Jurisdiction M Part A/B Medicare Updates

North Carolina Health Insurance Institute (NCHII)

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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Disclaimer

The content in this presentation is intended for Jurisdiction M Part A/B providers and is current as of April 1, 2024. Any changes or new information superseding this information is provided in articles with publication dates after April 1, 2024, at Palmetto GBA.

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Frequently Used Acronyms

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

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CMS Overview

CMS Purpose

Medical reviews identify errors through claims analysis and/or medical record review activities.

- Contractors use this information to help ensure they provide proper Medicare payments (and recover any improper payments if the claim was already paid)
- Contractors also provide education to help ensure future compliance

HHS Corrective Actions

Corrective Action	Description
MAC Medical Review/Targeted Probe and Educate (TPE)	On September 1, 2021, HHS reinstated the TPE process but continued to offer extensions, as needed. The TPE process consists of up to three rounds of review of 20–40 claims per round, with 1:1 education provided at the end of each round. HHS uses TPE in the hospital outpatient, IRF, SNF, HHH, and DMEPOS service areas.
Supplemental Medical Review Contractor (SMRC) Reviews	SMRC shares MR results with the MACs for claim adjustments upon review completion. The providers receive detailed SMRC result letters and MAC demand letters for overpayment recovery, which include educational information regarding what was incorrect in the original billing of the claim.
Recovery Audit Contractor (RAC) Reviews	Medicare FFS RACs identified and collected improper payments related to hospital outpatient, IRF, SNF, HH, and DMEPOS claims for several factors, including insufficient documentation and medical necessity, if appropriate.

CMS Oversight

CMS Center for Program Integrity (CPI) oversees Medicare medical review contractors. CPI conducts contractor oversight activities.

- Providing broad direction on medical review policy
- Reviewing and approving Medicare contractors' annual medical review strategies
- Facilitating Medicare contractors' implementation of recently enacted Medicare legislation
- Facilitating compliance with current regulations

CPI | CMS

Guidance NCD vs. LCD

NATIONAL COVERAGE DETERMINATIONS (NCDS)

- Medicare coverage is limited to items and services that are reasonable and necessary for the diagnosis or treatment of an illness or injury (and within the scope of a Medicare benefit category)
- Developed by CMS to describe the circumstances for which Medicare will cover specific services, procedures, or technologies on a national basis

Medicare Contractors are required to follow NCDs. If an NCD does not specifically exclude/limit an indication or circumstance, or if the item or service is not mentioned at all in an NCD or in a Medicare manual, it is up to the Medicare contractor to make the coverage decision.

Guidance NCD vs. LCD

LOCAL COVERAGE DETERMINATIONS (LCDS)

- In the absence of a national coverage policy, an item or service may be covered at the discretion of the Medicare Contractors based on a local coverage determination

CMS Manuals

- Medicare Benefit Policy Manual (100-02)
- Medicare Claims Processing Manual (100-04)
- Medicare Program Integrity Manual (100-08)

NCD

Medicare Coverage Database

MCD Reports

Select National Coverage Report

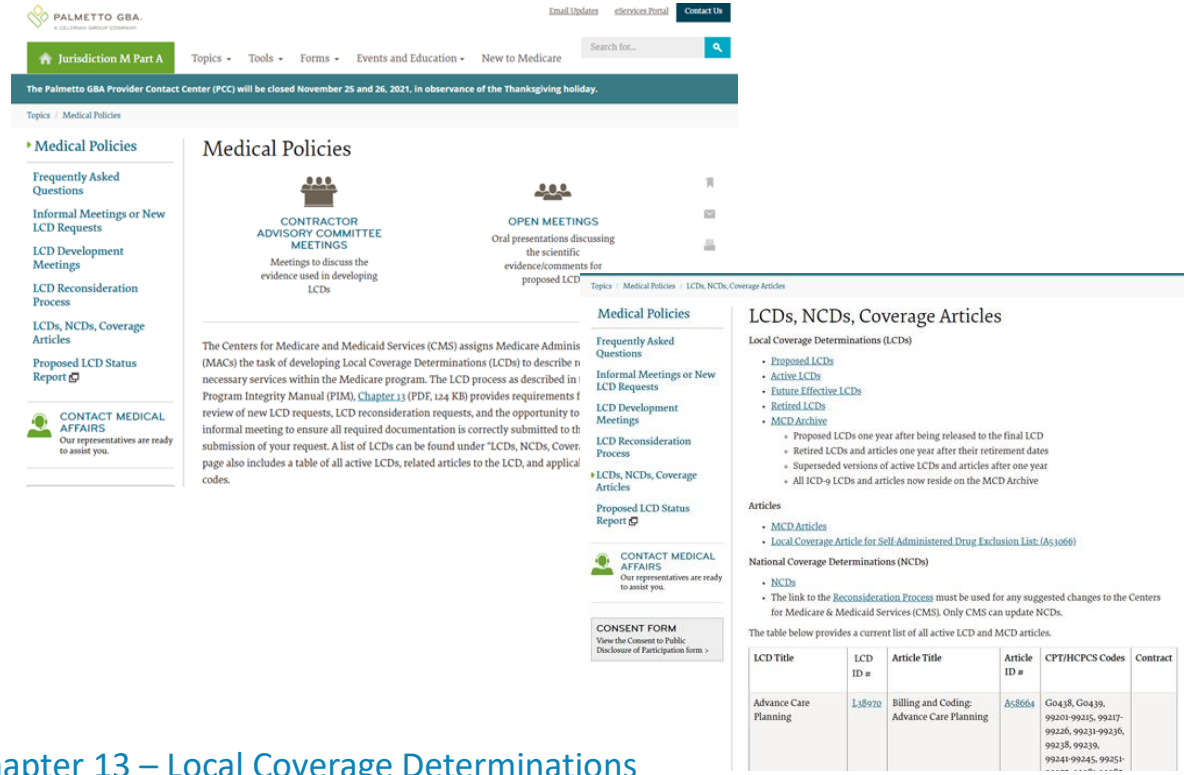
Medicare National Coverage Determinations Manual

LCD

Palmetto GBA

Topics

Medical Policies



Medicare Program Integrity Manual Chapter 13 – Local Coverage Determinations

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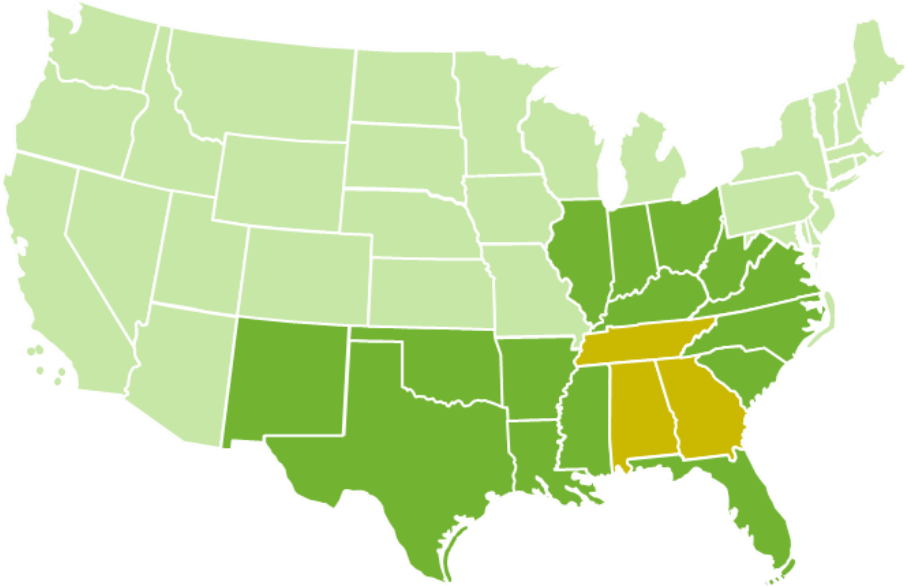
Palmetto GBA Medical Review (MR) Targeted Probe and Educate (TPE) Process



