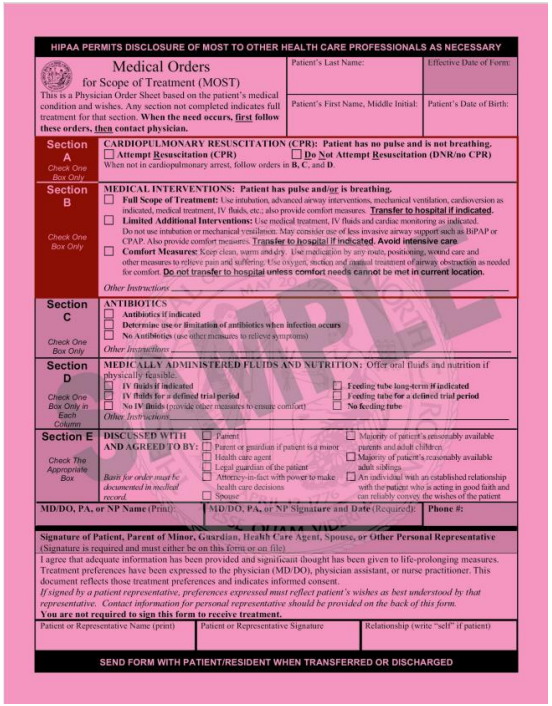
Telephone Number (office)

Telephone Number (emergency)

Do Not Copy Do Not Alter

[Microsoft PowerPoint — DNR.ppt (ncdhhs.gov)]

N.C. MOST Form



HIPAA PERMITS DISCLOSURE OF MOST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Medical Orders for Scope of Treatment (MOST)

This is a Physician Order Sheet based on the patient's medical condition and wishes. Any section not completed indicates full treatment for that section. **When the need occurs, first follow these orders, then contact physician.**

Patient's Last Name: | Effective Date of Form:

Patient's First Name, Middle Initial: | Patient's Date of Birth:

Section A (Check One Box Only)

CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and is not breathing.

☐ **Attempt Resuscitation (CPR)** ☐ **Do Not Attempt Resuscitation (DNR/no CPR)**

When not in cardiopulmonary arrest, follow orders in **B, C,** and **D**.

Section B (Check One Box Only)

MEDICAL INTERVENTIONS: Patient has pulse and/or is breathing.

☐ **Full Scope of Treatment:** Use intubation, advanced airway interventions, mechanical ventilation, cardioversion as indicated, medical treatment, IV fluids, etc.; also provide comfort measures. **Transfer to hospital if indicated.**

☐ **Limited Additional Interventions:** Use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation or mechanical ventilation. May consider use of less invasive airway support such as BiPAP or CPAP. Also provide comfort measures. **Transfer to hospital if indicated. Avoid intensive care.**

☐ **Comfort Measures:** Keep clean, warm and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. **Do not transfer to hospital unless comfort needs cannot be met in current location.**

Other Instructions:

Section C (Check One Box Only)

ANTIBIOTICS

☐ **Antibiotics if indicated**

☐ **Determine use or limitation of antibiotics when infection occurs**

☐ **No Antibiotics** (use other measures to relieve symptoms)

Other Instructions:

Section D (Check One Box Only in Each Column)

MEDICALLY ADMINISTERED FLUIDS AND NUTRITION: Offer oral fluids and nutrition if physically feasible.

☐ **IV fluids if indicated** ☐ **Feeding tube long-term if indicated**

☐ **IV fluids for a defined trial period** ☐ **Feeding tube for a defined trial period**

☐ **No IV fluids** (provide other measures to ensure comfort) ☐ **No feeding tube**

Other Instructions:

Section E (Check The Appropriate Box)

DISCUSSED WITH AND AGREED TO BY:

☐ Patient
☐ Patient or guardian if patient is a minor
☐ Health care agent
☐ Legal guardian of the patient
☐ Attorney-in-fact with power to make health care decisions
☐ Spouse
☐ Majority of patient's reasonably available patients and adult children
☐ Majority of patient's reasonably available adult siblings
☐ An individual with an established relationship with the patient who is acting in good faith and can reliably convey the wishes of the patient

Basis for order must be documented in medical record.

MD/DO, PA, or NP Name (Print): | MD/DO, PA, or NP Signature and Date (Required): | Phone #:

Signature of Patient, Parent of Minor, Guardian, Health Care Agent, Spouse, or Other Personal Representative
(Signature is required and must either be on this form or on file)

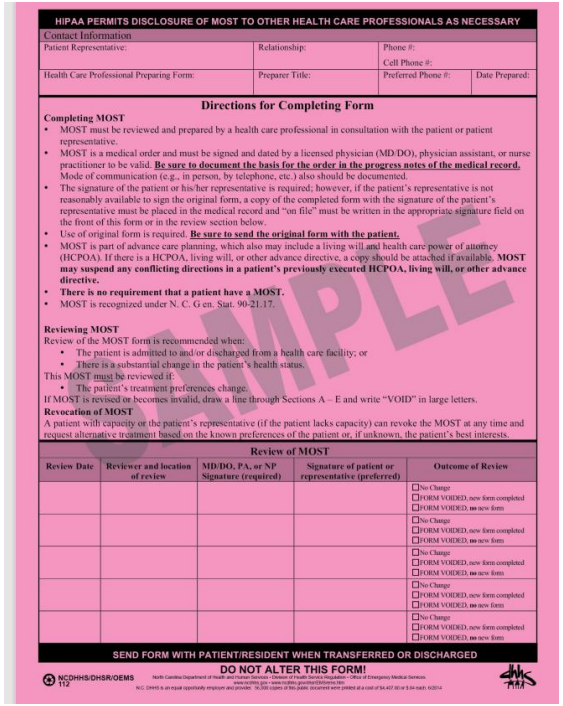
I agree that adequate information has been provided and significant thought has been given to life-prolonging measures. Treatment preferences have been expressed to the physician (MD/DO), physician assistant, or nurse practitioner. This document reflects those treatment preferences and indicates informed consent.

If signed by a patient representative, preferences expressed must reflect patient's wishes as best understood by that representative. Contact information for personal representative should be provided on the back of this form.

You are not required to sign this form to receive treatment.

Patient or Representative Name (print) | Patient or Representative Signature | Relationship (write "self" if patient)

SEND FORM WITH PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED



HIPAA PERMITS DISCLOSURE OF MOST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Contact Information

Patient Representative:	Relationship:	Phone #: Cell Phone #:	
Health Care Professional Preparing Form:	Preparer Title:	Preferred Phone #:	Date Prepared:

Directions for Completing Form

Completing MOST

- MOST must be reviewed and prepared by a health care professional in consultation with the patient or patient representative.
- MOST is a medical order and must be signed and dated by a licensed physician (MD/DO), physician assistant, or nurse practitioner to be valid. **Be sure to document the basis for the order in the progress notes of the medical record.** Mode of communication (e.g., in person, by telephone, etc.) also should be documented.
- The signature of the patient or his/her representative is required; however, if the patient's representative is not reasonably available to sign the original form, a copy of the completed form with the signature of the patient's representative must be placed in the medical record and "on file" must be written in the appropriate signature field on the front of this form or in the review section below.
- Use of original form is required. **Be sure to send the original form with the patient.**
- MOST is part of advance care planning, which also may include a living will and health care power of attorney (HCPOA). If there is a HCPOA, living will, or other advance directive, a copy should be attached if available. **MOST may suspend any conflicting directions in a patient's previously executed HCPOA, living will, or other advance directive.**
- **There is no requirement that a patient have a MOST.**
- MOST is recognized under N. C. Gen. Stat. 90-21.17.

Reviewing MOST

Review of the MOST form is recommended when:

- The patient is admitted to and/or discharged from a health care facility; or
- There is a substantial change in the patient's health status.

This MOST must be reviewed if:

- The patient's treatment preferences change.

If MOST is revised or becomes invalid, draw a line through Sections A – E and write "VOID" in large letters.

Revocation of MOST

A patient with capacity or the patient's representative (if the patient lacks capacity) can revoke the MOST at any time and request alternative treatment based on the known preferences of the patient or, if unknown, the patient's best interests.

