Medicare Part B

Coverage Determinations

Cahaba GBA 2014 EXPO
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Provider Outreach and Education
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Agenda

- Medicare Coverage Regulations
- The Medicare Review Program
- Coverage Determinations
  - National Coverage Determinations
  - Local Coverage Determinations
- Comprehensive Error Rate Testing (CERT)
- CMS and Cahaba GBA Resources
Medicare Coverage Regulations

- The primary authority for all coverage provisions and subsequent policies is the Social Security Act (the Act).

- Contractors use Medicare policies in the form of regulations, National Coverage Determinations (NCDs), coverage provisions in interpretive manuals, and Local Coverage Determinations (LCDs) to apply the provisions of the Act.
Preventing Improper Payments

The Social Security Act – Section 1833(e)
- Requires documentation of services

The Social Security Act – Section 1842(c)
- Authority to collect information

The Social Security Act - Section 1862(a)(1)(A)
- Reasonable and necessary services
Medicare Coverage Database (MCD)

- National Coverage Determinations (NCDs)
- Local Coverage Determinations (LCDs)
- Local articles, and proposed NCD decisions
- Other National Coverage policy related documents
The Medical Review Program

- Prevent improper payments in the Medicare FFS Program
- May evaluate medical records/claims
- Review for compliance
Medical Review and Data Analysis

Data Driven Program:

• Work to reduce paid claims error rate
• Identify vulnerabilities
• Identify questionable billing patterns
• Prevent and/or address provider errors
• Identify need for Local Coverage Determinations (LCD)
• Publish MLN Matters article related to Medical Review
National Coverage Determinations (NCDs)

Developed by the Centers for Medicare and Medicaid Services (CMS)

- Medicare coverage nationwide

- Outline conditions
  - Social Security Act §1862(a)(1)
  - Covered or non covered

- NCD is binding

Program Integrity Manual (PUB 100-08) Chapter 13.1.1
Local Coverage Determinations (LCDs)

Medicare Administrative Contractor (MAC) decisions

- Specify reasonable and necessary services
  - Social Security Act - Section 1862(a)(1)(A)

- Administrative and educational tools

- Guidance to the public and medical community

- Development based on medical literature, the advice of local medical societies and medical consultants, public comments, and comments from the provider community.

Program Integrity Manual (PUB 100-08) Chapter 13.1.2
## Coverage Determinations

### Local Coverage Determination (LCD) & Articles

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Cahaba GBA LCD link:
LCDs Converted to ICD-10

ICD-10 Compliance Date - October 1, 2015

- Locate LCDs converted to ICD-10
  - Navigate the CGBA website Medical Review page
  - Navigate the Medicare Coverage Database (MCD)
  - Policies listed under LCDs by Contractor Index
  - LCDs labeled as “FUTURE”

MLN Special Edition 1421: How to Access Updates to ICD-10 Local Coverage Determinations in the CMS Medicare Coverage Database

Date Correction on August 11, 2014
LCD Process
LCD Development

- Data analysis indicates a need
- Absence of a national determination
- Assure beneficiary access to care
- New jurisdiction
- Frequent denials
LCD Development

- Draft LCD developed
- Posted on the Contractor’s website
- Open LCD Development Meeting
- Contractor’s Advisory Committee (CAC)

- The next 2014 Cahaba GBA Draft LCD Open Meeting:
  - November 4, 2014
LCD Comment and Notice Process

• New or revised draft LCD

• Minimum comment period of 45 calendar days
  o All comments are considered
  o Written comments
  o Scientific literature
  o Draft LCD revised, if applicable

• Minimum notice period of 45 calendar days for final LCD

• Final LCD created and posted on the Cahaba GBA website
Proposed/Draft LCDs - July 15, 2014 Meeting

• Comment Period July 24, 2014 through September 8, 2014
  
  o DL30057 Surgery: Blepharoplasty
  
  o DL35306 CYP2C19, CYP2D6, CYP2C9, and VKORC1 Genetic Testing
  
  o DL35298 Surgery: Implantable Hormone Pellets
  
  o DL35300 Surgery: Ultrasound Therapy for Wound Healing
Where to Send Comments

Submit Draft LCD comments by either:

- **E-mail:**
  
  J10LCDComment@cahabagba.com

- **Fax:**
  
  (205) 220 - 1218
  
  Attention: Contractor Medical Director (CMD)

- **Written:**
  
  Cahaba Government Benefit Administrators®, LLC
  Comments for Draft LCDs
  ATTN: Contractor Medical Director (CMD)
  P.O. Box 13384
  Birmingham, AL 35202-3384
LCD Reconsideration Process

• Must be in writing (mail, email or fax)
• Note the LCD name and number
• Identify the language to add or delete in the LCD
• Include justification supported by new evidence
• May consolidate similar valid LCD reconsideration requests
Choose the Correct Process

