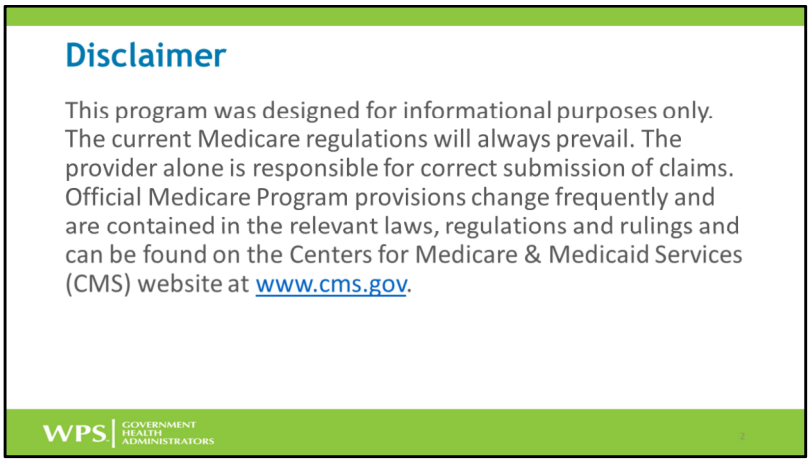
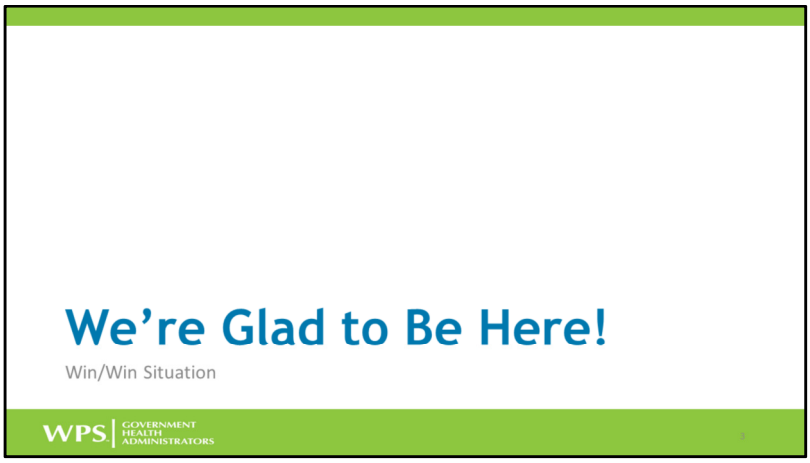
- Thanks to AAPC of KC for inviting WPS GHA to share important Medicare information with you**!**
- Your presenters today are Ellen Berra, CPC and Mary E. Muchow
- Ellen and Mary are Specialists in Provider Outreach and Education (POE)
- There are multiple handouts for today's presentations
    - Shared with AAPC of KC in advance

Notes:



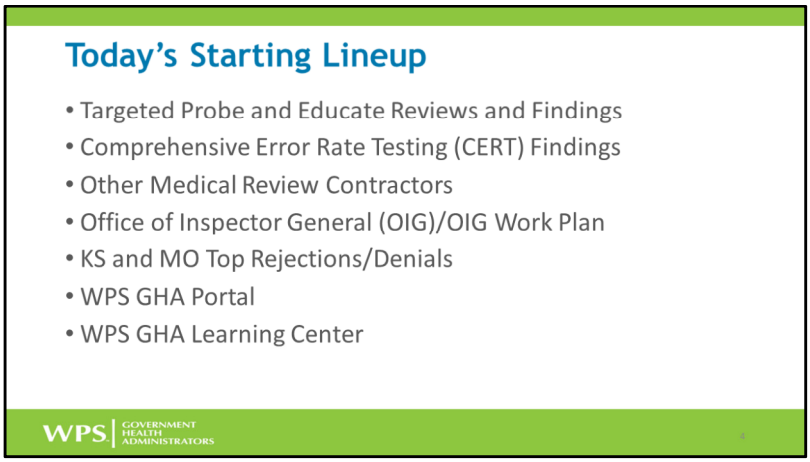
- This program was designed for informational purposes only. The current Medicare regulations will always prevail. Official Medicare Program provisions change frequently and are contained in the relevant laws, regulations and rulings and can be found on the Centers for Medicare & Medicaid Services (CMS) website at www.cms.gov.
- Please keep in mind this information may change at any time.

Notes:



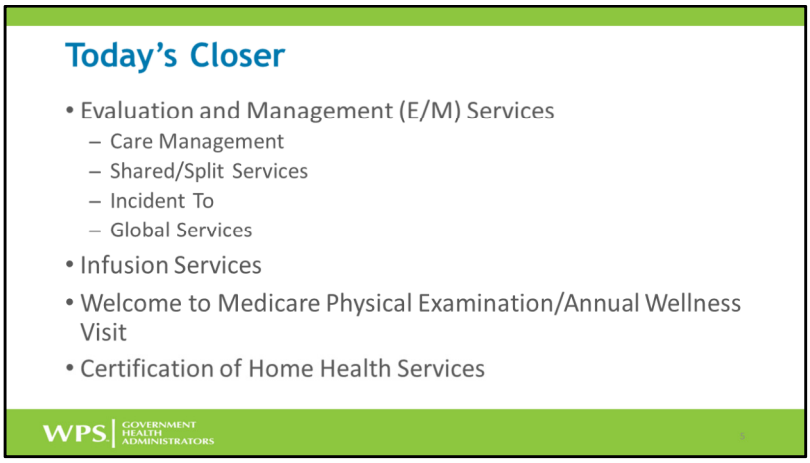
- What is a "partnership"?
- CMS IOM, Publication (Pub) 100-09, Medicare Beneficiary and Provider Communications Manual, Chapter 6, Section 20.2
    - Defines partnering entities
    - Lists examples of collaborative efforts
    - What should the partner do?
        - Please share this education and provide feedback

Notes:



- Targeted Probe and Educate Reviews and Findings
- 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:



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

Notes:

Targeted Probe and Educate (TPE)

WPS GOVERNMENT HEALTH ADMINISTRATORS

- Instructions found in CMS IOM Pub 100-08, Medicare Program Integrity Manual, Chapter 3, Section 3.2.5.
  - Navigate to www.cms.gov>Regulations and Guidance>Manuals>Internet-Only Manuals (IOMS)>100-08>Chapter 3
- CMS TPE web page
  - Navigate to www.cms.gov>Research, Statistics, Data & Systems, Medicare Fee-for-Service Compliance Programs>Medical Review and Education>Targeted Probe and Educate (TPE)

Notes:

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

WPS GOVERNMENT HEALTH ADMINISTRATORS

- Specific to analysis of MAC data
- Topics require CMS approval
- When TPE review is authorized by CMS, WPS GHA 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

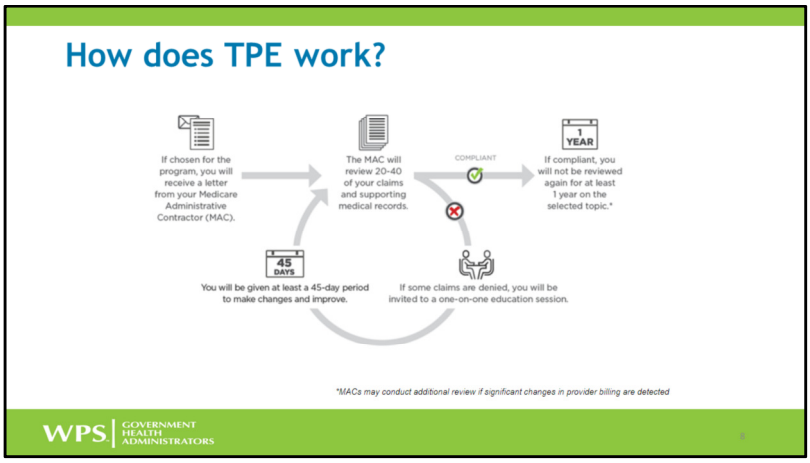
Continuing J5 Part B WPS GHA TPE Topics

- 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

New J5 Part B WPS GHA TPE Topics

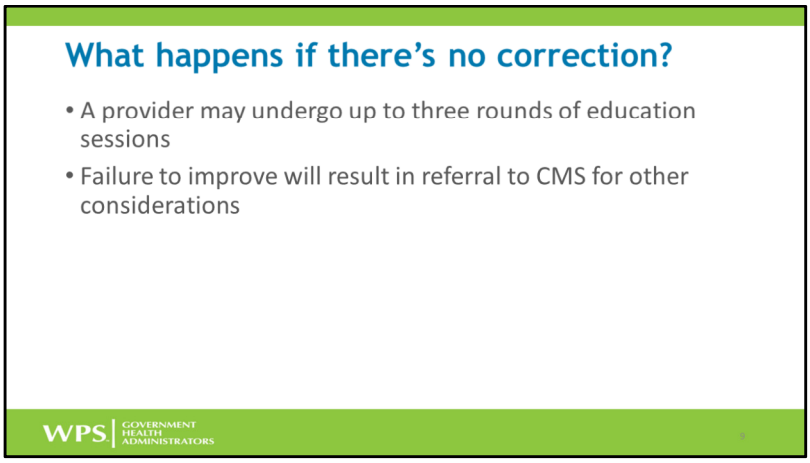
- Outpatient Therapy - Therapeutic Procedure
  - CPT code 97110
- Rituximab
  - HCPCS code J9310, J9312, and J9313

Notes:



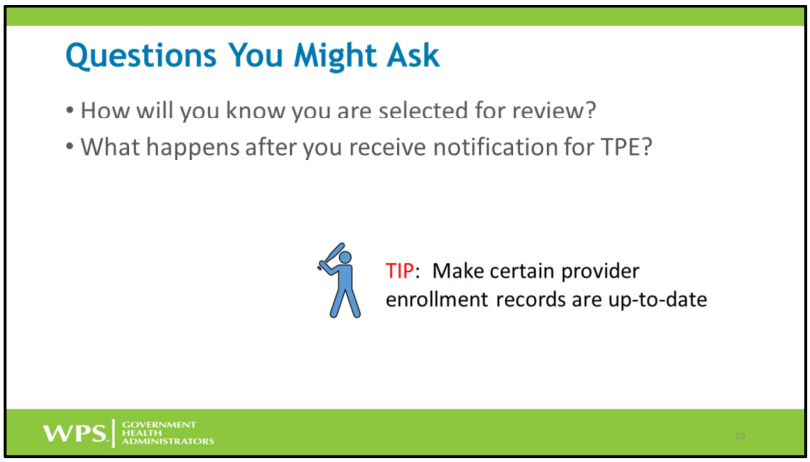
- If chosen, you will receive a letter from your MAC
  - Most providers will never be on TPE
- MAC will review 20-40 of your claims and supporting medical records
- If compliant, you will not be reviewed again for at least 1 year for the selected probe/topic
- Regardless of whether there are findings or if all claims in the TPE probe are paid, you will be invited to a one-on-one education session
  - WPS GHA provides this via teleconference
  - You will be given at least a 45-day period to make changes and improve
- Next round of TPE begins in 45 days
  - From date of education session, or
  - From date education session was refused

Notes:



- 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:



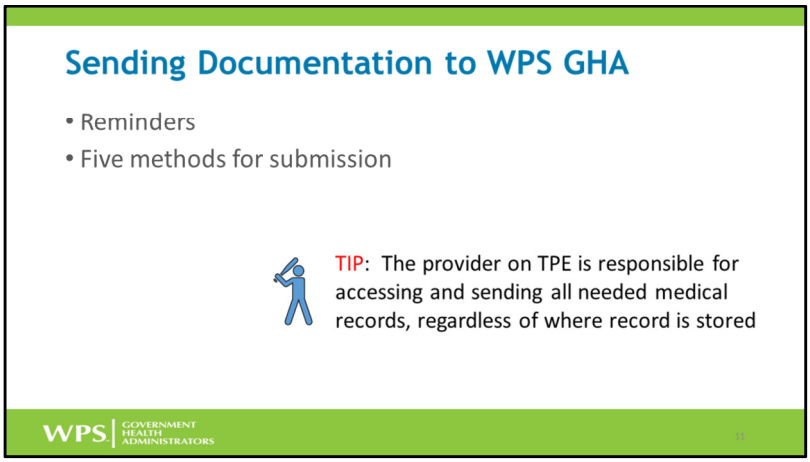
How will you know you are selected for review?

- 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)

What happens after you receive notification of your selection for TPE?

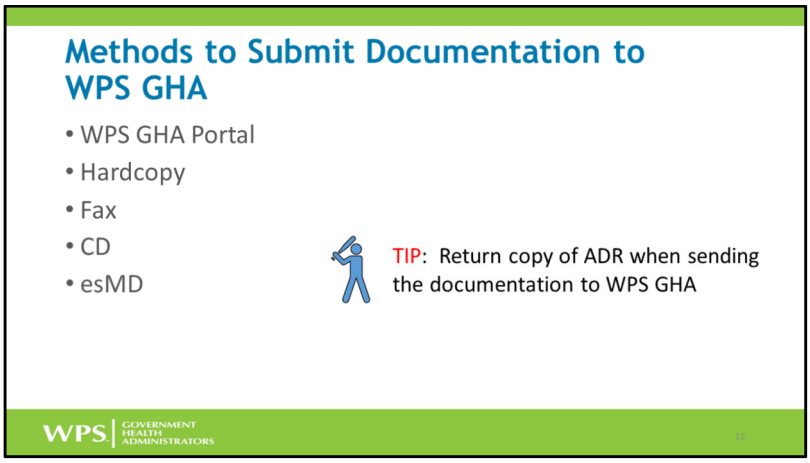
- Be alert and wait for Additional Documentation Requests (ADRs)
- When the ADR is received
  - Completely review ADR to identify all needed information/supporting documentation for probe review
    - Documentation may be housed elsewhere; you are responsible for provision of records for the probe review

Notes:



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

Notes:



Notes:

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- WPS GHA 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 GHA portal resources for additional information on hard copy submission
    - Claim Review Topic Center
- Fax
  - Fax number included on WPS GHA 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 GHA portal
    - Claim Review Topic Center
- esMD
  - Follow information, as directed on WPS GHA portal
    - Claim Review Topic Center

MR Denial - Documentation Not Returned Timely

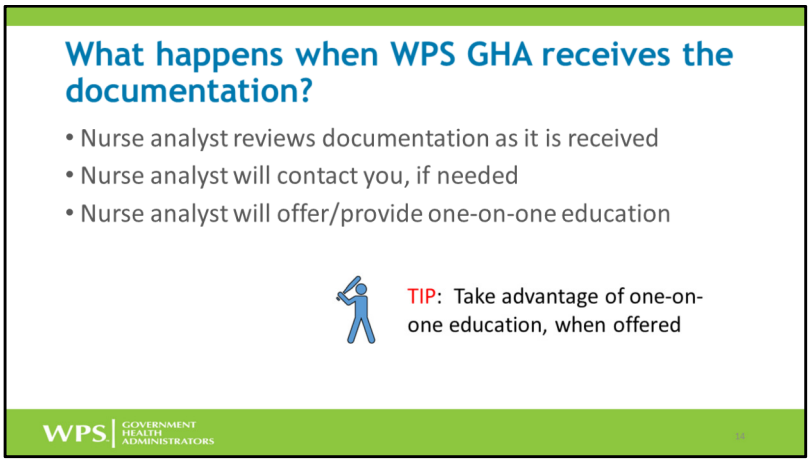
- Remittance Advice Remark Code M27
- Those who refuse to submit documentation
  - referred to CMS

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

WPS GOVERNMENT HEALTH ADMINISTRATORS

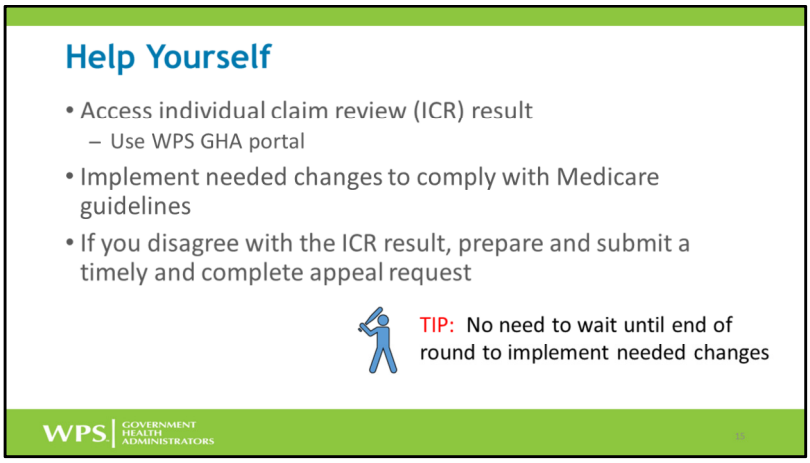
- Part B Claims
  - Remittance Advice Remark Code will be M27
  - Submit new claim with documentation
- Providers who refuse to submit documentation are referred to CMS

Notes:



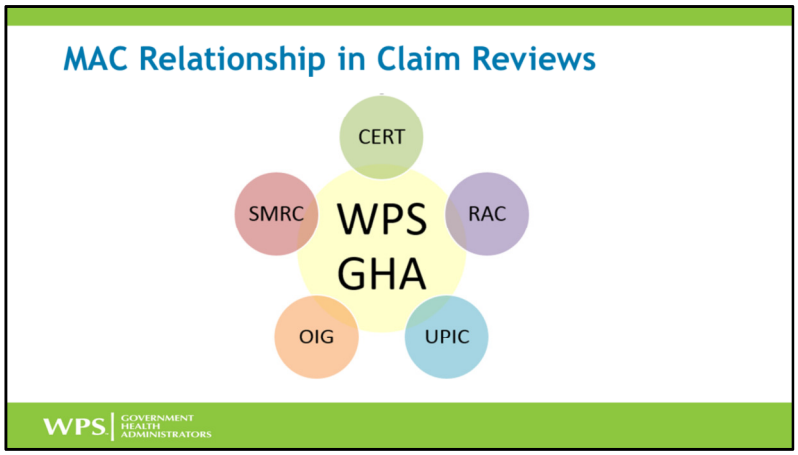
- Nurse analyst reviews documentation as it is received
- Nurse analyst will contact you, if needed
    - Additional needed documentation
    - Issue that can be resolved easily during the ongoing review
- If denied, nurse analyst will provide one-on-one education
    - Guidance on how to avoid or fix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

Notes:



- 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:



- MAC notified of review findings
    - Claim adjudicated based on findings
        - Remittance Advice generated
            - Issue payment or recover

Claim Review Contractors

- Comprehensive Error Rate Testing Contractor
    - CERT
- Recovery Audit Contractor
    - RAC
- Unified Program Integrity Contractor
    - UPIC
- Supplemental Medical Review Contractor
    - SMRC

Department of Health and Human Services Medicare Claim Review

- Office of Inspector General
    - OIG

Notes:

CERT Contractor

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

WPS GOVERNMENT HEALTH ADMINISTRATORS

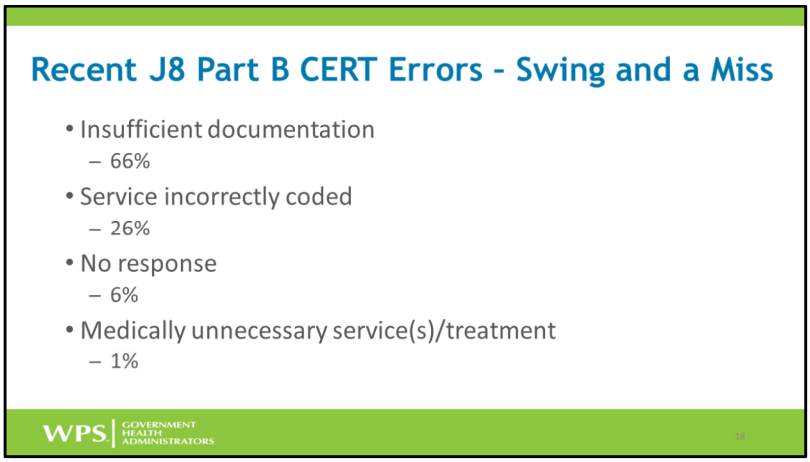
Responsibilities

- 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

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

Notes:



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:

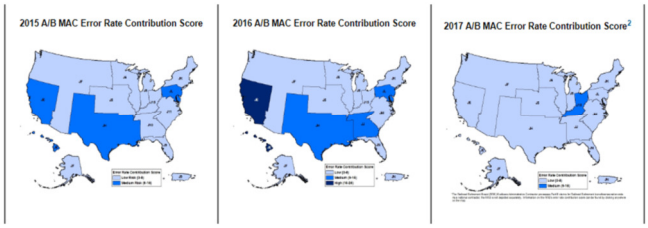
CMS CERT Report

WPS GOVERNMENT HEALTH ADMINISTRATORS

- Summary of high level findings
- Common causes of improper payments
- Monetary loss findings
    - Projected improper payment by state
- Detailed information
- More

Notes:

Jurisdiction Error Rate Contribution Data



WPS GOVERNMENT HEALTH ADMINISTRATORS

- Available on CMS web page by same name
- Key variables are the jurisdiction's
  - Improper payment rate
  - Share of national improper payments

Notes:

Appeal a CERT Error

- Submit to WPS GHA

WPS GOVERNMENT HEALTH ADMINISTRATORS

- 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

Notes:

RAC

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

COTIVITI

WPS GOVERNMENT HEALTH ADMINISTRATORS

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

Notes:

UPIC

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

WPS GOVERNMENT HEALTH ADMINISTRATORS

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

Notes:

SMRC

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

WPS GOVERNMENT HEALTH ADMINISTRATORS

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

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

Current projects

- Listed on SMRC website

Notes:

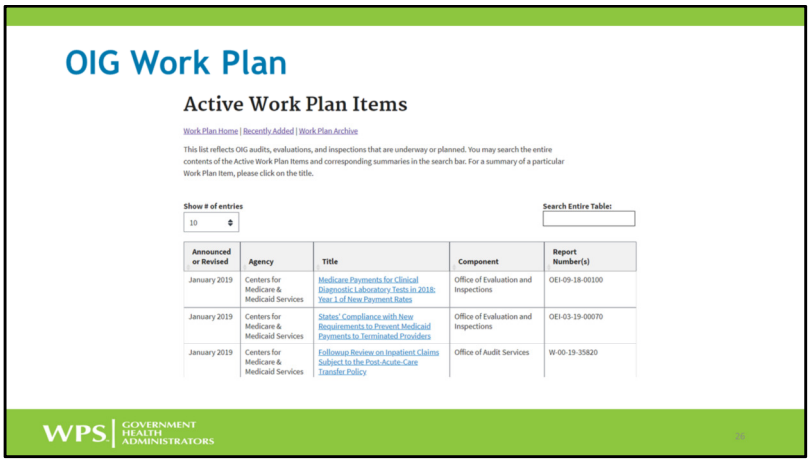
OIG Website

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

OIG Mission

- 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)

Notes:



What is the OIG Annual Work Plan?

- 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

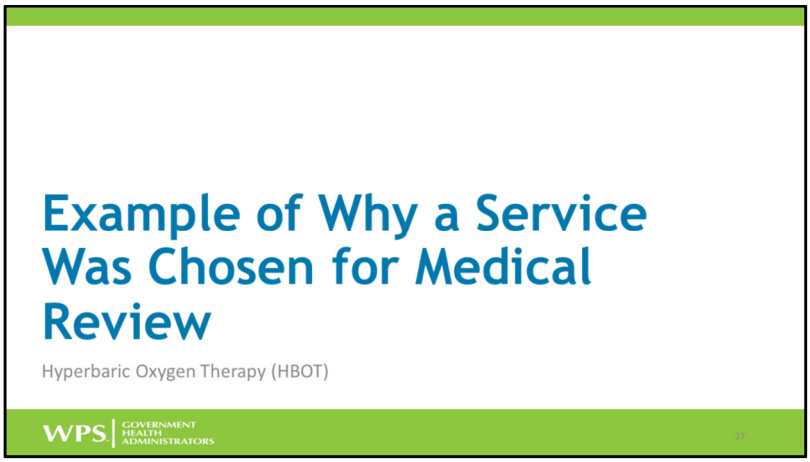
Web-Based Work Plan

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

Published Reports

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

Notes:



- Hyperbaric Oxygen Therapy (HBOT)

Notes:

OIG Selected WPS GHA for Review

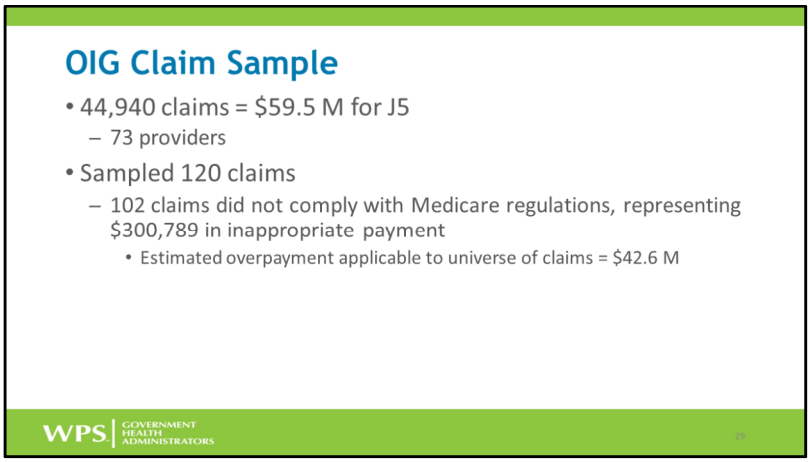
- Based on data
- Objective to determine if HBOT complied with regulations

WPS | GOVERNMENT HEALTH ADMINISTRATORS

Office of Inspector General (OIG) HBO Review of WPS GHA

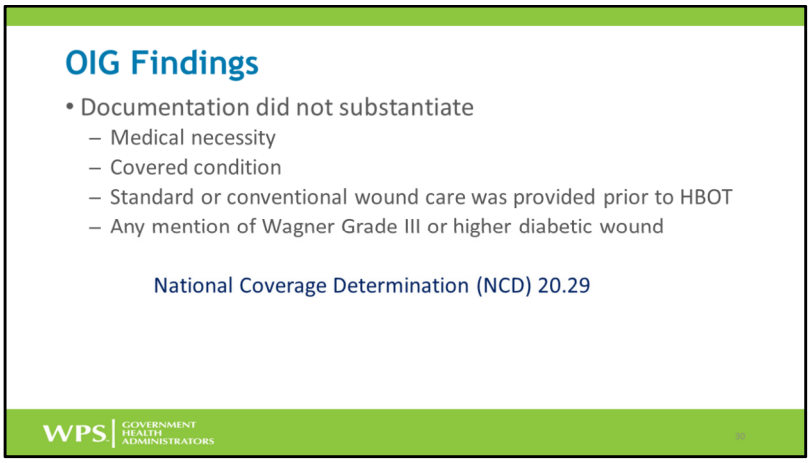
- Objective of review was to determine HBO complied with regulations
- Review by OIG was before the prior authorization demo of 2015
- WPS GHA (J5) was selected due to high volume of claim processing

Notes:



- This slide includes information on the OIG claim sample.

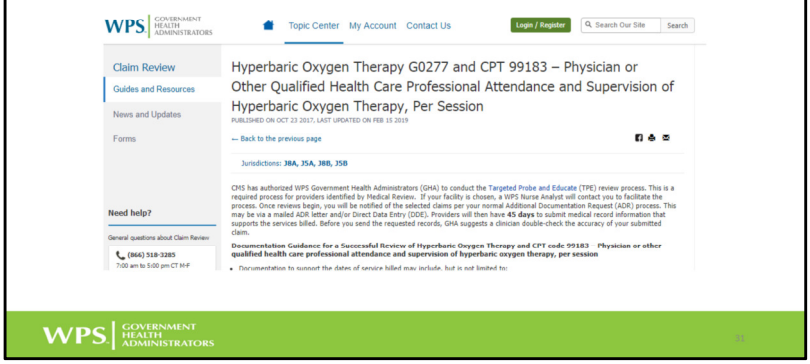
Notes:



- 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

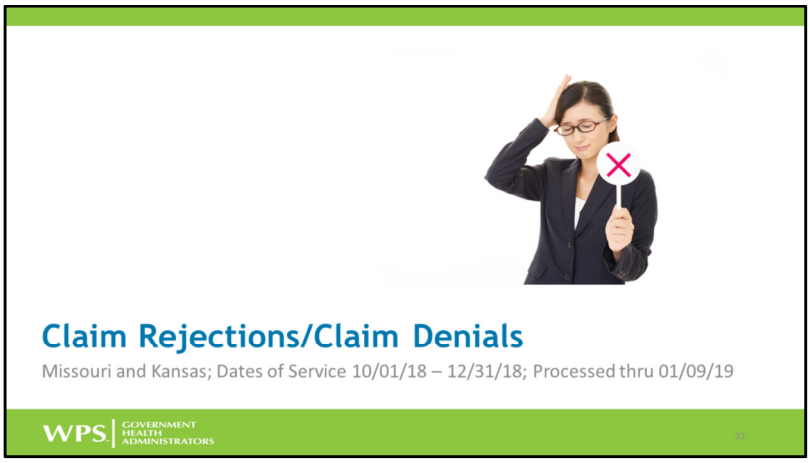
Notes:

OIG Recommendations/WPS GHA Response



- Recover the appropriate portion of the $300,789 identified overpayments
    - Response: WPS GHA recovering identified overpayments
- Notify providers responsible for the 44,820 non sampled claims to investigate and return any overpayments (estimated $42.3M)
    - Response: WPS GHA sent notification letters to affected providers and suggested they investigate/return overpayments
- Identify and recover any improper payments made after audit period
    - Response: WPS GHA initiated TPE reviews on at-risk providers