Review of MOST

Review Date	Reviewer and location of review	MD/DO, PA, or NP Signature (required)	Signature of patient or representative (preferred)	Outcome of Review
				☐ No Change ☐ FORM VOIDED, new form completed ☐ FORM VOIDED, no new form
				☐ No Change ☐ FORM VOIDED, new form completed ☐ FORM VOIDED, no new form
				☐ No Change ☐ FORM VOIDED, new form completed ☐ FORM VOIDED, no new form
				☐ No Change ☐ FORM VOIDED, new form completed ☐ FORM VOIDED, no new form
				☐ No Change ☐ FORM VOIDED, new form completed ☐ FORM VOIDED, no new form

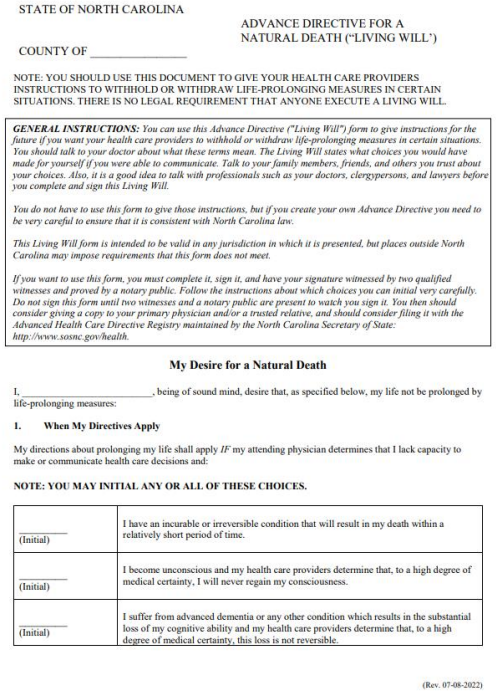
SEND FORM WITH PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

DO NOT ALTER THIS FORM!

NCDHHS/DHSR/OEMS 11/2

[NC DHSR OEMS: Medical Orders for Scope of Treatment Form (ncdhhs.gov)]

N.C. Advance Directive For a Natural Death (“Living Will”)



STATE OF NORTH CAROLINA

ADVANCE DIRECTIVE FOR A
NATURAL DEATH (“LIVING WILL’)

COUNTY OF _____

NOTE: YOU SHOULD USE THIS DOCUMENT TO GIVE YOUR HEALTH CARE PROVIDERS INSTRUCTIONS TO WITHHOLD OR WITHDRAW LIFE-PROLONGING MEASURES IN CERTAIN SITUATIONS. THERE IS NO LEGAL REQUIREMENT THAT ANYONE EXECUTE A LIVING WILL.

GENERAL INSTRUCTIONS: *You can use this Advance Directive ("Living Will") form to give instructions for the future if you want your health care providers to withhold or withdraw life-prolonging measures in certain situations. You should talk to your doctor about what these terms mean. The Living Will states what choices you would have made for yourself if you were able to communicate. Talk to your family members, friends, and others you trust about your choices. Also, it is a good idea to talk with professionals such as your doctors, clergypersons, and lawyers before you complete and sign this Living Will.*

You do not have to use this form to give those instructions, but if you create your own Advance Directive you need to be very careful to ensure that it is consistent with North Carolina law.

This Living Will form is intended to be valid in any jurisdiction in which it is presented, but places outside North Carolina may impose requirements that this form does not meet.

If you want to use this form, you must complete it, sign it, and have your signature witnessed by two qualified witnesses and proved by a notary public. Follow the instructions about which choices you can initial very carefully. Do not sign this form until two witnesses and a notary public are present to watch you sign it. You then should consider giving a copy to your primary physician and/or a trusted relative, and should consider filing it with the Advanced Health Care Directive Registry maintained by the North Carolina Secretary of State: http://www.sosnc.gov/health.

My Desire for a Natural Death

I, _____, being of sound mind, desire that, as specified below, my life not be prolonged by life-prolonging measures:

1. When My Directives Apply

My directions about prolonging my life shall apply *IF* my attending physician determines that I lack capacity to make or communicate health care decisions and:

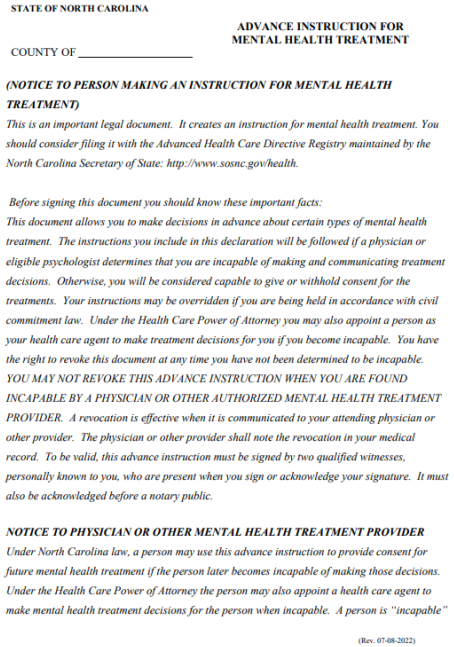
NOTE: YOU MAY INITIAL ANY OR ALL OF THESE CHOICES.

_____ (Initial)	I have an incurable or irreversible condition that will result in my death within a relatively short period of time.
_____ (Initial)	I become unconscious and my health care providers determine that, to a high degree of medical certainty, I will never regain my consciousness.
_____ (Initial)	I suffer from advanced dementia or any other condition which results in the substantial loss of my cognitive ability and my health care providers determine that, to a high degree of medical certainty, this loss is not reversible.

(Rev. 07-08-2022)

[ADVANCE DIRECTIVE FOR A NATURAL DEATH ("LIVING WILL") (sosnc.gov)]

N.C. Advance Instruction For Mental Health Treatment



STATE OF NORTH CAROLINA

ADVANCE INSTRUCTION FOR MENTAL HEALTH TREATMENT

COUNTY OF _____

(NOTICE TO PERSON MAKING AN INSTRUCTION FOR MENTAL HEALTH TREATMENT)

This is an important legal document. It creates an instruction for mental health treatment. You should consider filing it with the Advanced Health Care Directive Registry maintained by the North Carolina Secretary of State: http://www.sosnc.gov/health.

Before signing this document you should know these important facts:
This document allows you to make decisions in advance about certain types of mental health treatment. The instructions you include in this declaration will be followed if a physician or eligible psychologist determines that you are incapable of making and communicating treatment decisions. Otherwise, you will be considered capable to give or withhold consent for the treatments. Your instructions may be overridden if you are being held in accordance with civil commitment law. Under the Health Care Power of Attorney you may also appoint a person as your health care agent to make treatment decisions for you if you become incapable. You have the right to revoke this document at any time you have not been determined to be incapable. YOU MAY NOT REVOKE THIS ADVANCE INSTRUCTION WHEN YOU ARE FOUND INCAPABLE BY A PHYSICIAN OR OTHER AUTHORIZED MENTAL HEALTH TREATMENT PROVIDER. A revocation is effective when it is communicated to your attending physician or other provider. The physician or other provider shall note the revocation in your medical record. To be valid, this advance instruction must be signed by two qualified witnesses, personally known to you, who are present when you sign or acknowledge your signature. It must also be acknowledged before a notary public.

NOTICE TO PHYSICIAN OR OTHER MENTAL HEALTH TREATMENT PROVIDER

Under North Carolina law, a person may use this advance instruction to provide consent for future mental health treatment if the person later becomes incapable of making those decisions. Under the Health Care Power of Attorney the person may also appoint a health care agent to make mental health treatment decisions for the person when incapable. A person is "incapable"

(Rev. 07-08-2022)

[STATE OF NORTH CAROLINA (sosnc.gov)]

N.C. Health Care Power of Attorney

NORTH CAROLINA ADVANCE DIRECTIVE – PAGE 1 OF 14

PART I: HEALTH CARE POWER OF ATTORNEY

NOTE: YOU SHOULD ONLY USE THIS DOCUMENT TO NAME A PERSON AS YOUR HEALTH CARE AGENT IF YOU ARE COMFORTABLE GIVING THAT PERSON BROAD AND SWEEPING POWERS TO MAKE HEALTH CARE DECISIONS FOR YOU. THERE IS NO LEGAL REQUIREMENT THAT ANYONE EXECUTE A HEALTH CARE POWER OF ATTORNEY.

EXPLANATION

EXPLANATION: You have the right to name someone to make health care decisions for you when you cannot make or communicate those decisions. This form may be used to create a health care power of attorney, and meets the requirements of North Carolina law. However, you are not required to use this form, and North Carolina law allows the use of other forms that meet certain requirements. If you prepare your own health care power of attorney, you should be very careful to make sure it is consistent with North Carolina law.

This document gives the person you designate as your health care agent broad powers to make health care decisions for you when you cannot make the decision yourself or cannot communicate your decision to other people. You should discuss your wishes concerning life-prolonging measures, mental health treatment, and other health care decisions with your health care agent. Except to the extent that you express specific limitations or restrictions in this form, your health care agent may make any health care decision you could make yourself.

