Swing for the Fences

A Day of Learning Opportunities

WPS GOVERNMENT HEALTH ADMINISTRATORS Learning Center

wpsghalearningcenter.com

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Disclaimer

This program was designed for informational purposes only. The current Medicare regulations will always prevail. The provider alone is responsible for correct submission of claims. Official Medicare Program provisions change frequently and are contained in the relevant laws, regulations and rulings and can be found on the Centers for Medicare & Medicaid Services (CMS) website at www.cms.gov.

We're Glad to Be Here!

Win/Win Situation

Today's Starting Lineup

- Targeted Probe and Educate Reviews and Findings
- Comprehensive Error Rate Testing (CERT) Findings
- Other Medical Review Contractors
- Office of Inspector General (OIG)/OIG Work Plan
- KS and MO Top Rejections/Denials
- WPS GHA Portal
- WPS GHA Learning Center

Today's Closer

- Evaluation and Management (E/M) Services
  - Care Management
  - Shared/Split Services
  - Incident To
  - Global Services
- Infusion Services
- Welcome to Medicare Physical Examination/Annual Wellness Visit
- Certification of Home Health Services

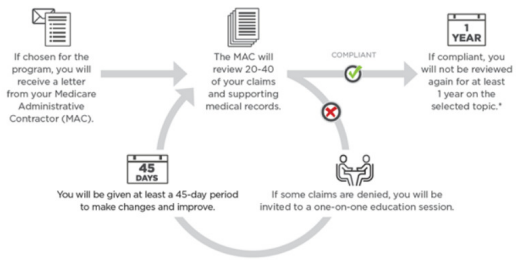
Targeted Probe and Educate (TPE)

Selection and Announcement of TPE Topics

- List available on WPS GHA Portal
  - Part A
  - Part B
- Includes ongoing and new TPE topics

TIP: WPS GHA Portal resources also include guidelines for successful review, and checklists for documentation

How does TPE work?



*MACs may conduct additional review if significant changes in provider billing are detected

What happens if there's no correction?

- A provider may undergo up to three rounds of education sessions
- Failure to improve will result in referral to CMS for other considerations

Questions You Might Ask

- How will you know you are selected for review?
- What happens after you receive notification for TPE?

TIP: Make certain provider enrollment records are up-to-date

Sending Documentation to WPS GHA

- Reminders
- Five methods for submission

TIP: The provider on TPE is responsible for accessing and sending all needed medical records, regardless of where record is stored

Methods to Submit Documentation to WPS GHA

- WPS GHA Portal
- Hardcopy
- Fax
- CD
- esMD

TIP: Return copy of ADR when sending the documentation to WPS GHA

MR Denial – Documentation Not Returned Timely

- Remittance Advice Remark Code M27
- Those who refuse to submit documentation
  - referred to CMS

TIP: M27 on the Remittance Advice means you may submit a new claim with documentation

What happens when WPS GHA receives the documentation?

- Nurse analyst reviews documentation as it is received
- Nurse analyst will contact you, if needed
- Nurse analyst will offer/provide one-on-one education

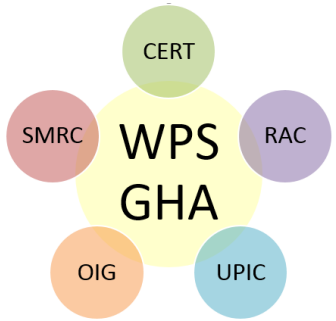
TIP: Take advantage of one-on-one education, when offered

Help Yourself

- Access individual claim review (ICR) result
  - Use WPS GHA portal
- Implement needed changes to comply with Medicare guidelines
- If you disagree with the ICR result, prepare and submit a timely and complete appeal request