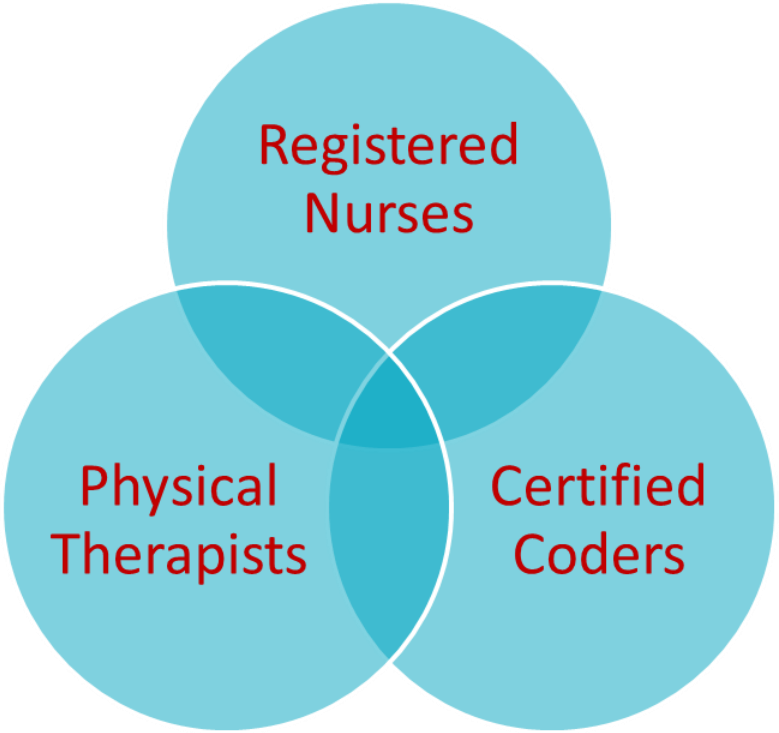
TPE Purpose

REDUCE APPEALS

DECREASE PROVIDER BURDEN

IMPROVE THE MEDICAL REVIEW AND EDUCATION PROCESS

Who Conducts the TPE Reviews?



Provider Selection

- Targeted Probe and Educate (TPE)
  - Based on data analysis and other findings indicative of a potential vulnerability
  - ✓ Comparative Billing Reports (CBR's)
  - ✓ Comprehensive Error Rate Testing (CERT) Contractor, the Office of Inspector General (OIG)
  - ✓ Government Accountability Office (GAO)
  - ✓ Recovery Audit Contractors (RACs)

TPE Process

TARGETED REVIEWS

Provider specific

- Pre/Post-Payment Review
    - 20–40 claims

Requires Provider Notification

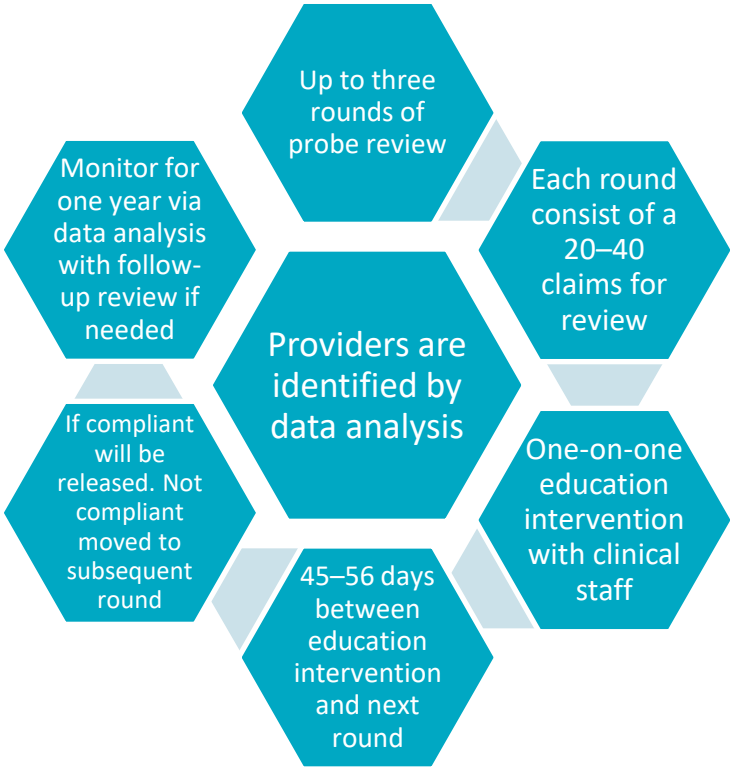
- Active edit article
- Notification letter

OBJECTIVES

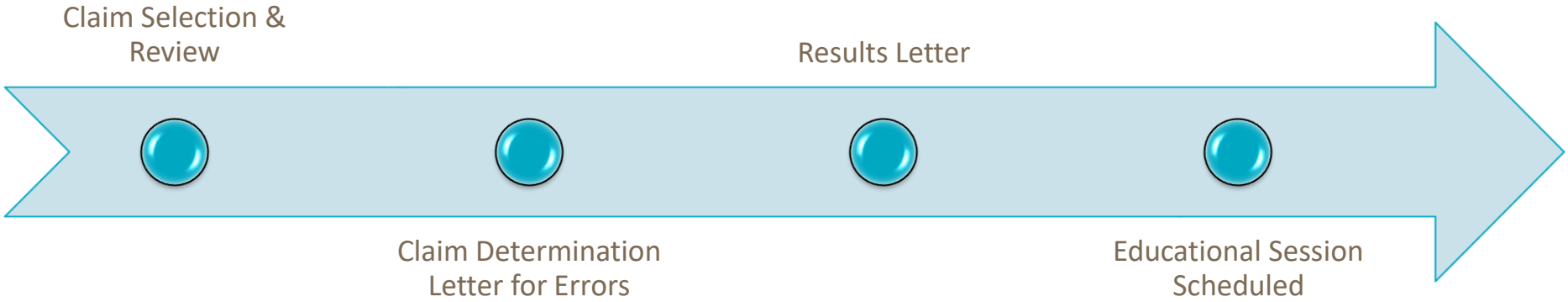
- Identification
- Analysis
- Education

Change Request 10249 (Original TPE)