• **Different Processes**
  o LCD Reconsideration Process
  o Standard Medicare Appeal Process

• **Processes not related** to the Appeal Process
  o Comment Period
  o LCD Reconsideration Processes

LCD Reconsiderations

Reconsiderations may be submitted to the following:

E-mail:
   J10LCDReconsideration@cahabagba.com

Fax:
   205-220-1218 ATTN: Contractor Medical Director (CMD)

Written:
   Cahaba Government Benefit Administrators®, LLC
   Reconsiderations for Active LCDs
   ATTN: Contractor Medical Director (CMD)
   P.O. Box 13384
   Birmingham, AL 35202-3384
Local Coverage Articles

- Articles may include any newly developed educational materials
- Tool to communicate certain information (e.g., billing, coding, etc.)
- Coding instructions
- Clarification of existing medical review related billing or claims policy

Program Integrity Manual (PUB 100-08) - Overview of Articles; Chapter 3 Section 3.3
Retired LCDs and Articles

- LCD is no longer in effect
- LCD replaced by a national policy
- Replaced by an active LCD
- Notification posted to web
Self-Administered Drugs (SAD) List

• MAC determine if drug/biological is “usually self-administered” (SAD)

• Determination applies only to the geographic area served by that specific contractor

• If given drug is determined “usually self-administered,” it cannot be covered by Medicare under any circumstance, regardless of whether the drug is administered by a physician or anyone else
How Can Coverage Determinations Assist Providers?
Compliance Recommendations

To Assist Your Practice:

• Read and know NCDs and LCDs related to your practice
• Refer to LCDs as ongoing references
• Review/read Contractor publications
• Ensure office staff is familiar with LCD claim filing rules
• Check records against billed claims
• Perform mock audits
NCD Documentation

- National Coverage Determinations (NCDs)
  - National coverage and administrative policies for clinical diagnostic laboratory services payable under Medicare Part B

- Documentation examples - NCD Coding Policy Manual

  - **Blood Glucose - Documentation Requirements (Page 86)**
    The ordering physician must include evidence in the patient’s clinical record that an evaluation of history and physical preceded the ordering of glucose testing and that manifestations of abnormal glucose levels were present to warrant the testing.

  - **Thyroid Function tests - Documentation Requirements (Page 97)**
    When these tests are billed at a greater frequency than the norm (two per year), the ordering physician’s documentation must support the medical necessity of this frequency.
LCD Documentation

- Local Coverage Determinations (LCDs)
  - LCD ID: L32971 Surgery: Major Joint Replacement (Hip and Knee)

- Associated Information - Documentation Requirements

  All coverage criteria must be clearly documented in the patient's medical record and made available to Medicare upon request.

  When the procedure is indicated for advanced joint disease, the following should be documented in the medical record:

  - Arthritis of the knee or hip supported by X-ray or MRI. The X-ray or MRI should demonstrate one of the following: subchondral cysts, subchondral sclerosis, periarticular osteophytes, joint subluxation, joint space narrowing, avascular necrosis or bone on bone articulations.

  - Pain and functional disability at the hip or knee

  - Unsuccessful conservative treatment

  Documentation must support CMS 'signature requirements' as described in the Medicare Program Integrity Manual (Pub. 100-08), Chapter 3.
Local Coverage Determinations (LCDs)

LCD ID: L33635 Pathology and Laboratory - Qualitative Drug Testing

General Information: Documentation Requirements

All "Indications" must be clearly documented in the patient’s medical record and made available to Medicare upon request.

Medical record documentation (e.g., history and physical, progress notes) maintained by the ordering physician/treating physician must indicate the medical necessity for performing a qualitative drug test. All tests must be ordered by the treating provider, and all drugs/drug classes to be tested must be indicated in the order.

If the provider of the service is other than the ordering/referring physician, that provider must maintain hard or digital copy documentation of the lab results, along with copies of the ordering/referring physician’s order for the qualitative drug test. The physician must include the clinical indication/medical necessity in the order for the qualitative drug test.

Documentation must support CMS 'signature requirements' as described in the Medicare Program Integrity Manual (Pub. 100-08), Chapter 3.
Documentation Errors

- **Signature errors**
  - Signatures are *illegal* or no *identifying* signature of who provided the service
  - Stamped signatures
  - No supervising physician signature after PA or CRNP “incident to” services

- **Medical Necessity Errors / Insufficient Documentation**
  - Services *were not* medically necessary
  - Documentation did not include DOS, name of beneficiary, or legible identity of performing provider
  - Progress notes not signed
  - Electronic records with no electronic signature and no typed signature

- **Incorrect Coding of Services**
  - Medical records do not support the level of services billed
Medical Record Documentation Tips

- Document medical necessity of services; validate with a signature.