TIP: No need to wait until end of round to implement needed changes

MAC Relationship in Claim Reviews



CERT Contractor

- AdvanceMed Corp.
  - https://certprovider.admedcorp.com/

CERT Provider Documentation Information

Recent J8 Part B CERT Errors – Swing and a Miss

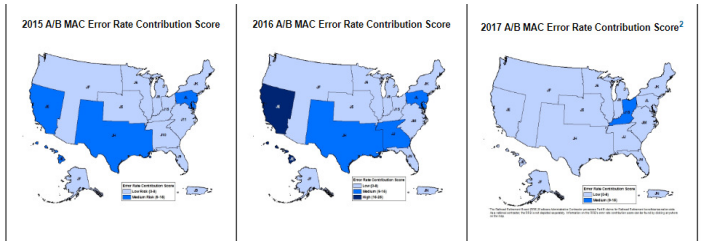
- Insufficient documentation
  - 66%
- Service incorrectly coded
  - 26%
- No response
  - 6%
- Medically unnecessary service(s)/treatment
  - 1%

CMS CERT Report


U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

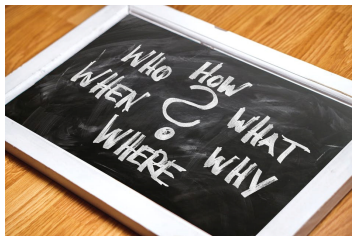
2018 Medicare Fee-for-Service Supplemental Improper Payment Data

Jurisdiction Error Rate Contribution Data



Appeal a CERT Error

- Submit to WPS GHA



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RAC

- Region II – Cotiviti, LLC (Includes IA, KS, MO and NE)
  - https://www.cotiviti.com/markets/cms-rac

COTIVITI

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UPIC

- AdvanceMed
  - https://www.nciinc.com/about-us/

advance med an NCI Company

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SMRC

- Noridian Healthcare Solutions, LLC
  - https://www.noridiansmrc.com/

noridian Healthcare Solutions

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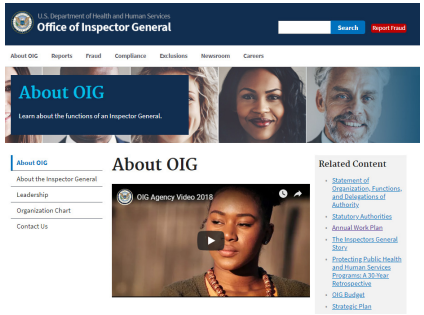
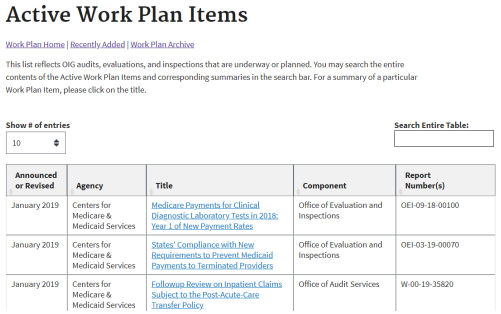
Office of Inspector General (OIG)



OIG Work Plan



Example of Why a Service Was Chosen for Medical Review

Hyperbaric Oxygen Therapy (HBOT)

OIG Selected WPS GHA for Review

- Based on data
- Objective to determine if HBOT complied with regulations

OIG Claim Sample

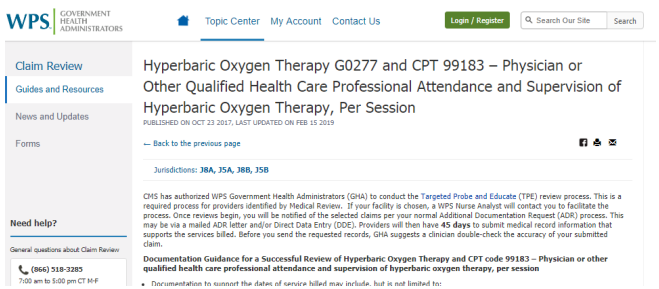
- 44,940 claims = $59.5 M for J5
  - 73 providers
- Sampled 120 claims
  - 102 claims did not comply with Medicare regulations, representing $300,789 in inappropriate payment
    - Estimated overpayment applicable to universe of claims = $42.6 M