This form does not impose a duty on your health care agent to exercise granted powers, but when a power is exercised, your health care agent will be obligated to use due care to act in your best interests and in accordance with this document.

This Health Care Power of Attorney form is intended to be valid in any jurisdiction in which it is presented, but places outside North Carolina may impose requirements that this form does not meet.

If you want to use this form, you must complete it, sign it, and have your signature witnessed by two qualified witnesses and proved by a notary public. Follow the instructions about which choices you can initial very carefully. Do not sign this form until two witnesses and a notary public are present to watch you sign it. You then should give a copy to your health care agent and to any alternates you name. You should consider filing it with the Advance Health Care Directive Registry maintained by the North Carolina Secretary of State: http://www.secretary.state.nc.us/ahcdr/Forms.aspx.

NORTH CAROLINA ADVANCE DIRECTIVE – PAGE 2 OF 14

1. Designation of Health Care Agent.

PRINT YOUR NAME

I, _____, being of sound mind,
(name)
hereby appoint the following person(s) to serve as my health care agent(s) to act for me and in my name (in any way I could act in person) to make health care decisions for me as authorized in this document. My designated health care agent(s) shall serve alone, in the order named.

PRINT YOUR AGENT'S AND SUCCESSOR AGENTS' NAMES, ADDRESSES AND TELEPHONE NUMBERS

A. Name: _____ Home Telephone: _____
Home Address: _____ Work Telephone: _____

_____ Cellular Telephone: _____

B. Name: _____ Home Telephone: _____
Home Address: _____ Work Telephone: _____

_____ Cellular Telephone: _____

C. Name: _____ Home Telephone: _____
Home Address: _____ Work Telephone: _____

_____ Cellular Telephone: _____

Any successor health care agent designated shall be vested with the same power and duties as if originally named as my health care agent, and shall serve any time his or her predecessor is not reasonably available or is unwilling or unable to serve in that capacity.

2. Effectiveness of appointment.

NAME THE PHYSICIAN(S) WHO YOU WANT TO DETERMINE THAT YOU CAN NO LONGER MAKE HEALTH CARE DECISIONS

3. My designation of a health care agent expires only when I revoke it. Absent revocation, the authority granted in this document shall become effective when and if one of the physician(s) listed below determines that I lack capacity to make or communicate decisions relating to my health care, and will continue in effect during that incapacity, or until my death, except if I authorize my health care agent to exercise my rights with respect to anatomical gifts, autopsy, or disposition of my remains, this authority will continue after my death to the extent necessary to exercise that authority.

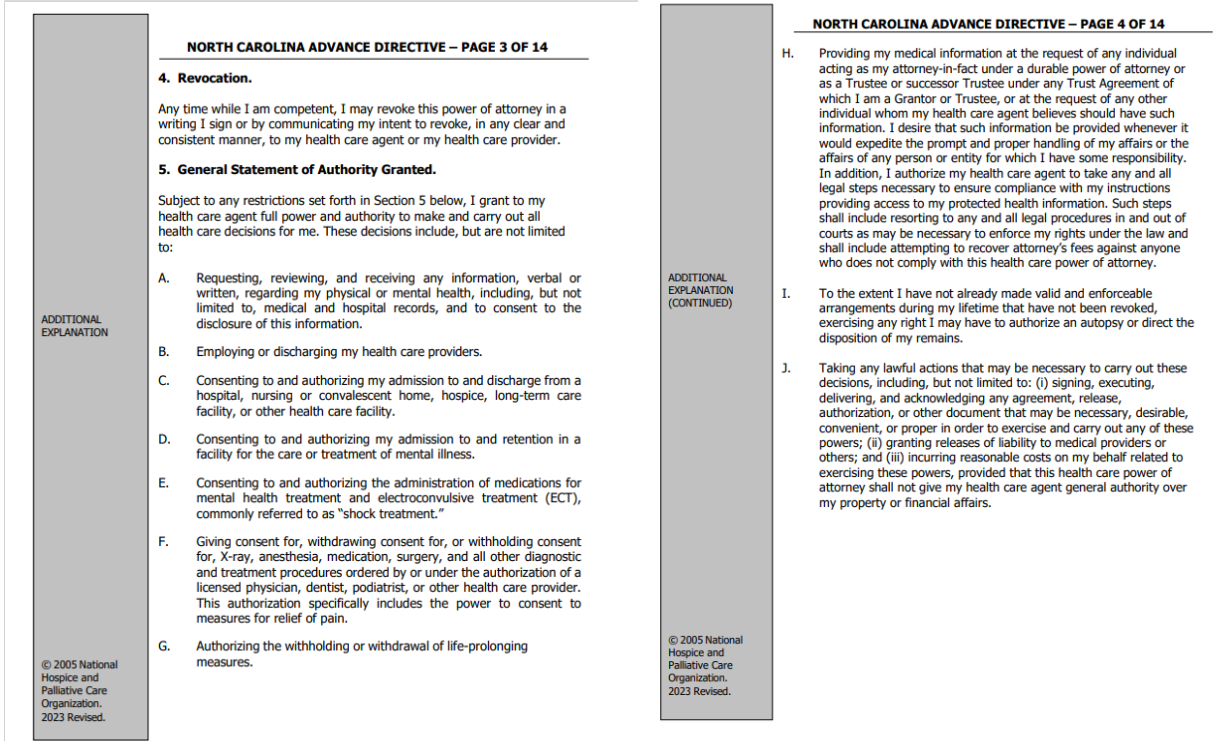
1. _____(Physician)

2. _____(Physician)

If I have not designated a physician, or no physician(s) named above is reasonably available, the determination that I lack capacity to make or communicate decisions relating to my health care shall be made by my attending physician.

health_care_power_of_attorney.pdf (sosnc.gov)

N.C. Health Care Power of Attorney



NORTH CAROLINA ADVANCE DIRECTIVE – PAGE 3 OF 14

ADDITIONAL EXPLANATION

4. Revocation.

Any time while I am competent, I may revoke this power of attorney in a writing I sign or by communicating my intent to revoke, in any clear and consistent manner, to my health care agent or my health care provider.

5. General Statement of Authority Granted.

Subject to any restrictions set forth in Section 5 below, I grant to my health care agent full power and authority to make and carry out all health care decisions for me. These decisions include, but are not limited to:

A. Requesting, reviewing, and receiving any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records, and to consent to the disclosure of this information.

B. Employing or discharging my health care providers.

C. Consenting to and authorizing my admission to and discharge from a hospital, nursing or convalescent home, hospice, long-term care facility, or other health care facility.

D. Consenting to and authorizing my admission to and retention in a facility for the care or treatment of mental illness.

E. Consenting to and authorizing the administration of medications for mental health treatment and electroconvulsive treatment (ECT), commonly referred to as "shock treatment."

F. Giving consent for, withdrawing consent for, or withholding consent for, X-ray, anesthesia, medication, surgery, and all other diagnostic and treatment procedures ordered by or under the authorization of a licensed physician, dentist, podiatrist, or other health care provider. This authorization specifically includes the power to consent to measures for relief of pain.

G. Authorizing the withholding or withdrawal of life-prolonging measures.

NORTH CAROLINA ADVANCE DIRECTIVE – PAGE 4 OF 14

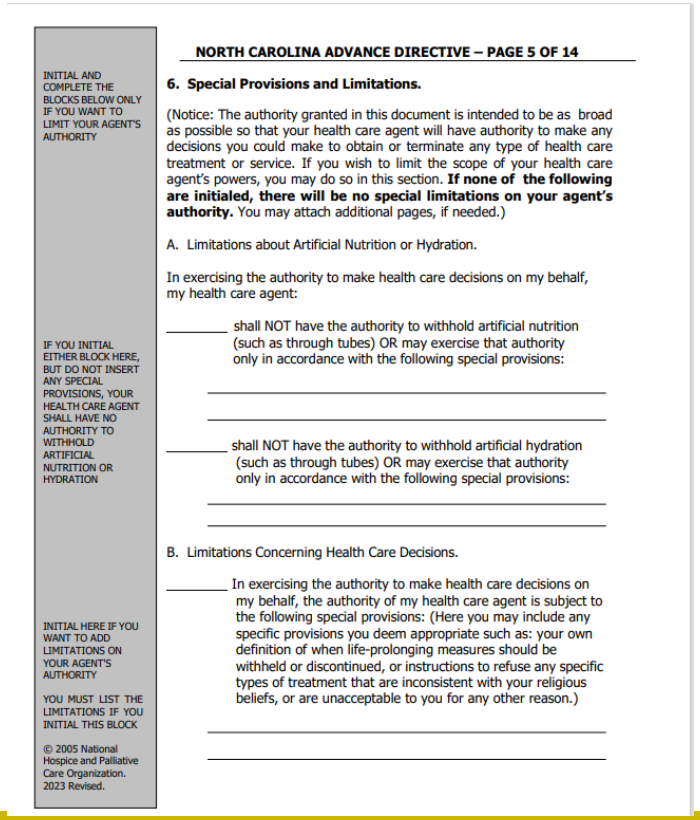
ADDITIONAL EXPLANATION (CONTINUED)