TPE Process

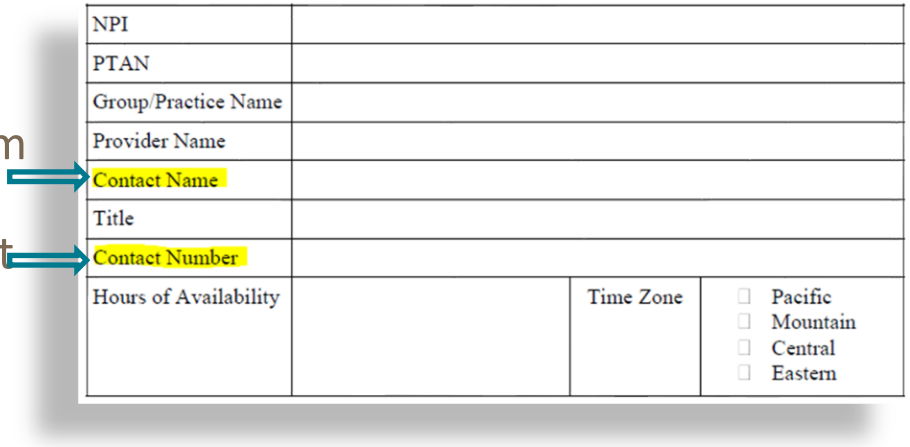

Up to three rounds of probe review
Each round consist of a 20–40 claims for review
One-on-one education intervention with clinical staff
45–56 days between education intervention and next round
If compliant will be released. Not compliant moved to subsequent round
Monitor for one year via data analysis with follow-up review if needed
Providers are identified by data analysis

TPE Timeline



Point of Contact (POC)

- Interaction between the reviewer and the provider is a key component of the TPE model
- Your notification letter will contain a form for providers to designate a point of contact (POC) for the reviewer to contact by phone for any education calls



NPI			
PTAN			
Group/Practice Name			
Provider Name			
Contact Name			
Title			
Contact Number			
Hours of Availability		Time Zone	☐ Pacific ☐ Mountain ☐ Central ☐ Eastern

TPE Threshold

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

Palmetto GBA's threshold is 20% or less will not be progressed to the next round.

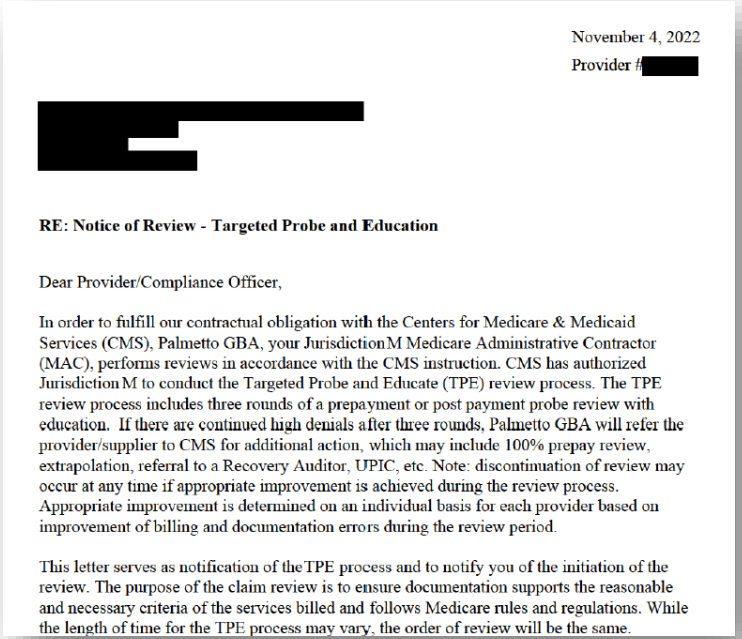
Providers with error rates that exceed the established threshold may be progressed to the next round.

This includes both the charge denial rate (CDR) and claim denial rate (CLDR) .

Notification Letter

Letter will be addressed to the Medicare Provider or Compliance Officer Identifies reason for review.

- Code identified by data analysis
- TPE timeline and process
- Submission methods
- ADR guidelines



November 4, 2022
Provider #[redacted]

[redacted]

RE: Notice of Review - Targeted Probe and Education

Dear Provider/Compliance Officer,

In order to fulfill our contractual obligation with the Centers for Medicare & Medicaid Services (CMS), Palmetto GBA, your Jurisdiction M Medicare Administrative Contractor (MAC), performs reviews in accordance with the CMS instruction. CMS has authorized Jurisdiction M to conduct the Targeted Probe and Educate (TPE) review process. The TPE review process includes three rounds of a prepayment or post payment probe review with education. If there are continued high denials after three rounds, Palmetto GBA will refer the provider/supplier to CMS for additional action, which may include 100% prepay review, extrapolation, referral to a Recovery Auditor, UPIC, etc. Note: discontinuation of review may occur at any time if appropriate improvement is achieved during the review process. Appropriate improvement is determined on an individual basis for each provider based on improvement of billing and documentation errors during the review period.

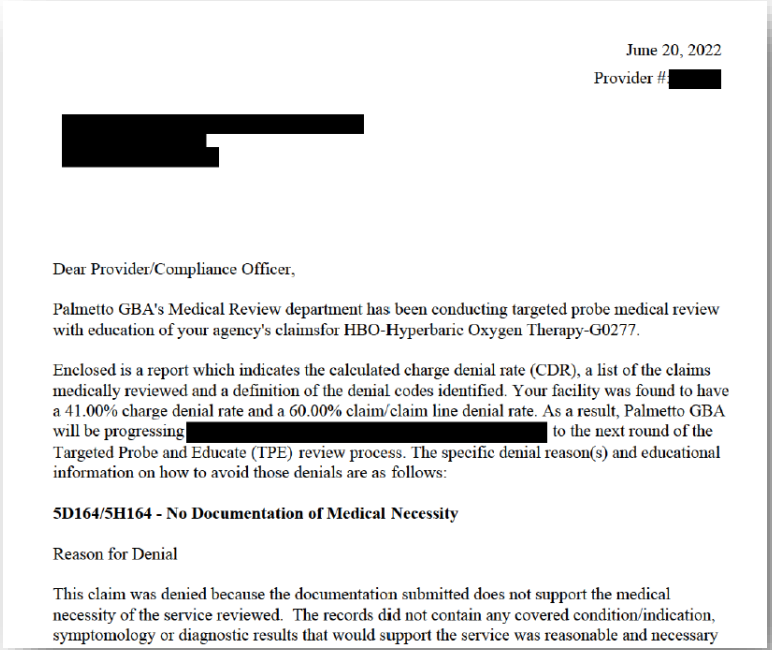
This letter serves as notification of the TPE process and to notify you of the initiation of the review. The purpose of the claim review is to ensure documentation supports the reasonable and necessary criteria of the services billed and follows Medicare rules and regulations. While the length of time for the TPE process may vary, the order of review will be the same.

Results Letter

Letter will be addressed to the Medicare Provider or Compliance Officer Identifies error rates.

- Charge denial rate
  - Total paid Charges/Total charges
- Claim denial rate
  - Number of claims denied/Number of total claims

Denial reason codes/Education



June 20, 2022

Provider #[redacted]

[redacted]

Dear Provider/Compliance Officer,

Palmetto GBA's Medical Review department has been conducting targeted probe medical review with education of your agency's claimsfor HBO-Hyperbaric Oxygen Therapy-G0277.

