

WPS | GOVERNMENT HEALTH ADMINISTRATORS
Learning Center

wpsghelearningcenter.com

CMS
 CENTER FOR MEDICARE & MEDICAID SERVICES

- [illegible]

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.

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- ## Notes:

[illegible]

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



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

Notes:

[illegible]

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




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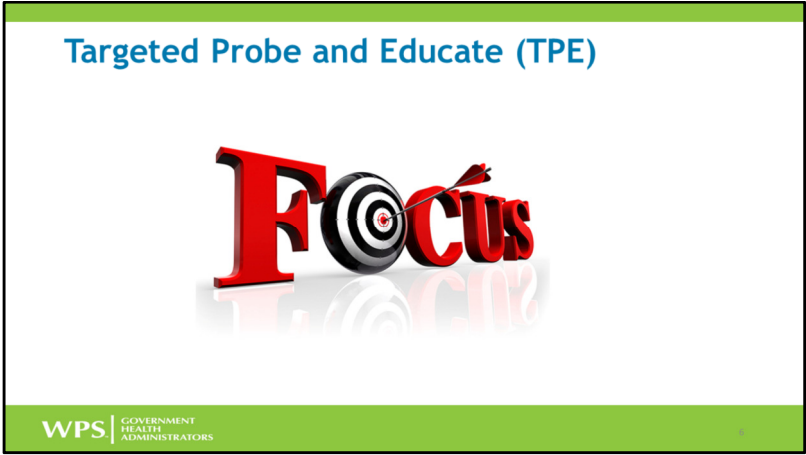
Targeted Probe and Educate (TPE)




A 3D graphic of the word "Focus" in red, bold, sans-serif font. The letter "o" is replaced by a black and white target with a red bullseye. A red arrow is shown hitting the bullseye. The entire graphic is set against a white background with a subtle reflection effect below it.

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9




Targeted Probe and Educate (TPE)



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- 5

[illegible]

- 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



- Specific to analysis of MAC data
- Topics require CMS approval
- When TPE review is authorized by CMS, WPS GHSA will publish
 - Notice in Claim Review News and Updates
 - Documentation guidance for successful review in Claim Review Guides and Resources (linked from notice in News and Updates)
 - Publish a documentation checklist

- Hyperbaric Oxygen (HBO)
 - CPT code 99183
- Outpatient E/M Services
 - CPT codes 99211-99215
- Inpatient E/M Services
 - CPT codes 99221-99223
- Emergency Room Visit
 - CPT codes 99281-99285

- Outpatient Therapy - Therapeutic Procedure
 - CPT code 97110
- Rituximab
 - HCPCS code J9310, J9312, and J9313

[illegible]

How does TPE work?

```
graph TD; A[Letter from MAC] --> B[45 DAYS]; B --> C[MAC Review]; C --> D[Compliant]; D --> E[1 YEAR]; E --> F[Education Session]; F --> C;
```

If chosen for the program, you will receive a letter from your Medicare Administrative Contractor (MAC).

The MAC will review 20-40 of your claims and supporting medical records.

COMPLIANT

If compliant, you will not be reviewed again for at least 1 year on the selected topic.*

45 DAYS

You will be given at least a 45-day period to make changes and improve.

If some claims are denied, you will be invited to a one-on-one education session.

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

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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

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- A provider may undergo up to three rounds of education sessions
 - WPS GHA will determine which providers need additional rounds
 - Based on 20% error rate
 - Round 2 starts 45 days from one-on one education session or the date the one-on-one education session was refused
- Failure to improve will result in referral to CMS for other considerations
 - 100 percent prepay review
 - Extrapolation
 - Referral to Recovery Auditor

Notes:

[illegible]

- 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



- You will receive a phone call from WPS GHA
 - To establish a point of contact
 - For all contact, except for the notification letter
- The notification letter from WPS GHA contains specifics of the probe
 - Sent via U.S. Mail to the Pay To address on the provider profile (in PECOS)


- Be alert and wait for Additional Documentation Requests (ADRs)
- When the ADR is received
 - Completely review ADR to identify all needed information/supporting documentation for probe review
 - Documentation may be housed elsewhere; you are responsible for provision of records for the probe review

Notes:

[illegible]

Sending Documentation to WPS GH A

- 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

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19

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- Reminders
 - Include a copy of the ADR letter
 - Submit within 45 days of ADR notification
- Five methods for submission
 - Resource available on WPS GH A Portal
 - Navigate to Claim Review Topic Center>Guides and Resources>Responding to a Medical Review Additional Documentation Request (ADR)

[illegible]