H. Providing my medical information at the request of any individual acting as my attorney-in-fact under a durable power of attorney or as a Trustee or successor Trustee under any Trust Agreement of which I am a Grantor or Trustee, or at the request of any other individual whom my health care agent believes should have such information. I desire that such information be provided whenever it would expedite the prompt and proper handling of my affairs or the affairs of any person or entity for which I have some responsibility. In addition, I authorize my health care agent to take any and all legal steps necessary to ensure compliance with my instructions providing access to my protected health information. Such steps shall include resorting to any and all legal procedures in and out of courts as may be necessary to enforce my rights under the law and shall include attempting to recover attorney's fees against anyone who does not comply with this health care power of attorney.

I. To the extent I have not already made valid and enforceable arrangements during my lifetime that have not been revoked, exercising any right I may have to authorize an autopsy or direct the disposition of my remains.

J. Taking any lawful actions that may be necessary to carry out these decisions, including, but not limited to: (i) signing, executing, delivering, and acknowledging any agreement, release, authorization, or other document that may be necessary, desirable, convenient, or proper in order to exercise and carry out any of these powers; (ii) granting releases of liability to medical providers or others; and (iii) incurring reasonable costs on my behalf related to exercising these powers, provided that this health care power of attorney shall not give my health care agent general authority over my property or financial affairs.

N.C. Health Care Power of Attorney



INITIAL AND COMPLETE THE BLOCKS BELOW ONLY IF YOU WANT TO LIMIT YOUR AGENT'S AUTHORITY

IF YOU INITIAL EITHER BLOCK HERE, BUT DO NOT INSERT ANY SPECIAL PROVISIONS, YOUR HEALTH CARE AGENT SHALL HAVE NO AUTHORITY TO WITHHOLD ARTIFICIAL NUTRITION OR HYDRATION

INITIAL HERE IF YOU WANT TO ADD LIMITATIONS ON YOUR AGENT'S AUTHORITY

YOU MUST LIST THE LIMITATIONS IF YOU INITIAL THIS BLOCK

6. Special Provisions and Limitations.

(Notice: The authority granted in this document is intended to be as broad as possible so that your health care agent will have authority to make any decisions you could make to obtain or terminate any type of health care treatment or service. If you wish to limit the scope of your health care agent's powers, you may do so in this section. **If none of the following are initialed, there will be no special limitations on your agent's authority.** You may attach additional pages, if needed.)

A. Limitations about Artificial Nutrition or Hydration.

In exercising the authority to make health care decisions on my behalf, my health care agent:

_____ shall NOT have the authority to withhold artificial nutrition (such as through tubes) OR may exercise that authority only in accordance with the following special provisions:

_____

_____

_____ shall NOT have the authority to withhold artificial hydration (such as through tubes) OR may exercise that authority only in accordance with the following special provisions:

_____

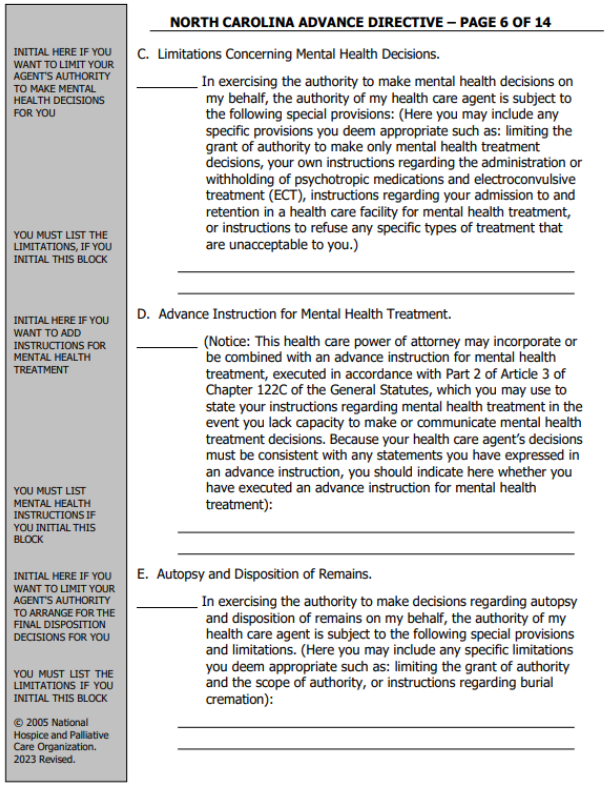
_____

B. Limitations Concerning Health Care Decisions.

_____ In exercising the authority to make health care decisions on my behalf, the authority of my health care agent is subject to the following special provisions: (Here you may include any specific provisions you deem appropriate such as: your own definition of when life-prolonging measures should be withheld or discontinued, or instructions to refuse any specific types of treatment that are inconsistent with your religious beliefs, or are unacceptable to you for any other reason.)

_____

_____



INITIAL HERE IF YOU WANT TO LIMIT YOUR AGENT'S AUTHORITY TO MAKE MENTAL HEALTH DECISIONS FOR YOU

YOU MUST LIST THE LIMITATIONS, IF YOU INITIAL THIS BLOCK

INITIAL HERE IF YOU WANT TO ADD INSTRUCTIONS FOR MENTAL HEALTH TREATMENT

YOU MUST LIST MENTAL HEALTH INSTRUCTIONS IF YOU INITIAL THIS BLOCK

INITIAL HERE IF YOU WANT TO LIMIT YOUR AGENT'S AUTHORITY TO ARRANGE FOR THE FINAL DISPOSITION DECISIONS FOR YOU

YOU MUST LIST THE LIMITATIONS IF YOU INITIAL THIS BLOCK

C. Limitations Concerning Mental Health Decisions.

_____ In exercising the authority to make mental health decisions on my behalf, the authority of my health care agent is subject to the following special provisions: (Here you may include any specific provisions you deem appropriate such as: limiting the grant of authority to make only mental health treatment decisions, your own instructions regarding the administration or withholding of psychotropic medications and electroconvulsive treatment (ECT), instructions regarding your admission to and retention in a health care facility for mental health treatment, or instructions to refuse any specific types of treatment that are unacceptable to you.)

_____

_____

D. Advance Instruction for Mental Health Treatment.

_____ (Notice: This health care power of attorney may incorporate or be combined with an advance instruction for mental health treatment, executed in accordance with Part 2 of Article 3 of Chapter 122C of the General Statutes, which you may use to state your instructions regarding mental health treatment in the event you lack capacity to make or communicate mental health treatment decisions. Because your health care agent's decisions must be consistent with any statements you have expressed in an advance instruction, you should indicate here whether you have executed an advance instruction for mental health treatment):

_____

_____

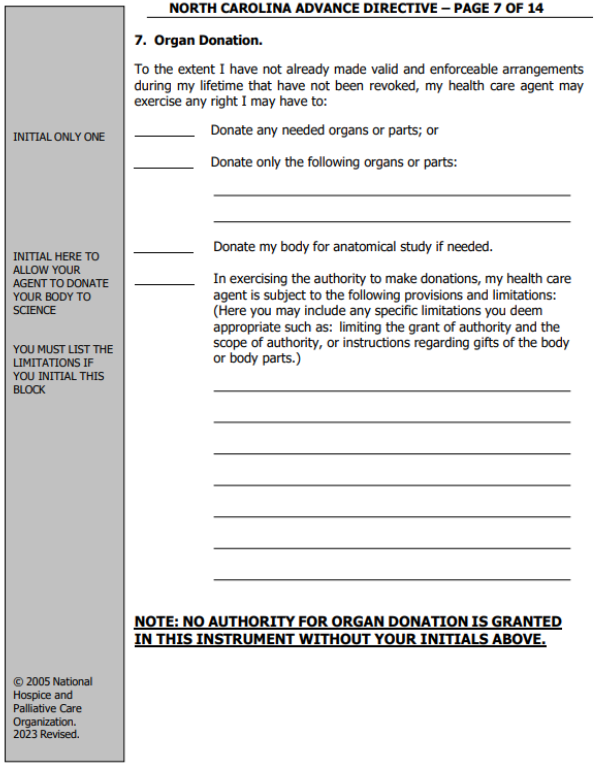
E. Autopsy and Disposition of Remains.