Enclosed is a report which indicates the calculated charge denial rate (CDR), a list of the claims medically reviewed and a definition of the denial codes identified. Your facility was found to have a 41.00% charge denial rate and a 60.00% claim/claim line denial rate. As a result, Palmetto GBA will be progressing [redacted] to the next round of the Targeted Probe and Educate (TPE) review process. The specific denial reason(s) and educational information on how to avoid those denials are as follows:

5D164/5H164 - No Documentation of Medical Necessity

Reason for Denial

This claim was denied because the documentation submitted does not support the medical necessity of the service reviewed. The records did not contain any covered condition/indication, symptomology or diagnostic results that would support the service was reasonable and necessary

Submitting Documentation

MAIL

- Submit original ADR request form with each claim
- Copy of documentation
- Mail to correct contract address for your contract and line of business

FAX

- Only select the “Medical Review ADR Response Cover Sheet”
- Complete all required fields for each ICN.
  Must print a new form for each one to generate a new barcode specific to that ICN (found at bottom of page).

- Fax the form to the correct contract fax number for your contract and line of business

Do not use the PWK for Med Review Part B

What To Submit/When To Submit

The ADR letter should give the basics of what to submit. Additional information can be found on Palmetto GBA websites at Palmetto GBA.

Include relevant documentation, provider signatures and orders.

Providers do not need to wait to receive all their ADRs prior to submitting the claim documentation. Please submit early enough to ensure the documentation arrives on time.

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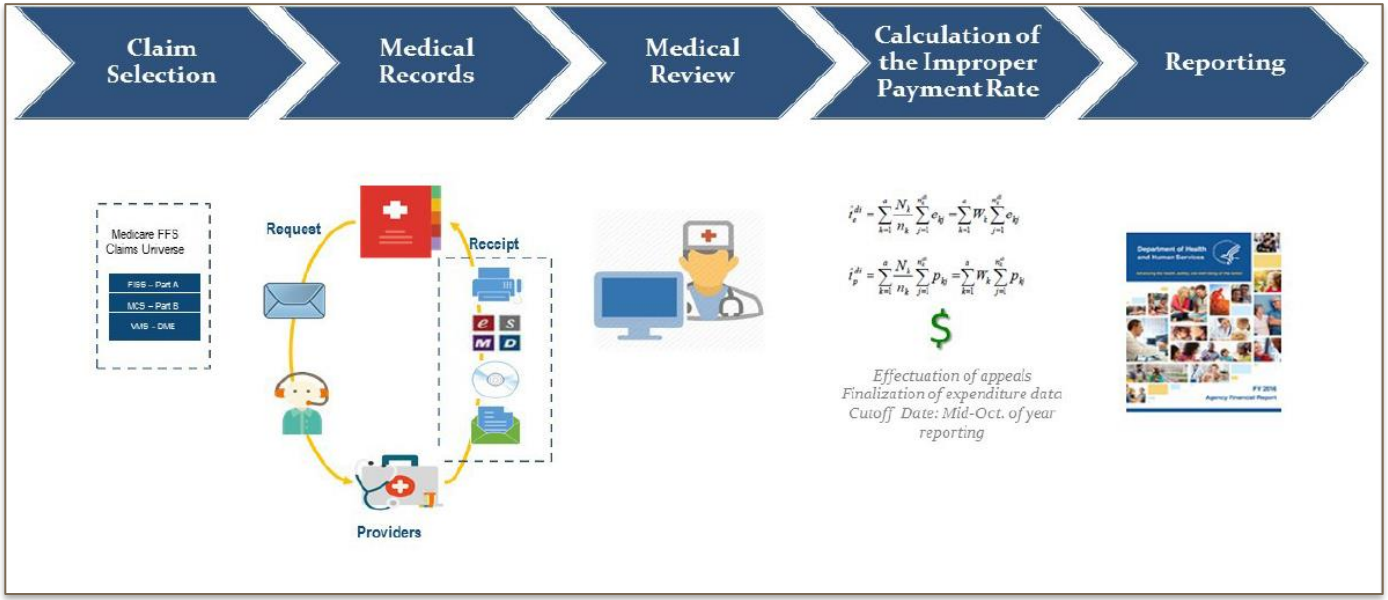
Comprehensive Error Rate Testing (CERT) Program



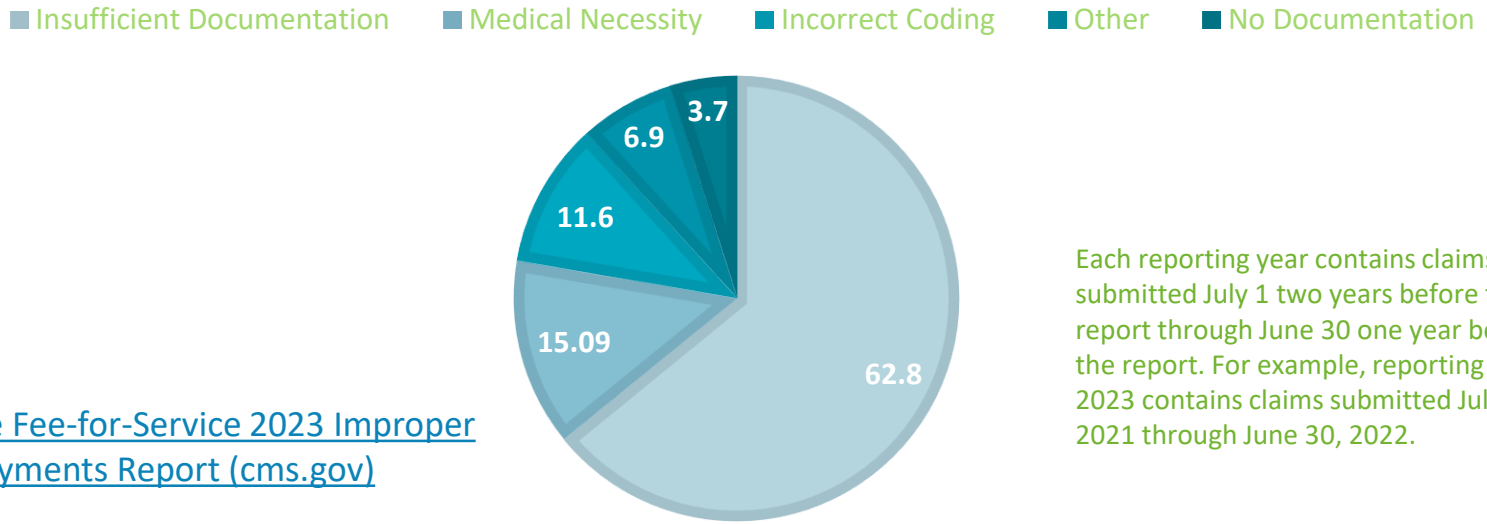
CERT

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

IMPROPER PAYMENT RATE ERROR CATEGORIES BY PERCENTAGE OF 2023 NATIONAL IMPROPER PAYMENTS



[Medicare Fee-for-Service 2023 Improper Payments Report (cms.gov)]

Each reporting year contains claims submitted July 1 two years before the report through June 30 one year before the report. For example, reporting year 2023 contains claims submitted July 1, 2021 through June 30, 2022.