Methods to Submit Documentation to WPS GH A

- WPS GH A Portal
- Hardcopy
- Fax
- CD
- esMD

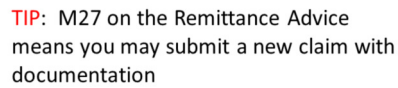


TIP: Return copy of ADR when sending the documentation to WPS GH A

Notes:

- WPS GH A Portal
 - Best, fastest
 - File size limitation is 15 MB
 - Can split files to accommodate file size limitations
- Hardcopy
 - Submit individual files clipped together, no staples
 - Full size sheets, single sided
 - Refer to WPS GH A portal resources for additional information on hard copy submission
 - Claim Review Topic Center
- Fax
 - Fax number included on WPS GH A portal
 - Fax each request individually
 - Full size sheets, single sided
- CD
 - Images must be in PDF or multipage TIF format
 - May submit multiple ADR requests on 1 CD, each must be separate PDF or TIF
 - ADR must be first item under each file
 - Must be password protected, password must be sent to secure email listed on portal
 - Follow all directions on WPS GH A portal
 - Claim Review Topic Center
- esMD
 - Follow information, as directed on WPS GH A portal
 - Claim Review Topic Center

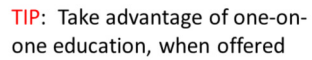
- Remittance Advice Remark Code M27
- Those who refuse to submit documentation
 - referred to CMS



- Part B Claims
 - Remittance Advice Remark Code will be M27
 - Submit new claim with documentation
- Providers who refuse to submit documentation are referred to CMS

[illegible]

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



- Nurse analyst reviews documentation as it is received
- Nurse analyst will contact you, if needed
 - Additional needed documentation
 - Issue that can be resolved easily during the ongoing review
- If denied, nurse analyst will provide one-on-one education
 - Guidance on how to avoid or fix findings for future reviews

[illegible]

Help Yourself

- Access individual claim review (ICR) result
 - Use WPS GH A 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

- Results of all completed individual claim reviews (ICRs) are available in the WPS GHA portal
 - Log in often to view results and implement needed change as the TPE process moves along
- Prepare and submit request for appeal, if you disagree with review findings
 - Be cognizant of timeframe (120 days from date of denial decision)

Notes:

[illegible]

MAC Relationship in Claim Reviews

The diagram illustrates the MAC (Medical Advisory Committee) relationship in claim reviews for WPS/GHA. At the center is a yellow circle labeled "WPS GHA". Surrounding this central circle are five other circles, each representing a different MAC: "CERT" (green) at the top, "SMRC" (red) at the top-left, "RAC" (purple) at the top-right, "UPIC" (blue) at the bottom-right, and "OIG" (orange) at the bottom-left.

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[illegible]

- Office of Inspector General
 - OIG

CERT Contractor

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



The logo features the word "CERT" in large, bold, blue capital letters. Above the letters are several curved, orange lines of varying lengths, suggesting motion or a signal. Below "CERT" is a dark blue rectangular box containing the text "Provider Documentation Information" in white, sans-serif font, arranged in three lines.

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Responsibilities

- Collect documentation and perform reviews on a statistically-valid random sample of Medicare Fee-for-Services (FFS) claims
 - Produces an annual improper payment rate
 - Measures performance of MACs
 - Provides insight into cause of errors
 - Evaluates/determines MAC education

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Review Process

- Claim is selected via statistically valid random sampling
- Documentation is requested
- Documentation is reviewed to determine if the claim was processed correctly
- CERT contractor shares review results with MAC
- If an error is assessed, the MAC will adjudicate the claim and issue payment or request an overpayment

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[illegible]

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%



WPS GHA Part B CERT Error Findings (4th Quarter
Calendar Year 2018)

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

Notes:

[illegible]

CMS CERT Report



The image shows the cover of a report titled "2018 Medicare Fee-for-Service Supplemental Improper Payment Data". The report is from the U.S. Department of Health and Human Services. The cover is white with a black border. The title is in a large, bold, black font. The department name is in a smaller, black font at the top. There is a small logo of a person with a magnifying glass at the top left of the report cover.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

2018 Medicare Fee-for-Service Supplemental Improper Payment Data

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

2018 Medicare Fee-for-Service Supplemental Improper Payment Data

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- U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
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- 19


[illegible]

Jurisdiction Error Rate Contribution Data

- Notes:

Appeal a CERT Error

- Submit to WPS GHA



A small, rectangular chalkboard with a white frame is shown at an angle. It is resting on a light-colored wooden surface. The chalkboard is black and has the words 'Who', 'How', 'When', 'What', 'Where', and 'Why' written in white chalk. A large white question mark is drawn in the center of the board, overlapping the words 'When' and 'Where'.