_____ In exercising the authority to make decisions regarding autopsy and disposition of remains on my behalf, the authority of my health care agent is subject to the following special provisions and limitations. (Here you may include any specific limitations you deem appropriate such as: limiting the grant of authority and the scope of authority, or instructions regarding burial cremation):

_____

_____

N.C. Health Care Power of Attorney



INITIAL ONLY ONE

INITIAL HERE TO ALLOW YOUR AGENT TO DONATE YOUR BODY TO SCIENCE

YOU MUST LIST THE LIMITATIONS IF YOU INITIAL THIS BLOCK

7. Organ Donation.

To the extent I have not already made valid and enforceable arrangements during my lifetime that have not been revoked, my health care agent may exercise any right I may have to:

_____ Donate any needed organs or parts; or

_____ Donate only the following organs or parts:

_____

_____

_____ Donate my body for anatomical study if needed.

_____ In exercising the authority to make donations, my health care agent is subject to the following provisions and limitations: (Here you may include any specific limitations you deem appropriate such as: limiting the grant of authority and the scope of authority, or instructions regarding gifts of the body or body parts.)

_____

_____

_____

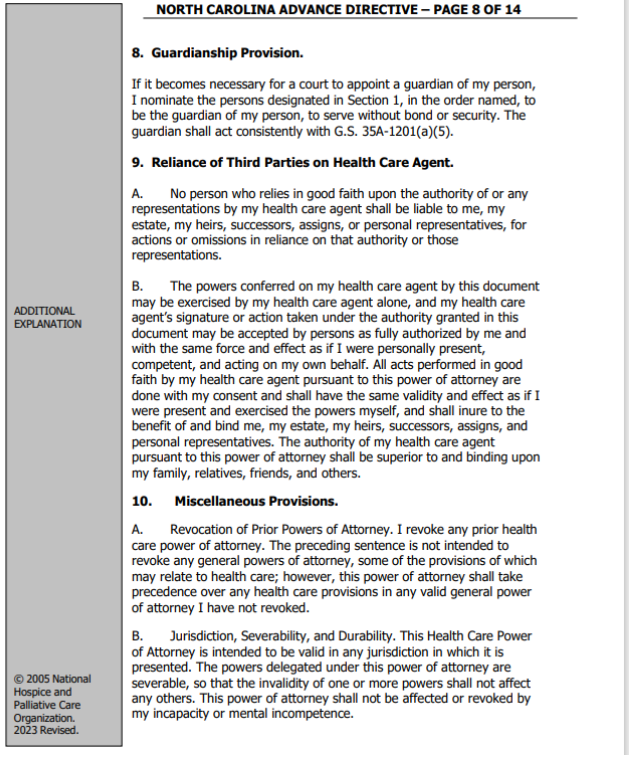
_____

_____

_____

_____

NOTE: NO AUTHORITY FOR ORGAN DONATION IS GRANTED IN THIS INSTRUMENT WITHOUT YOUR INITIALS ABOVE.



ADDITIONAL EXPLANATION

8. Guardianship Provision.

If it becomes necessary for a court to appoint a guardian of my person, I nominate the persons designated in Section 1, in the order named, to be the guardian of my person, to serve without bond or security. The guardian shall act consistently with G.S. 35A-1201(a)(5).

9. Reliance of Third Parties on Health Care Agent.

A. No person who relies in good faith upon the authority of or any representations by my health care agent shall be liable to me, my estate, my heirs, successors, assigns, or personal representatives, for actions or omissions in reliance on that authority or those representations.

B. The powers conferred on my health care agent by this document may be exercised by my health care agent alone, and my health care agent's signature or action taken under the authority granted in this document may be accepted by persons as fully authorized by me and with the same force and effect as if I were personally present, competent, and acting on my own behalf. All acts performed in good faith by my health care agent pursuant to this power of attorney are done with my consent and shall have the same validity and effect as if I were present and exercised the powers myself, and shall inure to the benefit of and bind me, my estate, my heirs, successors, assigns, and personal representatives. The authority of my health care agent pursuant to this power of attorney shall be superior to and binding upon my family, relatives, friends, and others.

10. Miscellaneous Provisions.

A. Revocation of Prior Powers of Attorney. I revoke any prior health care power of attorney. The preceding sentence is not intended to revoke any general powers of attorney, some of the provisions of which may relate to health care; however, this power of attorney shall take precedence over any health care provisions in any valid general power of attorney I have not revoked.

B. Jurisdiction, Severability, and Durability. This Health Care Power of Attorney is intended to be valid in any jurisdiction in which it is presented. The powers delegated under this power of attorney are severable, so that the invalidity of one or more powers shall not affect any others. This power of attorney shall not be affected or revoked by my incapacity or mental incompetence.

N.C. Health Care Power of Attorney

C. Health Care Agent Not Liable. My health care agent and my health care agent's estate, heirs, successors, and assigns are hereby released and forever discharged by me, my estate, my heirs, successors, assigns, and personal representatives from all liability and from all claims or demands of all kinds arising out of my health care agent's acts or omissions, except for my health care agent's willful misconduct or gross negligence.

D. No Civil or Criminal Liability. No act or omission of my health care agent, or of any other person, entity, institution, or facility acting in good faith in reliance on the authority of my health care agent pursuant to this Health Care Power of Attorney shall be considered suicide, nor the cause of my death for any civil or criminal purposes, nor shall it be considered unprofessional conduct or as lack of professional competence. Any person, entity, institution, or facility against whom criminal or civil liability is asserted because of conduct authorized by this Health Care Power of Attorney may interpose this document as a defense.

E. Reimbursement. My health care agent shall be entitled to reimbursement for all reasonable expenses incurred as a result of carrying out any provision of this directive.

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

11. Additional Instructions

My agent should also consider the following instructions in making decisions on my behalf:

(Attach additional pages, if needed.)

12. I Understand the Effect of this Health Care Power of Attorney.

By executing this document in Part III, I indicate that I am mentally alert and competent, fully informed as to the contents of this document, and understand the full import of this grant of powers to my health care agent.

PART II: ADVANCE DIRECTIVE FOR A NATURAL DEATH ("LIVING WILL")

NOTE: YOU SHOULD USE THIS DOCUMENT TO GIVE YOUR HEALTH CARE PROVIDERS INSTRUCTIONS TO WITHHOLD OR WITHDRAW LIFE-PROLONGING MEASURES IN CERTAIN SITUATIONS. THERE IS NO LEGAL REQUIREMENT THAT ANYONE EXECUTE A LIVING WILL.