Five Major CERT Error Categories

Improper Payment Error Categories, Definitions, and Examples

Insufficient Documentation	The documentation is insufficient to determine whether the claim was payable. This occurs when: • Medical documentation submitted is inadequate to support payment • It could not be concluded that the billed services were actually provided, were provided at the level billed, and/or were medically necessary • A specific documentation element, that is required as a condition of payment, is missing	A hospital billed for infusion of a medication provided in the outpatient department. The CERT program received a visit note to support the medical necessity of the medication. However, the order and the administration record for the infusion were missing.
Medical Necessity	Medical documentation supports: • Services billed were not medically necessary based upon Medicare coverage and payment policies	A provider billed for an inpatient rehabilitation facility (IRF) stay. There was not a reasonable expectation that the beneficiary was able to benefit from an intensive rehabilitation program because she was completely independent.
Incorrect Coding	Medical documentation supports: • A different code than what was billed • The service was performed by someone other than the billing provider • The billed service was unbundled • The beneficiary was discharged to a site other than the one coded on the claim	A provider billed for Healthcare Common Procedure Coding System (HCPCS) code 99214. The submitted documentation did not meet the requirements for 99214 but met the requirements for 99213.
No Documentation	The provider or supplier fails to respond to repeated requests for the medical records	A supplier billed for diabetic testing supplies. The provider did not submit any medical records to support the claim.
Other	An improper payment that does not fit into any of the other error categories	A DMEPOS supplier billed for an upper limb orthosis, which the CMS Pricing, Data Analysis and Coding (PDAC) contractor determined was classified as exercise equipment. Exercise equipment is not covered by Medicare.

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CERT Initial Documentation Request

Day 1	Send letter 1 requesting documentation. The provider has 45 days from this letter to furnish the requested documentation.
Day 25	Phone contact is made by CERT to follow-up on their initial request and to help.
Day 30	Send letter 2. (**15 days remaining to fulfill CERT's request timely.**)
Day 40	Phone contact is made by CERT to follow-up on their initial request and to help.
Day 45	Send letter 3. (Response is due.)
Day 49	Phone contact is made by CERT to follow-up on their initial request and to help. (Response is overdue.)
Day 60	Send letter 4. (Response is overdue.)

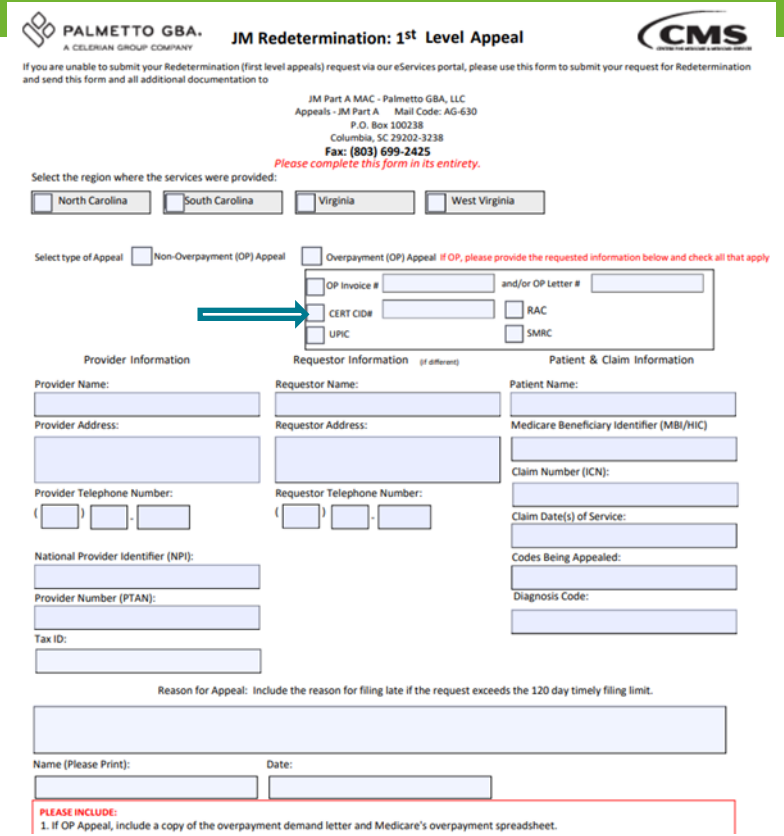
Finalizing CERT's Process

Day 76

- Claims are counted as a non-response error if requested documentation is not received
- Funds are subject to overpayment recovery
- Palmetto GBA's POE 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

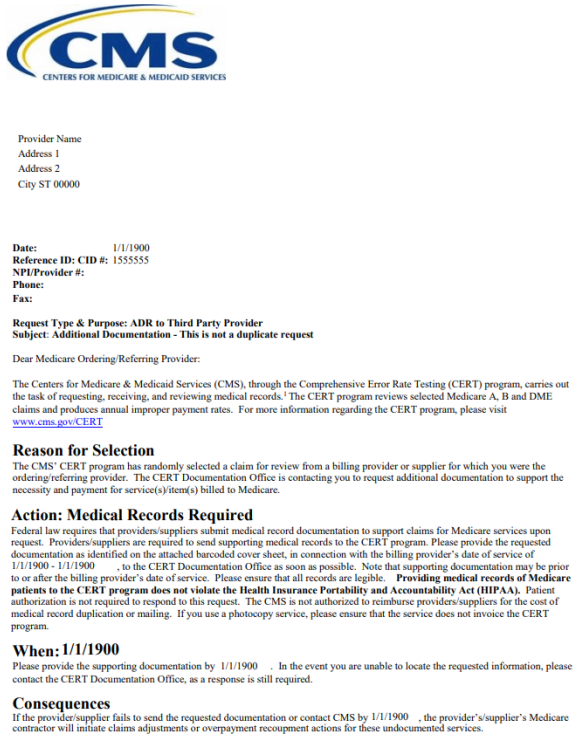
Provider Information	Requestor Information (if different)	Patient & Claim Information
Provider Name:	Requestor Name:	Patient Name:
Provider Address:	Requestor Address:	Medicare Beneficiary Identifier (MBI/HIC)
Provider Telephone Number:	Requestor Telephone Number:	Claim Number (ICN):
National Provider 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 SADR 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.