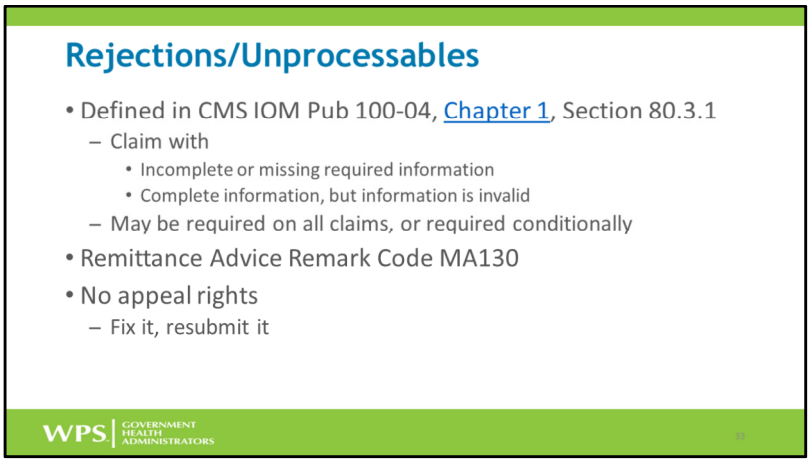
Notes:



Data Analysis Performed

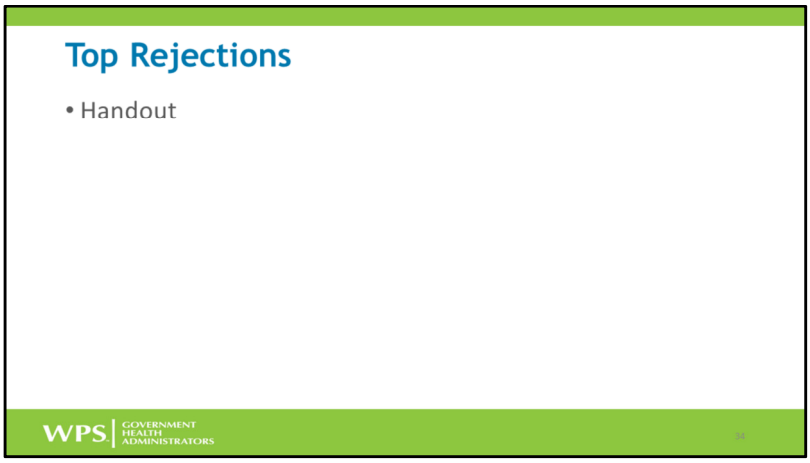
- Kansas, Missouri
- Dates of service 10/01/18 – 12/31/18
- Processed thru 01/09/19

Notes:



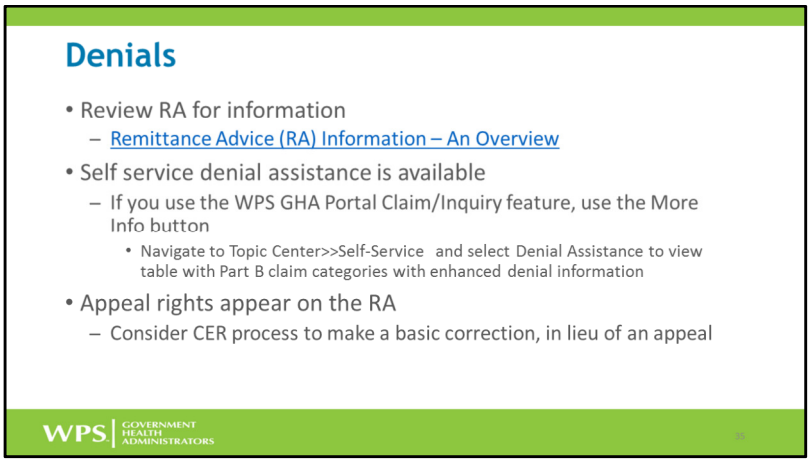
- "Unprocessable" defined by CMS in IOM Pub 00-04, Chapter 1, Section 80.3.1
    - A claim that is incomplete or missing information or a claim that is complete, but information is invalid
- Remittance Advice Remark Code MA130
    - Additional remark code will identity what must be corrected before resubmitting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

Notes:



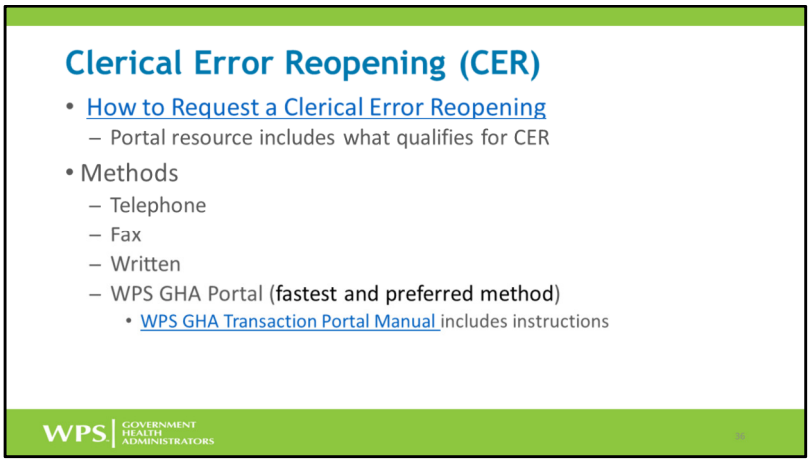
Please refer to the handout.

Notes:



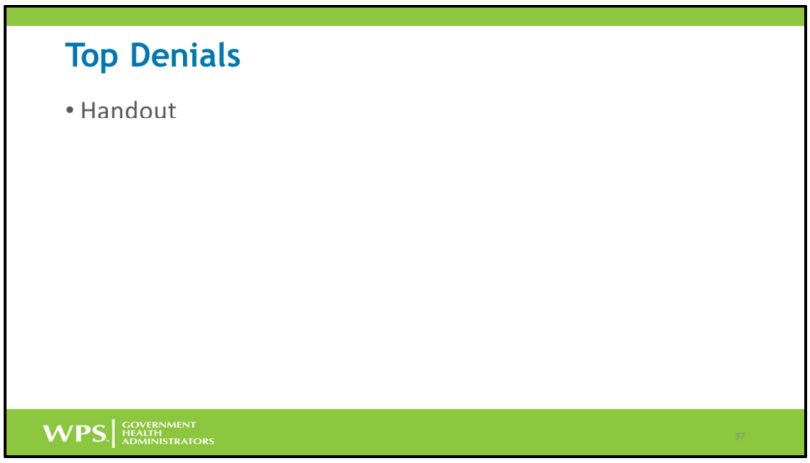
- Common denials are attributed to
  - Duplicate claims/services
  - Coverage/Entitlement
  - Medical Necessity
  - Payer/Contractor issues
  - Bundling
  - Medicare Secondary Payer situations
  - More
- Use WPS GHA Portal Claim/Inquiry feature for details on denials
  - Choose More Info button
- Refer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

Notes:



- Process to make minor correction to previously processed claim
- Can be accomplished by
    - Telephone
    - Fax
    - Written request
    - WPS GHA Portal (fastest/preferred)
        - Portal User Manual includes instructions

Notes:



Please refer to the handout.

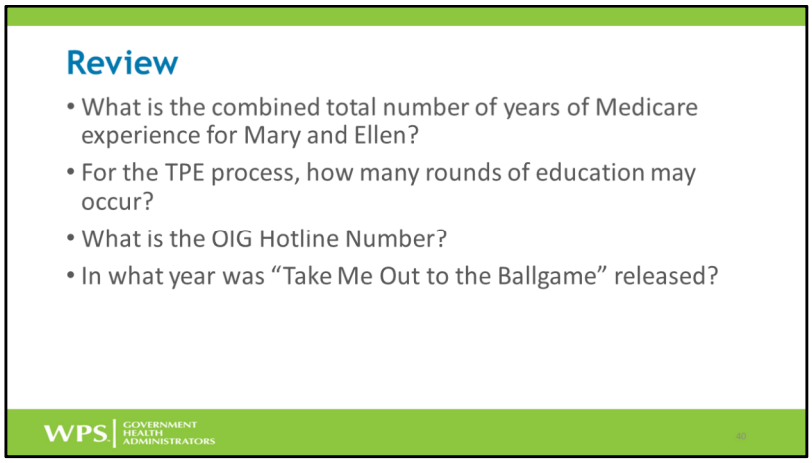
Notes:

- WPS GHA Portal
  - www.wpsgha.com
  - Public side
  - Transactional side
- Topic Centers for easy navigations
- Frequently Asked Questions
  - Searchable
- Please continue to periodically complete the ForeSee Website Satisfaction Survey when it presents itself

Notes:

- WPS GHA Learning Center
  - http://wpsghalearningcenter.com/
- Find
  - In Person Events
  - Teleconferences
  - Webinars
  - MAC Collaborations
  - On-Demands
  - Questions and Answers from numerous WPS GHA education events/opportunities

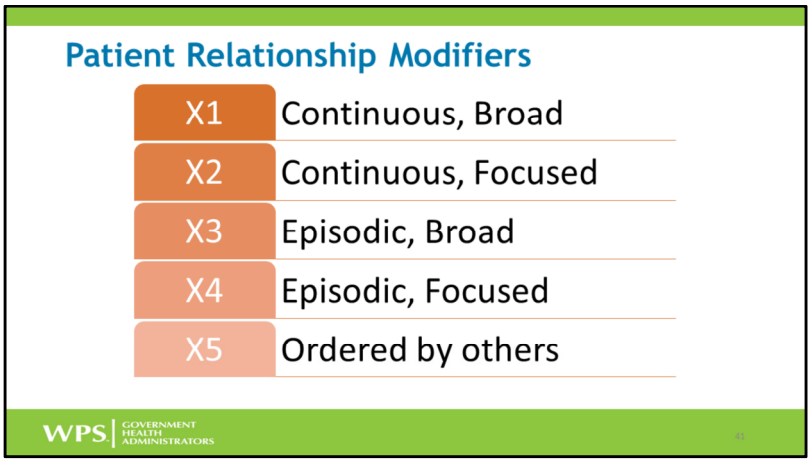
Notes:



Do you know the answers?