GENERAL INSTRUCTIONS

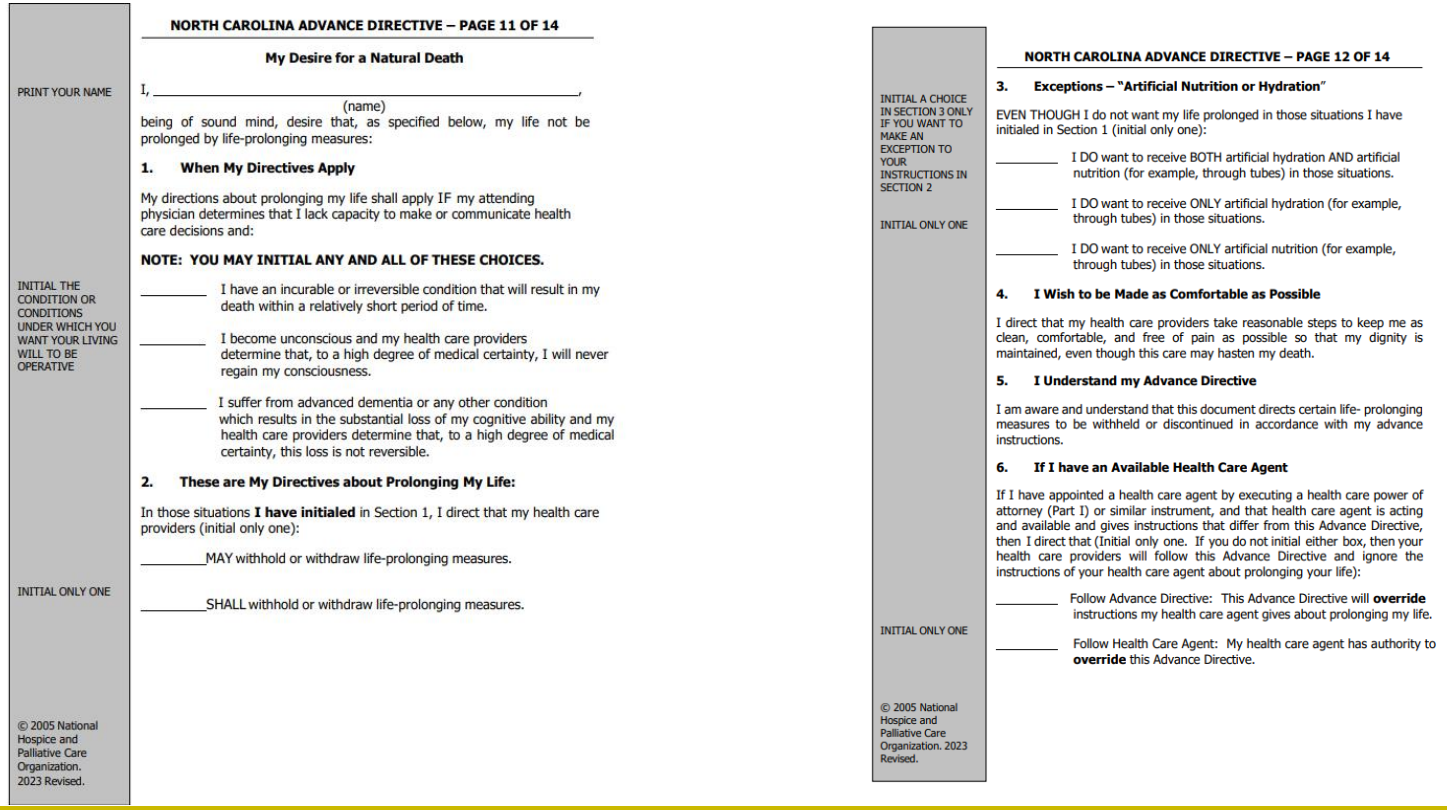
GENERAL INSTRUCTIONS: You can use this Advance Directive ("Living Will") form to give instructions for the future if you want your health care providers to withhold or withdraw life-prolonging measures in certain situations. You should talk to your doctor about what these terms mean. The Living Will states what choices you would have made for yourself if you were able to communicate. Talk to your family members, friends, and others you trust about your choices. Also, it is a good idea to talk with professionals such as your doctors, clergypersons, and lawyers before you complete and sign this Living Will.

You do not have to use this form to give those instructions, but if you create your own Advance Directive you need to be very careful to ensure that it is consistent with North Carolina law.

This Living Will form is intended to be valid in any jurisdiction in which it is presented, but places outside North Carolina may impose requirements that this form does not meet.

If you want to use this form, you must complete it, sign it, and have your signature witnessed by two qualified witnesses and proved by a notary public. Follow the instructions about which choices you can initial very carefully. Do not sign this form until two witnesses and a notary public are present to watch you sign it. You then should consider giving a copy to your primary physician and/or a trusted relative, and should consider filing it with the Advance Health Care Directive Registry maintained by the North Carolina Secretary of State: http://www.secretary.state.nc.us/ahcdr/Forms.aspx.

N.C. Health Care Power of Attorney



PRINT YOUR NAME

INITIAL THE CONDITION OR CONDITIONS UNDER WHICH YOU WANT YOUR LIVING WILL TO BE OPERATIVE

INITIAL ONLY ONE

NORTH CAROLINA ADVANCE DIRECTIVE – PAGE 11 OF 14

My Desire for a Natural Death

I, _____,
(name)
being of sound mind, desire that, as specified below, my life not be prolonged by life-prolonging measures:

1. When My Directives Apply

My directions about prolonging my life shall apply IF my attending physician determines that I lack capacity to make or communicate health care decisions and:

NOTE: YOU MAY INITIAL ANY AND ALL OF THESE CHOICES.

_____ I have an incurable or irreversible condition that will result in my death within a relatively short period of time.

_____ I become unconscious and my health care providers determine that, to a high degree of medical certainty, I will never regain my consciousness.

_____ I suffer from advanced dementia or any other condition which results in the substantial loss of my cognitive ability and my health care providers determine that, to a high degree of medical certainty, this loss is not reversible.

2. These are My Directives about Prolonging My Life:

In those situations **I have initialed** in Section 1, I direct that my health care providers (initial only one):

_____MAY withhold or withdraw life-prolonging measures.

_____SHALL withhold or withdraw life-prolonging measures.

INITIAL A CHOICE IN SECTION 3 ONLY IF YOU WANT TO MAKE AN EXCEPTION TO YOUR INSTRUCTIONS IN SECTION 2

INITIAL ONLY ONE

INITIAL ONLY ONE

NORTH CAROLINA ADVANCE DIRECTIVE – PAGE 12 OF 14

3. Exceptions – "Artificial Nutrition or Hydration"

EVEN THOUGH I do not want my life prolonged in those situations I have initialed in Section 1 (initial only one):

_____ I DO want to receive BOTH artificial hydration AND artificial nutrition (for example, through tubes) in those situations.

_____ I DO want to receive ONLY artificial hydration (for example, through tubes) in those situations.

_____ I DO want to receive ONLY artificial nutrition (for example, through tubes) in those situations.

4. I Wish to be Made as Comfortable as Possible

I direct that my health care providers take reasonable steps to keep me as clean, comfortable, and free of pain as possible so that my dignity is maintained, even though this care may hasten my death.

5. I Understand my Advance Directive

I am aware and understand that this document directs certain life- prolonging measures to be withheld or discontinued in accordance with my advance instructions.

6. If I have an Available Health Care Agent

If I have appointed a health care agent by executing a health care power of attorney (Part I) or similar instrument, and that health care agent is acting and available and gives instructions that differ from this Advance Directive, then I direct that (Initial only one. If you do not initial either box, then your health care providers will follow this Advance Directive and ignore the instructions of your health care agent about prolonging your life):

_____ Follow Advance Directive: This Advance Directive will **override** instructions my health care agent gives about prolonging my life.

_____ Follow Health Care Agent: My health care agent has authority to **override** this Advance Directive.

N.C. Health Care Power of Attorney

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

NORTH CAROLINA ADVANCE DIRECTIVE – PAGE 13 OF 14

7. Additional Instructions

I further direct that:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

8. My Health Care Providers May Rely on this Directive

My health care providers shall not be liable to me or to my family, my estate, my heirs, or my personal representative for following the instructions I give in this instrument. Following my directions shall not be considered suicide, or the cause of my death, or malpractice or unprofessional conduct. If I have revoked this instrument but my health care providers do not know that I have done so, and they follow the instructions in this instrument in good faith, they shall be entitled to the same protections to which they would have been entitled if the instrument had not been revoked.

9. I Want this Directive to be Effective Anywhere

I intend that this Advance Directive be followed by any health care provider in any place.

10. I have the Right to Revoke this Advance Directive

I understand that at any time I may revoke this Advance Directive in a writing I sign or by communicating in any clear and consistent manner my intent to revoke it to my attending physician. I understand that if I revoke this instrument I should try to destroy all copies of it.

SIGN AND DATE AND PRINT YOUR NAME HERE

YOUR TWO WITNESSES MUST PRINT THEIR NAMES, DATE, AND SIGN HERE

AND

A NOTARY PUBLIC MUST COMPLETE THIS PART OF YOUR DOCUMENT

NORTH CAROLINA ADVANCE DIRECTIVE – PAGE 14 OF 14

PART III: EXECUTION

_____ _____
Signature Date

I hereby state that the principal/declarant, _____(your name), being of sound mind, signed (or directed another to sign on declarant's behalf) the foregoing advance directive in my presence, and that I am not related to the declarant by blood or marriage, and I would not be entitled to any portion of the estate of the declarant under any existing will or codicil of the declarant or as an heir under the Intestate Succession Act, if the declarant died on this date without a will. I also state that I am not the declarant's attending physician, nor a licensed health care provider who is (1) an employee of the declarant's attending physician, (2) nor an employee of the health facility in which the declarant is a patient, or (3) an employee of a nursing home or any adult care home where the declarant resides. I further state that I do not have any claim against the declarant or the estate of the declarant.