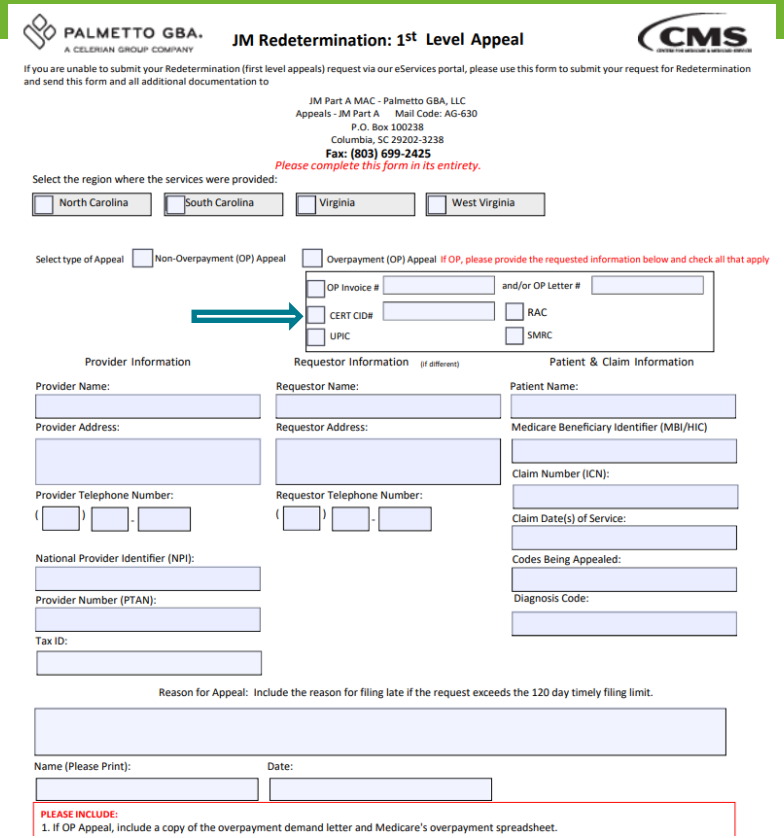
If, during CERT's initial medical review, the need for additional info is identified, a subsequent documentation request will be issued as follows:

- 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 the provider to follow-up on the request and to offer assistance
- Day 16 — Claim is back in the review process

Finalizing CERT's SADR Process

Day 16

- Claims are counted as an error if requested documentation is not received
- Funds are subject to overpayment recovery
- Palmetto GBA's MR staff will contact providers to encourage the filing of an Appeal



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☐ OP Invoice # _____ and/or OP Letter # _____
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☐ 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):
		Claim Date(s) of Service:
National Provider Identifier (NPI):		Codes Being Appealed:
Provider Number (PTAN):		Diagnosis Code:
Tax ID:		

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

Name (Please Print): Date:

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

Responding to CERT Requests

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

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


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.

Things to Know to Avoid CERT Errors

Avoid general payment errors by ensuring that:

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

PLACE THIS BARCODED COVER SHEET IN FRONT OF THE RECORD

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

CID: 1555555

Due Date: 1/1/1900 Medicare Part B Provider
Patient Name: Patient Name
Date of Birth: 1/1/1900 **Date of Service:** 1/1/1900 - 1/1/1900
Claim Control Number: CCN0000000000
Universe Date: 1/1/1900 Request Date: 1/1/1900
Contractor Number: 99999 Contractor Type: B
Billing Provider NPI: 0000000000
Letter Sequence: ADR to Billing Provider (First Request)

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

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

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

CERT's Chain Address Program

Providers that have at least 5 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 document-tation request letters to the POC

Comprehensive Error Rate Testing (CERT)

Claim Type	Improper Payment Rate	Improper Payment Amount
Overall	**7.38%**	**$31.23 B**
Part A Providers (excluding Hospital Inpatient Prospective Payment System (IPPS))	7.75%	$14.22 B
Part B Providers	10.03%	$10.99 B
Hospital IPPS	3.36%	$4.08 B
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies	22.51%	$1.95 B

Comprehensive Error Rate Testing (CERT) | CMS

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Common Denials and Documentation Requirements

Common Claim Denial Reasons

- No documentation submitted
- Service not documented
- All components not submitted
- Not medically necessary
- Wrong service documentation submitted

Example — No Documentation

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

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

No Documentation Submitted

Provider never responded to the ADR:

- ADR is sent to the address Medicare has on file from the PTAN under review
- ADR is reported as never received
  - **If a non-response denial is received**
    - TPE you may contact the PCC to request another ADR letter be sent
    - Contact CERT at (888) 779-7477

Examples — Insufficient Documentation

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

Service/Components Not Documented

- Actual service is not documented
  - **Example: IV drug and administration code billed; documentation included patient assessment but does not include the administration of the drug**
- All components to a billed code not documented
  - **Example: Initial AWV billed; documentation included documentation of eight required elements; however, there was no health risk assessment and no list of current healthcare providers/suppliers**

Not Medically Necessary

The submitted documentation did not support medical necessity.

- **Documentation is incomplete**
- **Documentation does not support the services billed**
- **Documentation does not substantiate the medical need for the services**

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**

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 (provider who doesn't provide any intervention) 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 non-physician practitioner (meaning a physician assistant, nurse practitioner or clinical nurse specialist) using an evidence-based decision tool on ICDs prior to initial ICD implantation**

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

HBO 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)

Drugs and Biologicals

- 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

Extracapsular Cataract Removal

- Patient complaint and statement that the patient desires surgical correction
- Statement outlining specific impairment of visual function resulting in activity limitations
- List activities of daily living affected and describe **how** they are affected (lifestyle)
- Statement/measurements of patient's visual function — **not** believed to be correctable with a tolerable change of glasses or contact lenses
- Record Visual Acuity
- Document the existence of the cataract (describe — severity; grade)
- Pre-operative ophthalmologic evaluation-comprehensive ophthalmologic exam/biometry
- Document appropriate ancillary testing
- Informed consent
- Operative Report

Extracapsular Cataract Removal with Insertion

- Missing documentation of comprehensive ophthalmologic exam and biometry
- No documentation regarding how activities of daily living (ADLs) were affected by the cataract
- Documentation submitted for the wrong date of service
- Documentation submitted for the wrong patient
- Signature issues
- No documentation submitted

E/M

- 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.*

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.

Outpatient Therapy

- Current level of function and Prior level of function
- Initial therapy evaluation
- Any previous therapy administered
- Medical diagnosis and treatment diagnosis
- Diagnosis onset date
- Physician certification and recertification
- Physician’s orders
- Progress notes detailing services provided for each date of service billed
- Treatment plan with long- and short-term goals

- No Plan of Care for applicable date of service (DOS)
- No Physician Certification of Physical Therapy Plan of Care
- No progress report for the applicable DOS

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

Surgical Debridement

- Document depth/severity or wound
- Include an appropriate diagnosis
- Document the level of tissue removal (skin, full or partial thickness, subcutaneous tissue, muscle or bone)
- Document the total area of tissue removal
- Document method of debridement
- Make sure documentation supports the units billed
- Medical decision to perform procedure
- Location and characteristic of the wound
- Pre and post debridement measurements

Surgical Debridement

Drugs of Abuse Testing

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**

Code Descriptors for Time

A timed code requires not only the service performed, but also the time spent. The procedure description may include several types of wording:

- Typical time — must meet the midpoint for the time identified
    - 15 minutes — would need at least eight minutes
- At least — must meet the minimum time reported
    - At least 15 minutes
- Specific time — must meet the minimum time required
    - 5–10 minutes
- Cumulative time
    - 30 minutes in a calendar month

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Part B Important Updates

Audiology Services

Audiology Services — hearing and balance assessment services:

- A physician order is generally required for audiology services
- Audiology services may be furnished and billed by audiologists
- Audiology services may also be provided by physicians and nonphysician practitioners (NPP)
- Audiology services are not covered under “incident to”

Audiology Services: Changes for 2023

Provides patients with limited direct access to audiology services (audiologist)