- Please write your answers down

Notes:



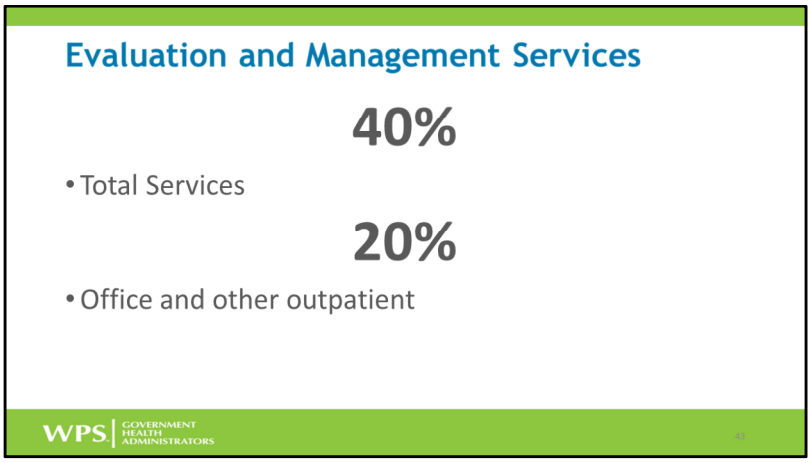
X1 – Continuous, broad service
For reporting services by clinicians who provide the principal care for a patient, with no planned endpoint of the relationship. Services in this category represent comprehensive care, dealing with the entire scope of patient problems, either directly or in a care coordination role.
X2 – Continuous, focused service
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.
X3 – Episodic, broad service
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.

Notes:

X4 – Episodic, focused service
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.
X5 – Only as ordered by another clinician
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.

- The use of these modifiers is voluntary for services January 1, 2018 and after for those providers eligible for the Quality Payment Program (QPP) and Medicare Incentive Payment System (MIPS)
- Other practitioners may also submit
- CMS may use these modifiers to adjust payments, either through the fee-for-service or QPP/MIPS, in the future
- CMS has a presentation on this from a webinar provided in October 2018

Notes:



- 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

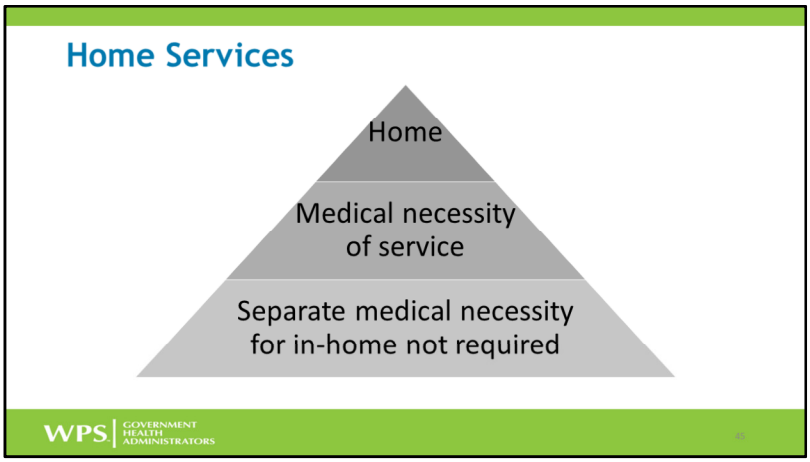
Notes:

Teaching Physician

WPS GOVERNMENT HEALTH ADMINISTRATORS

- The teaching physician presence for E/M services and procedures may be documented by the teaching physician, the resident, or the nurse

Notes:



- Services require the medical record to show the medical necessity for seeing the patient
- The final rule indicates that for services after January 1, 2019, there would not be a separate medical necessity requirement for seeing the patient in the home instead of the office or clinic setting
  - CMS has not changed IOM, Pub 100-04, Claims Processing Manual, Chapter 12, Section 30.6.14.1 as of the date of completion of this document

Notes:

- Virtual check-in - G2012
- Real-time interaction with billing provider
- Does not apply to ancillary staff
- Not subject to any geographic location restrictions
- Not related to a previous E/M service within 7 days or within 24 hours or the next available appointment following the service
- The patient has to give verbal consent as they have cost sharing responsibilities
- Reminder – provider cannot waive cost sharing across the board
- Purpose is the determination of whether the patient needs a visit
- There are no frequency limitations

Notes:

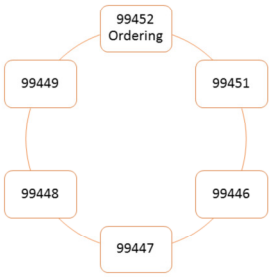
Remote Pre-recorded

WPS GOVERNMENT HEALTH ADMINISTRATORS

- 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:

Interprofessional Internet Consult



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- This is conversation or interaction between the patient's physician and a consulting physician
- These are time-based codes
- There are two sets of codes
  - Person requesting the consult – 99452
  - Consultant - 99446 – 99449, and 99451
- Need patent consent
- Patient has cost sharing
- Documentation
  - Treating physician – medical record necessitating the need for the consult and the consultation report
  - Consulting physician – medical record showing the medical necessity, the request, and the consultation report

Notes:

Chronic Care Remote

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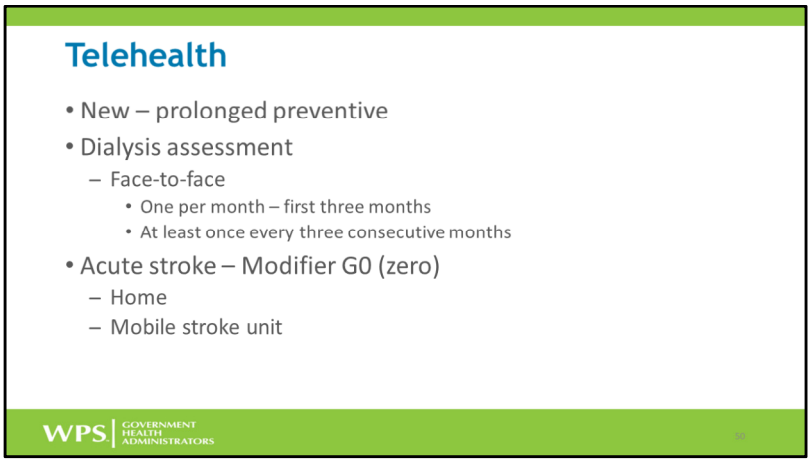
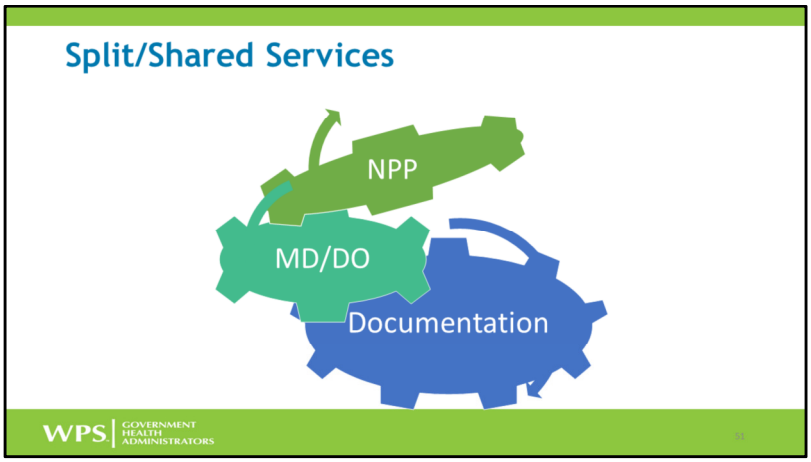
- Payment will now be allowed for code 99453, 99454, 99457
  - 99453 – patient set up and instruction
    - Professional time
    - Cannot be provided as an incident to service
  - 99454 – daily or programmed alerts
    - Billable every 30 days
    - Professional time
  - 99457 – 20 minutes or more of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

Notes:



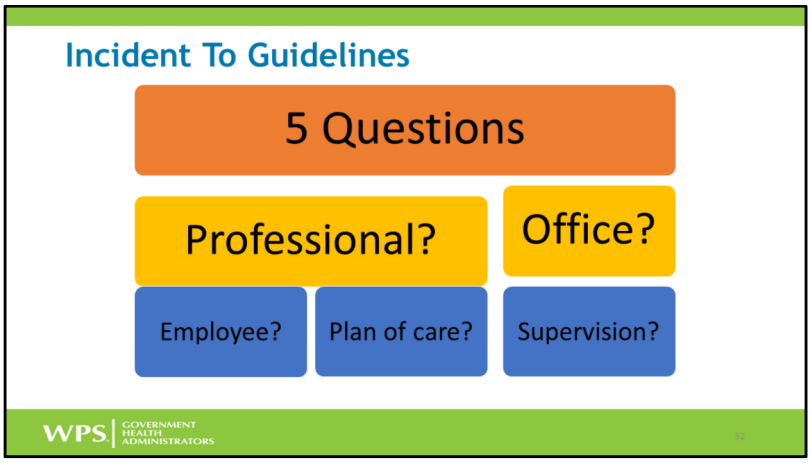
- G0513 and G0514 – These are prolonged preventive care services
  - Billable with appropriate preventive service available by telehealth
- Home dialysis clinical assessments
  - Face-to-face
    - One visit per month for the first three months of home dialysis
    - One visit every three consecutive 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

Notes:



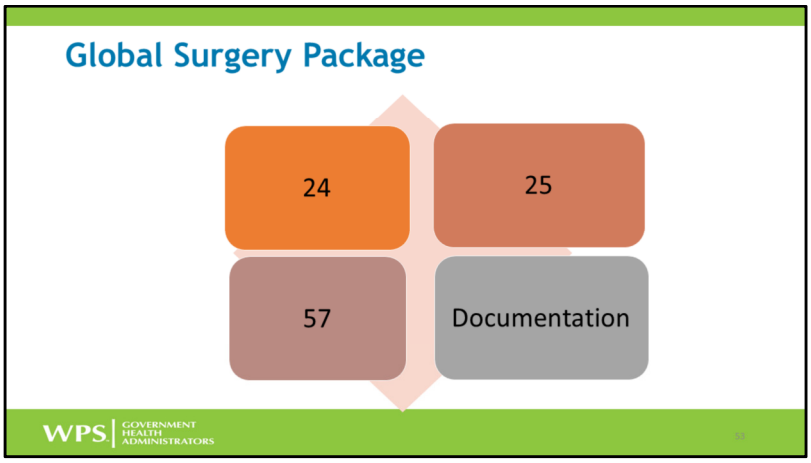
- Both parties perform a portion of the service
- Need signature from both parties
- Best practice is for both to document what they performed
- Appropriate place of service
    - Office
        - Must also meet Incident to guidelines
    - Outpatient
    - Inpatient
- Inappropriate
    - Nursing facility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