WITNESSES

Witness 1 name: _____

Date: _____ Witness Signature: _____

Witness 2 name: _____

Date: _____ Witness Signature: _____

NOTARY PUBLIC

_____COUNTY, _____STATE

Sworn to (or affirmed) and subscribed before me this day by

_____
(type/print name of declarant)

_____ _____
(type/print name of witness) (type/print name of witness)

Date: _____ _____
(Official Seal) Signature of Notary Public

_____, Notary Public
Printed or typed name

My commission expires: _____

Courtesy of Caring Info – www.caringinfo.org

Patient Profile — "Jasmine"

Jasmine is a 55-year-old woman who married later in life and finds her marriage on shaky ground. She has no children and estranged siblings. She is closest to a small group of coworkers in the office where she has worked for 20 years. Over the past few years, Jasmine has told her closest friends repeatedly that she would never want to be kept alive if she were very disabled and could not care for herself. Jasmine has high blood pressure that is poorly controlled. Unfortunately, she sustains a big bleed inside her brain. After surgery and a period of intensive care, her doctors say that if she survives to leave the hospital, she will likely never be able to care for herself again.

Sample Cases — Advance Care Planning | UCLA Health

No Advance Care Planning

Jasmine did not discuss her end-of-life care preferences with her doctor or her husband. She has no advance directive. When she has the brain bleed, the doctors in the hospital explain her clinical situation and ask her husband what she would want. He does not know. He feels guilty about that and the fact that they had grown apart. Jasmine's friends tell her husband that she said she would not want to be kept alive if she would be left profoundly disabled, but Jasmine’s husband is too overwhelmed to accept what they are saying. Instead, he instructs the doctors to do what is needed to preserve Jasmine’s life. Jasmine has a feeding tube placed and is transferred in a barely awake state to a nursing home for continued care.

Advance Care Planning Completed

In the context of a discussion about blood pressure control, Jasmine's primary care physician introduces advance care planning. He asks about her goals for medical care and whom she would want to make medical decisions if she were unable. She talks about the conversations she had with her friends and that she values independence and disdains needing the help of others. The physician asks her to document these values in an advance directive that is then recorded in her medical record. He also recommends she discuss her views with her husband, whom she chooses to designate as her health care agent. When the doctors discuss treatment plans with Jasmine's husband after her brain bleed, they tell him that her advance directive provides guidance on how to proceed. They explain that Jasmine's prognosis is too poor to prolong life because medical treatments could never achieve her goals. While it is not the choice he would have made on his own, her husband feels comfortable following the doctor's advice, which is guided by her explicit preferences. He is relieved not to have to make the decision alone. Jasmine's friends, deeply saddened by the turn of events, validate the decision.

Patient Profile — "DeShawn"

DeShawn had a good job and marriage, both of which disintegrated because of his drinking. After a series of missed opportunities, he ended up living in a park where he found a peer group that accepted his alcohol use. Two men, Mike and Ike, became his close friends and the three spent much time discussing politics, sports and playing cards. After witnessing an accident, DeShawn and Ike had a long discussion about medical care outcomes. DeShawn explained that life is precious to him and that he would want everything done to try to preserve his life if there were any chance at all that he could continue to watch TV and listen to music. One night DeShawn fell and struck his head. When transported to the hospital the next morning, he is found to have a severe brain injury. After three weeks of treatment, DeShawn has had minimal recovery and continues to require a ventilator to breath for him. The doctors say that his chance of recovering to be interactive with the outside world is close to zero.

Sample Cases — Advance Care Planning | UCLA Health

No Advance Care Planning

DeShawn had not had a regular source of medical care for many years. During a few sporadic ER visits, no one ever asked him about advance care planning. When he is hospitalized for head trauma, the medical team is unable to identify any next of kin. They query law enforcement and even send a volunteer to the park where he was injured, but come up empty. After three weeks of searching, no one can be found to speak for DeShawn, and he is considered an "unrepresented person without decision making capacity" for whom a medical decision must be made by others. Because DeShawn's prognosis for recovery is exceedingly poor, the doctors recommend that treatment be aimed at comfort and that the ventilator be stopped to permit a comfortable death. The committee of individuals charged with assisting in decision making for unrepresented persons agrees that the doctors' recommendation falls in the ethically appropriate range. The ventilator is stopped and DeShawn dies comfortably.

Advance Care Planning Completed

DeShawn receives no routine medical care, but he has several ER visits for trauma and alcohol related reasons. During an ER visit, a nurse notes that DeShawn is at risk for becoming unrepresented and incapable of making his own medical decisions. She asks him to complete an advance directive and he agrees, listing Mike and Ike as his health care agents. He does not complete the goals of care part of the document, but he and a notary sign the advance directive and a copy is maintained in the medical record. When DeShawn is hospitalized after the fall, Ike is contacted. Ike explains that DeShawn expressed strongly that he wanted to be kept alive if there was even a tiny chance of returning to a condition in which he could watch TV and communicate. When the doctors share Mike's poor prognosis, Ike asked if there any chance at all that DeShawn could recover to the point of being able to enjoy watching TV. The doctors indicated that a precise prognosis at this stage is difficult, but after a longer observation period they might have more clarity. They also note that if DeShawn worsened, then his goals could never be met. DeShawn receives a tracheostomy and G-tube is placed. A POLST with a DNR order was signed and Mike was transferred to a Long-Term Acute Care Hospital where Ike can visit and monitor his progress.

Patient Profile — "Alice"

Alice is an 84-year-old woman with oxygen-dependent emphysema from 60 years of smoking. She has three adult daughters who have never gotten along. Alice develops pneumonia and is slow to improve on the ventilator in the ICU. She now is developing kidney failure and the doctors think that she is unlikely to survive the hospitalization.

Sample Cases — Advance Care Planning | UCLA Health

No Advance Care Planning

Alice never discussed end of life issues with her doctors. Her pulmonologist gave her an advance directive, but she never returned it. The ICU doctors discuss prognosis with the daughters and recommend Alice be transitioned to comfort care because they think that Alice is very unlikely to survive the hospitalization. Although there is a tiny chance that she could recover to some degree, she would almost certainly be permanently dependent on a ventilator to breath. The daughters cannot come to an agreement regarding what treatment their mother would want. No decision is made and Alice dies in the ICU a month later.

Advance Care Planning Completed

Alice's pulmonologist discusses with Alice that she is in the last phase of her life and that decisions about her medical care might be needed. They discuss her goals for medical treatment. Alice was on a ventilator a few years ago and hated it. She explains that she would not want to be ventilator dependent for a long period of time. She wishes her children would get along with each other, and wants to make all three serve as her joint decision maker. Her doctor advises her to designate a lead decision maker to avoid conflict, but Alice is unwavering and completes her advance directive with all three daughters named. When a decision is needed regarding the ventilator, the daughters are poised to disagree, but the doctors explain that Alice’s preference to avoid long-term ventilator use is noted in her advance directive and will be followed. The daughters instead can focus on next steps.

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How to Get Started with Advance Care Planning

Five Steps for Planning

- Think about what matters to you
- Talk about your wishes with your family, friends and medical providers
- Put it in writing. Document your choices and decisions.
- Share your documents with your family, friends and medical providers
- Review your advance care plan, including any documents you created, at least once a year

Advance Care Planning (unchealth.org)

Reflect on Values and Wishes

This can help the beneficiary think through what matters most at the end of life and guide decisions about future care and medical treatment.

Share Forms

- Share forms with health care proxy, doctors, and loved ones
- Make copies and store them in a safe place
- Give copies to your health care proxy, health care providers, and lawyer
- North Carolina has a registry that can store advance directives for quick access by health care providers and the proxy

North Carolina Secretary of State Advance Health Care Directives Advance Health Care Directives (sosnc.gov)

Start the Conversation

- What should the provider know about you as a person to provide the best care possible for you?
- What are your beliefs about medical treatment, quality of life and living longer?
- What are your spiritual and religious beliefs? How do they affect your decision making?
- Are there any medical treatments that go against your beliefs? If yes, what treatments?

Advance Care Planning Workbook (mdanderson.org)

Quality of Life

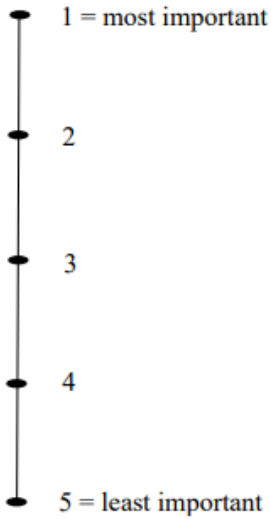
- Quality of life is a person's overall well-being. People have different views on what is a good quality of life. Factors that may affect a patient's quality of life include:
  - Treatments and their side effects
  - How well symptoms are controlled
  - Time spent with loved ones at home or in the hospital
  - Ability to engage in activities
  - Social and spiritual factors
- What does a good quality of life mean to you?