Limited to certain diagnostic tests for non-acute hearing conditions

Does not require an order from a physician or a nonphysician practitioner

Allowed once every 12 months, per patient

Audiology Services: Changes for 2023

- Applies to 36 Audiology CPT® Codes
- Use of the AB modifier required
  - **For use only when the patient has directly accessed the audiologist (without a physician/NPP order)**
- Audiologists may bill using modifier AB once every 12 months regardless of the number of applicable CPT® codes billed with the modifier on that date of service

Dental Services: What's New

- Clarification of payment policies for dental services when that service is an integral part of specific treatment of a beneficiary's primary medical condition
- Medicare payment (A and B) for dental services, such as dental examinations, including necessary treatment, performed as part of a comprehensive workup prior to organ transplant, or prior to a cardiac valve replacement or valvuloplasty procedures
- Medicare payment (A and B) for dental services, such as dental examinations, including necessary treatments, performed as part of a comprehensive workup prior to the treatment for head and neck cancers (effective for CY 2024)
- Medicare payment (A and B) for such dental services that occur within the inpatient hospital and outpatient setting, as clinically appropriate
- Process to identify additional dental services that are inextricably linked/substantially related/integral to the clinical success of other covered medical services

Lecanemab (Leqembi ™)

National Coverage Determination (NCD) 200.3

- Coverage
  - Patient enrolled in Medicare
  - Be diagnosed with mild cognitive impairment or mild Alzheimer's disease dementia
  - Must have documented evidence of beta-amyloid plaque on the brain
  - Physician who participates in a qualifying registry with an appropriate clinical team and follow-up care
  - May participate in the CMS National Patient Registry (https://qualitynet.cms.gov/alzheimers-ced-registry)

Lecanemab (Leqembi ™)

Part B Claims

- Report Leqembi HCPCS J0174
- Report appropriate modifier
  - **Q0 (investigational clinical service provided in a clinical research study that is in an approved clinical research study)**
- Report the trial number associated with the registry (in narrative description field or loop 2300 on electronic claim)
- Report Z00.6 (denotes a registry) **and** appropriate diagnosis code

Coinsurance and deductible apply.

CMS BHI

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
  - Behavioral Health Integration including the Collaborative Care Model
  - Opioid Use Disorder screening and treatment

CMS BHI 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

Appeals

Providers are encouraged to submit their appeals via Palmetto GBA's eServices Portal

- **Providers can submit the appeal request and the complete medical record online**
- **You will receive a confirmation from Palmetto GBA indicating that the appeal has been received**

You may also complete the forms electronically on our website or by printing them

- **Please include your first and last name**
- **Attach the complete medical record and mail to the address indicated on the form**

Appeals

APPEAL LETTERS

Appeal letters are sent with the results for partially paid services and denied services

STATUS LOOKUP TOOLS

- Appeals Status Tool
- Administrative Law Judge (ALJ)/Third level status lookup tool
  - HHS.gov website

Stay Prepared

- Know where previous improper payments have been found.
- Know if you are submitting claims with improper payments.
- Prepare to respond to all additional documentation requests.
- Look to see what improper payments have been found in OIG and CERT reports.
- Check on the status of your additional documentation.
- Be sure to keep your address up to date within PECOS.

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

Questions

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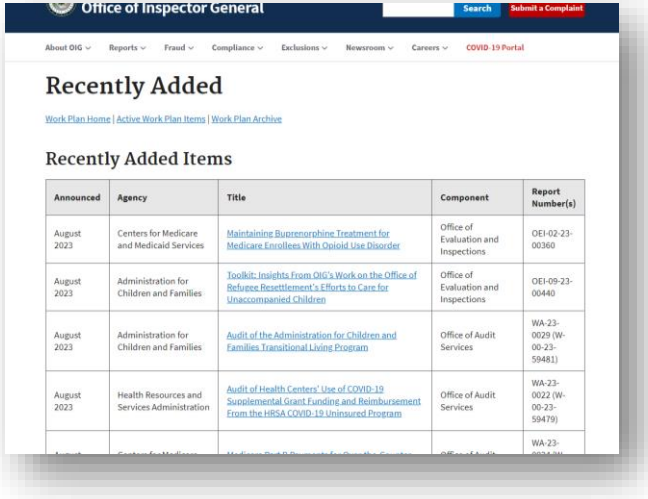
Resources

OIG Work Plan

- Contains continuing work planning efforts
- Updates projects monthly
- Some projects described in the work plan are statutorily required
- This work plan identifies potentially noncompliant areas the OIG intends to scrutinize



[Work Plan | Office of Inspector General | U.S. Department of Health and Human Services (hhs.gov)]

CMS Educational Opportunities

CMS.gov Centers for Medicare & Medicaid Services

About CMS Newsroom Data & Research

Medicare Medicaid/CHIP Marketplace & Private Insurance Priorities Training & Education

Training & Education > Medicare Learning Network (MLN) > Resources & training

Monthly Highlight

Help Reduce Health Gaps for Hispanic or Latino Patients

More than 50% of Medicare Fee-for-Service Hispanic or Latino patients report fair or poor health (see data highlight). During National Hispanic Heritage Month, help increase awareness of health disparities, reduce gaps in health care, and increase access to culturally and linguistically competent health care and coverage.

The Medicare Learning Network®

mln KNOWLEDGE • RESOURCES • TRAINING

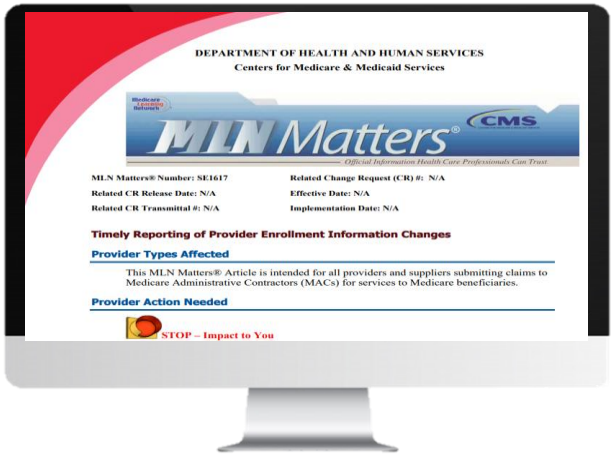
Free educational materials for health care providers on CMS programs, policies, and initiatives.