OIG Findings

- Documentation did not substantiate
  - Medical necessity
  - Covered condition
  - Standard or conventional wound care was provided prior to HBOT
  - Any mention of Wagner Grade III or higher diabetic wound

National Coverage Determination (NCD) 20.29

OIG Recommendations/WPS GHA Response



Claim Rejections/Claim Denials

Missouri and Kansas; Dates of Service 10/01/18 – 12/31/18; Processed thru 01/09/19

Rejections/Unprocessables

- Defined in CMS IOM Pub 100-04, Chapter 1, Section 80.3.1
  - Claim with
    - Incomplete or missing required information
    - Complete information, but information is invalid
  - May be required on all claims, or required conditionally
- Remittance Advice Remark Code MA130
- No appeal rights
  - Fix it, resubmit it

Top Rejections

- Handout

Denials

- Review RA for information
  - Remittance Advice (RA) Information – An Overview
- Self service denial assistance is available
  - If you use the WPS GHA Portal Claim/Inquiry feature, use the More Info button
    - Navigate to Topic Center>>Self-Service and select Denial Assistance to view table with Part B claim categories with enhanced denial information
- Appeal rights appear on the RA
  - Consider CER process to make a basic correction, in lieu of an appeal

Clerical Error Reopening (CER)

- How to Request a Clerical Error Reopening
  - Portal resource includes what qualifies for CER
- Methods
  - Telephone
  - Fax
  - Written
  - WPS GHA Portal (fastest and preferred method)
    - WPS GHA Transaction Portal Manual includes instructions

Top Denials

- Handout

WPS GHA Portal

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Register Now

Review

- What is the combined total number of years of Medicare experience for Mary and Ellen?
- For the TPE process, how many rounds of education may occur?
- What is the OIG Hotline Number?
- In what year was “Take Me Out to the Ballgame” released?

Patient Relationship Modifiers

X1	Continuous, Broad
X2	Continuous, Focused
X3	Episodic, Broad
X4	Episodic, Focused
X5	Ordered by others

Evaluation and Management Services

40%

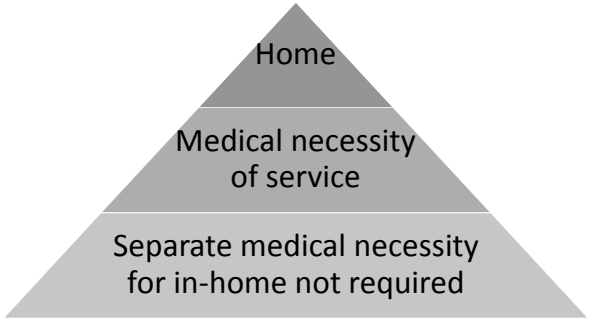
- Total Services

20%

- Office and other outpatient

Teaching Physician

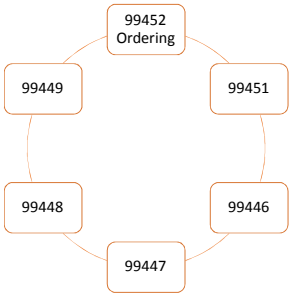
Home Services



Virtual Check-In

Remote Pre-recorded

Interprofessional Internet Consult

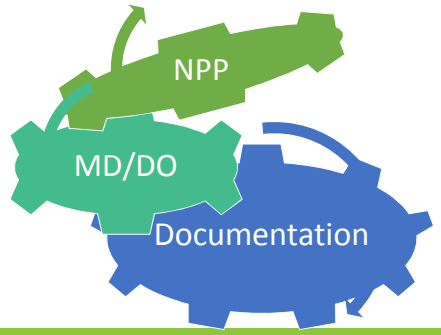


Chronic Care Remote

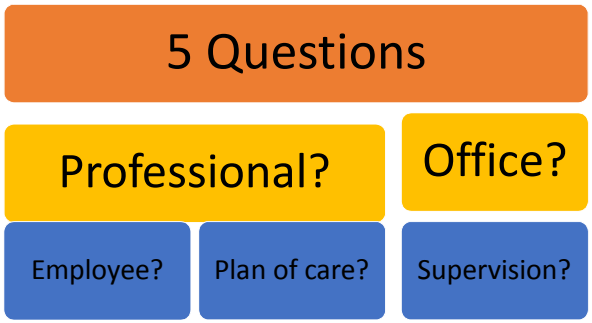
Telehealth

- New – prolonged preventive
- Dialysis assessment
  - Face-to-face
    - One per month – first three months
    - At least once every three consecutive months
- Acute stroke – Modifier G0 (zero)
  - Home
  - Mobile stroke unit