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- Send completed request for appeal to the MAC, not to the CERT contractor
 - Complete form
 - Sign it/date it
 - Submit all necessary documentation
- For greater efficacy, submit the appeal request via WPS GHA's transactional portal

[illegible]

RAC

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



The logo for Cotiviti, featuring the word "COTIVITI" in a sans-serif font. The letters "C", "O", "T", "I", "V", and "I" are purple, while the letters "I" and "T" are pink.



The logo for WPS Government Health Administrators, featuring the letters "WPS" in a large, bold, sans-serif font, followed by a vertical line and the words "GOVERNMENT HEALTH ADMINISTRATORS" in a smaller, all-caps, sans-serif font.

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Responsibilities

- Identify underpayments/overpayments, as part of the Recovery Audit Program
 - RAC publishes all CMS-approved issues before review commences

Review performed

- Unique to circumstances
- Vulnerabilities identified by data analysis
- CERT program findings

RAC sends letter to notify provider of review findings

- Outlines any improper payments
- References reason for denial

MAC role in RAC review

- Issues overpayment demand letter
- Conducts first level of appeal, if requested
- Can answer only general questions regarding the RAC program
 - Contact Recovery Auditor (RA) with specific questions

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[illegible]

Notes:

UPIC

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



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Responsibilities

- Identify cases of suspected fraud and take appropriate corrective actions

Review performed

- Unique to circumstances

Potential outcomes

- Identify need for administrative actions
 - Prepayment/auto-denial edits to be implemented by MAC
- Payment suspension
- Expanded review
- Referral to law enforcement
 - Consideration of civil/criminal penalties

SMRC

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



The logo for Noridian Healthcare Solutions, featuring the word "noridian" in a bold, lowercase, sans-serif font, with "Healthcare Solutions" in a smaller, italicized, lowercase font below it, all on a light blue rectangular background.

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Responsibilities

- Conduct nationwide medical review as directed by CMS in order to
 - Lower improper payment rate
 - Increase efficiencies of medical review functions of the Medicare and Medicaid programs

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- Conduct nationwide medical review as directed by CMS in order to
 - Lower improper payment rate
 - Increase efficiencies of medical review functions of the Medicare and Medicaid programs

- Project review types
 - Healthcare Fraud Prevention Partnership (HFPP) support review
 - Program Integrity (PI) support review
 - Provider Compliance Group (PCG) review
 - Increase efficiencies of medical review functions of the Medicare and Medicaid programs

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Current projects

- Listed on SMRC website

- Current projects
- Listed on SMRC website

[illegible]

Office of Inspector General (OIG)

Department of Health and Human Services
Office of Inspector General

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About the Inspector General

Leadership

Organization Chart

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- Statement of Organization, Functions, and Composition of the OIG
- Statutes & Authorities
- Annual Work Plan
- The Inspector General Short
- Production of Public Health and Insurance Services Performance, A 30-Year Retrospective
- OIG Briefing
- Inspector's Plan

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- Found at <https://oig.hhs.gov/>

- To protect the integrity of Department of Health & Human Services (HHS) programs as well as the health and welfare of program beneficiaries.
 - Six components to carry this out
 - Immediate Office of Inspector General (IO)
 - Office of Audit Services (OAS)
 - Office of Evaluation and Inspections (OEI)
 - Office of Management and Policy (OMP)
 - Office of Investigations (OI)
 - Office of Counsel to the Inspector General (OCIG)

[illegible]

OIG Work Plan

Active Work Plan Items

[Work Plan Home](#) | [Recently Added](#) | [Work Plan Archive](#)

This list reflects OIG audits, evaluations, and inspections that are underway or planned. You may search the entire contents of the Active Work Plan Items and corresponding summaries in the search bar. For a summary of a particular Work Plan Item, please click on the title.

Show # of entries

10

Search Entire Table

Announced or Revised	Agency	Title	Component	Report Number(s)
January 2019	Centers for Medicare & Medicaid Services	Medicare Payments for Clinical Diagnostic Laboratory Tests in 2018: Year 1 of New Payment Rates	Office of Evaluation and Inspections	OEI-09-18-00100
January 2019	Centers for Medicare & Medicaid Services	States: Compliance with New Requirements to Prevent Medicaid Payments to Terminated Providers	Office of Evaluation and Inspections	OEI-03-19-00070
January 2019	Centers for Medicare & Medicaid Services	Follow-up Review on Inpatient Claims Subject to The Post-Acute Care Transfer Policy	Office of Audit Services	W-00-19-35820

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[illegible]

- Sets forth various projects underway or planned to be addressed during the fiscal year and beyond by OIG's Office of Audit Services and Office of Evaluation and Inspections
 - Review of multiple HHS agencies
 - Includes the Centers for Medicare & Medicaid Services

- Searchable list of all OIG audits, evaluations and inspections underway or planned
- Updated monthly

- Access on OIG's What's New page
 - Includes recommendations to CMS
 - CMS will respond, potentially resulting in claim review

Hyperbaric Oxygen Therapy (HBOT)

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- Notes:

[illegible]

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



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- Objective of review was to determine HBO complied with regulations
- Review by OIG was before the prior authorization demo of 2015
- WPS GHA (J5) was selected due to high volume of claim processing

[illegible]

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

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- This slide includes information on the OIG claim sample.