Resources & Training

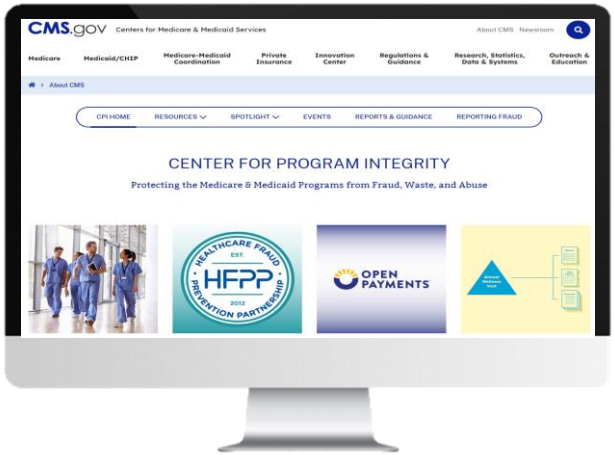
Learn about CMS policies and programs at your own pace

- Publications & Multimedia
- Web-Based Training
- MLN Matters® Articles

Resources

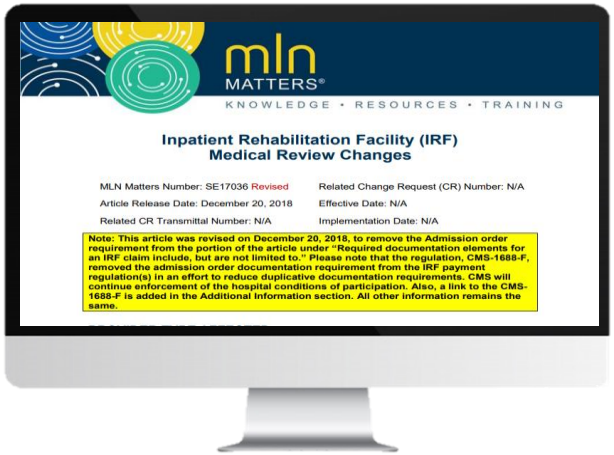


[SE1617 (hhs.gov)]



[CPI | CMS]

Resources

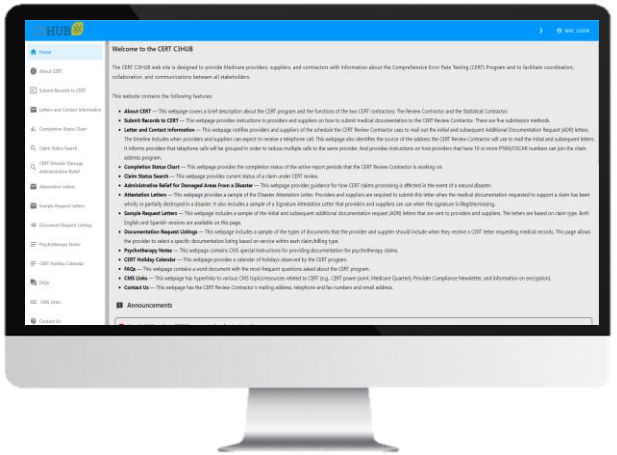


[MLN Matters Number: SE17036]

[OIG Report A-01-15-00500]

Resources

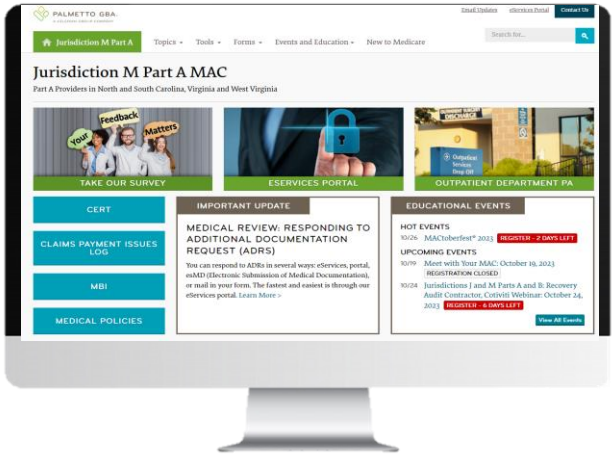
[MLN Matters Number: 909160]



[C3HUB (cms.gov)]

Resources

[MLN Matters Number: 4824456]



[Jurisdiction M Part A (palmettogba.com)]

Resources

- CMS IOM Medicare National Coverage Determinations (NCD) (Pub. 100-03), Chapter 1, Part 1 Sections 20.4/20.32/20.34
- CMS IOM Medicare Claims Processing Manual (Pub. 100-04), Chapter 32, Section 270/290
- Percutaneous Left Atrial Appendage (LAAC) Closure Therapy Decision Memo
- Percutaneous Left Atrial Appendage Closure (LAAC) NCD 20.34
- Implantable Defibrillators Decision Memo
- Implantable Automatic Defibrillators NCD 20.4

Resources

- Closing the Gap: Left Atrial Appendage Closure Module
- DRG 227: Cardiac Defibrillator Implant without Cardiac Catheterization without MCC
- DRG 266 and DRG 267: Endovascular Cardiac Valve Replacement
- Hospital Readmissions Reduction Program (HRRP)
- Inpatient Rehabilitation Facilities Required Documentation
- End Stage Renal Disease (ESRD) Center

Resources

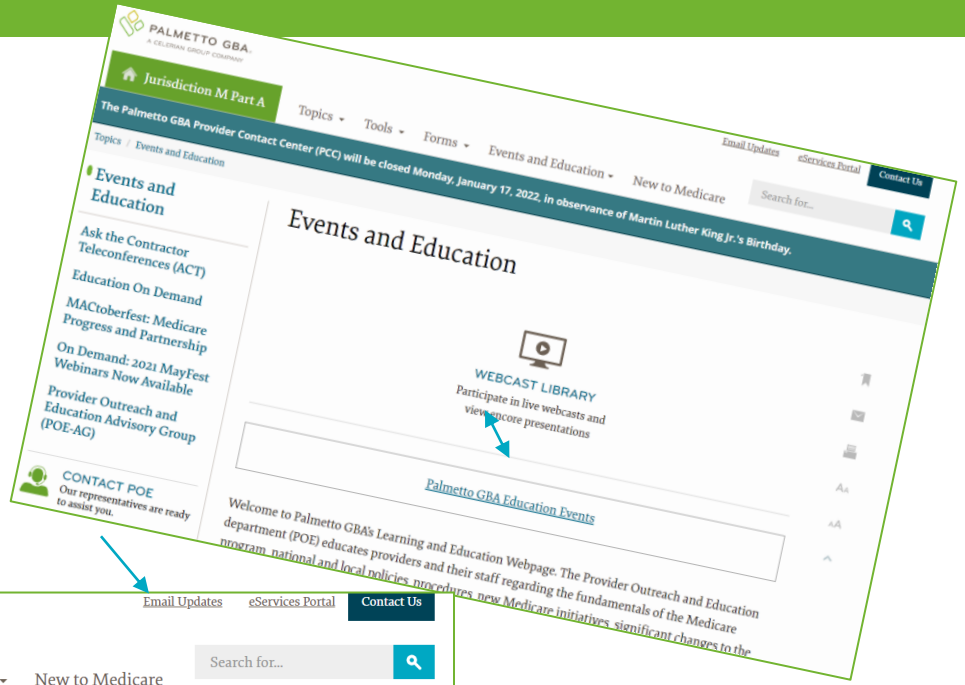
- Medicare Benefit Policy Manual, Chapter 15
  - https://tinyurl.com/4sfpkw5t
- Medicare Claims Processing Manual
  - https://tinyurl.com/4krad4b8
- Palmetto GBA Jurisdiction M Part B Website
  - https://tinyurl.com/3y5m3e5n

Educational Events

Upcoming Events/Webinars

- Weekly email updates

To view Educational Events, **Click on Events and or select Palmetto GBA Education Events** to view our upcoming schedule.



PECOS

- Supports Medicare Provider and Supplier enrollment process
- Allows registered users to securely and electronically submit and manage Medicare enrollment information

Have you updated PECOS?

Connect With Us

FACEBOOK

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

X (TWITTER)

#StayConnected on X 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