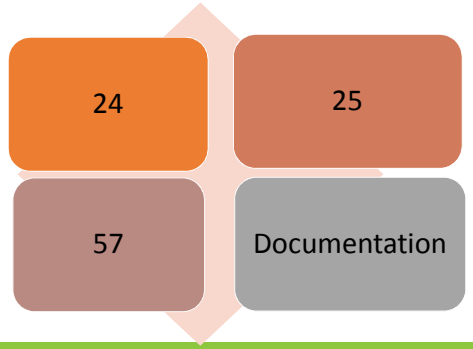
Split/Shared Services



Incident To Guidelines



Global Surgery Package



Welcome to Medicare

Annual Wellness Visit

Infusion Services

- Hydration
- Therapeutic, prophylactic, and diagnostic injections and infusion (excluding chemotherapy)
- Chemotherapy

CCM Procedure Codes

- 99490 – 20 minutes
  - At least 15 minutes documented
- 99487 – 60 minutes
  - At least 60 minutes documented
- 99489 – each additional 30 minutes in addition to 99487
  - At least 30 minutes documented
- Cannot report both CCM and Complex CCM in the same month

Practitioner Eligibility

- MD/DO
- CNM
- CNS
- NP
- PA

Clinical Staff

- Incident to
- General supervision
- Clinical personnel
- Time by non-clinical staff does not count toward the CCM requirements

Patient Eligibility

- Two or more chronic conditions
- Expected to last 12 months or until death
- Significant risk

Examples of Chronic Conditions

Condition	Condition
Alzheimer's	Arthritis
Asthma	Atrial Fibrillation
Autism Spectrum Disorders	Cancer
Cardiovascular Disease	Chronic Obstructive Pulmonary Disease
Depression	Diabetes
Hypertension	Infectious Diseases such as HIV/AIDS

Initiating Visit

- Patient seen within one year
- Procedure code G0506
  - Extensive assessment and care planning
  - Outside of care described by initiating visit
  - Billable only once

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Patient Consent

- Patient must consent
- Patient has cost-sharing
- Documented in medical record
  - Availability and cost-sharing
  - Only one practitioner may submit
  - Right to stop services effective at end of month

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Elements

- Structured recording of patient health
- Comprehensive electronic health plan
- Manage transitions of care
- Coordinate and share information
- Patient-centered
- Provide a copy to the patient

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Comprehensive Care Plan

- Problem list
- Expected outcome and prognosis
- Measurable treatment goals
- Symptom management
- Planned interventions
- Medication management
- Schedule for review and/or revision

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Access to Care

- 24/7 access
  - Where does the patient contact?
  - Who does the patient contact?
  - How does the patient contact?

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Comprehensive Care Management

- Assessment of patient needs
- System-based approaches to receive preventive services
- Medication reconciliation and documentation of adherence and potential interactions
- Oversight of patient self-management
- Coordinating community resources
- Manage transitions of care

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Concurrent Billing

- Cannot provide during
  - Care plan oversight for home health or hospice
  - End-stage renal disease services
  - Same time as TCM
  - Prolonged E/M

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Service Summary

- What to include
- What to document

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TCM Procedure Codes

- 99495 – Moderate medical decision-making with face-to-face within 14 days
- 99496 – High medical decision-making with face-to-face within 7 days