Notes:

[illegible]

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



- Documentation did not substantiate
 - Medical necessity for service
 - Services provided for a condition that is covered
 - Documentation of standard or conventional wound care prior to services
 - Documentation of Wagner Grade III or higher diabetic wound

Notes:

[illegible]

OIG Recommendations/WPS GHA Response

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Hyperbaric Oxygen Therapy G0277 and CPT 99183 – Physician or Other Qualified Health Care Professional Attendance and Supervision of Hyperbaric Oxygen Therapy, Per Session

PUBLISHED ON OCT 23 2017, LAST UPDATED ON FEB 10 2019

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Jurisdictions: [38A](#), [35A](#), [38B](#), [35B](#)

OIG has authorized WPS Government Health Administrators (GHA) to conduct the Targeted Probe and Educate (TPE) review process. This is a required process for providers identified by Medical Review. If your facility is chosen, a WPS Nurse Analyst will contact you to facilitate the process. Once reviews begin, you will be notified of the selected claims per your normal Additional Documentation Request (ADR) process. Since reviews begin, you will be notified of the selected claims per your normal Additional Documentation Request (ADR) process. Once reviews begin, you will be notified of the selected claims per your normal Additional Documentation Request (ADR) process. Since reviews begin, you will be notified of the selected claims per your normal Additional Documentation Request (ADR) process.

Documentation Guidance for a Successful Review of Hyperbaric Oxygen Therapy and CPT code 99183: Physician or other qualified health care professional attendance and supervision of hyperbaric oxygen therapy, per session

- Documentation to support the dates of service billed may include, but is not limited to:

General questions about Claim Review

(866) 518-3285
7:00 am to 5:00 pm CT (PT)

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29

[illegible]

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- Kansas, Missouri
- Dates of service 10/01/18 – 12/31/18
- Processed thru 01/09/19

[illegible]

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



- “Unprocessable” defined by CMS in IOM Pub 00-04, Chapter 1, Section 80.3.1
 - A claim that is incomplete or missing information or a claim that is complete, but information is invalid
- Remittance Advice Remark Code MA130
 - Additional remark code will identify what must be corrected before resubmitting the claim
 - No appeal rights

Notes:

[illegible]

Top Rejections

- Handout

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39

- # Top Rejections
- Handout
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- 39