Advance Care Planning Workbook (mdanderson.org)

Your Values

If you face a serious illness, permanent disability or death, what is most important to you? Use the number scale (1 to 5) below to rate the items in order of importance to you. You may give several items the same number rating. Your answers may change over time.

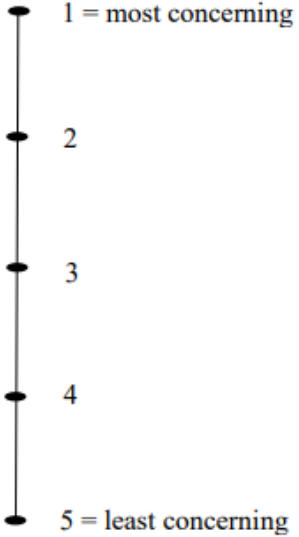
- Ability to speak to my loved ones
- Ability to live as long as possible no matter what
- Ability to communicate in some way even if I cannot speak
- Ability to read, write or sing
- Ability to eat and taste
- Ability to walk
- Being awake and thinking for myself
- Being free from pain as much as possible
- Maintaining as much control over my life as possible
- Maintaining my dignity. (What does dignity mean to you?)
- Other: _____



Your Concerns

If you face a serious illness, permanent disability or death, what is most concerning to you? Use the number scale (1 to 5) below to rate the items in order of concern to you. You may give several items the same number rating. Your answers may change over time.

- Being in pain
- Losing the ability to think
- Losing the ability to communicate
- Being a financial burden on loved ones
- Being a physical burden on loved ones
- Being an emotional burden on loved ones
- Being removed from life support too soon
- Being left on life support too long
- Being unable to care for my loved ones
- Leaving my loved ones behind
- Leaving my pets behind
- Other: _____



Important Questions About Advance Health Care Directives

Today's health care technologies are pretty amazing. They can keep us alive even if we are suffering from a serious illness. People have different ideas about the treatments they would want to have. If they are able to state their wishes, they can say yes or no to questions like these:

- Would you want CPR or other resuscitation if your heart were to stop beating?
- Would you want to be put on a ventilator if you could no longer breathe on your own?
- Would you wish to have tube or needle feeding if you lost the ability to swallow?
- If you had a life-limiting illness, would you wish to receive antibiotics that might prolong life?
- If you had progressive dementia, what health treatments would you want?
- Would you want to be an organ donor?
- At what point would you want palliative care (care that focuses on pain control and quality of life) rather than aggressive treatment?

Open-Ended Questions to Promote Discussions for Advanced Care Planning

- Addressing goals of care when prognosis is uncertain
- What are your most important hopes?
- What concerns you most about your illness?
- What is your quality of life like now?
- Is it more important for you to live as long as possible, despite some suffering, or to live without suffering for a shorter length of time?
- What are your biggest fears?
- Given the severity of your illness, what is most important for you to achieve?
- What do you understand about your illness?
- How much do you want to know?

More Examples of Questions

- Values
  - What makes life most worth living to you?
  - Are there circumstances in which you would find life not worth living?
  - Have you seen or been with someone who had a particularly good (or difficult) death?
  - What have been the worst and the best things about this illness for you?
- Directives
  - If you are unable to speak for yourself in the future, who would be best able to represent your views and values? (substitute decision maker)
  - Have you given any thought to what kinds of treatment you would want, or not want, if you become unable to speak for yourself in the future? (advanced directive)
  - Have you considered circumstances in which you would want to stop dialysis?
  - Where would you like to be and who would you like to be there when you die?

Open-Ended Questions to Promote Discussions for Advanced Care Planning | Nursing Best Practice Guidelines (rnao.ca)

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Medicare Advance Care Planning

What Is Medicare Advance Care Planning (ACP)?

Advance care planning (ACP) is a voluntary, face-to-face service between a physician or other qualified health care professional (QHP) and a patient, family member, caregiver, or surrogate to discuss the patient's health care wishes if they become unable to make their own medical decisions.

MLN909289 – Advance Care Planning (cms.gov)

Documentation Requirements

Provider must document the ACP discussion with a patient, family member, caregiver, or surrogate. In the documentation, include:

- The voluntary nature of the visit
- The explanation of advance directives
- Who was present
- The time spent discussing ACP during the face-to-face encounter
- Any change in health status or health care wishes if the patient becomes unable to make their own decisions

MLN909289 – Advance Care Planning (cms.gov)

ACP Coding

CPT® Codes	Billing Code Descriptors
99497	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate.
99498	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (list separately in addition to code for primary procedure).

CPT® Guidelines

CPT® codes 99497–99498 should not be reported by the same physician/qualified health provider on the same date of service as the following E/M services:

- 99291–99292 — Critical Care
- 99468–99469 — Inpatient Neonatal and Pediatric Critical Care 28 days or younger
- 99471–99472 — Inpatient Neonatal and Pediatric Critical Care 29 days to 24 months
- 99475–99480 — Inpatient Pediatric Critical Care 2–5 years of age
- 99483 — Cognitive Assessment and Care Plan Services

CPT® Guidelines

- CPT® instructions note that CPT® codes 99497 and 99498 may be billed on the same day or a different day as most other E/M services, and during the same service period as transitional care management services or chronic care management services and within global surgical periods
- These codes may be separately reported when performed on the same date of service in conjunction with the following E/M services: 99201–99215, 99217–99226, 99231–99236, 99238–99239, 99241–99245, 99251–99255, 99281–99285, 99304–99310, 99315–99316, 99318, 99324–99328, 99334–99337, 99341–99345, 99347–99350, 99381–99397 and 99495–99496
- Both codes should be reported with modifier 25 added, presuming the requirements for use of modifier 25 are met

Article — Billing and Coding: Advance Care Planning (A58664) (cms.gov)

ACP Services Are Time Based

- Must follow CPT® rules about minimum time requirements to report and bill ACP
- Shouldn't discuss any other active management of a patient's issues for the time reported when billing ACP codes
- When performing another service concurrently as a time-based service, don't include the time spent on the concurrent service with the time-based service
- Don't bill any ACP discussion of 15 minutes or less as ACP services. Bill a different Evaluation and Management (E/M) service, like an office visit (if you meet the other service's requirements).
- A unit of time is billable when the midpoint of the allowable unit of time passes

ACP Minutes & Corresponding CPT® Codes & Units

ACP Minutes	CPT® Code & Units
less than 15	Don’t bill any ACP services
16–45	CPT® code 99497 (1 unit)
46–75	CPT® code 99497 (1 unit) and CPT® code 99498 (1 unit)
76–105	CPT® code 99497 (1 unit) and CPT® code 99498 (2 units)

Health Care Professionals Who May Furnish and Bill ACP

- Physicians (any specialty)
- Clinical nurse specialist (CNS)
- Nurse practitioners (NPs)
- Physician assistants (PAs)
  - All other providers (social work, psychology, chaplains) may not report ACP codes independently

Place of Service

- ACP services can be provided in facility or non-facility settings. ACP codes can be reported when services are provided in any care setting including an office, hospital, skilled nursing facility (SNF), home, and via the specific Centers for Medicare and Medicaid Services (CMS) guidelines for telehealth in effect at the time of service
- Place of service (POS) must be included when reporting ACP services

Article — Billing and Coding: Advance Care Planning (A58664) (cms.gov)

ACP and Hospice

For patients receiving hospice benefits, ACP services can be billed under Medicare Part B, only if the practitioner is not employed by the hospice agency; otherwise, the ACP services would be billed on the Type of Bill 081x or 082x when performed by hospice employed physicians or by physicians who are under arrangement with the hospice.

Article — Billing and Coding: Advance Care Planning (A58664) (cms.gov)

ACP and Frequency of Billing

- There is no limit on the number of times that ACP services can be reported for a given patient in a given time period
- If these services are billed more than once, a change in the patient's health status and/or wishes about end-of-life care must be documented
- Some people may need ACP multiple times in a year if they are quite ill and/or their circumstances change. Others may not need the service at all in a year.

Article — Billing and Coding: Advance Care Planning (A58664) (cms.gov)

Medicare Payment

Medicare pays for ACP as either:

- An optional element of a Medical Wellness Visit (MWV), which includes the Annual Wellness Visit (AWV) or the Initial Preventive Physical Examination (IPPE); or
- A separate Medicare Part B medically necessary service

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http://tinyurl.com/5n95ykvf