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Services

- Interactive contact
- Non-face-to-face
- Face-to-face

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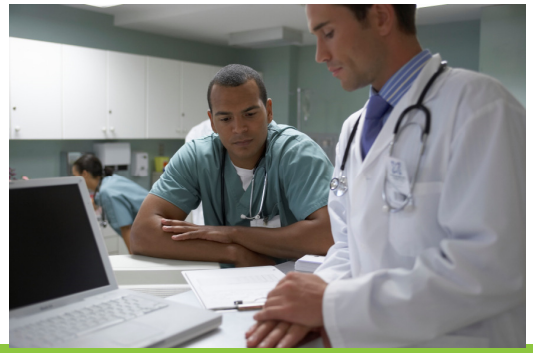
Who Can Perform



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Discharge

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Interactive Contact

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Non-Face-to-Face

- Clinical Staff
  - Communication
  - Adherence
- Practitioner
  - Discharge
  - Follow-up

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Face-to-Face

MDM

Code ⟷ Timing

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Other Information

One	Once
Aftercare	Medical Necessity

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Medicare Home Health Benefit

- Medicare Part A and/or Part B and section 1814(a)(2)(C) and section 1835(a)(2)(A) state that when the physician refers a patient to HH, the patient must:
  - Be confined to the home
  - Need skilled services
  - Be under the care of a physician
  - Receive services under plan of care (POC) established and reviewed by a physician
  - Have had a FTF encounter for their current diagnosis with a physician or allowed non-physician practitioner (NPP)

Homebound Status

Criteria One One Standard Must Be Met		Criteria Two Both Standards Must Be Met
Because of Illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs and walkers; the use of special transportation; or the assistance of another person to leave their place of residence.		There must exist a normal inability to leave home.
	OR	**AND**
Have a condition such that leaving his or her home is medically contraindicated.		Leaving home must require a considerable and taxing effort.

Medicare HH Benefit

- The six home health disciplines included in the 60-day episode rate are:
  - Skilled Nurse on an intermittent/part-time basis
  - Home Health aides on an intermittent/part-time basis
  - Physical Therapy
  - Occupational Therapy
  - Speech Language Pathology
  - Social Work

Plan of Care, Under the Care of a Physician

- The patient must be under the care of a physician who is qualified to sign the physician certification and plan of care in accordance with 42 Code of Federal Regulations (CFR) 424.22.
- It is expected that in most instances, the physician who certifies the patient's eligibility for Medicare home health services will be the same physician who establishes and signs the plan of care.

Face-to-Face Encounter

- A FTF encounter with the patient must be performed by the certifying referring physician himself or herself, a physician that cared for the patient in the acute or post-acute care facility or an allowed Non Physician Provider – NP, PA, CNM, CNS
- There are no forms required – just your clinical note

Certification: Example of a Complete Certification Statement

- I certify this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy, or continues to need occupational therapy. This patient is under my care, and I have authorized the services on this plan of care, and will periodically review the plan. I further certify this patient had a face-to-face encounter that was performed on xx/xx/xxxx by a physician or Medicare allowed non physician practitioner that was related to the primary reason the patient requires home health services.

Certifying is not following patient

- I certify this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy, or continues to need occupational therapy. I have authorized the services on this initial plan of care which will be further developed by Dr. XXX who is overseeing the home health services. I further certify this patient had a face-to-face encounter that was performed on xx/xx/xxxx by a physician or Medicare allowed NPP that was related to the primary reason the patient requires home health services.

Recertification

- Recertification is required at least every 60 days
- Medicare does not limit the number of continuous episode recertifications for patients who continue to be eligible for the HH benefit
- The physician recertifying the patient's eligibility is the physician that has been monitoring the POC and providing oversight of HH services

Physician Billing

- G0180 – Certification
- G0179 – Re-certification
- G0181 – Care Plan Oversight

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Who's on first? What's on second?

Things You Need to Know

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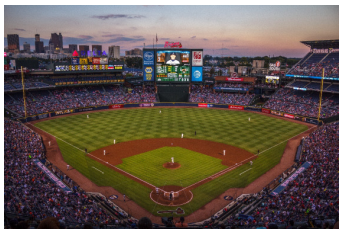

Thank You

You knocked it out of the park!

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