Notes:



- Documentation should support the questions above
- Professional service
  - E/M
  - Drugs and biologicals
  - Ancillary staff
  - Minor procedures
- Office location
- Employment relationship
- Plan of care
- Supervision

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

Notes:

Welcome to Medicare

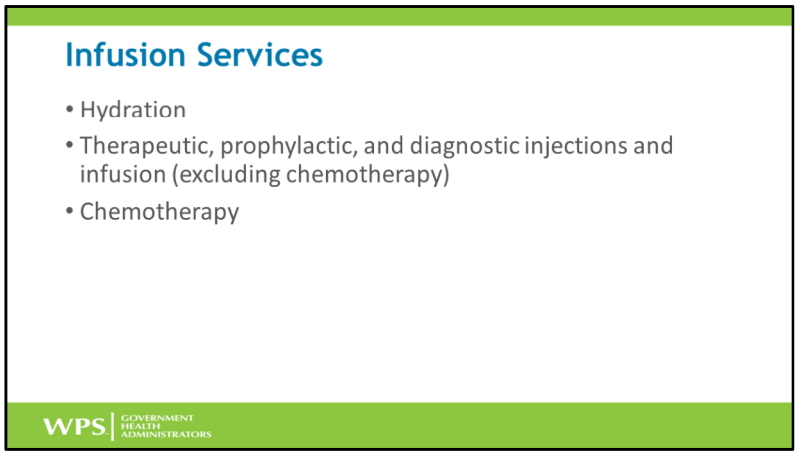
- Beneficiary history
- Assess for depression
- Functional ability and level of safety
- Exam
- End of life planning
- Education
- Preventive services

Notes:

Annual Wellness Visit

- Submitted by only one physician
- Health risk assessment
- Medical and family history
- Establish list of providers
- Measurements
- Cognitive impairments
- Depression screening
- Functional status and level of safety
- Written screening schedule
- Risk factors
- Personalized health advice
- Advanced care planning

Notes:



- 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

Notes:

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

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Please refer to the handout.

Notes:

Practitioner Eligibility

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

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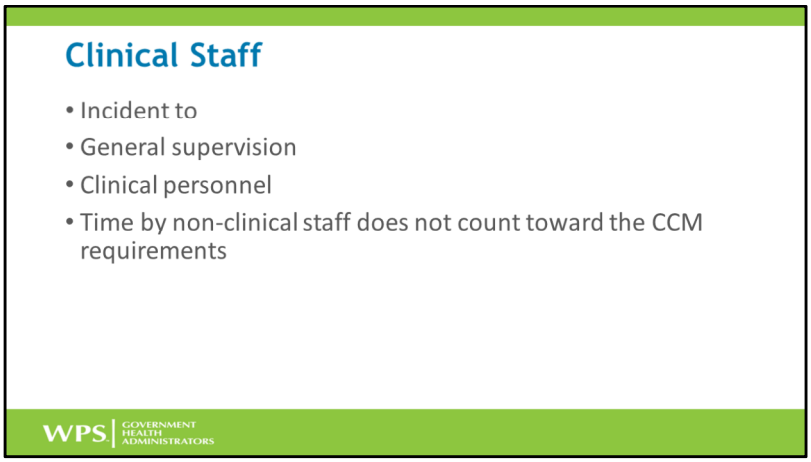
Please refer to the handout.

Notes:



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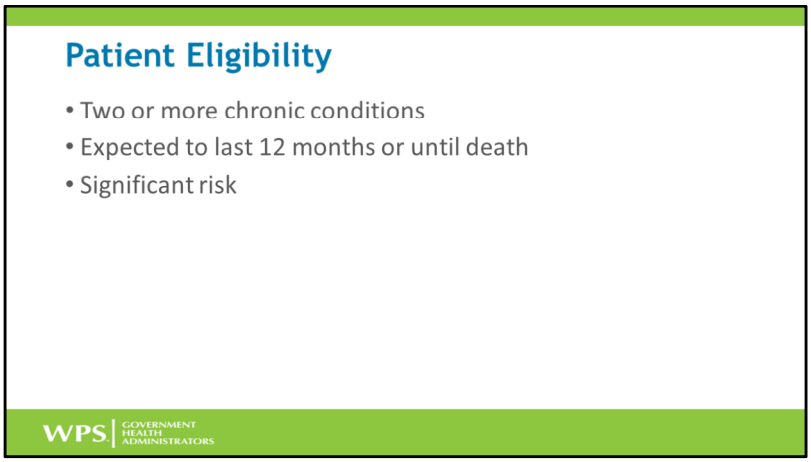

Please refer to the handout.

Notes:

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

WPS GOVERNMENT HEALTH ADMINISTRATORS

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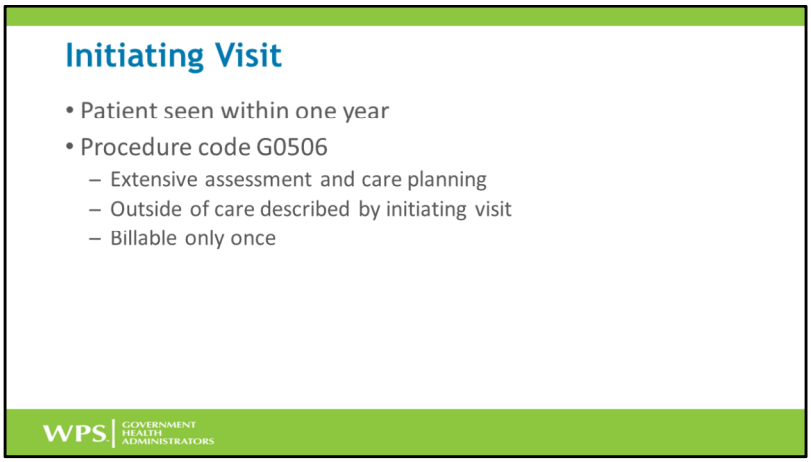
Notes:



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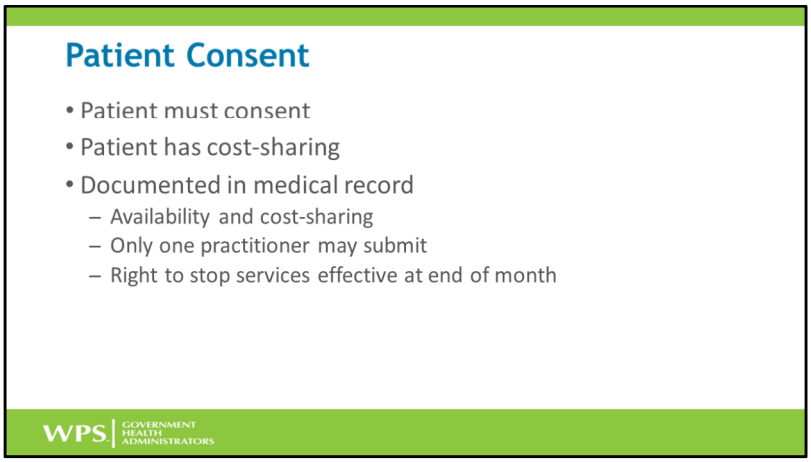

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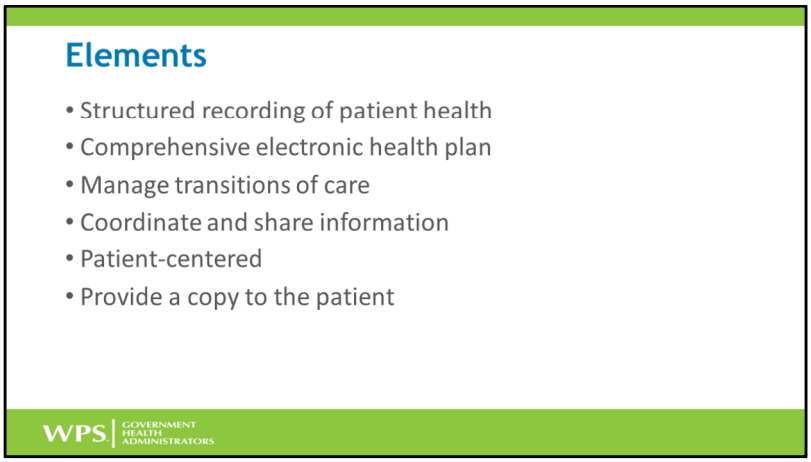

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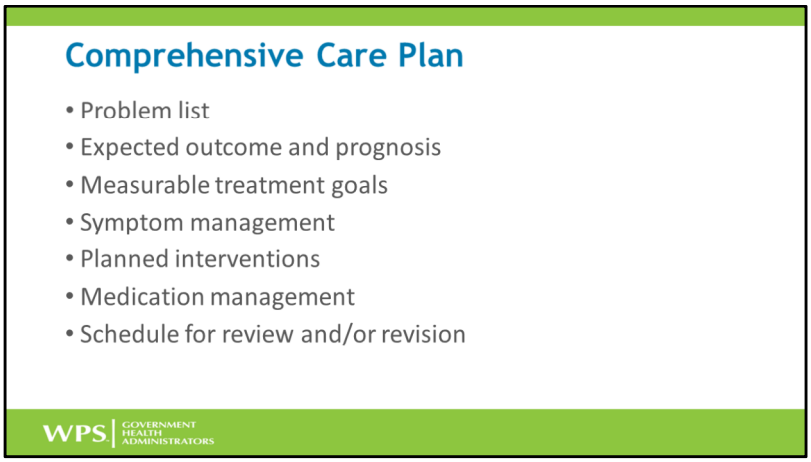