- Non-physician practitioner: The service provided must be medically necessary and the service must be within the scope of practice for a non-physician practitioner in the State in which he/she practices.

- It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted.

- The volume of documentation should not be the primary influence to determine a specific level of service. Documentation should support the level of service reported.

- Select the appropriate code for the service based upon the content of the service.

- The service should be documented during, or as soon as practicable after it is provided in order to maintain an accurate medical record.
MLN Matters® Number: MM8525 Revised
National Coverage Determination (NCD) for Single Chamber and Dual Chamber Permanent Cardiac Pacemakers

CR8525 is delayed until further notice from the CMS

• This article is based on Change Request (CR) 8525 which allows payment for nationally covered implanted permanent cardiac pacemakers, single chamber or dual chamber

• Indications outlined in the “Medicare National Coverage Determinations Manual” (Chapter 1, Part 1, Section 20.8, Cardiac Pacemakers) and the “Medicare Claims Processing Manual” (Chapter 32, Section 320, Billing Requirements for Cardiac Pacemakers: Single and Dual Chamber) which were revised by and included as attachments to CR 8525. CR 8525 is effective for claims with dates of service on or after August 13, 2013
LCD Updates

Local Coverage Educational Article (A50030)
Cardiac Rehabilitation and Intensive Cardiac Rehabilitation Services

- Chronic heart failure (cardiac conditions) listed
- Enable a beneficiary to obtain Cardiac Rehabilitation services
- ICD-9 codes added to section ‘ICD-9 Codes that are covered’
  - 428.22
  - 428.32
  - 428.42

Related to Change Request 8758
LCD Updates

Local Coverage Article: Self-Administered Drug (SAD) Exclusion List - J10 MAC (A48903)

Removed from SAD List - ‘Exclusion End Date’ of December 31, 2013
  - Injection, certolizumab pegol, 1 mg (Cimzia®) J0718

Certolizumab (Cimzia®)

  - J0718 (Injection, certolizumab pegol, 1 mg) was invalid after December 31, 2013
  - J0717 (Injection, certolizumab pegol, 1 mg (code may be used for Medicare when drug is administered under the direct supervision of a physician, not for use when drug is self administered) is effective January 1, 2014
  - A KX modifier is not required for J0717 billed for Dates of Service after 12/31/2013, however, the administration code CPT 96372 is required
  - To report certolizumab that does not meet the complete description of J0717, use J3590
Signature Requirements

MLN Matters® Special Edition Article 1419: Medicare Signature Requirements - Educational Resources for Health Care Professionals
  - Resources are related to signature requirements for Medicare-covered services

Change Request (CR) 6698: Signature Requirements for Medical Review Purposes
  - For medical review purposes, Medicare requires that services provided/ordered be authenticated by the author:
    - Hand written (legible)
    - Electronic signature
  - Stamp signatures - exception
    - Change Request 8219 - Use of Rubber Stamp
    - The Rehabilitation Act of 1973
    - Effective June 18, 2013
General LCD Signature Statement

LCD “General Information” section:

1. Specific LCD Documentation Requirements

2. LCD Signature Statement
   - Documentation must support CMS ‘signature requirements’
   - Medicare Program Integrity Manual

Medicare Program Integrity Manual (Publication 100-08) Chapter 3, Section 3.3.2.4
Comprehensive Error Rate Testing

CERT: Measures Improper Payments

Documentation Contractor:
Request Records
75 Days to Submit

Review Contractor:
Review Claims/Records

ERRORS
CERT A/B MAC Outreach & Education

CERT Task Force Education

- MAC partnership
- Reduce CERT errors
- National “Hot Topics”
  - Compliance scenarios

Disclaimer: Comprehensive Error Rate Testing (CERT) Part A and Part B (A/B) Contractor Task Force is independent from the Centers for Medicare & Medicaid Services (CMS) CERT team and CERT contractors, which are responsible for calculation of the Medicare fee-for-service improper payment rate.
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This survey is conducted by an independent company ForeSee, on behalf of the site you are visiting.

No, thanks

Yes, I'll give feedback

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References

CMS Home Page: http://www.cms.gov/

Cahaba GBA Home Page: http://www.cahabagba.com/

Comprehensive Error Rate Testing Program: www.cms.gov/cert

Medicare Signature Requirements - Educational Resources for Health Care Professionals

Program Integrity Manual (PIM) Publication 100-08 - Medical Review Program:

MLN® Documentation Guidelines for Evaluation and Management (E/M) Services:

Pub. 100-07 State Operations Manual - Appendix A - Regulations and Interpretive Guidelines for Hospitals - §482.24(c) - §482.24(c)(1) Standard: Content of Record
Questions

Thanks for Your Attendance!

➢ Please Complete the Evaluation

Provider Contact Center
Alabama, Georgia and Tennessee Providers: 1-877-567-7271