Top Rejections

- Handout

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39

Year	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030
Population (millions)	7.5	7.6	7.7	7.8	7.9	8.0	8.1	8.2	8.3	8.4	8.5	8.6	8.7	8.8	8.9	9.0	9.1	9.2	9.3	9.4	9.5
GDP (trillion USD)	45.0	48.0	51.0	54.0	57.0	60.0	63.0	66.0	69.0	72.0	75.0	78.0	81.0	84.0	87.0	90.0	93.0	96.0	99.0	102.0	105.0
Life expectancy (years)	75.0	75.5	76.0	76.5	77.0	77.5	78.0	78.5	79.0	79.5	80.0	80.5	81.0	81.5	82.0	82.5	83.0	83.5	84.0	84.5	85.0
Urban population (%)	55.0	56.0	57.0	58.0	59.0	60.0	61.0	62.0	63.0	64.0	65.0	66.0	67.0	68.0	69.0	70.0	71.0	72.0	73.0	74.0	75.0
Renewable energy (%)	10.0	12.0	14.0	16.0	18.0	20.0	22.0	24.0	26.0	28.0	30.0	32.0	34.0	36.0	38.0	40.0	42.0	44.0	46.0	48.0	50.0
Carbon emissions (Gt CO2e)	15.0	16.0	17.0	18.0	19.0	20.0	21.0	22.0	23.0	24.0	25.0	26.0	27.0	28.0	29.0	30.0	31.0	32.0	33.0	34.0	35.0
Forest cover (%)	22.0	22.5	23.0	23.5	24.0	24.5	25.0	25.5	26.0	26.5	27.0	27.5	28.0	28.5	29.0	29.5	30.0	30.5	31.0	31.5	32.0
Water stress (%)	15.0	16.0	17.0	18.0	19.0	20.0	21.0	22.0	23.0	24.0	25.0	26.0	27.0	28.0	29.0	30.0	31.0	32.0	33.0	34.0	35.0
Healthcare expenditure (GDP %)	5.0	5.2	5.4	5.6	5.8	6.0	6.2	6.4	6.6	6.8	7.0	7.2	7.4	7.6	7.8	8.0	8.2	8.4	8.6	8.8	9.0
Education expenditure (GDP %)	3.0	3.1	3.2	3.3	3.4	3.5	3.6	3.7	3.8	3.9	4.0	4.1	4.2	4.3	4.4	4.5	4.6	4.7	4.8	4.9	5.0
Urbanization rate (%)	55.0	56.0	57.0	58.0	59.0	60.0	61.0	62.0	63.0	64.0	65.0	66.0	67.0	68.0	69.0	70.0	71.0	72.0	73.0	74.0	75.0
Renewable energy share (%)	10.0	12.0	14.0	16.0	18.0	20.0	22.0	24.0	26.0	28.0	30.0	32.0	34.0	36.0	38.0	40.0	42.0	44.0	46.0	48.0	50.0
Carbon emissions (Gt CO2e)	15.0	16.0	17.0	18.0	19.0	20.0	21.0	22.0	23.0	24.0	25.0	26.0	27.0	28.0	29.0	30.0	31.0	32.0	33.0	34.0	35.0
Forest cover (%)	22.0	22.5	23.0	23.5	24.0	24.5	25.0	25.5	26.0	26.5	27.0	27.5	28.0	28.5	29.0	29.5	30.0	30.5	31.0	31.5	32.0
Water stress (%)	15.0	16.0	17.0	18.0	19.0	20.0	21.0	22.0	23.0	24.0	25.0	26.0	27.0	28.0	29.0	30.0	31.0	32.0	33.0	34.0	35.0
Healthcare expenditure (GDP %)	5.0	5.2	5.4	5.6	5.8	6.0	6.2	6.4	6.6	6.8	7.0	7.2	7.4	7.6	7.8	8.0	8.2	8.4	8.6	8.8	9.0
Education expenditure (GDP %)	3.0	3.1	3.2	3.3	3.4	3.5	3.6	3.7	3.8	3.9	4.0	4.1	4.2	4.3	4.4	4.5	4.6	4.7	4.8	4.9	5.0

Denials

- Review RA for information
 - [Remittance Advice \(RA\) Information – An Overview](#)
- Self service denial assistance is available
 - If you use the WPS GH A 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



- Common denials are attributed to
 - Duplicate claims/services
 - Coverage/Entitlement
 - Medical Necessity
 - Payer/Contractor issues
 - Bundling
 - Medicare Secondary Payer situations
 - More
- Use WPS GH A Portal Claim/Inquiry feature for details on denials
 - Choose More Info button
- Refer to CMS booklet for details on the RA
 - Remittance Advice (RA) Information - An Overview

Notes:

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

- [WPS GHA Transaction Portal Manual](#) includes instructions

Notes:

Top Denials

- Handout

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39

- # Top Denials
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- 39

Top Denials

- Handout

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39

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GDP (trillion USD)	45.0	48.0	51.0	54.0	57.0	60.0	63.0	66.0	69.0	72.0	75.0	78.0	81.0	84.0	87.0	90.0	93.0	96.0	99.0	102.0	105.0
Life expectancy (years)	75.0	75.5	76.0	76.5	77.0	77.5	78.0	78.5	79.0	79.5	80.0	80.5	81.0	81.5	82.0	82.5	83.0	83.5	84.0	84.5	85.0
Urban population (%)	55.0	56.0	57.0	58.0	59.0	60.0	61.0	62.0	63.0	64.0	65.0	66.0	67.0	68.0	69.0	70.0	71.0	72.0	73.0	74.0	75.0
Renewable energy (%)	10.0	11.0	12.0	13.0	14.0	15.0	16.0	17.0	18.0	19.0	20.0	21.0	22.0	23.0	24.0	25.0	26.0	27.0	28.0	29.0	30.0
CO2 emissions (Gt)	15.0	16.0	17.0	18.0	19.0	20.0	21.0	22.0	23.0	24.0	25.0	26.0	27.0	28.0	29.0	30.0	31.0	32.0	33.0	34.0	35.0
Forest cover (%)	31.0	31.5	32.0	32.5	33.0	33.5	34.0	34.5	35.0	35.5	36.0	36.5	37.0	37.5	38.0	38.5	39.0	39.5	40.0	40.5	41.0
Healthcare expenditure (GDP %)	5.0	5.2	5.4	5.6	5.8	6.0	6.2	6.4	6.6	6.8	7.0	7.2	7.4	7.6	7.8	8.0	8.2	8.4	8.6	8.8	9.0
Internet usage (%)	20.0	25.0	30.0	35.0	40.0	45.0	50.0	55.0	60.0	65.0	70.0	75.0	80.0	85.0	90.0	95.0	98.0	100.0	100.0	100.0	100.0
Gender inequality index	0.65	0.64	0.63	0.62	0.61	0.60	0.59	0.58	0.57	0.56	0.55	0.54	0.53	0.52	0.51	0.50	0.49	0.48	0.47	0.46	0.45
Human Development Index	0.70	0.72	0.74	0.76	0.78	0.80	0.82	0.84	0.86	0.88	0.90	0.92	0.94	0.96	0.98	1.00	1.02	1.04	1.06	1.08	1.10

WPS GHA Portal



The logo for WPS Government Health Administrators features the letters 'WPS' in a large, bold, blue sans-serif font. To the right of 'WPS' is a vertical green line. To the right of the line, the words 'GOVERNMENT', 'HEALTH', and 'ADMINISTRATORS' are stacked vertically in a smaller, blue, all-caps sans-serif font.



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39

[illegible]

- [illegible]

A presentation slide with a white background and a green header and footer. The header contains the text "WPS GHA Learning Center" in blue. The main content area features the WPS Government Health Administrators logo, which includes the text "WPS" in large blue letters, "GOVERNMENT HEALTH ADMINISTRATORS" in smaller blue letters, and "Learning Center" in green. To the right of the logo is a blue button with the text "Register Now" in white. The footer contains the WPS logo and the text "GOVERNMENT HEALTH ADMINISTRATORS" in white on a green background.

[illegible]

- [illegible]

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?

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Do you know the answers?

- Please write your answers down

Notes:

[illegible]

Patient Relationship Modifiers

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

For reporting services by clinicians who provide the principal care for a patient, with no planned endpoint of the relationship. Services in this category represent comprehensive care, dealing with the entire scope of patient problems, either directly or in a care coordination role.

For reporting services by clinicians whose expertise is needed for the ongoing management of a chronic disease or a condition that needs to be managed and followed for a long time.

For reporting services by clinicians who have broad responsibility for the comprehensive needs of the patients, that is limited to a defined period and circumstance, such as a hospitalization.

[illegible]

[illegible]

For reporting services by specialty focused clinicians who provide time-limited care. The patient has a problem, acute or chronic, that will be treated with surgery, radiation, or some other type of generally time-limited intervention.

For reporting services by a clinician who furnishes care to the patient only as ordered by another clinician. This patient relationship category is reported for patient relationships that may not be adequately captured in the previous four categories.

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Evaluation and Management Services

40%

- Total Services

20%

- Office and other outpatient

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- E/M services are approximately 40% of allowed charges under the Physician Fee Schedule
- Office or other outpatient services are approximately 20% of allowed charges
- There are three ways to document to choose a level of service
 - The 1995 Documentation Guidelines
 - The 1997 Documentation Guidelines
 - Time
- Elements in medical record for new and established office or other outpatient visits
- Providers will no longer be required to re-enter information in the patient's medical record
- Provider will be required to review what they believe is clinically appropriate
- Identify any new, changed, updated, information
- Notate the review in the medical record
- CMS is not implementing the primary and specialty care add-on codes

[illegible]

Teaching Physician



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39

[illegible]

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Home Services

Home

Medical necessity
of service

Separate medical necessity
for in-home not required

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26

- Notes:

Virtual Check-In



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9



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- ## Notes:

Remote Pre-recorded



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- New service G2010
- Not within 7 days of previous related E/M service or within 24 hours or the next available appointment of E/M
- Physician or NPP looking at pictures, video, etc. of what patient has taken and determining medical decision-making
- The physician or NPP would follow up with the patient within 24 hours
 - Documentation – what was viewed, clinical assessment, and follow-up with patient
 - Follow up can be e-mail, telephone, text, etc.
 - If video or photos not clear, the practitioner must contact the patient

Notes:

[illegible]

Interprofessional Internet Consult

```
graph TD; 99452[99452 Ordering] --- 99449[99449]; 99449 --- 99448[99448]; 99448 --- 99447[99447]; 99447 --- 99446[99446]; 99446 --- 99451[99451]; 99451 --- 99452
```

99452 Ordering

99449

99451

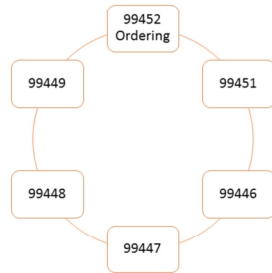
99448

99447

99446

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26



- Notes:

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- Payment will now be allowed for code 99453, 99454, 99457
 - 99453 – patient set up and instruction
 - Professional time
 - Cannot be provided as an incident to service
 - 99454 – daily or programmed alerts
 - Billable every 30 days
 - Professional time
 - 99457 – 20 minutes or more of clinical staff, MD/DO or NPP time during the month
- Will require beneficiary consent
- Beneficiary will have cost sharing

Notes:

[illegible]

- 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

[illegible]

- G0513 and G0514 – These are prolonged preventive care services
 - Billable with appropriate preventive service available by telehealth
- Home dialysis clinical assessments
 - Face-to-face
 - One visit per month for the first three months of home dialysis
 - One visit every three consecutive months thereafter
 - The patient's home can be an originating site, but cannot submit a fee
 - A renal dialysis facility can be an originating site and can submit an originating site fee
- Patients with an acute stroke
 - Removes the rural restriction
- Applies to the current list of originating sites
- Adds a mobile stroke unit
 - Definition – a mobile unit that furnishes services to diagnose, evaluate, and/or treat symptoms of an acute stroke
 - The mobile unit may not submit an originating site fee
 - Both the originating and distant site practitioner will add modifier G0 (zero) to the procedure code

Split/Shared Services

A diagram illustrating the concept of 'Split/Shared Services' using three interlocking gears. The gears are colored green, teal, and blue. The top green gear is labeled 'NPP'. The middle teal gear is labeled 'MD/DO'. The bottom blue gear is labeled 'Documentation'. Arrows indicate a clockwise flow of interaction between the gears, starting from the NPP gear, moving to the MD/DO gear, then to the Documentation gear, and finally back to the NPP gear.

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- Both parties perform a portion of the service
- Need signature from both parties
- Best practice is for both to document what they performed
- Appropriate place of service
 - Office
 - Must also meet Incident to guidelines
 - Outpatient
 - Inpatient
- Inappropriate
 - Nursing facility
 - Critical care services

[illegible]

```
graph TD; A[Incident To Guidelines] --> B[5 Questions]; B --> C[Professional?]; B --> D[Office?]; C --> E[Employee?]; C --> F[Plan of care?]; D --> G[Supervision?];
```

Incident To Guidelines

5 Questions

Professional?

Office?

Employee?

Plan of care?

Supervision?

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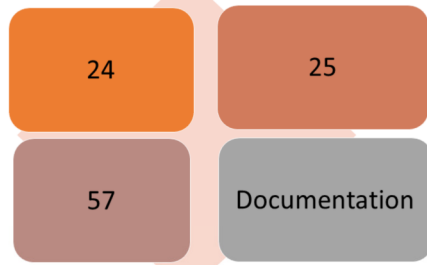
39

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Global Surgery Package

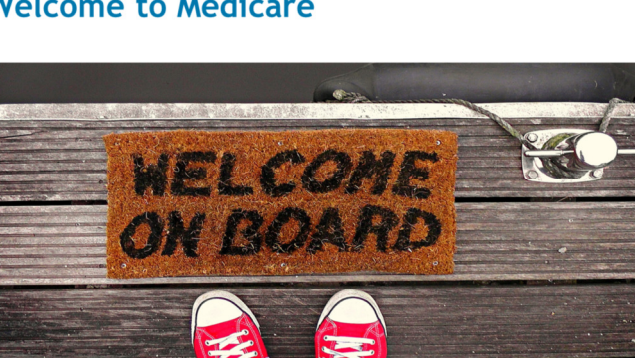


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Notes:

- Services provided by the same physician or a member of the same group with the same specialty
- E/M is reimbursed as part of the procedure
- Determine the number of global days
 - 000
 - 010
 - 090
- Determine if your service meets an exception as identified by a Modifier
- Modifier 24 – unrelated during the post-operative period
- Modifier 25 – Significant, separately identifiable
- Modifier 57 – Decision for major surgery
- Clearance for surgery

Welcome to Medicare

A photograph showing a person's feet wearing red sneakers with white laces, standing on a wooden dock. A brown doormat with the words 'WELCOME ON BOARD' in black capital letters is placed on the dock. To the right of the mat is a metal cleat with a rope tied around it. The background is a solid green color.

- [illegible]

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- Notes:

[illegible]

Infusion Services

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

- Hydration (normal saline, D5-W, etc.)
- Therapeutic, prophylactic, and diagnostic injections and infusion (excluding chemotherapy)
 - Multiple included services
 - Procedure 90772 and CPT
 - Do not use 99211 when non-supervised
 - If non-supervised, the service is non-payable
- Chemotherapy
 - Coding article A54176 has list of codes considered chemotherapy (not all inclusive)
- Submit only one initial code
 - Exceptions
 - Protocol requires two IV sites
 - Services provided during different patient encounters
 - Use Modifier 59
- Documentation
 - Plan of care including drug, dosage, and route of administration
 - Who performed
 - Who supervised

[illegible]

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

- ## CCM Procedure Codes
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[illegible]

Practitioner Eligibility

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

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- MD/DO
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 - CNS
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 - PA

Practitioner Eligibility

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[illegible]

Clinical Staff

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

- ## Clinical Staff
- Incident to
 - General supervision
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Clinical Staff

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[illegible]

Patient Eligibility

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

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Patient Eligibility

- Two or more chronic conditions
- Expected to last 12 months or until death
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[illegible]

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

[illegible]

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 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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Please refer to the handout.

[illegible]

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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[illegible]

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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Please refer to the handout.

Notes:

[illegible]

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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- # Comprehensive Care Plan
- Problem list
 - Expected outcome and prognosis
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- WPS | GOVERNMENT
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Please refer to the handout.

[illegible]

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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[illegible]

Concurrent Billing

- Cannot provide during
 - Care plan oversight for home health or hospice
 - End-stage renal disease services
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[illegible]

Service Summary

- What to include
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[illegible]

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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[illegible]

Services

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

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[illegible]

Who Can Perform



A male doctor in a white lab coat and stethoscope stands next to a male nurse in green scrubs, both looking at a laptop in a hospital setting.

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[illegible]


Discharge



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[illegible]

Interactive Contact

A photograph showing a person's hands holding a white smartphone. The screen displays a chat application with a header 'CHAT' and a list of messages. The background is a blurred indoor setting with a blue couch and a person lying down.[illegible]

Non-Face-to-Face

```
graph TD; CS[Clinical Staff] --- C[Communication]; CS --- A[Adherence]; P[Practitioner] --- D[Discharge]; P --- F[Follow-up];
```

The diagram illustrates non-face-to-face interactions between two groups: Clinical Staff and Practitioner. Clinical Staff are associated with Communication and Adherence. Practitioner are associated with Discharge and Follow-up.

Clinical Staff

- Communication
- Adherence

Practitioner

- Discharge
- Follow-up

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[illegible]

Face-to-Face

```
graph TD; MDM[MDM] <--> Code[Code]; MDM <--> Timing[Timing]; Code <--> Timing;
```

The diagram illustrates the relationship between three components: MDM (Master Data Management), Code, and Timing. MDM is positioned at the top, while Code and Timing are positioned below it. Double-headed arrows connect MDM to both Code and Timing, and a double-headed arrow connects Code and Timing, indicating a bidirectional relationship between all three components.

[illegible]

Other Information

One	Once
Aftercare	Medical Necessity

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[illegible]

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)

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The patient/beneficiary must:

1. Be confined to the home
2. Require “skilled” services
3. Remain under the care of a physician
4. Receive services under a POC established and reviewed by a physician
5. Must have had a FTF encounter for their current diagnosis with a physician or NPP

Notes:

[illegible]

Homebound Status	
<p>Criteria One One Standard Must Be Met</p> <p>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.</p>	<p>Criteria Two Both Standards Must Be Met</p> <p>There must exist a normal inability to leave home.</p>
OR	AND
<p>Have a condition such that leaving his or her home is medically contraindicated.</p>	<p>Leaving home must require a considerable and taxing effort.</p>

[illegible]

- [illegible]

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

- Services that the Medicare Patient/Beneficiary may receive at home include:
 - 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

[illegible]

- 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.

- Certifying must be MD/DO
- MD/DO following patient in the home
- May be other than the ordering physician

[illegible]

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

- Face-to-face encounter must occur within 90 days prior to or 30 days after the start of care
- Must be for the same reason as necessitating home health care
- Can be by NPP
 - Ordering physician can utilize another practitioner's notes
- Clinical note must support the order for home health care

[illegible]

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.

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- Shows patient is homebound
- Shows they need skilled services
- Shows who is going to follow the patient
- Shows the date of the face-to-face service

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

- Does not require a face-to-face service
- Documentation will show patient meets the criteria
- Recertification is required at least every 60 days
- Provided by physician that has been monitoring the plan of care and providing oversight

[illegible]

Physician Billing

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

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- G0180 – Certification
 - When the physician is attesting to the patient meeting the requirements
- G0179 – Re-certification
 - When the physician is attesting to the patient still meeting the requirements
- G0181 – Care plan oversight
 - The physician has provided at least 30 minutes of clinical oversight

[illegible]

Things You Need to Know

- Available March 2019
- Share feedback about your experience with WPS GHA directly to CMS

[illegible]