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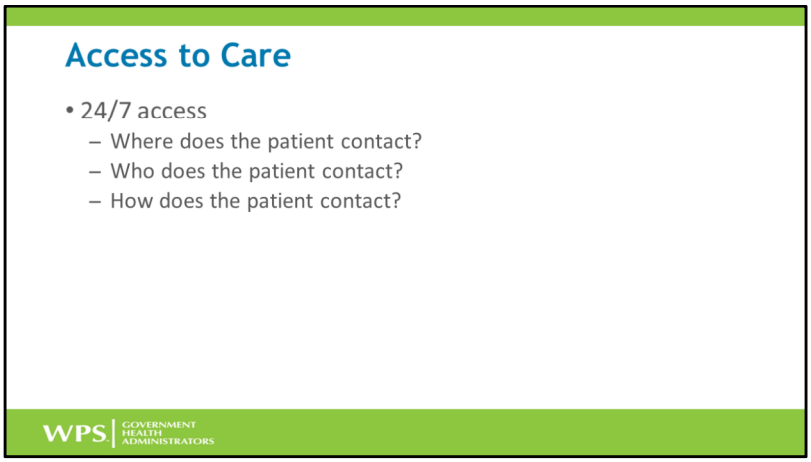

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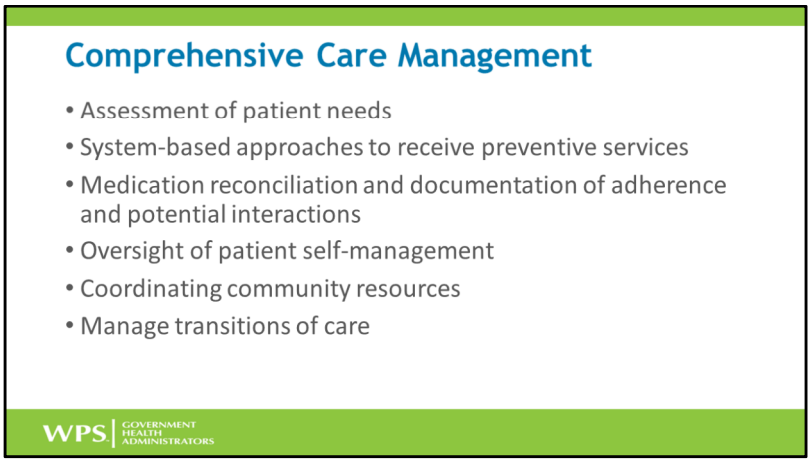

Please refer to the handout.

Notes:

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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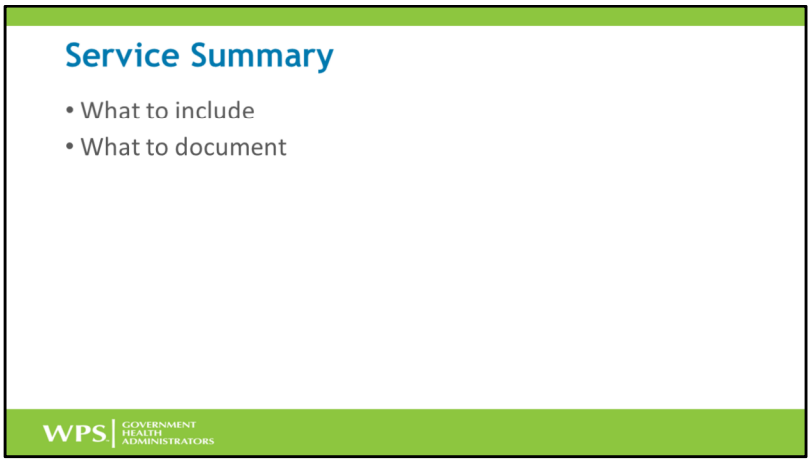
Please refer to the handout.

Notes:



Please refer to the handout.

Notes:

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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Please refer to the handout.

Notes:

Services

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

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Please refer to the handout.

Notes:

Please refer to the handout.

Notes:

Discharge

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Please refer to the handout.

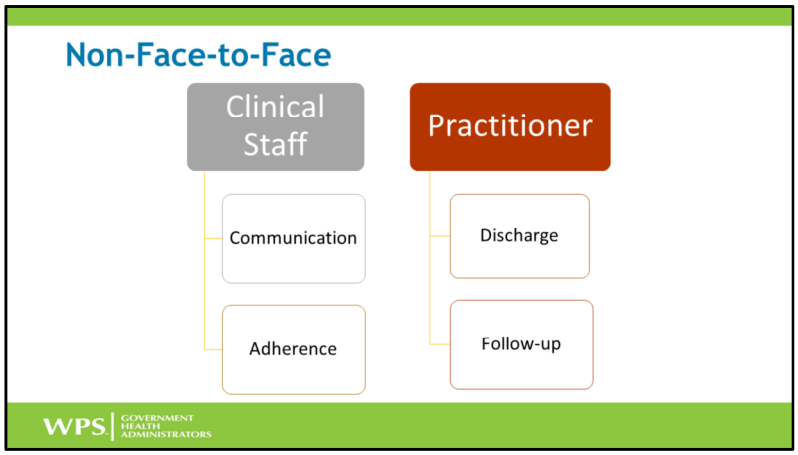
Notes:

Interactive Contact

WPS GOVERNMENT HEALTH ADMINISTRATORS

Please refer to the handout.

Notes:



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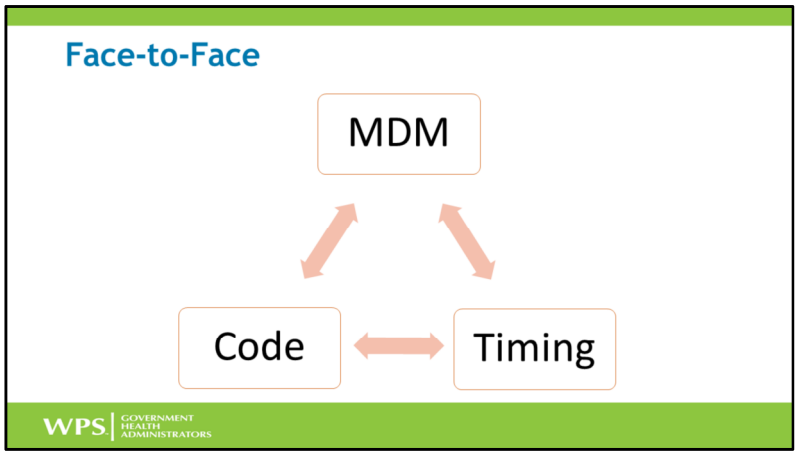

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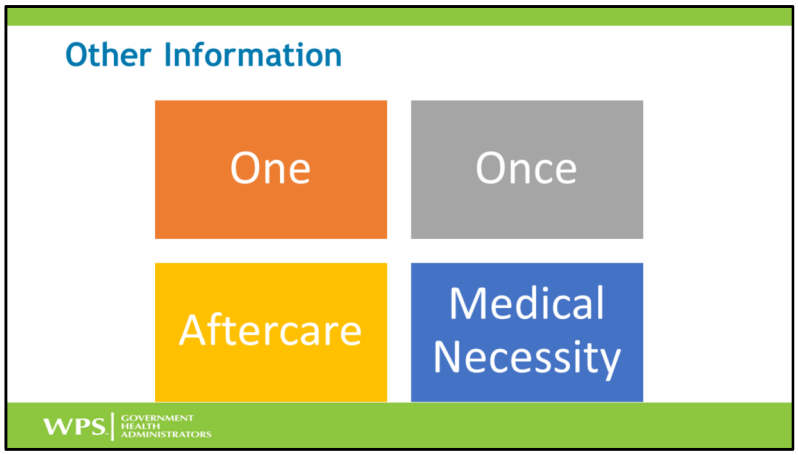

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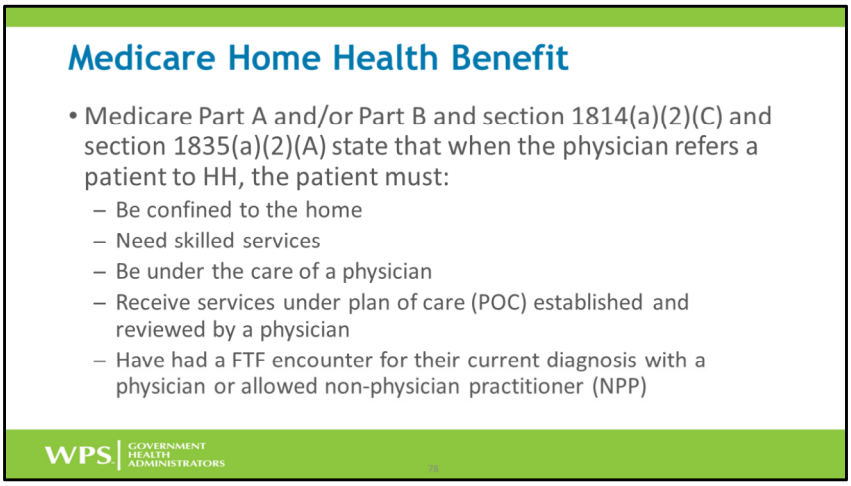
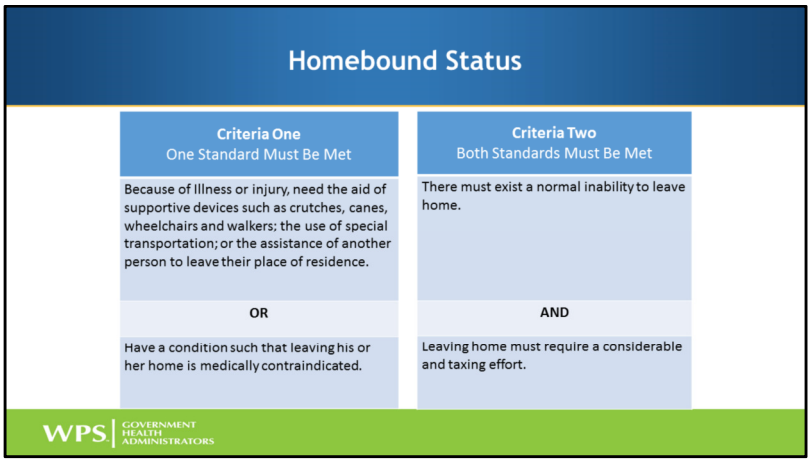


The patient/beneficiary must:

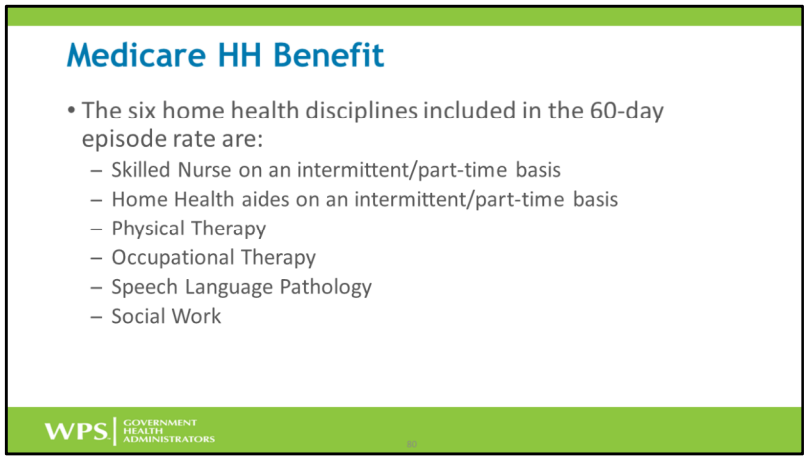
1. Be confined to the home
2. Require "skilled" services
3. Remain under the care of a physician
4. Receive services under a POC established and reviewed by a physician
5. Must have had a FTF encounter for their current diagnosis with a physician or NPP

Notes:



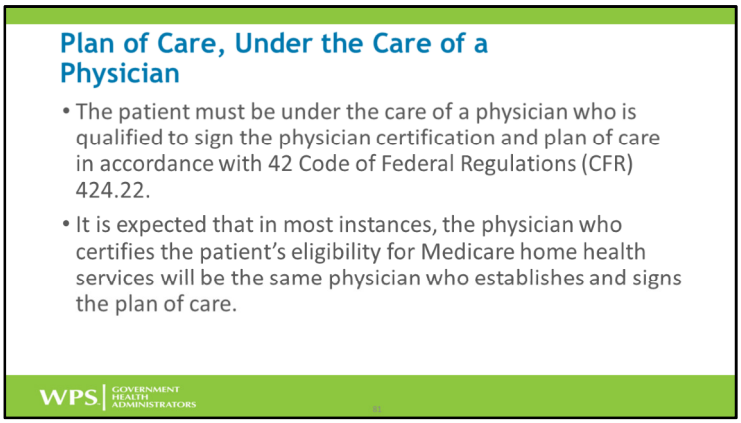
- Patient must meet both Criteria One and Criteria Two
- Include information about the injury/illness
- The type of support and/or supportive device/assistance required
- Detailed information on how current condition makes leaving home contraindicated
- Describe normal inability to leave home
- Describe the “considerable and taxing” effort

Notes:



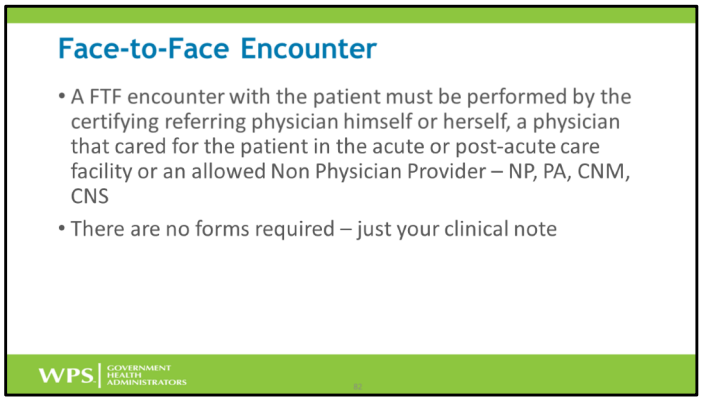
- Services that the Medicare Patient/Beneficiary may receive at home include:
    - Skilled Nurse on an intermittent/part-time basis
    - Home Health aides on an intermittent/part-time basis
    - Physical Therapy
    - Occupational Therapy
    - Speech Language Pathology
    - Social Work

Notes:



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

Notes:



- 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

Notes:

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.

WPS GOVERNMENT HEALTH ADMINISTRATORS

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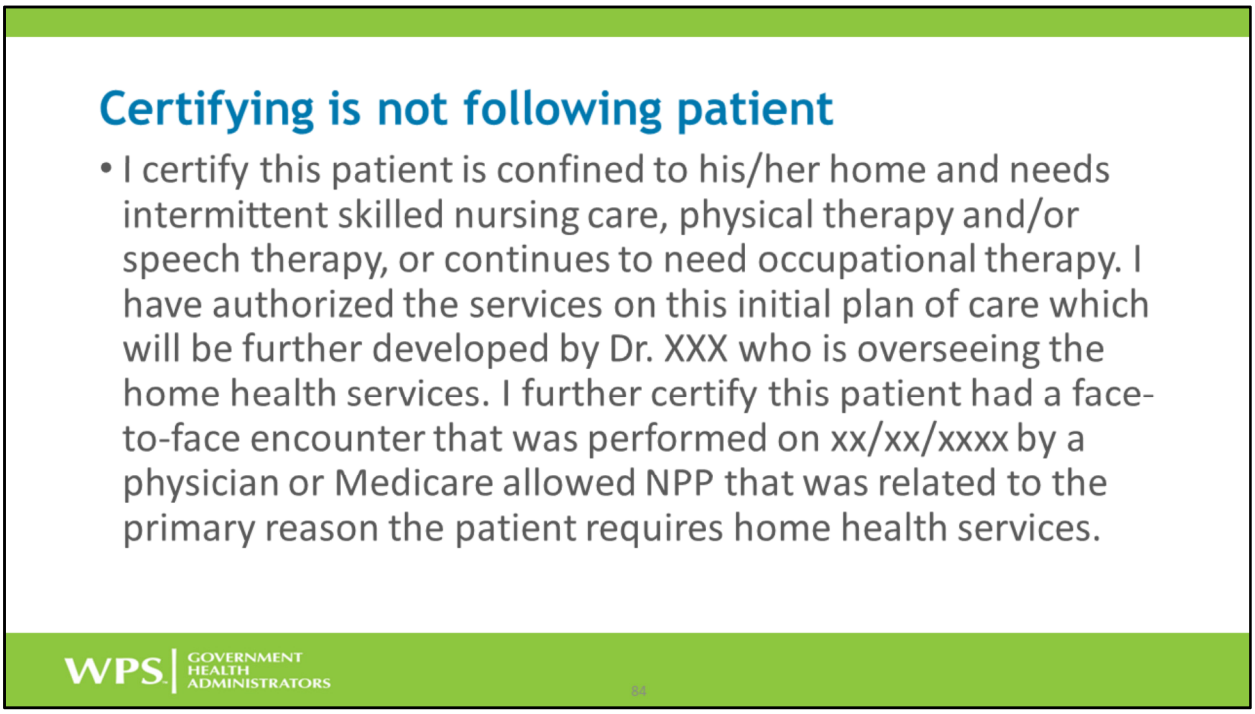
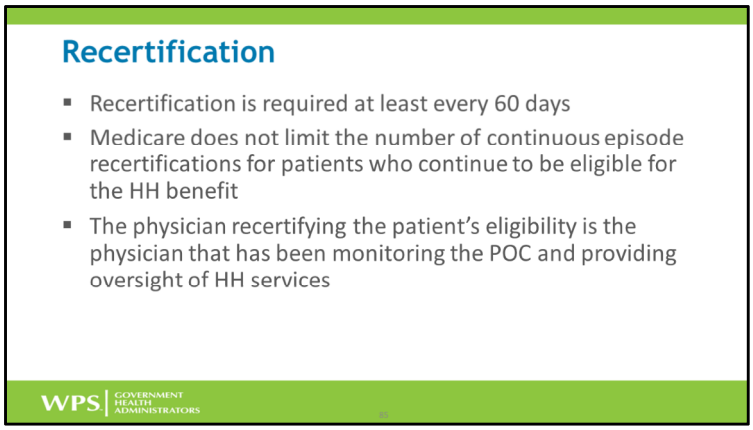


- Shows patient is homebound
- Shows they need skilled services
- Shows who is going to follow the patient
- Shows the date of the face-to-face service

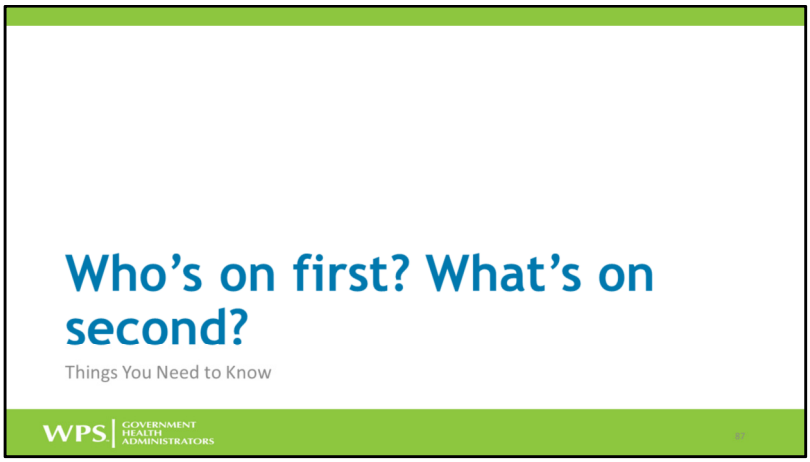


- Does not require a face-to-face service
- Documentation will show patient meets the criteria
- Recertification is required at least every 60 days
- Provided by physician that has been monitoring the plan of care and providing oversight

Notes:

- 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

Notes:



WPS GHA Departmental Items of Significance

- Appeals
- Claims
- Payment Recovery
- Provider Enrollment

CMS MAC Satisfaction Indicator (MSI) Survey

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

Notes:

Thank You

You knocked it out of the park!

WPS GOVERNMENT HEALTH ADMINISTRATORS

Do you have a follow up question?

- For a period of ten days, you may send presentation related questions to aapcofkc@gmail.com..
    - Claim specific questions and those not presentation-related must be handled by Customer Service

Thank You

- Please be certain to provide feedback to AAPC of KC
- This helps assure future WPS GHA participation in partner endeavors

Notes: