North Carolina HFMA Medicare Workshop

Novant Health Conference Center
January 22, 2025

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

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Welcome!
Opening Remarks

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Disclaimer

The content in this presentation is intended for Jurisdictions J and M Medicare providers and is current as of December 1, 2024. Any changes or new information superseding this information is provided in articles with publication dates after December 1, 2024, 2024, at https://palmettogba.com.

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EDI Enrollment Process and Tools

PALMETTO GBA®
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Acronyms used by EDI

- **EDI** (Electronic Data Interchange) – Sending and receiving data files electronically: claims, remittances, reports
- **Submitter/Receiver ID** – Unique ID used by providers and clearinghouses to submit and receive data files directly from us
- **GPNet** – Palmetto GBA's front end system for sending and receiving data files
- **837** File – Claims batched together into one file and submitted
- **277CA Report** – Claim Acknowledgement Report generated through GPNet that provides claim rejections or acceptance
- **835/ERA** (Electronic Remittance Advice) – Electronic file of remittances
- **DDE ID** (Direct Data Entry ID) – Unique ID assigned to an individual to access the standard processing system to key and correct Part A claims
- **eServices** – Palmetto GBA's provider portal
- **PCC** – Provider Contact Center or Customer Service

EDI Options

- Submit claims electronically directly or through a clearinghouse
- Receive 277CA Reports showing acceptance or rejections
- Receive remittances electronically
- Part A providers may key and correct claims directly into the processing system using DDE IDs
- Part B providers(only) may submit claims through eServices
- Claim Status and Eligibility may be checked using the eServices portal among many other eServices options

Requirements Prior to Enrolling with EDI

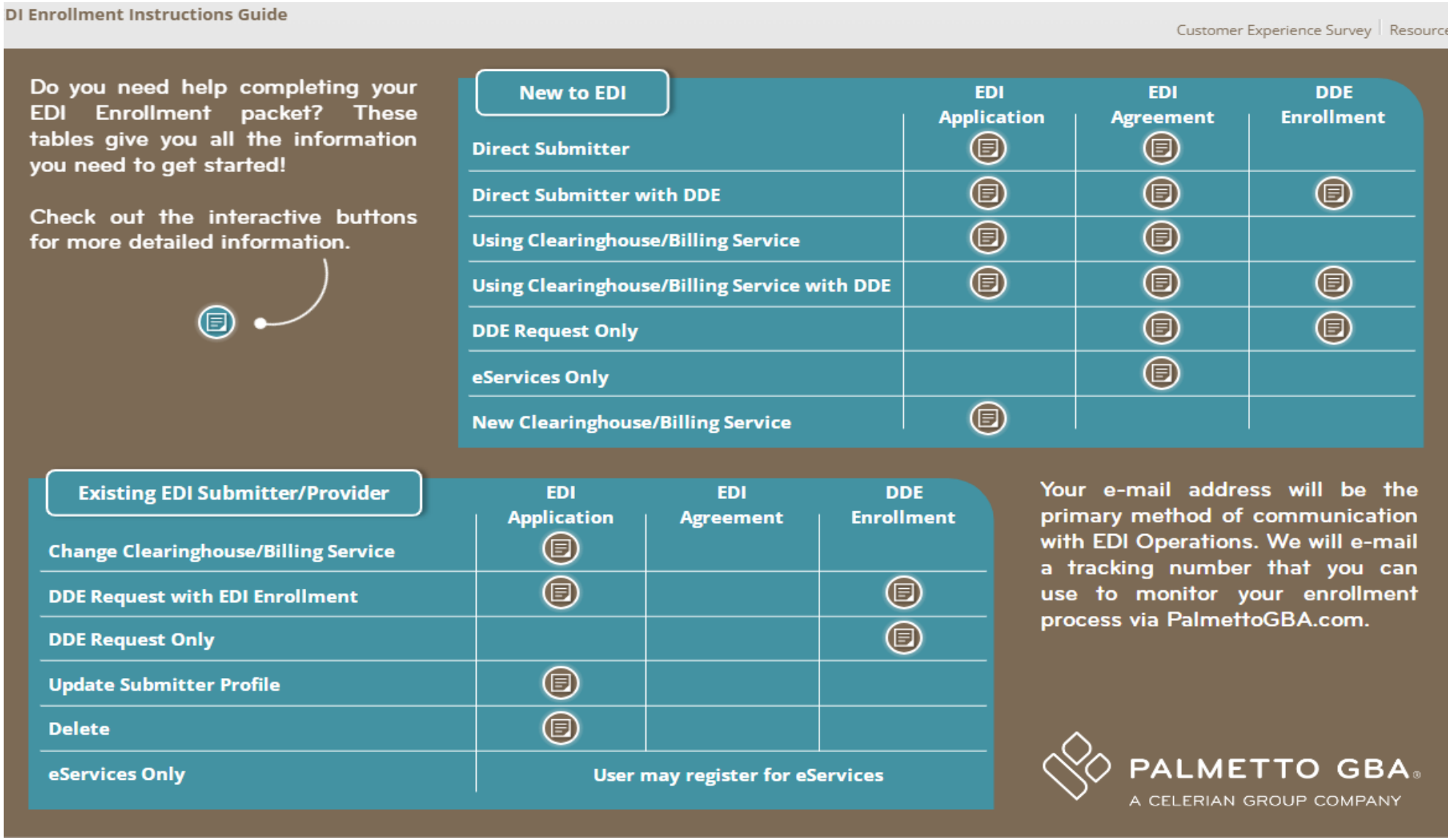
- For JJ and JM Providers:
  - You must receive your Welcome to Medicare acknowledgement from Provider Enrollment which indicates your PTAN/NPI combination is set up in the standard system for processing
  - Please use the address on file with Provider Enrollment when enrolling – either physical or mailing address
- For RR Providers:
  - You must be assigned a Railroad PTAN from RR Provider Enrollment which indicates your RR PTAN/NPI combination is set up in the standard system to process railroad claims
  - Please use the address on file with your local MAC when enrolling – either physical or mailing address

Note: All updates made with Provider Enrollment require three business days to update EDI Systems.

Enrolling with EDI

- Select contract and line of business from Palmetto GBA Medicare homepage
- View the EDI Enrollment Instructions Guide Tool and decide how you want to submit your claims to Palmetto GBA
- On the home page, select New to Medicare at the top of the page and follow the EDI Instructions
- For established providers needing to make updates, please visit the EDI Enrollment section for your specific contract on the Palmetto GBA website
- For additional assistance with completing the online forms view the EDI Enrollment Finding Forms Online article

EDI Enrollment Instructions Guide



Providers New to Medicare

Steps to Becoming a Successful Medicare Provider

Welcome to Medicare! Our goal is to provide a step-by-step process for you to become a Medicare provider, obtain access to all appropriate systems and be well on your way to becoming a Medicare expert. For general information about the Medicare program view our Medicare Made Easy Module.

Our Jurisdiction M Part B website provides information about the Medicare program, training modules and videos, upcoming educational events and much more. Sign up to receive Palmetto GBA's email updates to keep abreast of any program changes.

If you have any questions or need assistance please contact us

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Enroll in Medicare

Complete your enrollment application and apply for your Medicare provider numbers.

Enroll Now Check Enrollment Status

Enroll in Electronic Claims Submission

Electronic submissions are quick and easy.

Enroll Now

Register for eServices

The eServices portal is a secure, internet-based application that allows access to beneficiary and claim information. You may obtain eligibility, claims status, financial information and many other features.

Register Today

Specific Instructions for Enrolling

New to Medicare

- ✓ Provider Enrollment Training Modules
- ✓ Enroll in Medicare
- 3 Enroll in Electronic Claims Submission
- 4 Register for eServices
- 5 Register for Provider Statistical and Reimbursement Access
- 6 Become a Medicare Expert

Enroll in Electronic Claims Submission

Published 04/05/2023

Palmetto GBA encourages providers to submit their claims electronically and to utilize the electronic features we offer. You can also access certain claim and patient eligibility records and retrieve your remittance notices electronically. Claims may be filed to Palmetto GBA electronically (this applies to most Medicare providers) or on paper if certain conditions or exceptions exist (PDF).

For additional assistance, please review the EDI Enrollment Instruction Guide Module.

How Do I Enroll?

The fastest Method is to enroll online using the EDI Online Enrollment tool. You can also enroll via fax or email by completing the PDF version of the EDI Enrollment forms. For more details, read the EDI Enrollment overview (PDF).

- Access eServices - complete an EDI Enrollment Agreement (PDF) with separate EDI Enrollment Agreement instructions (PDF)
- Submitting claims directly to Palmetto GBA and not using a clearinghouse - complete the Direct Submitter forms (PDF) with separate Direct Submitter forms instruction (PDF)
  - Select a Network Service Vendor (PDF) or an Approved Vendor (PDF)
- Using a Billing Service or a Clearinghouse to submit your claims - complete the Billing Service - Clearinghouse forms (PDF) with separate Billing Service-Clearinghouse forms instruction (PDF)
- Requesting access to Direct Data Entry (DDE) – complete the DDE Enrollment Forms (PDF) with separate DDE Enrollment forms instruction (PDF)
- Submit all forms and supporting documentation via one of the following methods:
  - Email: ediparta.enroll@palmettogba.com
  - Fax: (803) 699-2429

What to Expect

Next Steps

Chat Now

Tips for Completing Forms

- Use the Provider Name and Address on file with Provider Enrollment – either physical or mailing address
- Part B & Railroad – Enroll with group information only – PTAN, Provider Name and Address; member of group does not need to enroll
- Railroad Providers enroll with your Railroad PTAN on file with Railroad Provider Enrollment and address on file with your local MAC
- Complete all fields on the enrollment forms

Tips (continued)

- If using a clearinghouse, contact them prior to submitting any forms – use current pdf forms from the Palmetto GBA web site
- If submitting directly or through eServices – complete the Online Enrollment Forms
- If requesting a Direct Data Entry(DDE) ID – include DDE ID if person previously had an ID, new ID will not be assigned if ID already exists

Note: DDE IDs are assigned to individuals and should not be shared with anyone.

Completion of Enrollment Forms

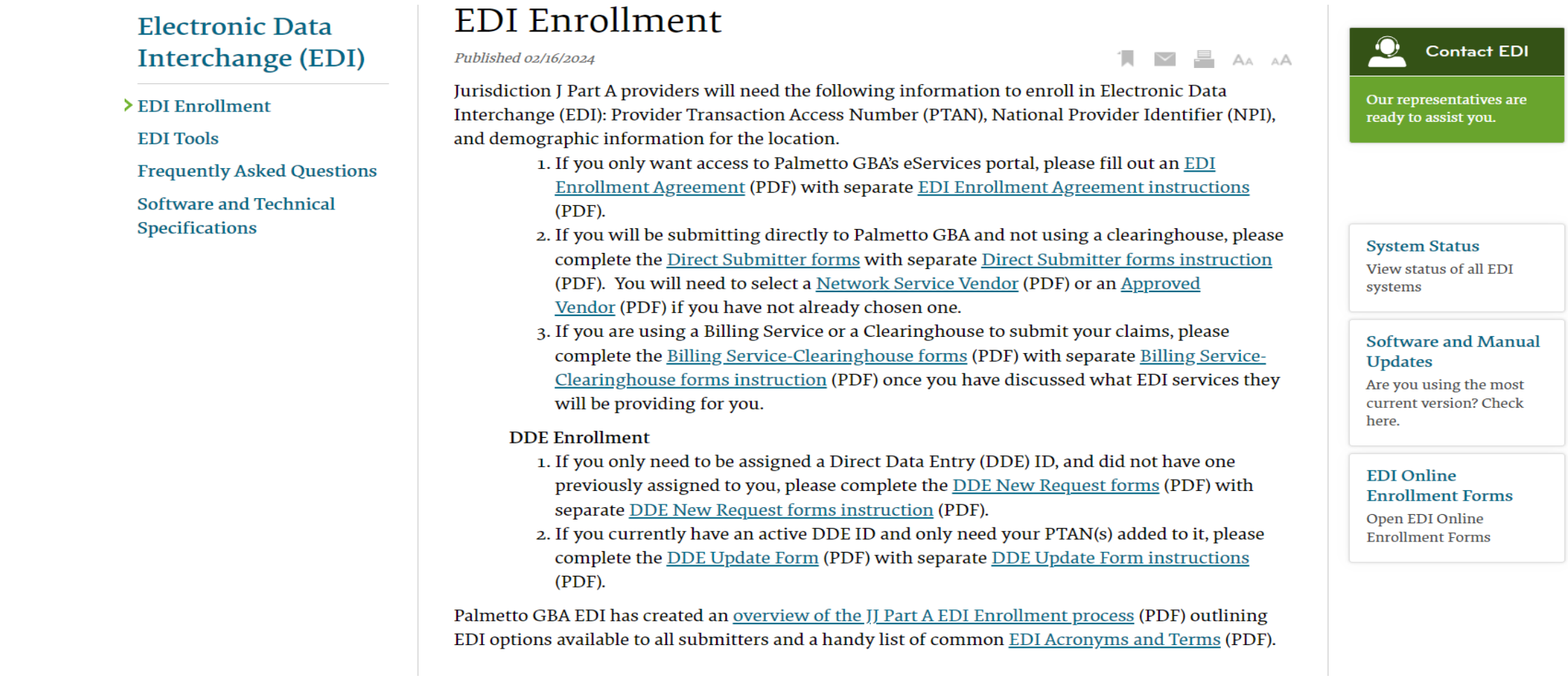
- Allow 15 business days for forms to process
- Email notification will be sent out to email address listed on the forms
- If forms are approved, contact clearinghouse or allow 24 hours before submitting
- If forms are rejected a description of the rejection will be provided on the notification
- Status of forms may also be checked using the EDI Enrollment Status Tool located under the EDI Tools section for each contract on the Palmetto GBA website
- Contact our EDI Helpdesk if assistance is needed with any rejections

eServices Registration Requirements

- EDI Enrollment Agreement on file
- Access Code will be sent to the email listed on the EDI Enrollment Agreement
- Person who is going to be Administrator needs to be the person setting up the account
- Should have a backup Administrator
- Administrators set up their user ids and profiles

EDI Updates for Existing Providers

- Options for each contract are listed with the correct form and instructions



Electronic Data Interchange (EDI)

- EDI Enrollment
- EDI Tools
- Frequently Asked Questions
- Software and Technical Specifications

EDI Enrollment

Published 02/16/2024

Jurisdiction J Part A providers will need the following information to enroll in Electronic Data Interchange (EDI): Provider Transaction Access Number (PTAN), National Provider Identifier (NPI), and demographic information for the location.

1. If you only want access to Palmetto GBA's eServices portal, please fill out an EDI Enrollment Agreement (PDF) with separate EDI Enrollment Agreement instructions (PDF).
2. If you will be submitting directly to Palmetto GBA and not using a clearinghouse, please complete the Direct Submitter forms with separate Direct Submitter forms instruction (PDF). You will need to select a Network Service Vendor (PDF) or an Approved Vendor (PDF) if you have not already chosen one.
3. If you are using a Billing Service or a Clearinghouse to submit your claims, please complete the Billing Service-Clearinghouse forms (PDF) with separate Billing Service-Clearinghouse forms instruction (PDF) once you have discussed what EDI services they will be providing for you.

DDE Enrollment

1. If you only need to be assigned a Direct Data Entry (DDE) ID, and did not have one previously assigned to you, please complete the DDE New Request forms (PDF) with separate DDE New Request forms instruction (PDF).
2. If you currently have an active DDE ID and only need your PTAN(s) added to it, please complete the DDE Update Form (PDF) with separate DDE Update Form instructions (PDF).

Palmetto GBA EDI has created an overview of the JJ Part A EDI Enrollment process (PDF) outlining EDI options available to all submitters and a handy list of common EDI Acronyms and Terms (PDF).

Contact EDI

Our representatives are ready to assist you.

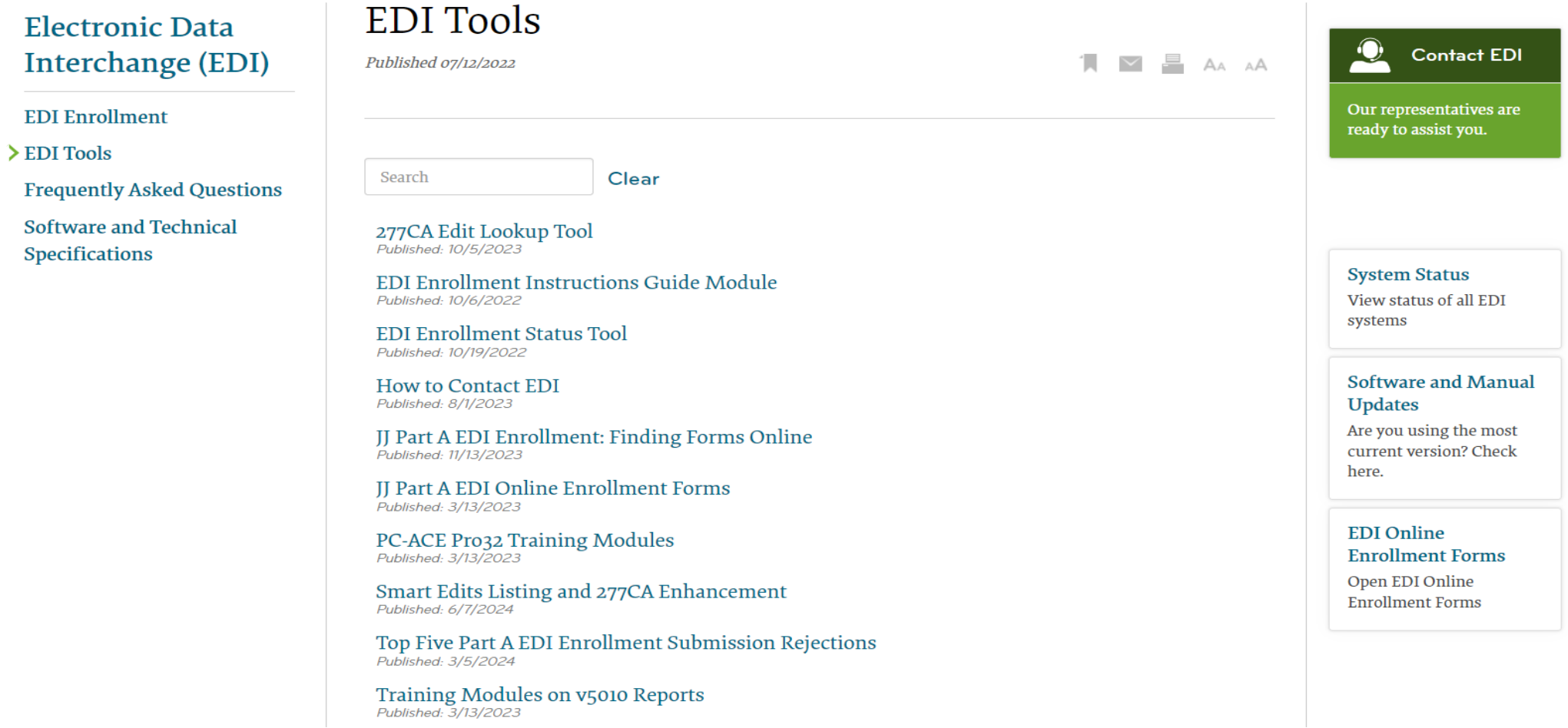
System Status
View status of all EDI systems

Software and Manual Updates
Are you using the most current version? Check here.

EDI Online Enrollment Forms
Open EDI Online Enrollment Forms

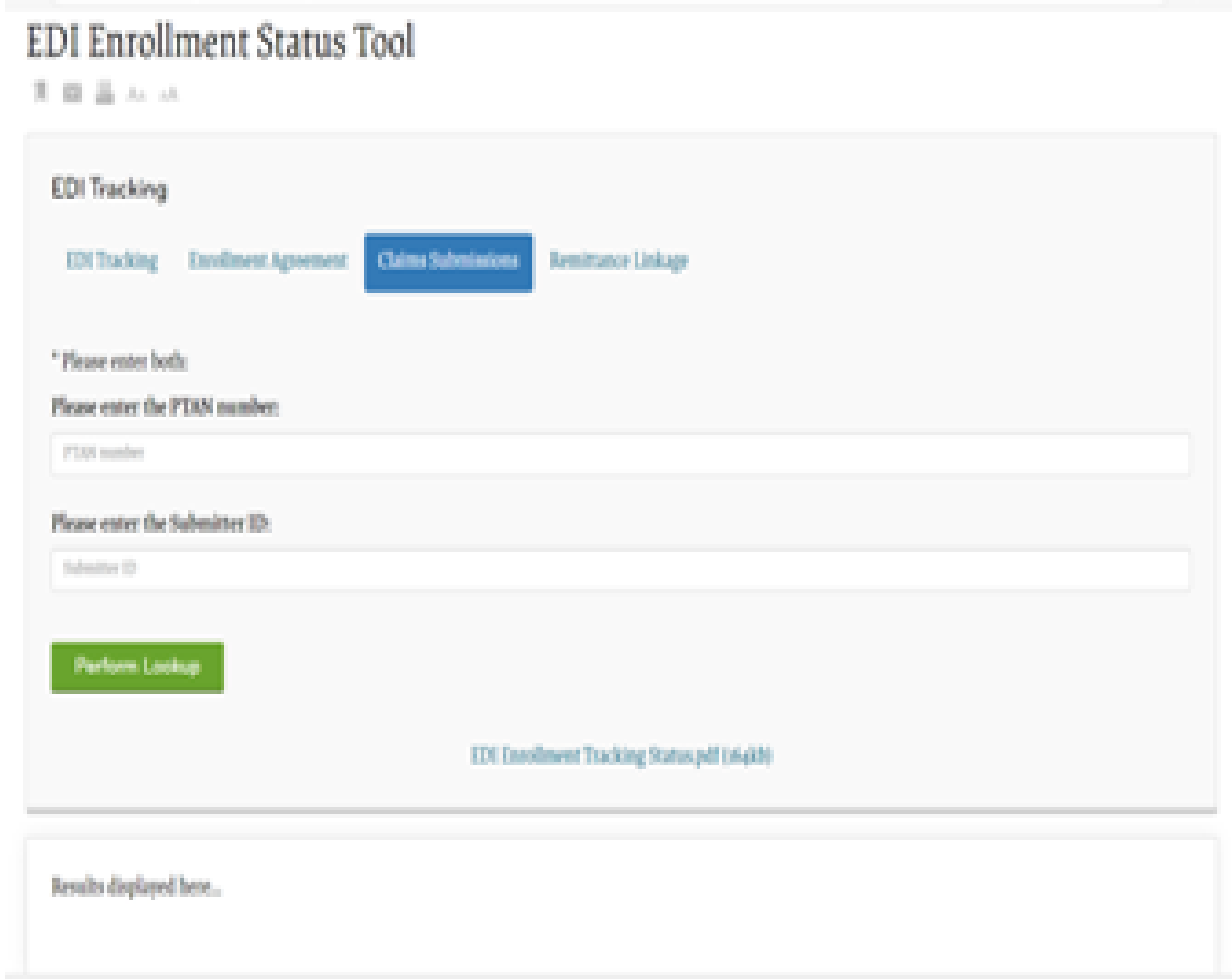
EDI Tools

- Under the EDI Tools Section are various tools to assist with all aspects of EDI

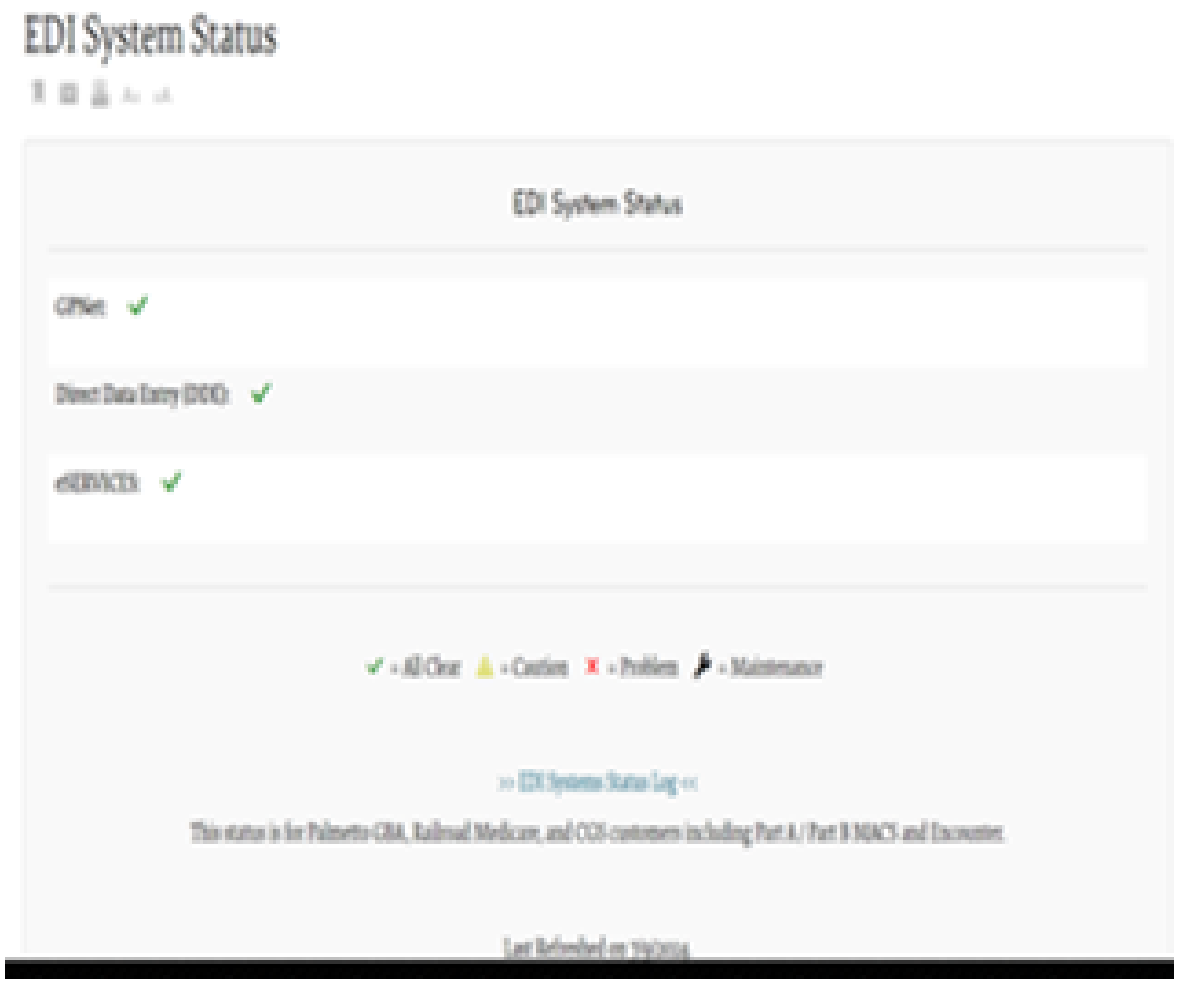


Two Examples of Status Tools

EDI ENROLLMENT STATUS TOOL



SYSTEM STATUS TOOL

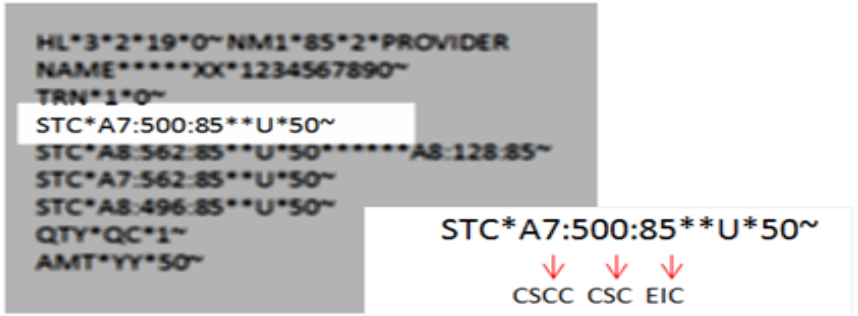


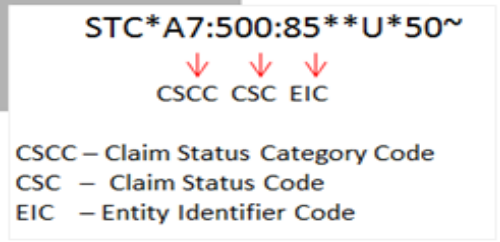
277CA Edit Lookup Tool

- Key in the rejection code from the 277CA Report and a detailed message about the error will display

The 277CA Edit Lookup Tool will assist you with Medicare Fee-For-Service (FFS) Part A and Part B edits produced via the ASC X12 Version 5010 Common Edit and Enhancements Module (CEM). In addition to the tool, you may also refer to CEM 837 Professional Edits and CEM 837 Institutional Edits.

Enter the codes in the STC segment of the 277CA report into the appropriate fields and click on Submit. The tool will display the detailed edit description.





CSCC *

CSC *

EIC

Submit Clear

Security Reminders

- All DDE and eServices IDs are assigned to individuals and cannot be shared with other people
- If an ID is shared it will be deleted
- All IDs are required to be certified and if they are not, they will be deleted
- Individuals must respond to emails from the Palmetto GBA security team to avoid their id being deleted

When to Contact EDI for Assistance

- ✓ Change Clearinghouses
- ✓ Update your DDE ID
- ✓ Update the EDI Contact
- ✓ Check the status of an EDI Application
- ✓ Verify current EDI enrollment
- ✓ Get assistance with understanding GPNet errors
- ✓ Look up a GPNet error message
- ✓ Get a missing 277CA Report restored
- ✓ Get an 835 remit file restored
- ✓ Know if all systems are available and running on time – GPNet, eServices, DDE

How to Contact EDI

- Call our PCC EDI telephone number and follow the prompts:
  - **JJ 877–567–7271**
  - **JM 855–696–0705**
  - **RR 888–355–9165**

- Chat with EDI staff Monday through Friday from 8 a.m. until 4 p.m. ET. It’s secure and can respond to PHI!

Compliance Training: Using Third Party Billing Companies

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Disclaimer

This presentation is a collaborative effort by the POE MAC Workgroup.

- It is not intended to imply all third-party contractors are engaged in inappropriate activities or practices
- The intent of this educational session is to help providers set themselves up for success by:
  - **Providing educational material as a tool for provider and supplier community; and**
  - **Bringing attention to provider liability in situations when a third-party contactor is used**

Objectives

- Definition
- Legal responsibilities
- Common trends
- Questions to ask vendors and contractors
- Training and resources to share

Why Are We Doing This Education?

- Reduce cost
  - **Medicare Trust Fund**
  - **Provider**
- Identify vulnerabilities
  - **Protected Health Information (PHI)**
  - **Provider legal responsibilities**
- Assist
  - **Identifying inappropriate third-party activities**
  - **Questions to ask when contracting**

Summary: It is vital providers know exactly who is handling their claims and what they are doing with their information.

What Are Third-Party Companies?

- A third-party company or individual outside of your organization with whom the provider of service contracts to perform certain duties
- Common examples include:
  - **Billing agencies**
  - **Clearinghouses**
  - **Software vendors**
  - **Auditing firms**

Third-Party Companies: Be in the Know!

- Like all businesses, some third-party companies do excellent work for providers, but there may be others that look for ways to take advantage of their providers
- This training focuses on:
  - **Situations where providers have been taken advantage of, and**
  - **Assisting providers with making positive choices when selecting who they wish to contract with for clearing houses and billing companies**
  - **Awareness**

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Legal Responsibilities

How CMS Treats Third-Party Billers

- Providers are legally responsible for all actions taken by their employees and companies with whom they contract
  - **Any legal action falls on the provider of service, not the third-party vendor**
- Providers sign Medicare contracts and accept full responsibility of their claims and handling of PHI
  - **Enrollment forms**
  - **Claims submission**
  - **Electronic Data Interchange (EDI)**
- Vital for providers to know exactly who is handling their claims and how they are handling their information
- CMS does not make distinctions between provider and third-party biller agencies

Evaluate Your Contracts

- Step 1 – Identify how your third-party entities protect your data
  - **Patient PHI, provider enrollment number, provider financial information**
- Step 2 – Understand how they will ensure accurate and timely claim, appeal, etc., submission
  - **Knowledge of Medicare guidelines and training practices**
- Step 3 – Determine your contractual charge structure
  - **Percentage of Medicare payment**
  - **Separate charges for each activity**
  - **Actions when Medicare does not pay**
  - **Actions when Medicare recoups incorrect payments**
    - Additional charges or fees charged to provider

Identifying Risk – Definition

- Providers are legally obligated to identify the risk and impact involved with using third party vendors
- Resources
  - **Business Associates | HHS.gov**
  - **Guidance on HIPAA Covered Entities' Responsibility**
  - **Compliance Program Guidance for Third-Party Medical Billing Companies**

Real Life Example #1

- A company-hired a physician
- The hiring company uses a third-party vendor to handle the enrollment process and all claim submission activities
- Third-party vendor:
  - **Enrolled the physician incorrectly as a solo practitioner; and**
  - **The vendor made many errors in the submission the physician's claims but did not refund Medicare**
- Medicare is now garnishing the physician's tax refunds due to lack of appropriate repayment of debt

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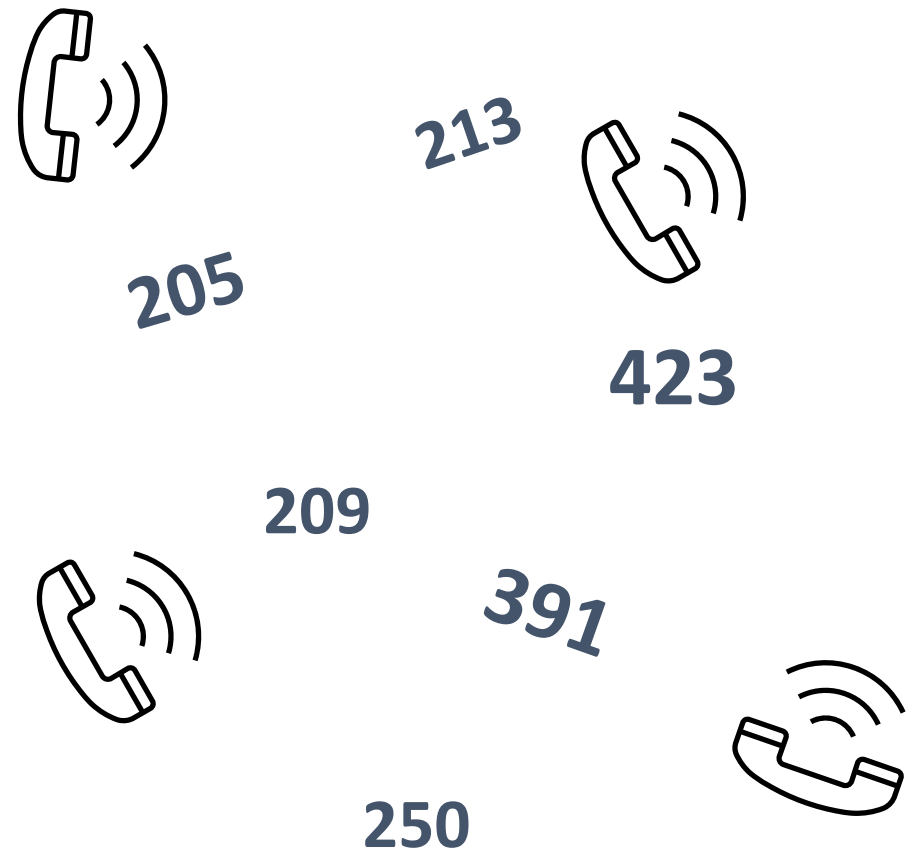
Common Trends

MAC Education Attempts

- MACs track high-volume callers and contact the billing provider when identifying inappropriate trends
- MACs take an active approach to high-volume callers to reduce costs to the Medicare Trust Fund
- Utilizing data available by provider NPI, PTAN, and call-in phone numbers
- MACS are required to report to CMS specific providers not in compliance after education



Direct Line of Communication Missing

- Cannot contact via the number called from

- Provider business office is not familiar with
  - **Phone numbers used to contact Medicare**
  - **Name of individuals contacting Medicare**
  - **Person knowing patient's PHI**
  - **Person knowing provider financial information**

Provider Impact

- Increases risk of
  - **PHI breaches**
  - **Abusive billing practices**
- Providers are held accountable for **all** actions taken on their behalf by their third-party contracts

Real Life Example #2

- A physician hired a third-party vendor for all claims and appeals. The vendor's payment was a percentage of the Medicare payments. As part of a review, Medicare requested additional documentation. The vendor did not respond. This resulted in thousands of dollars in denials and recoupments. Medicare held the provider responsible for the incorrect payments and required the provider to refund overpayment.
- The physician would be responsible for taking any legal or court action against the third-party vendor

Lack of Access to Self-Service

- MACs receive numerous calls asking for information already available
- Third-party vendors express they do not have access to Palmetto GBA's self-service tools
  - **Many vendors use spreadsheets of claim information**
    - They do not contain all needed information
    - They are unaware of the claim status
- Use of self-service tools is required in accordance with CMS
  - **CMS Internet Only Manual, 100-09, Chapter 6, Section 50–50.1**

Provider Impact 2

- Delays in claim payment
- Missing Medicare timeliness guidelines
  - **Initial claim submission**
  - **Responding to record requests**
  - **Appeals**
  - **Recoupments**

Increase in Common Errors

- When assisting providers with how to successfully submit a claim, MACs have observed a drastic increase in errors when providers decide to take their billing “out of house”
- Many claims are repeatedly billed with the same error
- Most errors are easy to prevent:
  - **Verifying other payer status**
  - **Verifying location of the patient**
  - **Verifying if claim was already partially/fully paid before resubmitting**
- Incorrect spellings of provider or ordering/referring names
- Incorrect forms used

Provider Impact 3

- Delayed or lack of payments for Medicare claims
- Higher risk of failing reviews and audits
- Charges from third-party vendors for additional:
  - **Phone calls**
  - **Claim submission**
  - **Appeals request**

Real Life Example #3

- A provider had a third party overseeing their claims. When multiple of their claims denied, the third party “appealed” the 100s of claims for the provider. However, instead of sending the correct request, they submitted reopening requests. Because of this, all the requests were dismissed, and the provider was put into a difficult situation for timeliness.
- This is a common situation

Scripted Calls To Medicare

- Third-party vendors asking for claim status information
  - **Available on the Remittance Advice and through the self-service portals**
  - **Example: Asking for denial reason on claim submitted with GA or GZ modifier. These modifiers indicate the provider anticipated denials from Medicare.**
- Many calls include scripted questions that don't relate to claims and information is already available:
  - **Asking for the provider's mailing address, MACs address, provider submitter ID, date claim was received or denied, reason for denial, where to send appeals, or simply calling to ask for a call reference number**

Provider Impact 4

- Many third-party companies charge the provider for each phone call they make, creating an incentive for them to make unnecessary and sometimes inappropriate calls to Provider Contact Center to add additional fees to the provider
- Reduces time for legitimate requests for assistance
- Additional calls results in larger costs to Medicare which are in turn passed down to providers and the general population through higher taxes and Medicare application fees

Additional Provider Impact

- Call Center privileges revoked!
- MACs monitor calls for
  - **Non-compliance**
  - **Non-use of self-service technology**
  - **Abuse to MAC staff**
- MACs report to CMS for possible revocation of privileges
- Monitoring requirement in IOM 100-09, Chapter 6, Section 30.4

Real Life Example #4

- A couple of providers who for over a year have billing staff call over 100 times per month for inquires that could be resolved via self-service
- Many of these inquires included scripted questions. These calls resulted in longer wait times for callers needing assistance.
- Their inquires reached a point where these providers are in jeopardy of loss of their calling privileges

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Questions to Ask Vendors and Contractors

Who Has Access to Patients' PHI?

- Who has access to your patient's PHI information? Verify!
- What steps do they have in place to protect you and your patient's data?

Third-Party Vendors and Subcontractors

- Does your contractor use subcontractors?
- Does your contractor sell any part of you or your patient's information?
- Does your patient information go outside of the United States (offshore)?
  - **Electronic health information processed or stored outside of the United States has a greater risk and vulnerability for unauthorized disclosure and potential security breaches**
- Resources
  - **MLN8816413 — Checking Medicare Eligibility**
  - **eCFR :: 45 CFR Part 164 Subpart C — Security Standards for the Protection of Electronic Protected Health Information**

Subcontractor Fees

- Are you charged a percentage of your Medicare reimbursement, or are there other fees?
  - **Are they upcoding claims?**
  - **Are they adding charges on your claim?**
  - **Are they using diagnosis codes not documented in the record to get claim paid?**
- Do they refund if Medicare recoups a payment?
- Other possible fees/charges?
  - **Hourly amounts for certain services**
  - **Piece work**
  - **Every phone call and/or question made or asked on your behalf**
  - **Appeals status**
  - **Refunds**

Claims Denials and Rejections

- Are the individuals working on your claims thoroughly reviewing each claim denial and rejection or just resubmitting and/or calling Medicare on every claim?
  - **Example: If a claim denies as a duplicate or patient having another insurance, are they logging into Portal to verify the rejection/denials?**

Access to and Using Available Tools

- Does vendor staff have access to the tools they need?
  - **Remittance Advice**
  - **Patient insurance info**
  - **Medical records**
- Palmetto GBA self-service technology

Proper Training

Are vendor staff properly trained?

- **Medicare rules and regulations**
- **Self-service technology**
- **Website**
- **Education offerings**
- **YouTube channel**
- **Reading Remittance Advice**
- **Understanding common denials messages**
- **Appeal process and appeal time limits**

Enforcing Compliance

- What are your expectations?
- What are consequences when expectations are not met?
- Who is fiscally responsible for overpayment refunds?
- Do you audit your vendors?
- Does your vendor understand the legal responsibilities?
  - **HIPAA violations**
  - **Understanding Medicare guidelines**
  - **Repaying Medicare when errors are identified**
- Did you know **Medicare holds providers legally responsible** for the actions they or their contractors make and that a provider can have their Medicare billing privileges revoked?

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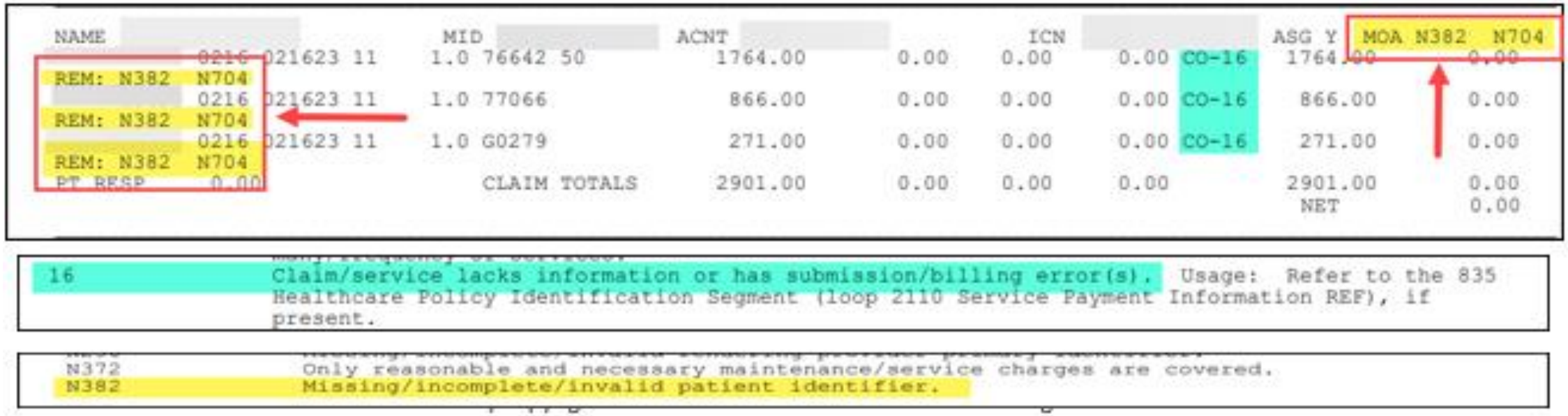
Training and Resources to Share

Appropriate vs. Inappropriate Calls to Palmetto GBA

- Contact Centers are only to be utilized for complex issues that providers cannot answer via any self-service tool (e.g., Palmetto GBA eServices portal, IVR, remit, Palmetto GBA/CMS websites)
- MACs are to refer all inquiries to self-service technology when appropriate
- Resource: **IOM 100-09, Capter 6, Section 50**

Remittance Advice

- **Payment information and claim adjustment reason and remark codes**
- **Appeal rights (or lack thereof)**
- **Cross over claim information when applicable**
- **LCD/NCD number applicable to specific services denied**



NAME		MID	ACNT		ICN		ASG Y	MOA N382 N704
0216	021623 11	1.0 76642 50	1764.00	0.00	0.00	0.00 CO-16	1764.00	0.00
REM: N382 N704								
0216	021623 11	1.0 77066	866.00	0.00	0.00	0.00 CO-16	866.00	0.00
REM: N382 N704								
0216	021623 11	1.0 G0279	271.00	0.00	0.00	0.00 CO-16	271.00	0.00
REM: N382 N704								
PT RESP 0.00		CLAIM TOTALS	2901.00	0.00	0.00	0.00	2901.00	0.00
							NET	0.00

16 Claim/service lacks information or has submission/billing error(s). Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

N372 Only reasonable and necessary maintenance/service charges are covered.

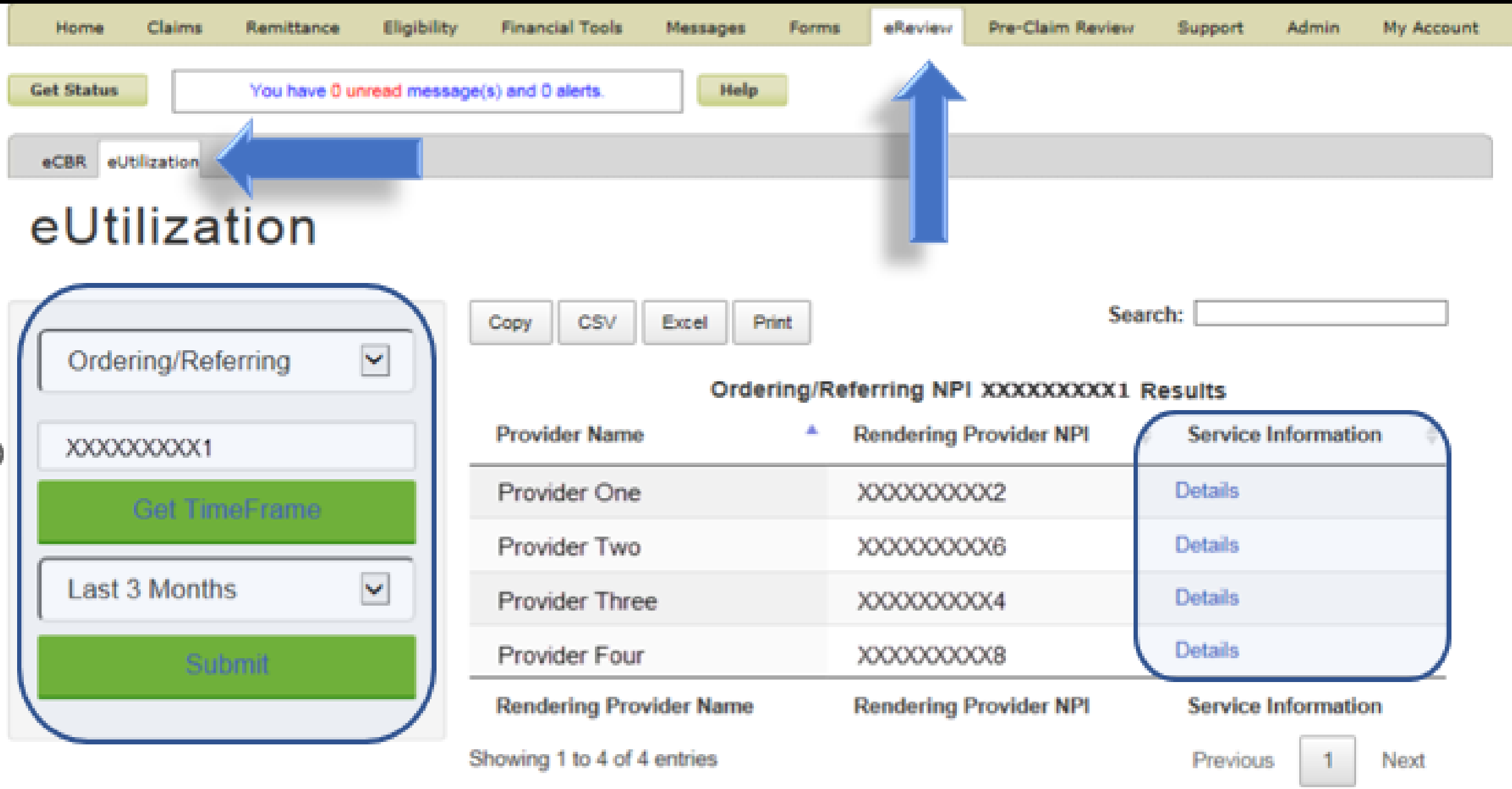
N382 Missing/incomplete/invalid patient identifier.

Palmetto GBA eServices Portal

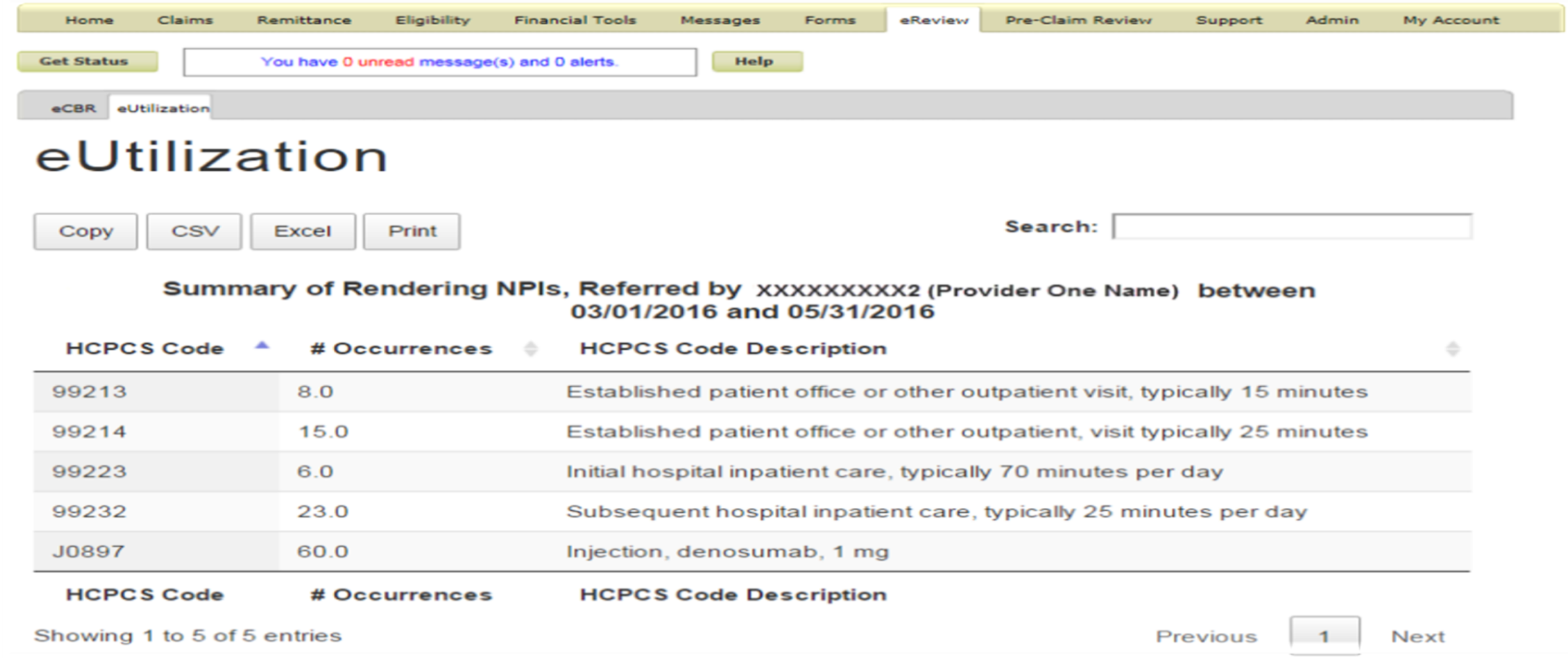
- Critical for retrieving:
  - **Patient eligibility**
  - **Patient deductible**
  - **Patient eligible for frequency coverage limits for certain services**
  - **Medicare secondary payer**
  - **Claim status including explanation of denials codes**
  - **Duplicate denial information**
  - **Recoupments**
  - **Debt satisfaction**

eUtilization: See Who Has Been Using Your NPI

- eUtilization reports provide rendering providers **and** ordering and referring providers access to their personal data
- Data should be reviewed to ensure providers are aware of when and by whom their NPI is being used for billing Medicare services and when their NPI is entered on a Medicare claim as the ordering referring physician
- Select a period from one to 12 months for previous 12 months of data


Home
Claims
Remittance
Eligibility
Financial Tools
Messages
Forms
eReview
Pre-Claim Review
Support
Admin
My Account
Get Status
You have 0 unread message(s) and 0 alerts.
Help
eCBR
eUtilization
eUtilization
Ordering/Referring
XXXXXXXXX1
Get TimeFrame
Last 3 Months
Submit
Copy
CSV
Excel
Print
Search:
Ordering/Referring NPI XXXXXXXXX1 Results
Provider Name
Rendering Provider NPI
Service Information
Provider One
XXXXXXXXX2
Details
Provider Two
XXXXXXXXX6
Details
Provider Three
XXXXXXXXX4
Details
Provider Four
XXXXXXXXX8
Details
Rendering Provider Name
Rendering Provider NPI
Service Information
Showing 1 to 4 of 4 entries
Previous
1
Next

eUtilization

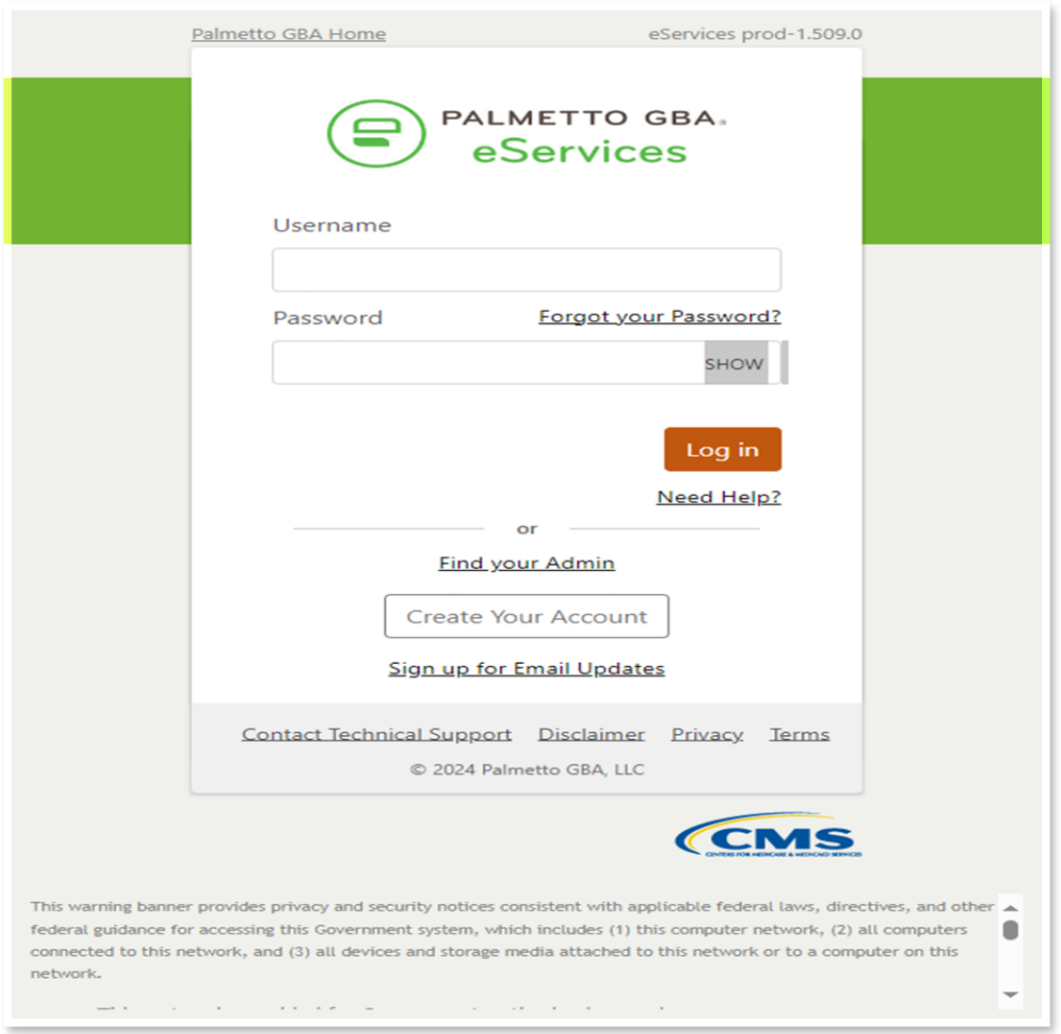


[Jurisdiction M Part B — Now You Can Access Your Personal Data to See Who Has Been Using Your NPI]

Palmetto GBA eServices

From the home screen:

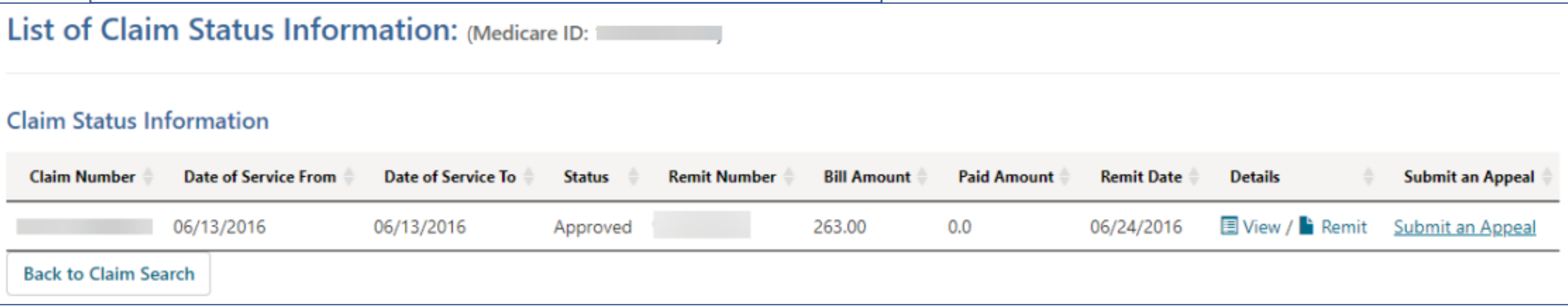
- Sign up for eServices
- Sign in
- Find your administrator
- Access the User Manual



https://www.onlineproviderservices.com/ecx_improvev2/

Claims Tab


Claim Status Inquiry
To view claim data for a patient, please enter the Medicare ID or Claim Number.
Select Type of Search:
Medicare ID
Medicare ID: *
Medicare ID
Optional. When no dates are entered, all claims for the past 3 years will be returned up to 2,000 claims
Date of Service From:
Date of Service From
Date of Service To:
Date of Service To
Submit


List of Claim Status Information: (Medicare ID:
Claim Status Information
Claim Number
Date of Service From
Date of Service To
Status
Remit Number
Bill Amount
Paid Amount
Remit Date
Details
Submit an Appeal
06/13/2016
06/13/2016
Approved
263.00
0.0
06/24/2016
View / Remit
Submit an Appeal
Back to Claim Search

Claim Status Information

List of Claim Status Information: XXXXXXXXXX

Provider Number: 0000000000
Medicare ID: XXXXXXXXXX

Claim Status Information

Claim Number	Date of Service	Bill Amt	Process Date	Check Number	Claim Status	Details	Remittance
0000000000003	10/13/2018 - 10/13/2018	5440.03	01/30/19	000000003	Completed	link	link
0000000000002	10/13/2018 - 10/13/2018	3040.03	12/26/18	000000002	Completed	link	link
0000000000001	10/13/2018 - 10/13/2018	5440.03	11/13/18	000000001	Completed	link	link

If a single match is found, the option to save as a PDF file will display at the bottom of the screen.

In Summary

- Providers are legally responsible for all actions taken by their employees and any vendors they contract with
- Third party vendors are the provider’s employees
- Clear lines of communication and expectations on all employees and vendors are key factors to avoid reconciliation issues
- Ensuring proper tools and education materials are available is vital

Role of Provider Enrollment

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Daniel Johnson
Provider Enrollment
File Operations Supervisor

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Provider Enrollment Function

Review, validate and process CMS form 855 enrollment application, including supporting documentation, to ensure only eligible and qualified individuals and organizations participate in the Medicare program.

Ensuring CMS requirements are consistently and accurately met.

Maintain provider enrollment records and internet-based PECOS, FISS and MXCS records.

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Provider Enrollment Applications

CMS-855 Applications

Form	Description
CMS-855A	Instructional Providers (Part A)
CMS-855B	Clinics/Group Practices and Certain Other Suppliers (Part B, non-DME Suppliers)
CMS-855I	Physicians and Nonphysician Practitioners (Part B, non-DME Individuals)
CMS-855O	Eligible Ordering, Referring and Prescribing Physicians and Nonphysician Practitioners (Part B, non-DME Individuals)
CMS-20134	Medicare Diabetes Prevention Program
CMS-588	Electronic Funds Transfer Agreement
CMS-460	Participation Agreement

Part A Provider Enrollment

CMS-855A Medicare Enrollment Application: Institutional Providers

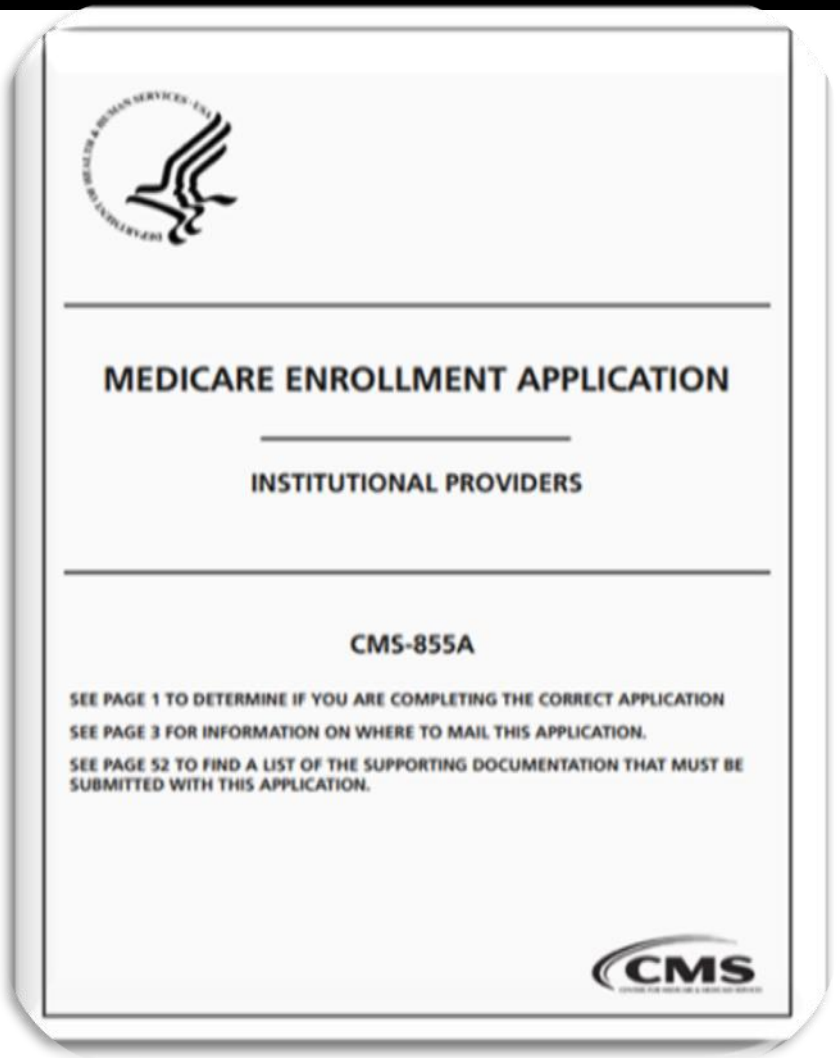
- Community Mental Health Center (CMHC)
- Comprehensive Outpatient Rehabilitation Facility (CORF)
- Critical Access Hospital (CAH)
- End-Stage Renal Disease Facility (ESRD)
- Federally Qualified Health Center (FQHC)
- Histocompatibility Laboratory
- Home Health Agency
- Hospice
- Hospital and Hospital Units
- Indian Health Services Facilities
- Organ Procurement Organization (OPO)
- Outpatient Physical Therapy, Occupational Therapy, Speech Pathology Services
- Religious Non-Medical Health Care Initiative
- Rural Emergency Hospital
- Rural Health Clinic
- Skill Nursing Facility

855A: Initial Enrollment Overview

- **Supporting Documentation**
  - IRS documentation which verifies LBN and EIN
  - CMS-588 EFT agreement and preprinted voided check/bank letter
  - Organizational chart/diagram
  - Evidence of HHS-690 submitted via the Office of Civil Rights (OCR) Portal (not required for FQHCs)
  - CMS-1561 Provider Agreement (not required for ESRDs and FQHCs)
  - CMS-3427 (ESRDs only)
  - Exhibit 177 (FQHCs only)
  - HRSA (FQHCs only)
  - State license (if applicable)
  - Certificate of Need (CON) (If applicable)
  - Patient Transfer Agreement (SNFs only)

When to Submit an 855A Application

- Joining Medicare program for the first time
- Anytime something changes with your facility/practice
  - Address changes
  - Management changes
- Ownership changes
  - Change of Ownership (CHOW)
  - Stock transfer
- Revalidating



Submitting Part A Forms and Supporting Documents

855-A: Submission of Paper Documents

U.S. Mail:

Palmetto GBA
Mail Code: AG-310
P.O. Box 100190
Columbia, SC 29202-3190

Overnight Courier:

Palmetto GBA
Mail Code: AG - 310
2300 Springdale Drive, Building One
Camden, SC 29020-1728

Part B Providers Enrolling by Mail

- Download and complete the correct form based on what type of provider you are:
  - Organizations — **CMS-855B**
  - Physicians and nonphysician practitioners — **CMS-855I**
  - Physicians/nonphysician practitioners reassigning Medicare benefits — **CMS-855I**
  - Medicare Enrollment Application for Eligible Ordering and Referring Physicians and Nonphysician Practitioners — **CMS-855O**
  - Medicare Diabetes Prevention Program — **CMS-20134**

Palmetto GBA: Enrollment Application Finder

Submitting Part B Forms and Supporting Documents

855-B, 855-I, 855-O, CMS 20134: Submission of Paper Documents

U.S. Mail and Certified Mail

Palmetto GBA
Mail Code: AG-310
P.O. Box 100306
Columbia, SC 29202-3306

Overnight Courier

Palmetto GBA
2300 Springdale Drive
Building One
Camden, SC 29020-1728

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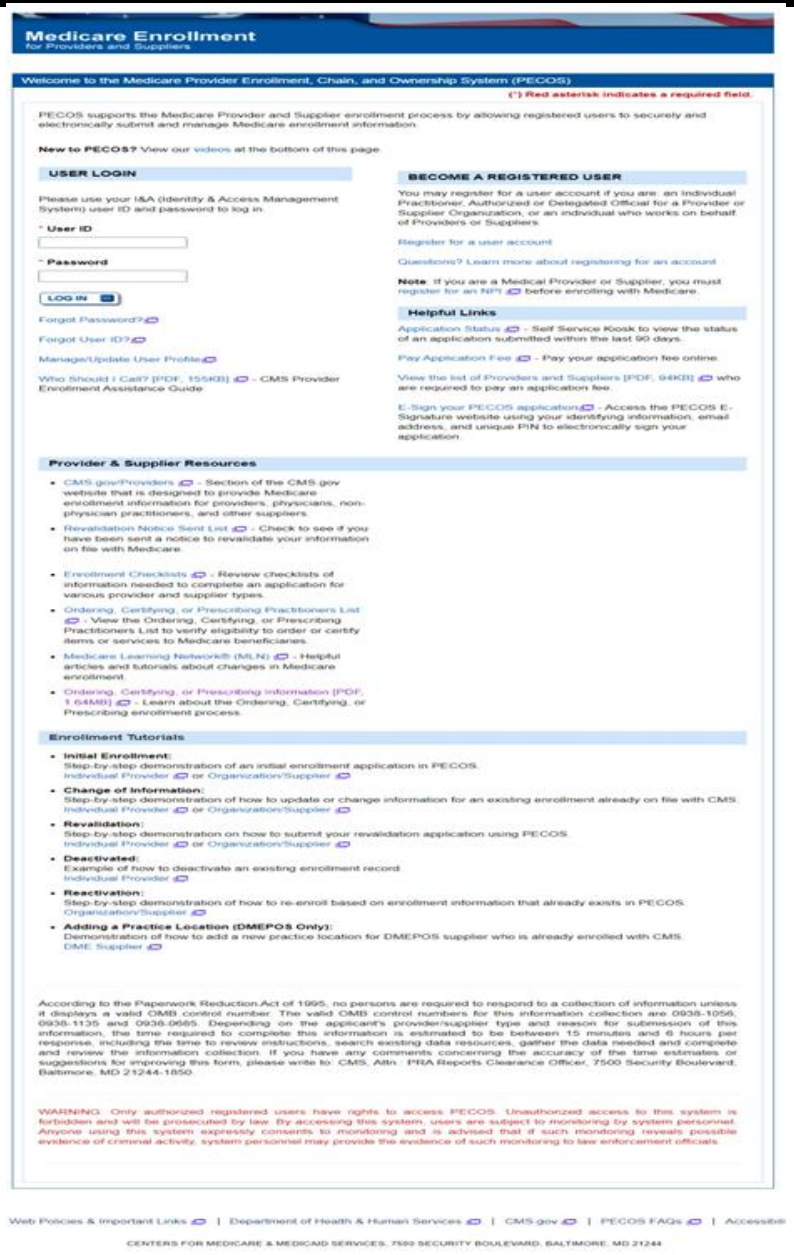
Provider Enrollment Chain and Ownership System (PECOS)

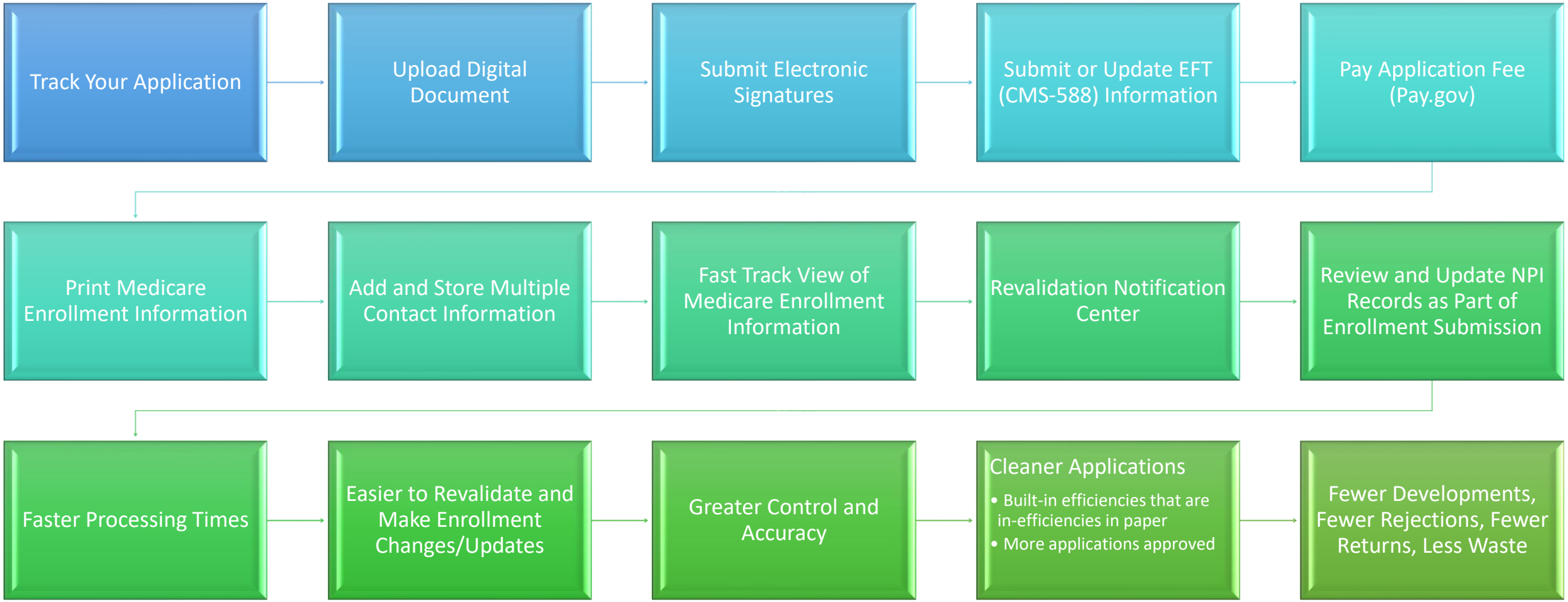
What Is PECOS?

- PECOS is a national database of Medicare provider and supplier enrollment information.
- PECOS can be used in lieu of applications to:
  - Submit an initial Medicare enrollment application
  - Submit changes to existing Medicare enrollment information
  - Revalidate your enrollment information
  - Reactivate an existing enrollment record
  - Withdraw from the Medicare program

Electronic Medicare Enrollment: PECOS



Advantages of Using PECOS



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Pre-Screening and Verification Process

Screening and Verifying

- **Confirmation that current version of application has been submitted, signed, and dated**
- **Verification of:**
  - **Paid Application Fee**
  - **Name/Legal business name**
  - **Social Security Number and Date of Birth**
  - **License Verification**
  - **Adverse Actions Reported**
  - **National Provider Identifier (NPI)**
    - **Name used to obtain NPI must be the same as reported on 855 application**

Application Fees (as Applicable)

- **2025 Application Fee Amount: $730**
- **Institutional providers who are submitting applications for the following reasons are required to pay when:**
  - Initial Enrollment
  - Revalidation
  - Change of Information
    - Adding Practice Location
- **Part B institutional providers and suppliers required to pay:**
  - Ambulance
  - Ambulatory Surgical Centers
  - Portable X-Ray Suppliers
  - Independent Clinical Laboratories
  - Independent Diagnostic Testing Facility
  - Mammography Centers
  - Mass Immunization, Pharmacies
  - Radiation Therapy Centers
  - Home Infusion Therapy Suppliers

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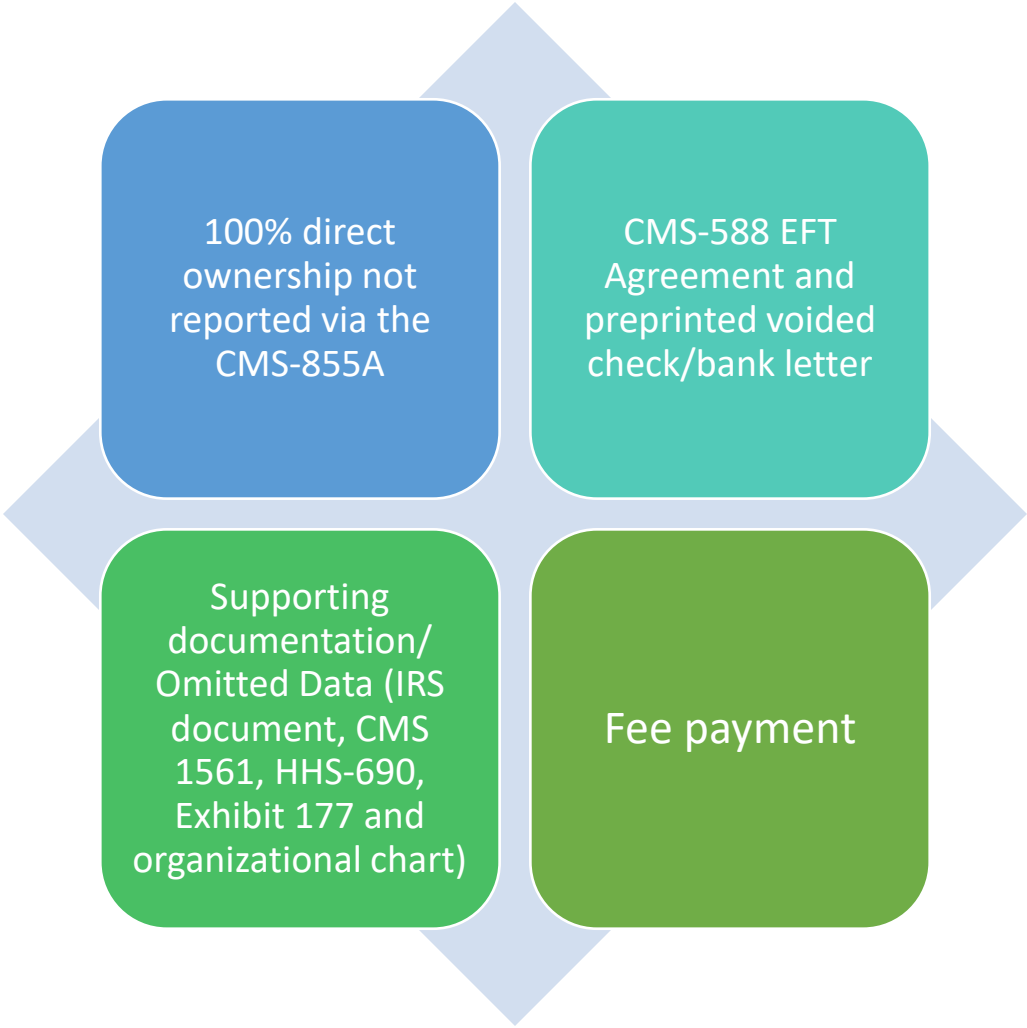
Development Request

What Is a Development Request?

- Letter from processing analyst detailing missing or incomplete application information
- Development request will be sent via email if an email address was reported in Section 13 (Contact Person), or Section 2 (Correspondence Address)
- Most development can be returned via email
  - **“Reply All” to the email received from Palmetto GBA**
  - **Do not change the subject line of the email**
- Respond to development within 30 days to avoid rejection

Part A Top Development Reasons



Part B Top Development Reasons

- Pending Signatures (provider, authorized/designated official)
- Supporting documentation (board certifications, voided check/bank letter, IRS documentation, organization chart)
- CMS 855I application
- Incorrect roles selected Section 5/6 of CMS-855B application
- Legal business name matches
- Type 2 NPI
- EFT/special payments verifications

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Recommendation to the State

Approval from the State

- Some transactions require approval from the state prior to the MAC being able to approve the provider's enrollment application
- These transactions type include:
  - Initial enrollments
  - Certain changes of information
  - CHOWs (Change of Ownership)
  - Stock transfers for non-transition provider/supplier types

Recommendation to the State

Changes of Information that require recommendation to the state — Post-Transition

- Addition of outpatient physical therapy/outpatient speech pathology extension site
- Addition, deletion, or relocation of a hospice practice location
- Addition of HHA branch
- Addition or deletion of a prospective payment system (PPS)-excluded psychiatric unit, rehabilitation unit, or transplant program
- Addition or deletion of swing-bed approval (see Section 2A2 of the Form CMS-855A)
- Conversion of a hospital from one type to another (e.g., acute care to psychiatric)
- Addition, change, and/or relocation of a hospital practice location when a survey of the new site may be required

Changes of Information that require recommendation to the state — Non-Transition

- Change and/or relocation of a practice location
- Stock transfer (unless there is a CHOW)

Post-Transition Providers & Suppliers

- In the past, the SOG (Survey and Operational Group) Location had vital functions in reviewing requests for Medicare participation and finalizing CMS's decision
  - Due to the transition of certain SOG activities to the state agencies, the MACs, and CMS Provider Enrollment Operations Group (PEOG), the operational process of reviewing requests for participation and enrollment were updated

Part A Providers: Post Transition vs. Non-Transition

- The following provider/supplier types are referred to as “post-transition” due to the change in their approval process
  - Community Mental Health Center (CMHC)
  - Comprehensive Outpatient Rehabilitation Facility (CORF)
  - Home Health Agency
  - Hospice
  - Outpatient Physical Therapy/Occupational Therapy/Speech Pathology Services
  - Skilled Nursing Facility (SNF)
  - Federally Qualified Health Center (FQHC)
  - Hospitals

Part A Providers: Post Transition vs. Non-Transition

- The following provider/supplier types are referred to as “non-transition” due to their approval process being unchanged
  - Critical Access Hospital (CAH)
  - Histocompatibility Laboratory
  - Indian Health Services Facility
  - Organ Procurement Organization (OPO)
  - Religious Non-Medical Health Care Institution (RNHCI)
  - Rural Emergency Hospital (REH)
  - Rural Health Clinic (RHC)
  - End-Stage Renal Disease Facility (SRDF)

State Recommendation Post-Transition Process

1. Provider submits completed CMS-855A to the MAC serving your state
2. The MAC performs initial verification, screening, and processing and then sends the enrollment application (and all supporting documentation) and its recommendation for approval to the state for review
3. The state notifies the MAC of its recommendation
4. The MAC notifies PEOG of the recommendation
5. If applicable, PEOG signs the provider agreement, performs other administrative functions pertaining to the enrollment, and notifies MAC of its approval
6. The MAC completes processing and notifies the provider of the approval of the transaction using the appropriate letter (sending a copy to the state and, if applicable, accrediting organization)

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CMS-588 Electronic Funds Transfer (EFT) Agreement

CMS-588 EFT Agreement

All providers must be enrolled to receive reimbursement via EFT.

11/2023 version of the CMS-588 is the only version being accepted.

Name on bank account can be the provider's legal business name or the chain home office legal business name if payment is being made to the chain home office.

If governmental, doesn't have to match provider's legal business name if required by law to have payments made to a specific account.

Must provide copy of statute/regulation supporting this.

CMS-588 EFT Supporting Documents

Supporting Documents

- **Pre-printed** voided check or a signed (by a bank representative) letter from the bank confirming name on account, account number, and routing number
- A deposit slip is not acceptable
- If payment is being made to the chain home office, a letter authorizing EFT payments due the provider to the chain home office's bank account

EFT and Special Payment Address Changes

In order to protect the financial information of Medicare providers and suppliers, additional verifications are required when changes are received to the EFT account information and/or special payments address.

Verification of EFT account/special payments address information must be verified with the sole proprietor, authorized/delegated official or contact person on file.

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Revalidation

Submitting Revalidation

- Section 6401 (a) of the Affordable Care Act
  - Reinforces the revalidation requirements of 42 CFR §424.515 — all providers/suppliers must resubmit and recertify the accuracy of enrollment information every five years
  - Establishes new screening requirements for new and existing providers
  - Requires existing providers to be revalidated under new screening requirements

Revalidation — Current Status

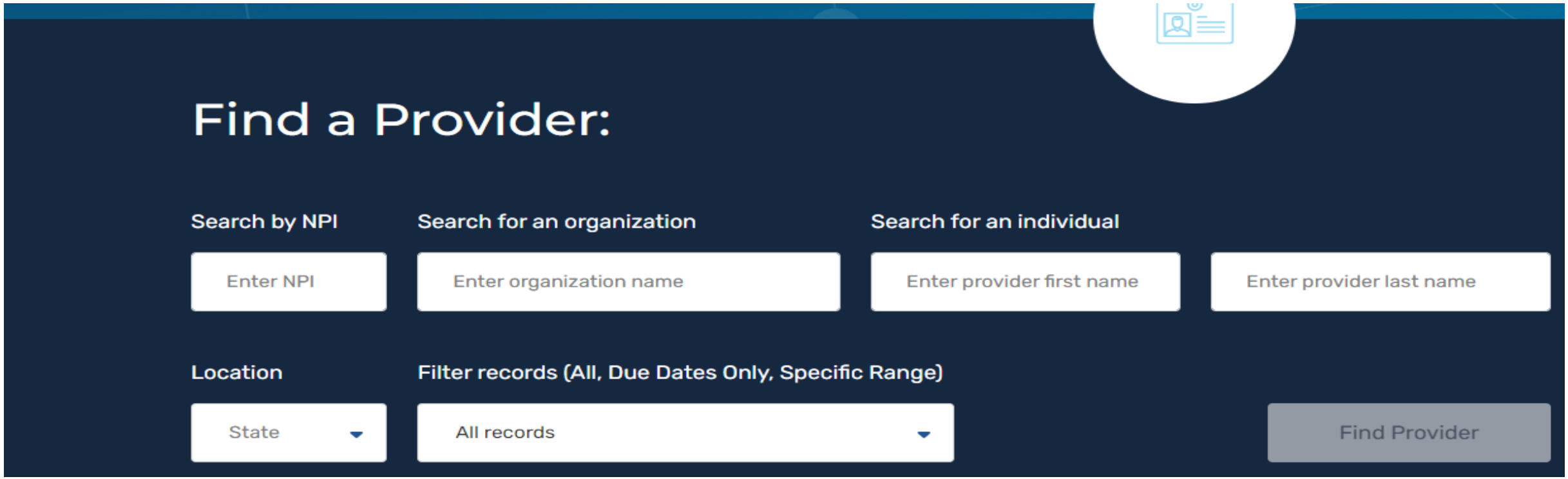
- Providers may be asked to revalidate off-cycle (in advance of or beyond their three- or five-year due date)
- Off-cycle revalidation notifications may not happen six months in advance but at least 90 days will be given
- No action needed until you see a revalidation due date on the revalidation look up tool and/or receive a letter from your MAC
- Revalidation due dates on or after July 2023, will show under “Due Dates” and not “Adjusted Due Dates”

Revalidation Due Dates

- Due dates are on the last day of the month (e.g., Feb. 28, March 31, April 30, etc.)
- Due dates are posted to CMS.gov “Revalidation Due Date Lookup Tool”
  - Will display all currently enrolled providers
    - Due date
    - TBD (to be determined)
- Posted seven months before the revalidation due date
- Post-PHE clean-up is occurring to move back to revalidating providers every five years

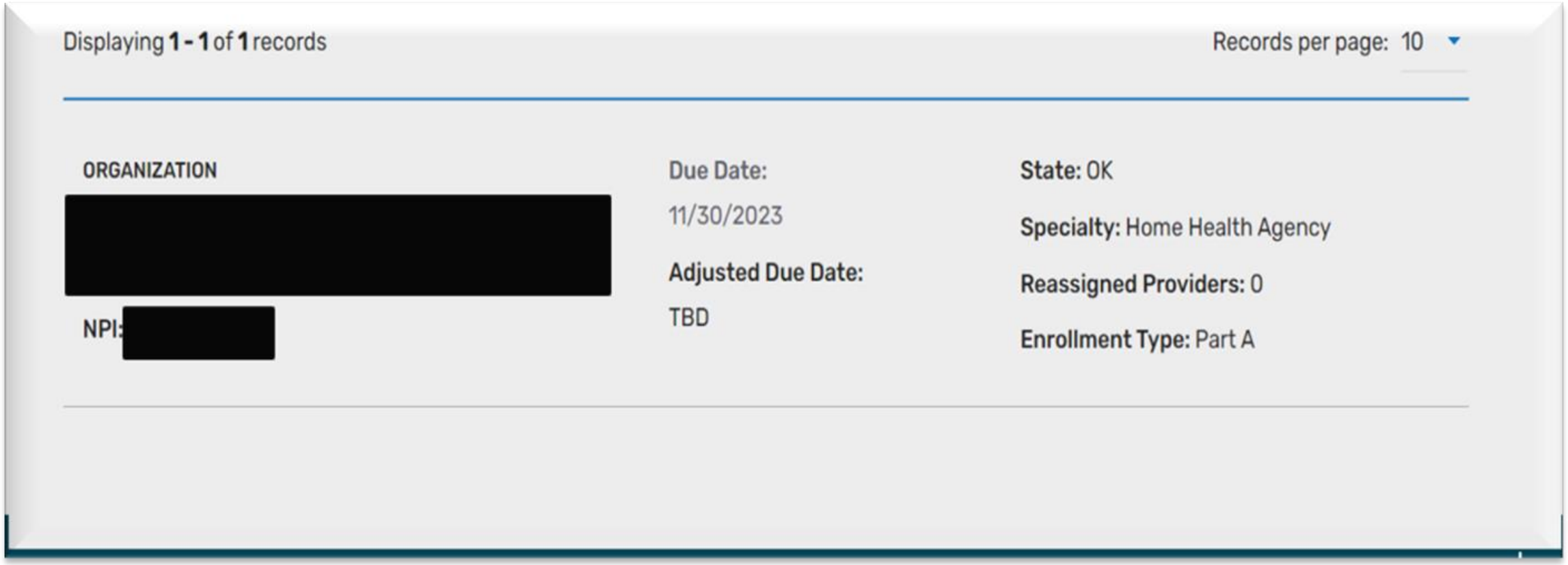
Revalidation Lookup Tool Website

The Revalidation Lookup Tool can be found at https://data.cms.gov/revalidation.



Revalidation Lookup Tool Results

- Results with display due date, specialty, state, enrollment type, NPI and organization/individual legal name



Unsolicited Revalidations

- Unsolicited revalidations are defined as:
  - Revalidation submitted more than seven months in advance of the due date
  - TBD listed on the CMS.gov “Revalidation Due Date Lookup Tool”
  - No notice received from Palmetto GBA requesting you to revalidate*
- All unsolicited revalidations will be returned without processing
- If your intention is to submit a change to your provider enrollment record, submit a “**change of information”** application on appropriate CMS Form 855
  - If a change of information is submitted while a revalidation is due, it will be processed as a revalidation

** Notices of revalidation due dates are sent to the provider’s correspondence and special payments address on file.*

Failure to Revalidate Timely

- Possible deactivation of Medicare billing privileges
- Hold on Medicare Payments
  - Submit revalidation application by due date and include all active practice locations
  - Respond to all development requests within 30 days of receipt

Revalidation – Part B

- Sole owners can revalidate using the CMS-855B or CMS-855I
- Submitting the CMS-855B, only revalidates the organization
- Submitting the CMS-855I, revalidates both the organization and the individual
- If no response to revalidation, only the organization and their reassignments are deactivated
  - Individual provider's enrollment will remain active with any other reassignments
  - Individual providers with no other active reassignments will be deactivated after 90 days if a change of information reporting a new reassignment or practice location is not submitted

Non-Response to Revalidation

- **Stay of Enrollment**
  - Interim action taken against providers who have not responded to revalidation prior to imposing a deactivation or revocation
    - Not considered a sanction or adverse action
  - Pauses enrollment temporarily until provider is compliant
  - Provider remains enrolled in Medicare during the stay
    - Enrollment status will continue to be approved
  - Claims submitted with dates of service during the stay period are rejected
  - Stay lasts no longer than 60 days

Reactivations

- Deactivated providers/suppliers are required to submit a complete enrollment application to reactivate

- The provider/supplier will maintain their original PTAN and certification date

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Rebuttal and Appeals Process

Rebuttal Process

What Is a Rebuttal?

Written disagreement with deactivation determination

- Rebuttals may be submitted (in writing) if the provider disagrees with the deactivation
- The rebuttal submission must be received within 15 calendar days from the date of the deactivation letter, or it is considered untimely
- The rebuttal submission must specify the facts or issues in which the provider disagrees, and the reasons for disagreement
- The rebuttal must be signed by the individual provider, supplier, authorized or delegated official, or a legal representative.
- If signed by a legal representative, the rebuttal must include a statement constituting their authority.

Part A: Rebuttal Submission Methods

Email, Fax or U.S. Mail

JJ Part A

JJARebuttalRequest@palmettogba.com
Fax: (803) 870–6044
Palmetto GBA Provider Enrollment
P.O. Box 100305
Columbia, SC 29202

JM Part A

JMARebuttalRequest@palmettogba.com
Fax: (803) 870–6042
Palmetto GBA Provider Enrollment
P.O. Box 100144
Columbia, SC 29202

Note: All Rebuttals are processed and rendered a determination within 30 calendar days of the date of receipt.

Part B: Rebuttal Submission Methods

Rebuttals can be submitted via hard-copy mail, email, and fax:

- **JMB: JMRebuttalRequest@Palmettogba.com**
- **Fax:** (803) 870–6043
- **JJB: JJRebuttalRequest@Palmettogba.com**
- **Fax: (803) 870–6045**

- All Rebuttals are processed and rendered a determination within 30 calendar days of the date of receipt.

Appeal Process

- A provider or supplier whose Medicare enrollment request has been **denied** or whose Medicare billing privileges are **revoked** may request an appeal of that determination
- A Corrective Action Plan (CAP) and/or reconsideration request must be submitted in the form of a letter that is signed by the individual provider, supplier, the authorized or delegated official, or a properly appointed representative

Appeal Process

- If the representative is an attorney, the attorney must include a statement that he or she has the authority to represent the provider or supplier
- If the representative is not an attorney, the provider or supplier must file written notice of the appointment of a representative with the contractor

Appeal Process

- This notice of appointment must be signed by the individual provider or supplier, or the authorized or delegated official. The signature need not be original and can be electronic
- **Note:** The provider/supplier's contact person (as listed in section 13 of the Form CMS-855) does not qualify as a "legal representative" for purposes of signing a reconsideration request

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Change of Information

Change of Information Timliness

- **When to submit a change of information**
  - A change of information should be submitted anytime something changes with your facility/practice
- **Change of Information Time Frames**
  - Change in ownership within 30 days
  - An adverse legal action within 30 days
  - A change in practice location within 30 days
  - All other changes within 90 days

Note: Failure to report changes timely may result in revocation or deactivation of your Medicare billing privileges.

Change of Information Supporting Documentation

Part A Change of Information

- **IRS Documentation Verifying LBN and EIN**
  - Needed if legal business name or tax ID changes
- **Preprinted Voided Check/Bank Letter**
  - Needed if changes are being made to account and/or routing number
- **Organizational Chart/Diagram**
  - Needed if changes are made in Section 5/6 of CMS-855A

Change of Information Supporting Documentation (continued)

Part A Change of Information

- **State License**
  - Needed if a license is being added or changed
- **Clinical Lab Improvement Amendments (CLIA) Certificate**
  - Needed if a CLIA is being added or changed
- **Stock Transfer/Sales Agreement**
  - Needed if Direct ownership percentage changes are reported via the CMS-855A

Reporting Address Changes

- Addresses reported using the CMS Form 855A
  - Correspondence address
  - Practice location address
  - Special payment address
- Report address/practice location change within 30 days of the change occurring
- All addresses reported on the 855 are captured in FISS

Tax Identification Changes

- If a provider is changing its tax identification number, the transaction is treated as a brand-new enrollment
- This may include two forms/applications
  1. Initially enroll as a new provider
  2. Voluntarily terminate the existing enrollment

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Site Visits

Site Visits & Notification

- Providers or suppliers may be subject to on-site inspections (site visits) in order to verify the provider's or supplier's compliance with all enrollment requirements for the Medicare program
  - Prior to ordering a site visit, notification will be sent to your contact person or correspondence address
  - The purpose of this notification is to make the you aware that a site visit will be performed at your location

Notification/Development Request Letters

- The following language will be included in the site visit notification letter and/or any development request letter:
  - “As a result of your application submission on xx/xx/xxxx, authorized under 42 CFR §424.517, an unannounced site visit will be required at the following location(s): 123 Main St. Please ensure that staff at these location(s) are aware that CMS contractor personnel will be conducting a site visit in the coming days. Since the intent of the visit is to determine if the location(s) is operational, your staff may or may not encounter the CMS contractor personnel. CMS contractor personnel will provide identifying information upon request. Remember that site visit(s) are unannounced, and we cannot provide specific information on when it will be conducted”

Site Visits — Requirements

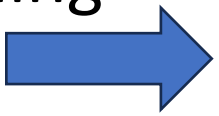
- Site visits are required for Providers and Suppliers with screening levels of **Moderate** and **High:**
  - Ambulance Service Suppliers
  - Community Mental Health Centers (CMHCs)
  - Comprehensive Outpatient Rehabilitation Facilities (CORFs)
  - Hospice Organizations
  - Independent Clinical Laboratories
  - Independent Diagnostic Testing Facilities (IDTFs)
  - Physical Therapists Enrolling As Individuals or As Group Practices
  - Portable X-ray Suppliers (PXRSs)
  - Home Health Agencies (HHAs)
  - Diabetes Prevention Program (MDPP) suppliers
  - Opioid Treatment Programs (OTP)
  - Skilled Nursing Facilities (SNF)
  - DMEPOS Suppliers

- Site visits are required for Providers and Suppliers with screening levels of **Moderate** and **High:**
  - Ambulance Service Suppliers
  - Community Mental Health Centers (CMHCs)
  - Comprehensive Outpatient Rehabilitation Facilities (CORFs)
  - Hospice Organizations
  - Independent Clinical Laboratories
  - Independent Diagnostic Testing Facilities (IDTFs)
  - Physical Therapists Enrolling As Individuals or As Group Practices
  - Portable X-ray Suppliers (PXRSs)
  - Home Health Agencies (HHAs)
  - Diabetes Prevention Program (MDPP) suppliers
  - Opioid Treatment Programs (OTP)
  - Skilled Nursing Facilities (SNF)
  - DMEPOS Suppliers

Site Visits — Requirements

Newly-enrolling and existing providers/suppliers are placed into one of three levels of categorical screening: **Limited**, **Moderate** or **High.**

Site visits are required for providers/suppliers with screening levels of **Moderate and High**



MODERATE AND HIGH

- Ambulance Service Suppliers
- Community Mental Health Centers (CMHCs)
- Comprehensive Outpatient Rehabilitation Facilities (CORFs)
- Hospice Organizations
- Independent Clinical Laboratories
- Independent Diagnostic Testing Facilities (IDTFs)
- Physical Therapists Enrolling as Individuals or as Group Practices
- Portable X-ray Suppliers (PXRSs)
- Home Health Agencies (HHAs)
- Diabetes Prevention Program (MDPP) suppliers
- Opioid Treatment Programs (OTP)
- Skilled Nursing Facilities (SNF)
- DMEPOS Suppliers

Site Visit Delays

To avoid processing delays related to site visits, the information below should be submitted with the application:

- Hours of operation
- Access to the facility is available by appointment only

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Fingerprint-Based Background Checks

Fingerprint-Based Background Checks

The Affordable Care Act requires fingerprint-based background checks be completed by:

- All individual providers and suppliers designated at the high screening level category
- 5% or greater owners of Medicare providers/suppliers in the high screen level category
  - ***5% or greater ownership is based upon interests held directly or indirectly and general or limited partnership interest***

Fingerprint-Based Background Checks

The screening level of a provider/supplier may be elevated to "high" due any of the following:

- Excluded from Medicare or any other Federal Health Care program
- Terminated or prohibited from billing Medicaid
- Applied for Medicare enrollment within six months after temporary moratorium
- Within the last 10 years:
  - Medicare payments suspended
  - Medicare billing privileges revoked
  - Final adverse actions

Fingerprint-Based Background Checks

- Fingerprint-based background checks must be completed within 30 calendar days from the postmarked date of the fingerprint request letter
- Failure to submit fingerprints for all individuals listed within the timeframe may result in the denial/revocation of Medicare billing privileges
- Fingerprinting must be completed by contacting Accurate Biometric at www.cmsfingerprinting.com and following the instructions received

A/B CERT Analysis Review

PALMETTO GBA®
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April Gause. LPN
Senior Provider Education Consultant

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Frequently Used Acronyms

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

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CMS Overview

HHS Corrective Actions

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

CMS Oversite

- CMS Center for Program Integrity (CPI) oversees Medicare medical review contractors. CPI conducts contractor oversight activities.
  - Providing broad direction on medical review policy
  - Reviewing and approving Medicare contractors' annual medical review strategies
  - Facilitating Medicare contractors' implementation of recently enacted Medicare legislation
  - Facilitating compliance with current regulations

- CPI / CMS https://www.cms.gov/about-cms/components/cpi

Guidance NCD vs. LCD

NATIONAL COVERAGE DETERMINATIONS (NCDS)

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

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

Guidance NCD vs. LCD

LOCAL COVERAGE DETERMINATIONS (LCDS)

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

CMS Manuals

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

NCD

Medicare Coverage Database

MCD Reports

Select National Coverage Report

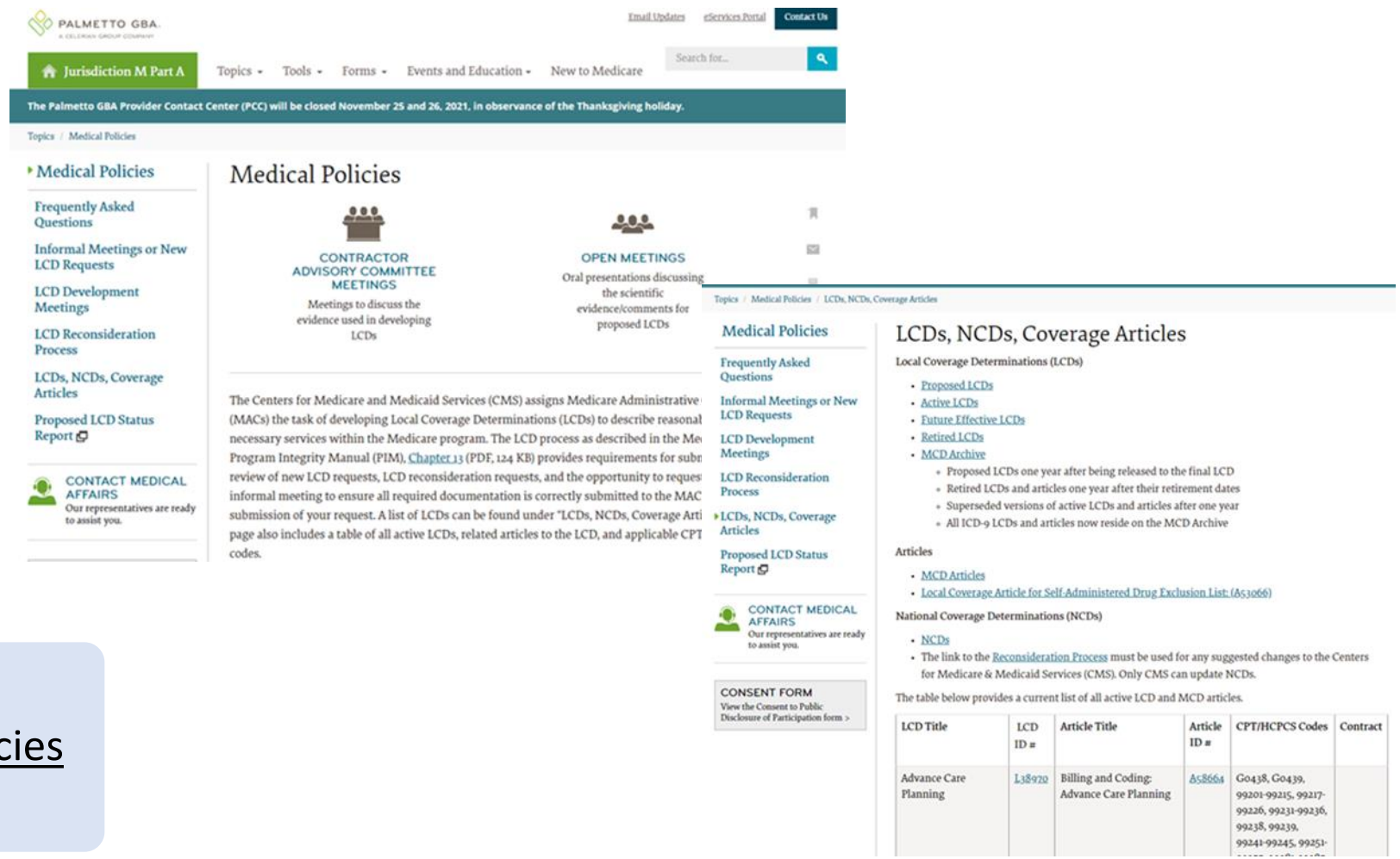
Medicare National Coverage Determinations Manual

LCD

Palmetto GBA

Topics

Medical Policies



[Medicare Program Integrity Manual Chapter 13 – Local Coverage Determinations]

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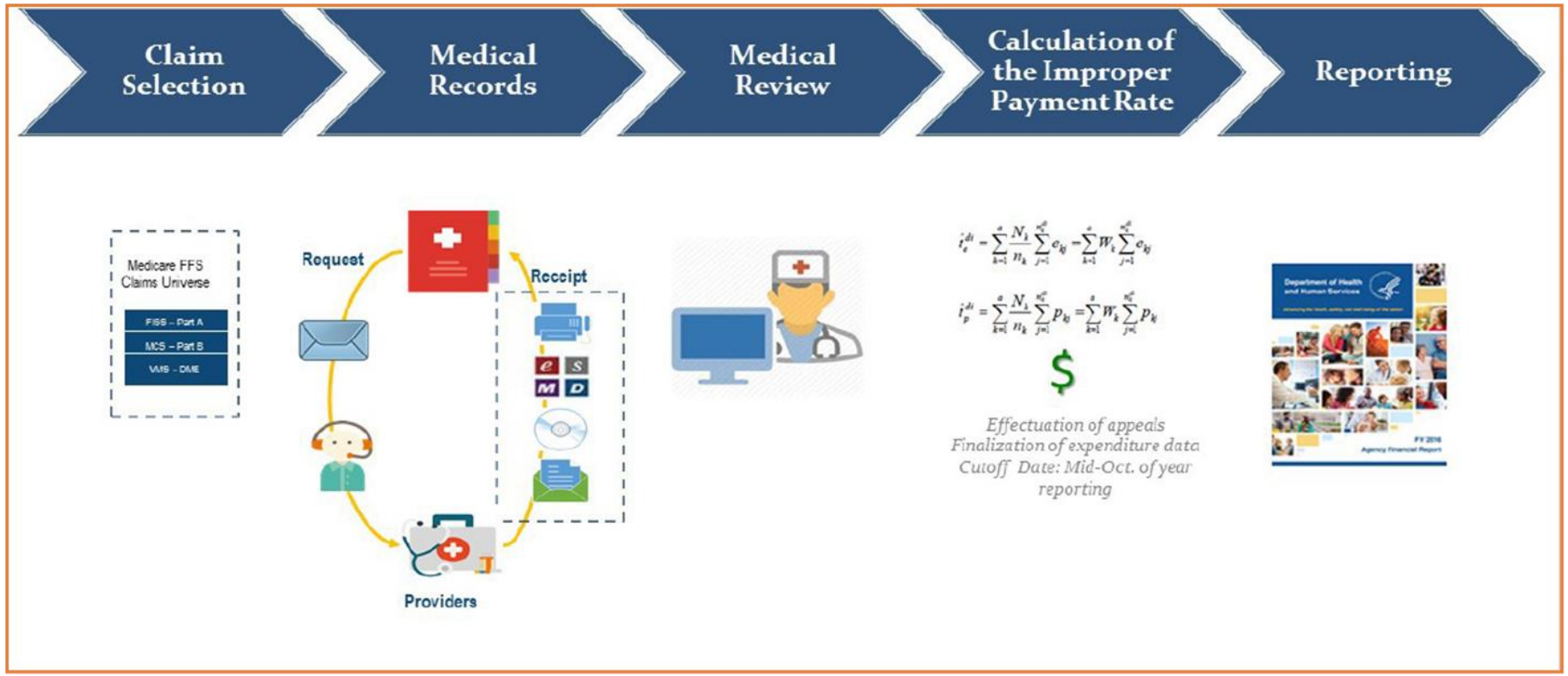
Comprehensive Error Rate Testing (CERT) Program

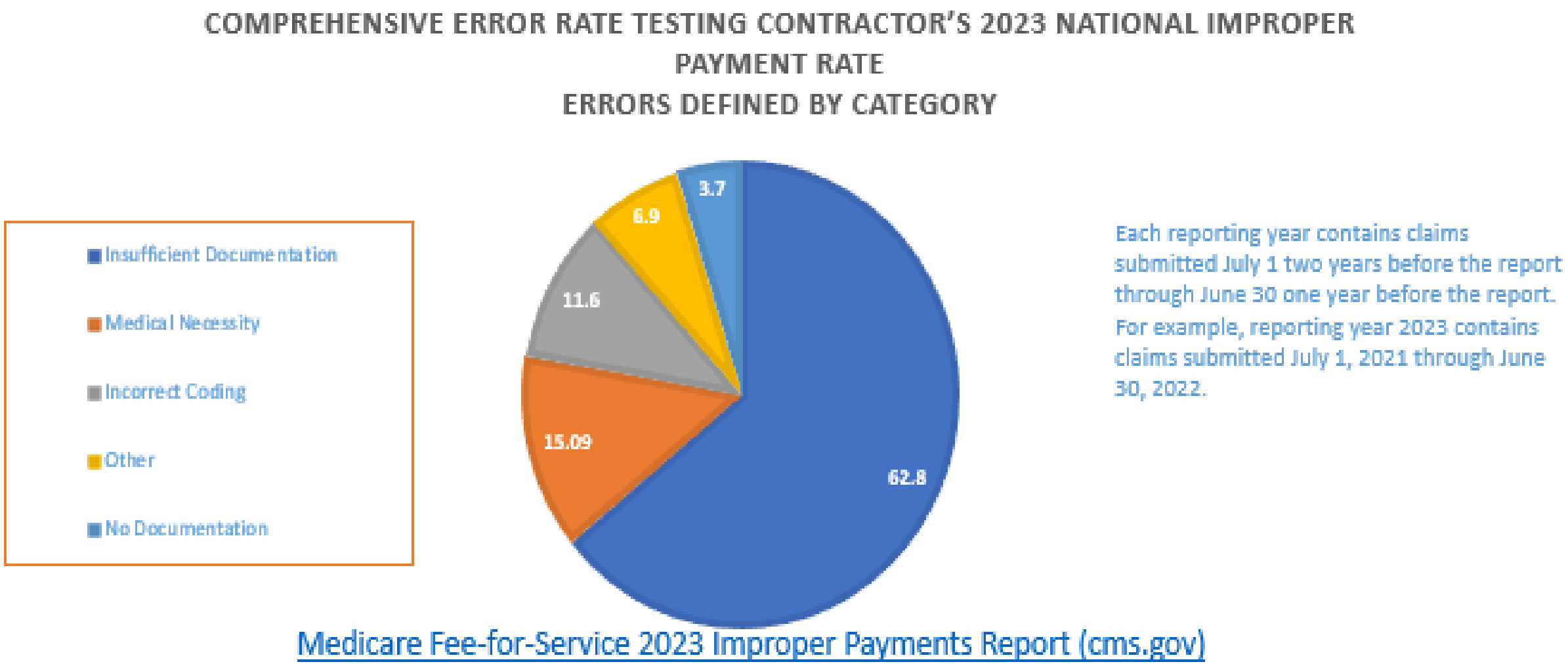


CERT Defined

CMS developed the CERT program to:

- Measure the accuracy of Medicare's payments on a national level for each MAC region
- Assist CMS in understanding the educational needs of the provider community and their contractors
- Prevent improper payments

Improper Payment Categories



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

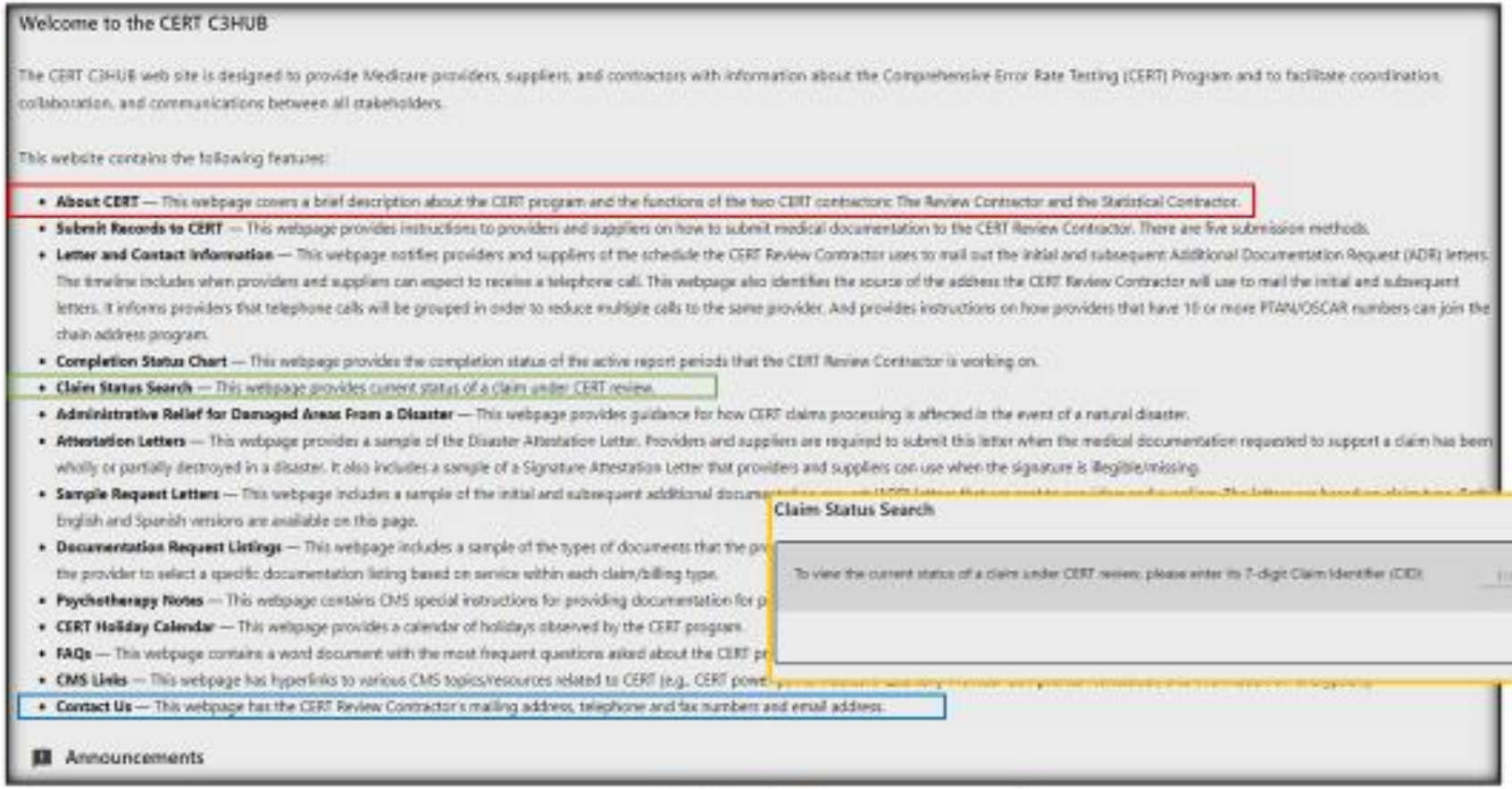
Medicare Fee-for-Service 2023 Improper Payments Report (cms.gov)

Comprehensive Error Rate Testing (CERT)

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

Comprehensive Error Rate Testing (CERT) | CMS

Welcome to the CERT C3Hub!



Contact Us

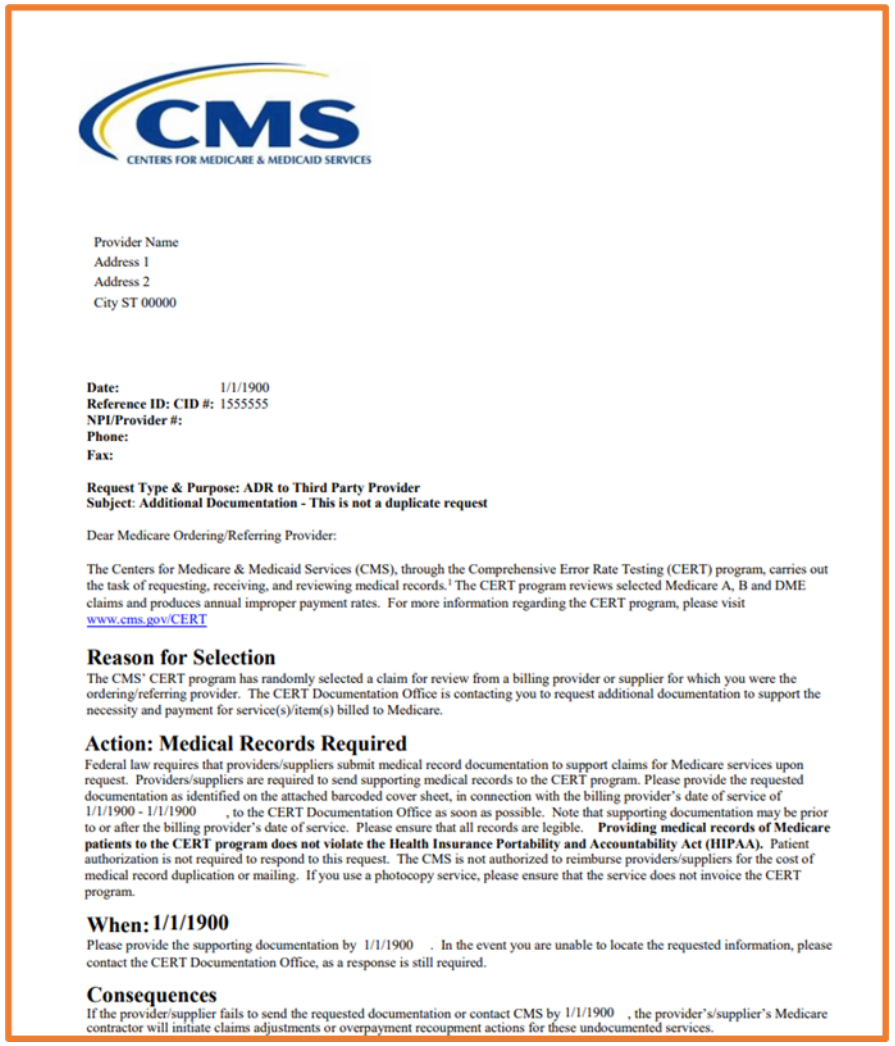
CERT Documentation Center
8701 Park Central Drive, Suite 400-A
Richmond, VA 23227
Fax: 804-261-8100
Customer Service: 443-663-2699
Toll Free: 888-779-7477
Email: certprovider@empower.ai

[C3HUB (cms.gov)]

CERT Initial Documentation Request

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

CERT SADR Request



CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Provider Name
Address 1
Address 2
City ST 00000

Date: 1/1/1900
Reference ID: CID #: 1555555
NPI/Provider #:
Phone:
Fax:

Request Type & Purpose: ADR to Third Party Provider
Subject: Additional Documentation - This is not a duplicate request

Dear Medicare Ordering/Referring Provider:

The Centers for Medicare & Medicaid Services (CMS), through the Comprehensive Error Rate Testing (CERT) program, carries out the task of requesting, receiving, and reviewing medical records.[1] The CERT program reviews selected Medicare A, B and DME claims and produces annual improper payment rates. For more information regarding the CERT program, please visit www.cms.gov/CERT

Reason for Selection
The CMS' CERT program has randomly selected a claim for review from a billing provider or supplier for which you were the ordering/referring provider. The CERT Documentation Office is contacting you to request additional documentation to support the necessity and payment for service(s)/item(s) billed to Medicare.

Action: Medical Records Required
Federal law requires that providers/suppliers submit medical record documentation to support claims for Medicare services upon request. Providers/suppliers are required to send supporting medical records to the CERT program. Please provide the requested documentation as identified on the attached barcoded cover sheet, in connection with the billing provider's date of service of 1/1/1900 - 1/1/1900 , to the CERT Documentation Office as soon as possible. Note that supporting documentation may be prior to or after the billing provider's date of service. Please ensure that all records are legible. **Providing medical records of Medicare patients to the CERT program does not violate the Health Insurance Portability and Accountability Act (HIPAA).** Patient authorization is not required to respond to this request. The CMS is not authorized to reimburse providers/suppliers for the cost of medical record duplication or mailing. If you use a photocopy service, please ensure that the service does not invoice the CERT program.

When: 1/1/1900
Please provide the supporting documentation by 1/1/1900 . In the event you are unable to locate the requested information, please contact the CERT Documentation Office, as a response is still required.

Consequences
If the provider/supplier fails to send the requested documentation or contact CMS by 1/1/1900 , the provider's/supplier's Medicare contractor will initiate claims adjustments or overpayment recoupment actions for these undocumented services.

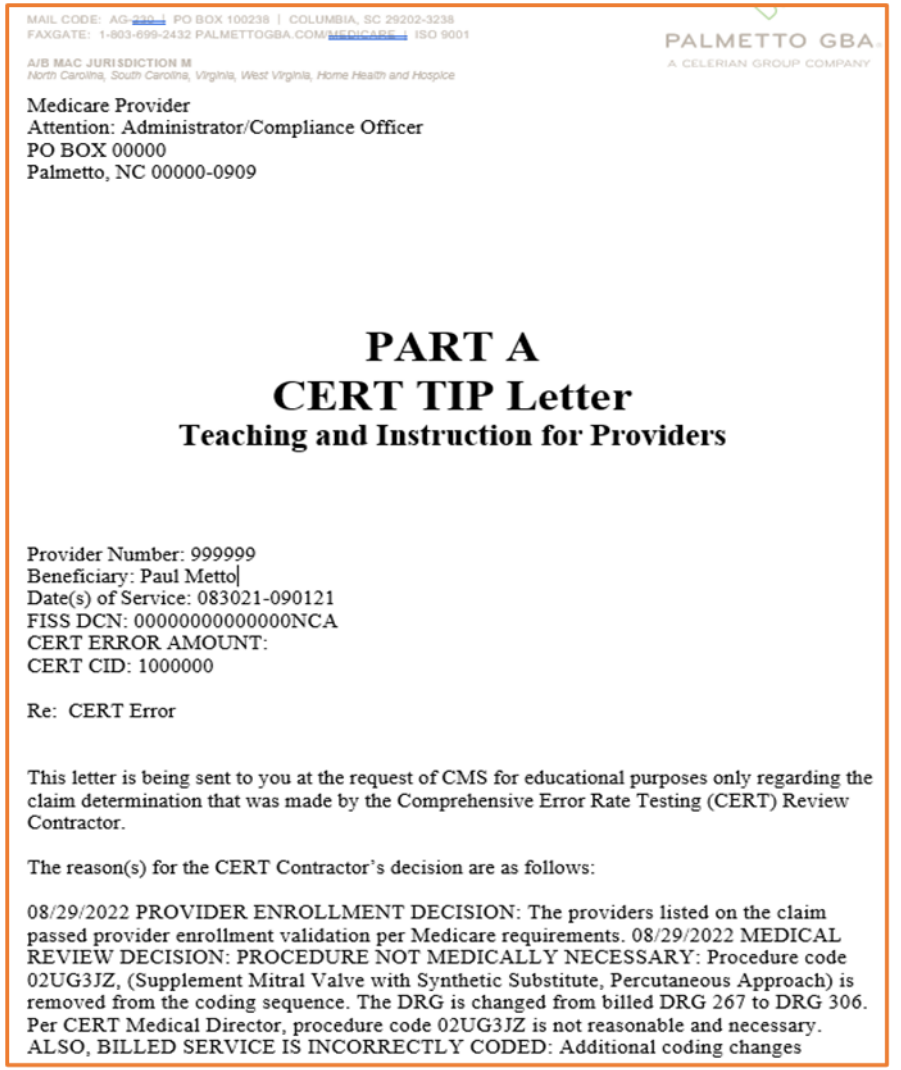
If, during CERT's initial medical review, the need for additional info is identified, a subsequent documentation request will be issued as follows:

- Day 1 — CERT sends an initial subsequent request letter, and a phone call is made by CERT to the provider to follow-up on the request and to offer assistance
- Day 10 — CERT sends a second subsequent request letter, and a phone call is made by CERT to the provider to follow-up on the request and to offer assistance
- Day 16 — Claim is back in the review process

Finalizing CERT's ADR Request

- Claims are counted as a non-response error if requested documentation is not received
- Claims are counted as insufficient documentation error if requested documentation is not received after SADR request
- Palmetto GBA will adjust the claim based on CERT's review decision

- A Teaching and Instruction Paragraph Letter or "TIP Letter" will be sent within 10 business days of the adjusted claim finalizing



MAIL CODE: AG-[redacted] PO BOX 100238 | COLUMBIA, SC 29202-3238
FAXGATE: 1-803-699-2432 PALMETTOGBA.COM/[redacted] ISO 9001

PALMETTO GBA
A CELERIAN GROUP COMPANY

A/B MAC JURISDICTION M
North Carolina, South Carolina, Virginia, West Virginia, Home Health and Hospice

Medicare Provider
Attention: Administrator/Compliance Officer
PO BOX 00000
Palmetto, NC 00000-0909

PART A
CERT TIP Letter
Teaching and Instruction for Providers

Provider Number: 999999
Beneficiary: Paul Metto
Date(s) of Service: 083021-090121
FISS DCN: 00000000000000NCA
CERT ERROR AMOUNT:
CERT CID: 1000000

Re: CERT Error

This letter is being sent to you at the request of CMS for educational purposes only regarding the claim determination that was made by the Comprehensive Error Rate Testing (CERT) Review Contractor.

The reason(s) for the CERT Contractor's decision are as follows:

08/29/2022 PROVIDER ENROLLMENT DECISION: The providers listed on the claim passed provider enrollment validation per Medicare requirements. 08/29/2022 MEDICAL REVIEW DECISION: PROCEDURE NOT MEDICALLY NECESSARY: Procedure code 02UG3JZ, (Supplement Mitral Valve with Synthetic Substitute, Percutaneous Approach) is removed from the coding sequence. The DRG is changed from billed DRG 267 to DRG 306. Per CERT Medical Director, procedure code 02UG3JZ is not reasonable and necessary. ALSO, BILLED SERVICE IS INCORRECTLY CODED: Additional coding changes

CERT Submission Methods

The original barcoded cover sheet should be included with all submissions

CERT Documentation can be submitted by:	
Postal Mail	CERT Documentation Center 8701 Park Central Drive, Suite 400-A Richmond, Virginia 23227
Fax (804) 261–8100	• Use the barcoded cover sheet as the only coversheet • Do not add your own cover sheet—this slows down receipt and identification process • Send a separate fax transmission for each individual claim
Electronic Submission of Medical Documentation (esMD)	• Include a CID# or Claim number and the barcoded cover sheet in your file transmission. • Information on esMD can be found at www.cms.gov/esMD. • For questions about esMD please contact: esMDBusinessOwners@cms.hhs.gov
CD	• The images should be encrypted per HIPAA security rules • If encrypted, the password and CID# **must be** provided via email to CERTMail@empower.ai or via fax to (804) 261–8100 • Must contain only images in TIFF or PDF format
Email Attachment	• The email attachment(s) should be encrypted per HIPAA security rules • If encrypted, the password and CID# **must be** provided via phone to 888-779-7477 or via fax to (804) 261–8100 • Must contain only attachments in TIFF or PDF format

CERT's Chain Address Program

Providers that have at least 5 PTAN numbers can elect a single point of contact (POC).

Providers Must:

- Call the CERT office or their local MAC CERT Coordinator with a list of PTAN numbers and their designated POC information
- This information should be provided to CERT within 45 days from the initial notification of CERT's request for documentation

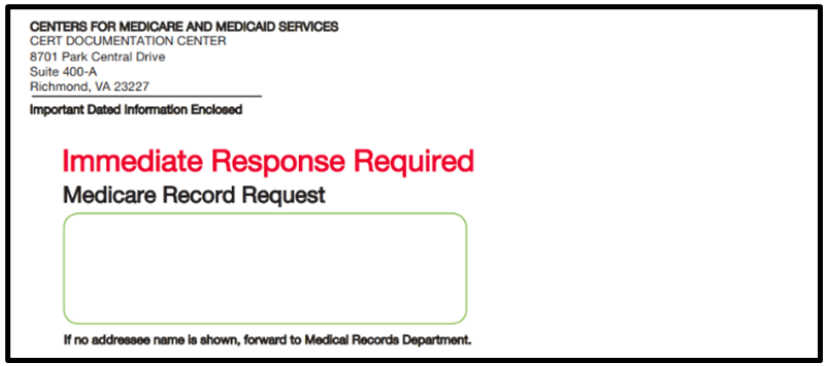
CERT's Response:

- CERT will email/call the POC with a list of outstanding CID numbers
- When requested, the CERT CSR will forward a copy of documentation request letters to the POC

Responding to CERT Request

Responding to a CERT requests is <u>not</u> optional, it is required by CMS

- This is not a HIPPA violation
- Patient authorization is not required to respond
- Billing providers, are responsible for obtaining medical records from third parties (e.g., hospitals, nursing homes, etc.)
- A reply is still required if records can't be located
- Contact the CERT Documentation Center at 888–779–7477, if you have questions regarding requested documentation


CENTERS FOR MEDICARE AND MEDICAID SERVICES
CERT DOCUMENTATION CENTER
8701 Park Central Drive
Suite 400-A
Richmond, VA 23227

Important Dated Information Enclosed

Immediate Response Required
Medicare Record Request

If no addressee name is shown, forward to Medical Records Department.

Major Joint Replacement or Reattachment of Lower Extremity

- The primary reason for these errors is inpatient admission wasn't medically necessary when the invasive procedure should've been billed as an outpatient procedure
- Review of the medical record must indicate that inpatient hospital care was medically necessary, reasonable, and appropriate for the diagnosis and condition of the beneficiary at any time during the stay
  - **The beneficiary must demonstrate signs and/or symptoms severe enough to warrant the need for medical care and must receive services of such intensity that they can be furnished safely and effectively only on an inpatient basis**

Total Hip Arthroplasty/Total Knee Arthroplasty

DOCUMENTATION TO SUPPORT REASONABLE/NECESSARY

- The treating physician must discuss the significant benefits and risks with the patient
- To meet Medicare's reasonable and necessary (R&N) threshold for coverage of a procedure
  - The physician's documentation for the case should clearly support both the diagnostic criteria for the indication (standard test results and/or clinical findings as applicable) and,
  - The medical need (the procedure does not exceed the medical need and is at least as beneficial as existing alternatives and the procedure is furnished with accepted standards of medical practice in a setting appropriate for the patient's medical needs and condition).

OBJECTIVE FINDINGS TO INCLUDE IN THE PHYSICAL EXAMINATION

- Any deformity
- Range of motion
- Crepitus
- Effusions
- Tenderness
- Gait description (with or without mobility aides)
- Include any test that were given (plain radiography and pre-operative imaging studies)

LCD 33456 Total Joint Arthroplasty
LCA 56777 Total Joint Arthroplasty

Inpatient Hospital Stay

- Authenticated history and physical
- Authenticated M.D. inpatient admission order
- MD progress notes
- Labs/MAR
- Operative report
- Provider emergency records if applicable
- Case management, discharge planning, or social worker notes
- Consult records (**Signed preoperative provider office notes, diagnostic/X-ray or imaging reports that support the medical necessity for billed surgery**)

Inpatient Hospital Stay

Most common denials related to this service:

- The documentation submitted for review did not support the medical necessity of the services provided
- Submitted documentation does not support that all services were medically necessary on an inpatient basis instead of a less intensive setting
- Insufficient documentation to support services provided or codes billed

Inpatient Rehabilitation Facility (IRF)

- Admission and all other orders
- Team conference notes with legible signatures
- Pre-admission screening
- Overall individualized plan of care/update plan of care
- H&P/post-admission physician evaluation (PAPE no longer required)
- MD progress notes and DC summary
- PT, OT evaluations, treatment notes, POCs and DC notes
- Team conference, nursing, and case management notes
- IRF-PAI
- MAR/Diagnostic testing results

Inpatient Rehabilitation Facility (IRF)

CERTIFICATION/RECERTIFICATION

There is a difference in the content of the certification and recertification statements. The required physician's statement should certify that the IPF admission was medically necessary for either

- Treatment which could reasonably be expected to improve the patient's condition
- Diagnostic study

The physician's recertification should state each of the following. That inpatient psychiatric hospital **services furnished since the previous certification or recertification were, and continue to be**, medically necessary for either

- Treatment which could reasonably be expected to improve the patient's condition
- Diagnostic study

LCD 34570 PSYCHIATRIC INPATIENT HOSPITALIZATION

Inpatient Psychiatric Facilities (IPF)

- Initial Psychiatric Evaluation
- Physician Orders
- Plan of Treatment
- Progress Notes
- Physician Progress Notes
- Individual and Group Psychotherapy and Patient Education and Training Progress Notes
- Discharge Plan

Hyperbaric Oxygen Therapy (HBOT)

COVERAGE REQUIREMENTS

HCPC: G0277

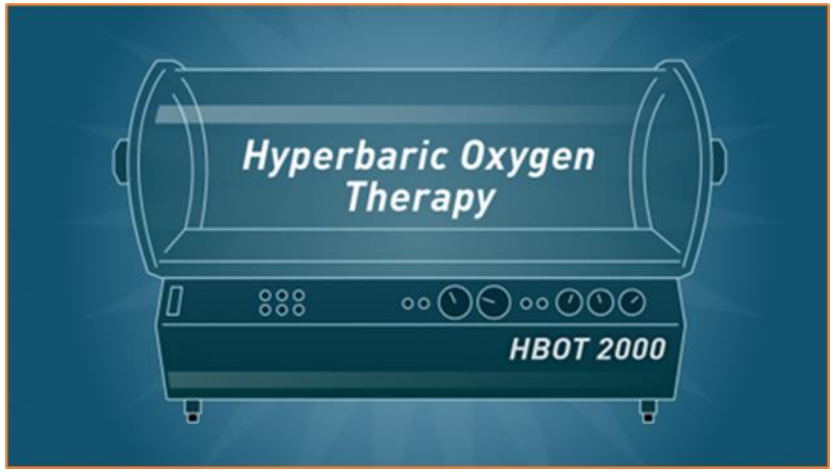
Revenue Code: 0413

TOB: 13x (Hospital Outpatient)

Billed in 30-minute intervals

- ✓ 30 minutes = 1 unit
- ✓ 2 hours = 4 units

- Hyperbaric chambers are medical devices that require FDA clearance
- FDA: Hyperbaric Oxygen Therapy: Get the Facts



HBO Physician Responsibilities

PRIMARY PHYSICIAN

Must:

- Provide direct supervision per CMS requirements as an outpatient service
- Must be readily available to provide immediate physical presence for assistance and direction through out the procedure
- Personally see the patient periodically to assess
- Treatment course
- Patient's progress
- Make any necessary changes to the treatment regimen

- Provide a signed and dated order for therapy to be administered
- Progress notes
- History & Physical (HP) and any other pertinent clinical documentation
- Diagnostic testing to confirm the diagnosis and support medical necessity

NCD — Hyperbaric Oxygen Therapy (20.29)

Drugs and Biologicals

- Include relevant history and physical to support the **medical necessity** of administration and/or dose of the drug (including any testing to support diagnosis)
  - **Relevant clinical signs and symptoms related to the medical condition for which the drug is indicated**
- Include a physician certified diagnosis that supports the need for the drug
- Signed physician order for drug/biological
- Order for protocol, if applicable
- Diagnostic test results that support medical necessity, when applicable
- Documentation of medication administration
- Document discarded amount (when applicable)
- Include documentation/signature of supervising provider

Dialysis

- Treatment records for each visit
- POC documenting education and training
- Home dialysis order/home treatment logs
- Progress notes
- Assessment report
- Authenticated physician/NPP's visit/progress notes
- Signed order or protocol orders

Extracapsular Cataract Removal

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

Extracapsular Cataract Removal with Insertion

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

E/M

Should identify the patient, date of service and provider of service.

Should be clear, concise and reflect the patient's condition.

Documentation should substantiate the service performed/billed.

Documentation should substantiate the diagnosis code billed.

Document time

- In and out time
- Total time

**If billing based on time, include documentation that reflects the entire visit with a clear explanation of what occurred during the visit and the plan.*

Evaluation and Management (E/M)

- Documentation does not support the level of service billed — Incorrect coding
- Documentation did not support medical necessity
- Insufficient documentation
- No documentation received
- Unsigned medical record encounter

Medical necessity is the primary reason Medicare pays for a service. It is not medically necessary or appropriate to bill a higher level of E/M service when a lower level of service is more appropriate.

Outpatient Therapy

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

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

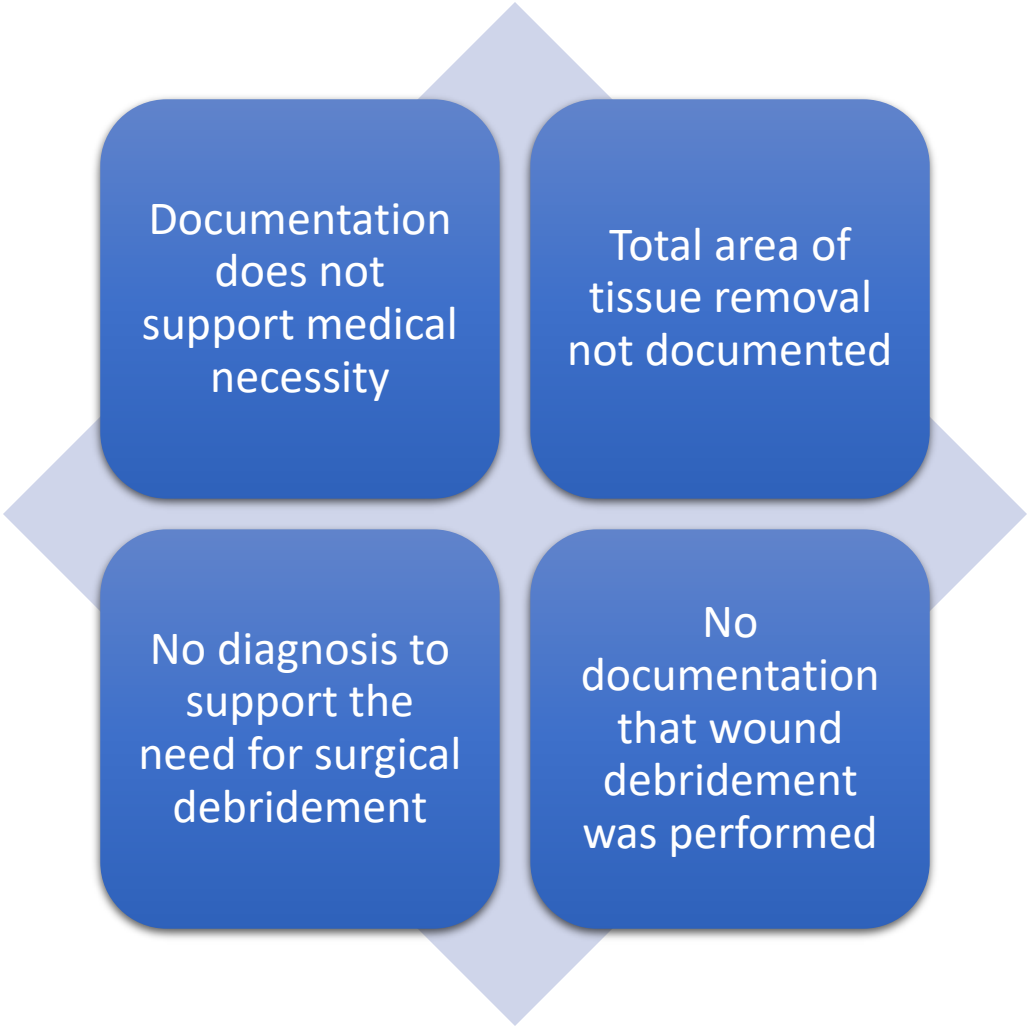
ESRD — Monthly Outpatient ESRD — Related Services

- Missing comprehensive assessment/reassessment of the beneficiary relative to the DOS developed by Interdisciplinary team
- No Plan of Care for home dialysis relative to the DOS developed and signed by at least one team member and the beneficiary or their designee
- Documentation did not support a face-to-face visit
- Not submitting the monthly comprehensive note from the billing provider
- Incorrectly billed ESRD MCP claim prior to the end of the month

Surgical Debridement

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

Surgical Debridement



Drugs of Abuse Testing

Adhere to requirements outlined in Local Coverage Determination: L35724

Document the covered indication

Document medical necessity

Documented risk assessment

- **The patient's risk category must be clearly defined in the medical record is essential in determining the number of UDTs billed over time and medical necessity**

Code Descriptors for Time

- A timed code requires not only the service performed, but also the time spent. The procedure description may include several types of wording:
- Typical time — must meet the midpoint for the time identified
    - **15 minutes — would need at least eight minutes**
- At least — must meet the minimum time reported
    - **At least 15 minutes**
- Specific time — must meet the minimum time required
    - **5–10 minutes**
- Cumulative time
    - **30 minutes in a calendar month**

Stay Prepared

Know where previous improper payments have been found.

Know if you are submitting claims with improper payments.

Prepare to respond to all additional documentation requests.

Look to see what improper payments have been found in OIG and CERT reports.

Check on the status of your additional documentation.

Be sure to keep your address up to date within PECOS.

Documentation Tips

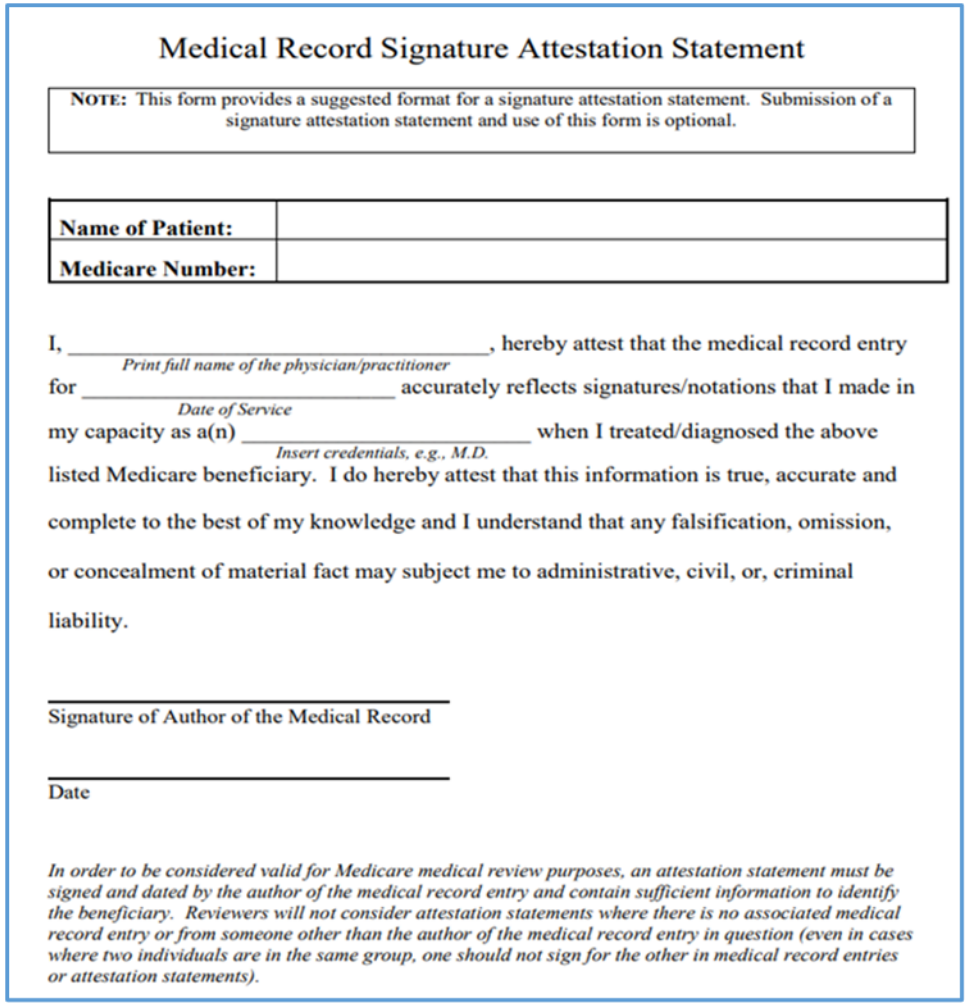
Audit Proof Your Documentation

- Design an internal quality control record review
- Establish protocols and procedures
- Identify key personnel
- Implement the process
- Develop a checklist for documentation based on the information in this session
- Design and fix bad habits
- Keep records of the results of the audits
- Educate staff on what to look for when submitting medical records
- Educate professional medical staff on proper elements of documentation, especially signatures

Attestation Letters

Are you familiar with signature attestation statements?

- CMS does not require or instruct providers to use a certain form or format for attestation forms
- CERT has a downloadable PDF available for providers
- CERT C3Hub/Attestation Letters



Medical Record Signature Attestation Statement

NOTE: This form provides a suggested format for a signature attestation statement. Submission of a signature attestation statement and use of this form is optional.

Name of Patient:	
Medicare Number:	

I, _____, hereby attest that the medical record entry
Print full name of the physician/practitioner
for _____ accurately reflects signatures/notations that I made in
Date of Service
my capacity as a(n) _____ when I treated/diagnosed the above
Insert credentials, e.g., M.D.
listed Medicare beneficiary. I do hereby attest that this information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or, criminal liability.

_____
Signature of Author of the Medical Record

_____
Date

In order to be considered valid for Medicare medical review purposes, an attestation statement must be signed and dated by the author of the medical record entry and contain sufficient information to identify the beneficiary. Reviewers will not consider attestation statements where there is no associated medical record entry or from someone other than the author of the medical record entry in question (even in cases where two individuals are in the same group, one should not sign for the other in medical record entries or attestation statements).

Things to Know to Avoid CERT Errors

Avoid general payment errors by ensuring that:

- You are aware of CERT requests
- Updates are made to your contact information when necessary
- The original barcoded cover sheet is used when responding to request
- Documentation should be received within 45 days from the date of CERT's initial request

PLACE THIS BARCODED COVER SHEET IN FRONT OF THE RECORD

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

CID: 0000000

Due Date: 5/4/2023
Medicare Part {A|B} Provider or Medicare DME Supplier
Patient Name: Patient Name
Date of Birth: 11/20/1950
Date of Service: 10/15/2020 - 10/16/2020
Claim Control Number: 000000000000000
Universe Date: 11/20/2020
Request Date: 4/19/2023
Contractor Number: 00000
Contractor Type: {A|B|D}
Billing Provider NPI: 0000000000
Letter Sequence: ADR to Billing Provider (First Request)

Please send documentation to:
Fax #: 804-261-8100 or
Mail: CERT Documentation Office - Attn: CID # 0000000 , 8701 Park Central Drive, Suite 400-A, Richmond VA 23227
Phone #: 888-779-7477

Consequences: If the provider/supplier fails to send the requested documentation or contact CMS by the Due Date specified above, the provider's/supplier's Medicare contractor will initiate claims adjustments or overpayment recoupment actions for these undocumented services.

Please provide the name and contact phone number of the individual submitting the documents in support of this request. This information may be used if additional information is necessary.

NAME: _____ Contact Phone Number: _____

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

Missing:
List of documentation still needed by CERT.

Received:
List of documentation received by CERT.

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

Palmetto GBA CERT Resources

Palmetto GBA

Comprehensive Error Rate Testing (CERT)

- Announcements and Reports
- CERT MAC Task Force
- Checklists
- Documentation
- Frequently Asked Questions
- Modules and Videos
- Tips

Provider Minute: Utilizing Your MAC (youtube.com)

CERT MLN Resources

Understanding Targeted Probe & Educate (TPE)

PALMETTO GBA®
A CELERIAN GROUP COMPANY

Daliyl Skinner
Operational Services Director

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Agenda

- Medical Review
- Targeted Probe and Educate (TPE)
- Data Strategy and Edit Effectiveness
- Additional Documentation Request (ADR)
- Common Errors

Medical Review

Medical review involves the collection and clinical review of medical records and related information to ensure that payment is made only for services that meet all Medicare coverage, coding, billing, and medical necessity requirements

- Designed to prevent improper payments and protect the Medicare Trust Fund
- Medical reviews identify and address errors through claims analysis and/or medical record review activities
- A Medicare contractor may use any relevant information they deem necessary to make a prepayment or post-payment claim review determination, including documentation submitted with the claim or through and additional documentation request

Medical Review and Education | CMS

Goal of Medical Review

- Proactively identifies patterns of potential billing errors concerning Medicare coverage and coding made by providers through data analysis and evaluation of other information (e.g., complaints)
- Reviews data analysis reports

- Takes action to prevent and/or address the identified error
- Publishes local medical review policies via Local Coverage Determinations (LCDs) to provide guidance to the public and medical community about when items and services will be eligible for payment under the Medicare statute

Targeted Probe and Educate (TPE)

CMS's Targeted Probe and Educate (TPE) program is designed to help providers and suppliers reduce claim denials and appeals through one-on-one help.

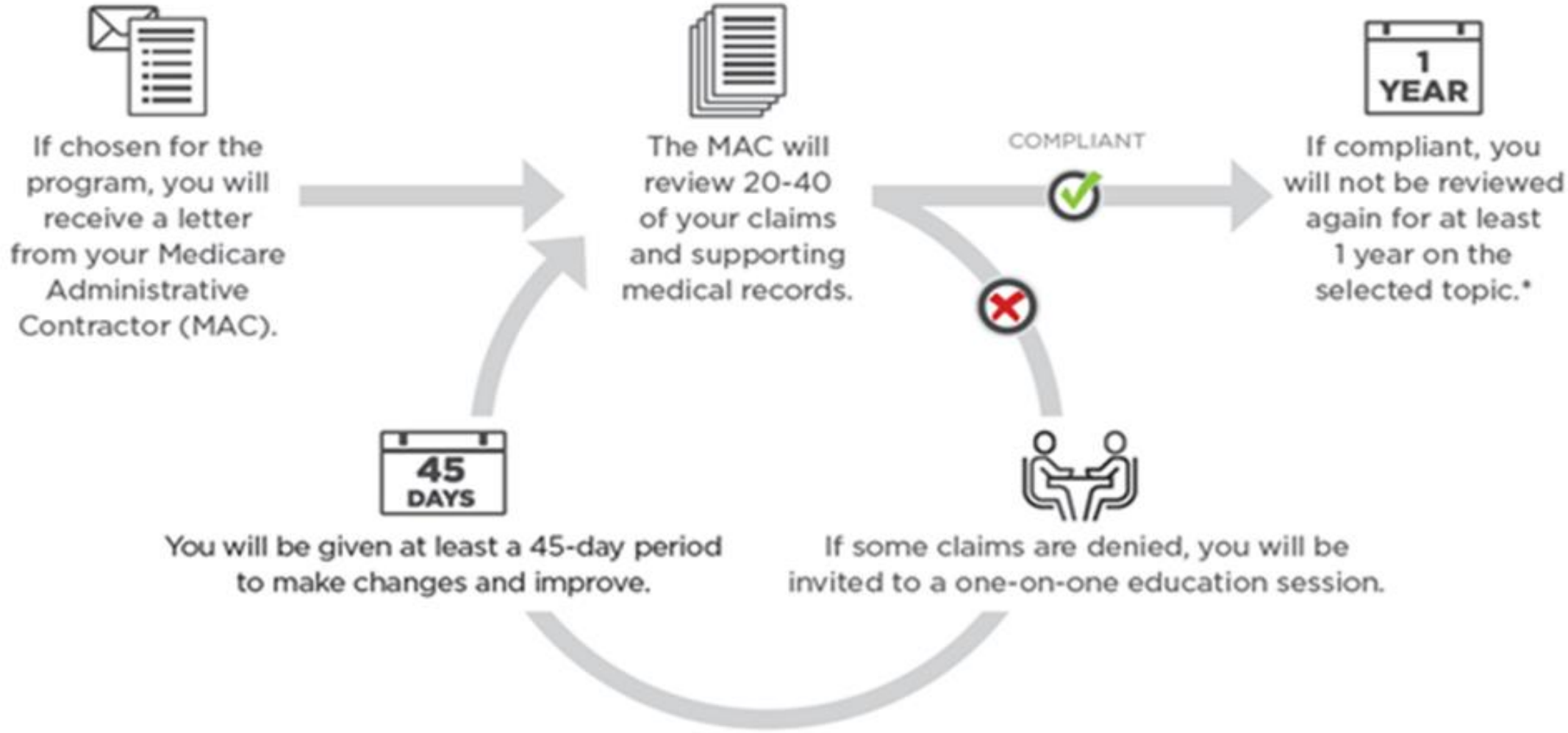
Who Conducts the TPE Reviews?

- Registered Nurses
- Clinical Therapists (PT, OT, ST)
- Certified Coders

Most providers Will Never Need TPE

- TPE is intended to increase accuracy in very specific areas. MACs use data analysis to identify:
  - Providers and suppliers who have high claim error rates or unusual billing practices
  - Items and services that have high national error rates and are a financial risk to Medicare
- Providers whose claims are compliant with Medicare policy won't be chosen for TPE

How Does It Work?



Data Strategy and Edit Effectiveness

- Define/Measure/Analyze/Improve and Control
  - Analysis of data and evaluation from independent resources
  - Measure
  - Analyze
  - Improve
  - Control

Define

Analysis of Data

- Provider, service and beneficiary specific
- Historical Claims Data
    - National, regional and state
- Utilization trending and patterns
    - High volume / cost
    - Change in frequency
- Evaluation from independent resources

- Reports from CMS and other government agencies
    - Office of Inspector General (OIG)
    - Government Accountability Office (GAO)
- Reports from other contractors
    - Comprehensive Error Rate Testing (CERT)
    - Recovery Auditor
- Jurisdiction Specific Prioritization Reports

Measure

- Once risks are identified medical review of claims may be initiated
  - Validate issues
    - Targeted Probe and Educate (TPE)
    - Review of 20–40 claims
- Establish benchmarks

Analyze

Review edit effectiveness reports for reviewed claims once universe of claims in the selected sample are completed.

Improve

One-on-one provider specific education

- Education by Medical Review
- Providers with moderate and high error rates will continue to a second round, followed by additional education
- Based on results a provider may be advanced to a third round

Control

- After completion of TPE providers will be monitored by continued data analysis to ensure compliance with Medicare coverage guidelines
- We at Palmetto GBA, will strive to manage effective programs and communication to work toward improving performance of both ourselves and you, the providers we serve

Active Medical Review List and Denial Codes

- Navigate Palmetto GBA website — Palmetto GBA
- Select your jurisdiction
  - Ala., Ga. or Tenn. — Jurisdiction J Part A
  - N.C., S.C., Va or W.Va. — Jurisdiction M Part A
- Access Medical Review found under Topics tab
  - Jurisdiction M Part A — Medical Review
  - Jurisdiction J Part A — Medical Review
- Articles will populate on landing page

Additional Documentation Request

- Per the Social Security Act, Sections 1815(a), 1833€ and 1962 (a)(1)(A), providers are required to submit medical record documentation to support claims for Medicare services to the Medicare Administrative Contractor (MAC) upon request
- This is done by our Medicare medical review contractors through an Additional Documentation Request (ADR)

TPE

- If selected for TPE, the provider will receive a Notice of Review/TPE letter addressed to the Medicare provider of compliance officer
- Please ensure the process for routing this information to the person(s) who should receive the notification is timely and effective
- The ADR will outline the information specific to the service and claim selected for review

How to Respond to an ADR

Submit a “Medical Review ADR Response” cover sheet

- **Jurisdiction J Part A** **Medical Review ADR Response Cover Sheet**
- **Jurisdiction M Part A** **Medical Review ADR Response Cover Sheet**

How to Respond to an ADR

Timeframe to submit additional documentation is 45 days from the date of the request, located in the upper right-hand corner of the ADR letter

- Submit the ADR cover letter with EACH separate claim and associated attached documentation
- Ensure each packet submitted has:
  - One identified beneficiary on the ADR letter
  - The Correct Dates of Service (DOS) specified on the ADR letter
  - The Point of Contact form filled out in its entirety which is contained within the ADR

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

ADR Response Calculator

- There is an ADR response calculator located on the Palmetto GBA site and can be found under Tools

- Palmetto GBA may accept documentation received after 45 calendar days for good cause. Good cause means situations such as natural disasters, interruptions in business practices, or other extenuating circumstances that the contractor deems good cause in accepting the documentation.

Instructions for Document Submission

- We recommend you include the original ADR with your response
- The ADR will include a list of recommended documentation to submit in response to ADR
- The ADR advises the provider to submit the name of the Point of Contact for their facility/agency and their contact information (direct number, email address)
- The records should be submitted to Palmetto GBA Medical Review via one of the methods listed in this presentation

- Providers are responsible for obtaining supporting documentation from third parties (hospitals, nursing homes, suppliers, etc.)
- Patient identification, date of service and provider of the service should be clearly identified on the submitted documentation

Instructions for Document Submission

- Medicare requires that medical record entries for services provided/ordered be authenticated by the author
- The method used shall be a handwritten or electronic signature. If you question the legibility of a signature, submit an attestation statement in the ADR response. If there is a signature log, submit that as well.
- If signature requirements are not met, the reviewer will conduct the review without considering documentation with the missing or illegible signature

- This could lead the reviewer to determine that the medical necessity for the service billed has not been substantiated
- Electronic submissions are the preferred method as they can be received in a timely matter
- Stamped signatures are not acceptable

Medicare Provider Integrity Manual Chapter 3 Section 3.3.2.4

Submission Methods

VIA ESERVICES PORTAL

Visit the eServices portal on our website to sign up or log in to eServices.

https://www.palmettogba.com/eservices

VIA ESMD

Include a copy of the ADR with your documents.

Learn more on the esMD website.

https://www.cms.gov/esMD

Submission Methods

JURISDICTION J PART A

JJA Fax: (803) 870–0131

U.S. Mail

Palmetto GBA
Part A Medical Review
Mail Code AG-230
P.O. Box 100305
Columbia, SC 29202-3305

Overnight Mail

Palmetto GBA
Part A Medical Review
Mail Code AG-230
2300 Springdale Dr., Bldg. 1
Camden, SC 29020

JURISDICTION M PART A

JMA Fax: (803) 699–2432

U.S. Mail

Palmetto GBA
Part A Medical Review
Mail Code AG-230
P.O. Box 100238
Columbia, SC 29202-3238

Overnight Mail

Palmetto GBA
Part A Medical Review
Mail Code AG-230
2300 Springdale Dr.
Camden, SC 29020

Results and Education

- During the probe review, the reviewer may contact the designated POC for any missing information or to provide education on a specific claim or issue identified
- If a complete documentation package has been submitted or no education requirement was identified during the probe, the reviewer will not contact you during the probe
- Providers will receive an education letter at the conclusion of each reviewed claim with the individual claim specific results and any applicable education
- At the conclusion of the 20–40 claim review, cumulative results for the 20–40 claims reviewed will be issued and the Medical Review clinician will contact the provider POC to schedule a 1:1 education session
- If after the 1:1 education session, further education is desired an education request form can be found online for further assistance from our Provider Outreach and Education department

Tips When Responding to TPE ADRs

- Be prompt. Respond to ADRs within 45 days from the date of your request letter.
- Keep your contact information up to date
- Include ADR letter
- Use the Medical Review ADR Response cover sheet (jurisdiction-specific)

TPE ADR Tips

- When sending multiple claim ADR responses, you must use one ADR response cover sheet for each ADR claim (one cover sheet per claim) and submit each ADR separately
- Include the ADR letter and all documentation relating to the requested date of service (including related physician orders and requested medical records)
- Ensure signatures are legible or include appropriate signature attestations

DO NOT…

- Do not initially respond to an ADR to the Appeals Department. Initial responses should always go through Medical Review.
- Do not resubmit replacement of duplicate forms for claims you may have pending in medical review as duplicate ADR responses are not accepted
- Do not submit more than one ADR per response

Next Steps

Frequently check for communication in eServices as ADRs and other letters are delivered via the portal.

Not Responding

As outlined in **42 CFR § 405.930 Failure to respond to additional documentation request**, if a contractor gives a provider or supplier notice and time to respond to an additional documentation request and the provider or supplier does not provide the additional documentation in a timely manner, the contractor has authority to deny the claim.

Common Errors

The signature of the certifying physician was not included

Documentation does not meet medical necessity

Encounter notes did not support all elements of eligibility

Missing or incomplete initial certification or recertification

TPE Denial Codes

Denial Codes	Descriptions
5D169/5H169	Insufficient Documentation
5D165/5H165	No Physician Certification/Recertification
5D151/5H151	Units Billed More Than Ordered
5D164/5H164	No Documentation of Medical Necessity
5D700	No Valid Plan of Treatment Present
5D800	Inpatient Psychiatric Services Not Medically Necessary
5D650/5H650	No Valid Certification/Recertification Present
56900	Requested Records Not Submitted Timely
5DMDP/5HMDP	Dependent Services Denied (Qualifying Service Denied Medically)
5D920/5H920	The Recommended Protocol Was Not Ordered and/or Followed

TPE Denial Codes

Denial Codes	Descriptions
5D199/5H199	Billing Error
5J502/5K502	Information Submitted Does Not Support Dates Billed
5J504/5K504	Need For Services Not Medically and Reasonably Necessary
5FFSG	Missing or Illegible Signature
5D504	Not Medically and Reasonably Necessary
5D510	No Evidence of at Least Three Consecutive Day of Inpatient Hospital Stay
5DTDP/5HTDP	Dependent Services Denied (Qualifying Service Denied Tech

Denial 56900 Requested Records Not Timely Submitted

If you want to submit an ADR for a claim that has already received denial code 56900, you need to first submit to Medical Review and not to appeals.

Documentation Tips

Audit-Proof Your Documentation

- Design an internal quality control record review
- Establish protocols and procedures
- Identify key personnel
- Implement the process
- Develop a checklist for documentation based on the information in this session
- Design and fix bad habits
- Keep records of the results of the audits
- Educate staff on what to look for when submitting medical records
- Educate professional medical staff on proper elements of documentation, especially signatures

Signature Tips

- Signatures may be handwritten or electronically signed
  - **Exceptions for stamped signatures are described in MLN Matters article MM8219**
- Do not add late signatures to a medical record
  - **Consider using the signature authentication process outlined in MLN Matters article MM6698**

Resources

- CMS Publication 100-08, Medicare Program Integrity Manual, Chapter 3 (PDF)
- Medical Review and Education | CMS
- Jurisdiction M Part A — Medical Review
- Jurisdiction J Part A — Medical Review
- Jurisdiction J Part A — ADR Response Calculator (palmettogba.com)
- Jurisdiction M Part A — ADR Response Calculator
- Medical Review ADR Response Cover Sheet
- Welcome to the Medicare Provider Enrollment, Chain, and Ownership System (PECOS)
- Provider Enrollment, Chain, and Ownership System (PECOS)

A/B Cardiac Procedures

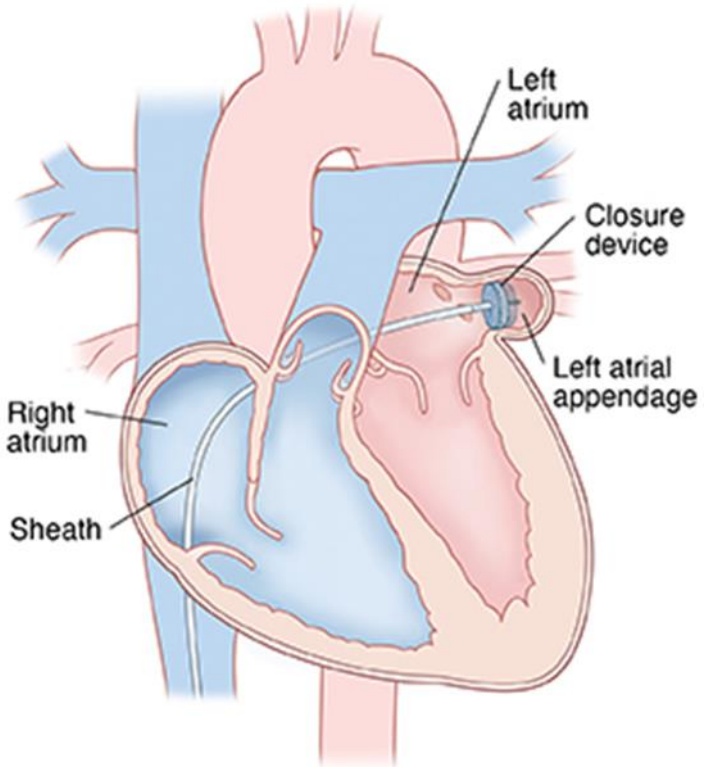
PALMETTO GBA®
A CELERIAN GROUP COMPANY

Dr. Jennifer Abrams
Sr. Medical Director and
Chief Medical Officer

Frequently Used Acronyms

Acronym	Description
AF	Atrial Fibrillation
ASD	Atrial Septal Defect
AV	Aortic Valve
CVA	Cerebral Vascular Accident
ICD	Implantable Cardiac Defibrillator
LA	Left Atrial
LAA	Left Atrial Appendage
LAAC	Left Atrial Appendage Closure
LAAO	Left Atrial Appendage Occlusion
LCD/NCD	Local/National Coverage Determination
IOM	Internet Only Manual
MR	Medical Review
SDM	Shared Decision Making
TAVR	Trans Aortic Valve Replacement

Left Atrial Appendage Closure (LAAC)



LAAC

- LAAC is a minimally invasive procedure
  - **Also know as Left Atrial Appendage Occlusion, LAAO**
- During the procedure, the left atrial appendage of the heart is sealed. The left atrial appendage serves no known function. It is the main site of blood clot formation in Atrial Fibrillation (AF).
- The Left Atrial Appendage (LAA) is a trabeculated long tubular structure that opens into the left atrium through a narrow connection and is a potential source of blood clot formation

LAAC

- The procedure is used for beneficiaries with non-valvular AF who are at high risk for cerebrovascular accidents, CVAs (stroke). It is an alternative to oral anticoagulation therapy.
- The sealing of the appendage prevents blood from pooling in the heart and thus decreases clot formation. This decrease in clot formation decreases the risk of stroke.
- Guidance can be found in NCD 20.34
- Typically, this procedure is performed under general anesthesia

LAAC

- *Lariat: Epicardial device delivered by catheter insertion within the LAA
  - Requires CT prior to procedure
- Sierra Litigation System: Epicardial device, subxiphoid access
- PLAATO: Nitinol device, a self expanding metal cage
  - Withdrawn from market in 2006
- *Watchman (or) Amplatzer Cardiac Plug: Catheter insertion within the LAA
- Wave Crest: Nitinol device placed in the neck of the LAA

- Occlutech LAA Occluder: Conical shaped nitinol self expanding mesh
- Lamber LAA Closure System: Nitinol device with a LA cover and self-expanding umbrella
- Ultraseal LAA Closure Device
- PFM Device: nitinol frame device
- *Surgical Clamping
  - Not a minimally invasive procedure

* Will be discussed further

Lariat Procedure

The Lariat Procedure involves guiding a catheter through the blood vessels to the Left Atrial Appendage in the heart. The catheters are used to tighten a loop (pre-tied sutures) around the mouth (opening) of the LAA, ligating the appendage and sealing it off from the rest of the heart and preventing blood from entering the appendage. Without the blood pooling, the risk of clot formation is substantially decreased.

Watchman (or) Amplatzer™ Cardiac Plug

- Watchman: A tiny, umbrella-shaped device. It is delivered to the heart through a catheter. The catheter is positioned at the opening of the LAA where the Watchman is implanted in the LAA to block the blood from entering the LAA.
- Amplatzer™ Cardiac Plug is implanted into the LAA via a catheter to prevent blood flow into the LAA. This plug is shaped differently than the Watchman.

Surgical Clamping

- Not a minimally invasive procedure
- Usually requires open heart surgery and is performed when having another procedure such as coronary bypass surgery or valve surgery
- In this procedure, the LAA is clamped off from the rest of the heart preventing blood flow to the appendage

Post-Procedure

- After a Lariat or Watchman procedure, a TEE (transesophageal echocardiogram) will be done to be sure the procedure was a success and there is no longer blood flow to the appendage
- The TEE will also check to ensure that no blood/ blood clots remain in the sealed off appendage
- Blood thinners will be prescribed for a period of time following the procedure to keep the blood from clotting
- Daily aspirin regime is recommended to be taken indefinitely to reduce risk of clot formation elsewhere in the heart

Indications

- Atrial Fibrillation (AF) patients at risk for bleeding on anti-coagulants
- Thromboembolic events in AF patients on oral anticoagulants
- AF Patients with high probability of non-compliance with oral anticoagulants
- AF patients who have oral anticoagulant intolerance
- The depth of the LAA must be greater than the width for optimal deployment of the device

Contraindications

- AF patients with low risk for stroke
- AF Patients with Valvular Heart Disease (e.g., Mitral Stenosis)
- LA Thrombosis present at the time of the procedure
- LA tumor
- Active infection
- ASD (Atrial Septal Defect)
- Prior patent foramen ovale (PFO)

Contraindications (cont.)

- Patient on oral anticoagulants for other indications
- Depth of the LAA is significantly shorter than the width of the ostium of the LAA
- Patients unable to tolerate short term anticoagulation post-LAAC procedure

Complications

- Pericardial Effusion (1.2–5% incidence)
  - **Managed by pericardiocentesis**
- Cardiac Tamponade
- Device-related thrombus (Up to 14% of cases)
  - **Managed with a longer course of anticoagulation**
- Device embolization (Up to 3.5% incidence)
  - **Management by transcatheter removal**

Complications (cont.)

- Persistent Atrial Septal Defect (ASD)
  - **11% at six months**
  - **7% 12 months post-procedure**
- Cardiac Perforation (0.4% occurrence)
- Procedure related CVA (Up to 1.1%)
- Less common
  - **Procedure-related death**
  - **Hematoma/bleeding**
  - **AV fistula formation**

CHADS2 and CHA2DS2 VASc Score

Used in beneficiaries with Atrial fibrillation as a non-pharmacologic treatment

Devices are covered when FDA pre-market approval conditions are met:

- CHADS2 score ≥ 2
  - Congestive heart failure/Hypertension
  - Age > 75
  - Diabetes
  - Stroke/transient ischemia attack/thromboembolism
  - Vascular disease
  - Sex category

- CHA2DS2-VASc score ≥ 3
  - Congestive heart failure/Hypertension
  - Age ≥ 65
  - Diabetes
  - Stroke/transient ischemia attack/thromboembolism
  - Vascular disease
  - Sex category

CHA2DS2-VASc-Assessment-QI-Toolkit-UCM_490779.pdf

NCD 20.34

- A documented formal shared decision-making interaction with an independent non-interventional physician using an evidence-based tool on oral anticoagulants, in a beneficiary with non-valvular AF (NVAF)
- Beneficiary unsuitable for long-term anticoagulants following the conclusion of shared decision-making (SDM) encounter
  - **LAAC is only covered as a second line therapy to oral anticoagulants**

- Procedure must be performed by an interventional cardiologist, an electrophysiologist or cardiovascular surgeon (with proper training and criteria)

NCD 20.34 (cont.)

- Beneficiary is enrolled in, and the MDT and hospital must participate in, a prospective, national, audited registry that:
  - **1 — Consecutively enrolls LAAC patients**
  - **2 — Tracks the following annual outcomes for each patient for a period of at least four years from the time of the LAAC:**
    - Operator-specific complications
    - Device-specific complications including device thrombosis
    - Stroke, adjudicated, by type
    - Transient Ischemic Attack (TIA)
    - Systemic embolism
    - Major bleeding, by site and severity
    - Death

Key Points to Prevent Denials

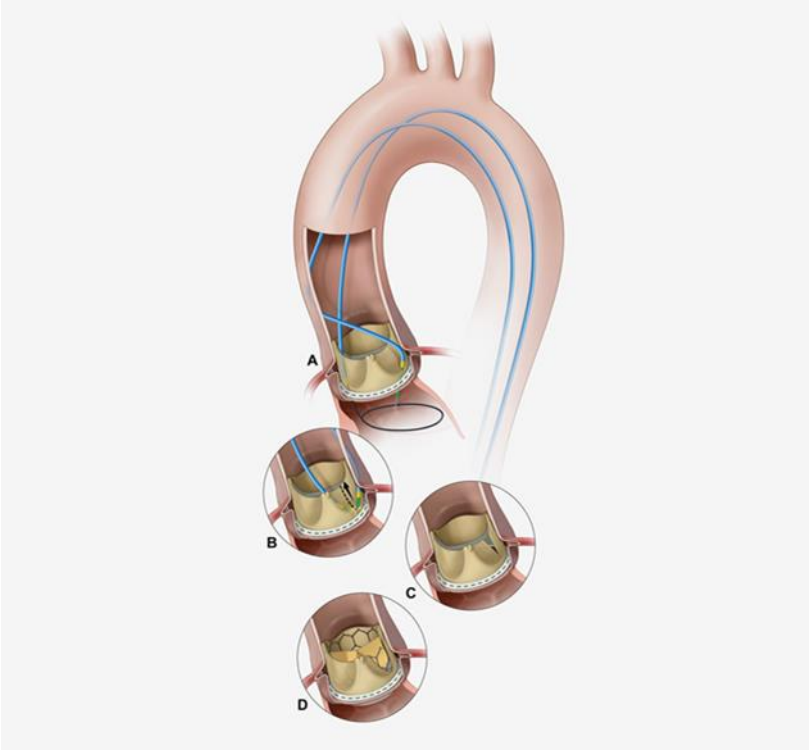
- SDM encounter must occur prior to the procedure
- Be performed by **non interventional** physician
  - **NCD decision memo (CAG-00045N) states, "The shared decision-making interaction will be augmented with the addition of non-interventional providers that either have a relationship with the patient, such as the primary care provider, or those with experience caring for stroke patients, to the patient's care team"**
- Must be documented in the medical record
  - **Documentation that includes discussions with the patient and/or signed informed consent forms is insufficient**
  - **Tool used and score if tool not included**

Claim Denial Example

- Medical Records Submitted: 1. Authenticated 8/9/2022 EP H&P with documentation to support the need for Watchman device. 2. Authenticated Physician's Discharge summary. 3. Authenticated Physician's Operative report. 4. Authenticated Physician's Inpatient admission order. 5. Labs. 6. MAR.

- Medical Review Decision — Missing: 1. A formal shared decision-making interaction with an independent non-interventional physician using an evidence-based decision tool on oral anticoagulation in patients with NVAF prior to LAAC

Transcatheter Aortic Valve replacement (TAVR)



TAVR

- Minimally invasive procedure
- Usually, an outpatient procedure or a single overnight visit
- Also known as TAVI, Transcatheter Aortic Valve Implantation
- The TAVR replaces an improperly functioning aortic valve with a new bioprosthetic valve
- Access is through the femoral artery, the transapical artery, subclavian artery, carotid artery or the vena cava through caval access (rarely, the septal approach may be utilized)

TAVR

- Treats Symptomatic Aortic Stenosis, the narrowing of the aortic valve. This can cause chest pain, shortness of breath, and results in cardiomegaly amongst other issues.
- Guidance can be found in NCD 20.32
- Aortic stenosis is caused by the progressive calcification of the aortic valve. It is a common cause of left ventricular outflow obstruction.

TAVR

- Prior to the availability of the TAVR procedure, for the patients deemed inoperable, the only option for treatment was palliative diuretics and balloon valvuloplasty. These options had no affect on long-term outcomes.
- Initially, this procedure was only offered to those who were deemed too high risk for open heart surgery. Now includes all patients with severe aortic stenosis, regardless of surgical risk.

TAVR

- This procedure requires a multi-disciplinary team, consisting of a cardiologist, a cardiac surgeon, an interventional cardiologist as well as an echocardiographic imaging specialist, a cardiac anesthesiologist, and specialized nurses
- In addition, a cardiac electrophysiologist, neurologist, nephrologist and a vascular surgeon must be readily available during the procedure

TAVR

- Percutaneous access via the vascular system, done under conscious sedation or general anesthesia, during which, a catheter is utilized to insert the bioprosthetic valve in the orifice of the native aortic valve
- Prior to the procedure, a CTA (computed tomography angiography) of the chest, abdomen, and pelvis will be performed to determine valve size and to visualize vascularity to determine the best approach

As well, an echocardiogram, transthoracic, transesophageal will be done. Left heart catheterization may be done to determine invasive hemodynamic measurements and to rule out coexisting coronary artery disease

Post-Procedure

- TAVR is favored over SAVR (Surgical Aortic Valve Replacement) in overall mortality and stroke
- TAVR benefits over SAVR include
  - **Lower rate of CVA, acute kidney injury, and major bleeding.**
  - **Shorter length of stays**
- TAVR patients have a higher incidence in vascular injury, paravalvular regurgitation, and need for permanent pacemaker insertion

Indications

- Symptomatic aortic valve stenosis
- Rheumatic heart disease
- Bicuspid aortic valve
- Indicated in patients at high risk for open heart surgery
- Recommended in patients over 75 years of age, or with a history of congestive heart failure

Benefits

- Faster recovery than open heart procedures
- Quicker improvement of:
  - **Quality of life**
  - **Faster decrease of symptomatology (e.g., shortness of breath, fatigue, lightheadedness, lower extremity edema and chest pain)**

- Conduction disturbances resulting in the need for permanent pacemaker
- CVA
- Paravalvular leak
- Vascular site complications
- Bleeding
- Annular Rupture
- Left ventricular perforation
- Cardiac tamponade

PROCEDURE

- Need for surgery
- Myocardial infarction (MI)
- Acute kidney injury
- Infection
- Hypotension
- Death
- Damage and bleeding at the site of catheter insertion

Contraindications

- Infection of the Aortic Valve
- Significant, critical coronary artery disease that requires addressing
  - **The two procedures can be done in one open heart surgery**
- Patients less than 70 may require another valve replacement later in life
  - **Therefore, these patients are recommended to have SAVR**
- MI within the past month
- Congenital heart defects
- Recent TIA or CVA
- Severe kidney disease

NCD 20.32

- Used in the treatment of symptomatic Aortic Valve (AV) stenosis, must meet the following conditions:
  - Furnished with a complete AV and implantation system with FDA premarket approval

- Beneficiary must be under the care of a “heart team” (multidisciplinary group)
- Cardiac surgeon and interventional cardiologist **who must both meet face to face with the patient** for suitability and jointly perform the procedure as well as the necessary other provider groups.

NCD 20.32 (cont.)

- Surgery must be done in an appropriate hospital setting and infrastructure
- Heart team and hospital must participate in a prospective national, audited registry that
  - **Consecutively enrolls TAVR patients**
  - **Accepts all manufactured devices**
  - **Follows the patient at least one year**
  - **Complies with relevant human research subject regulations**
  - **Collects the data required**

Key Points to Prevent Denials

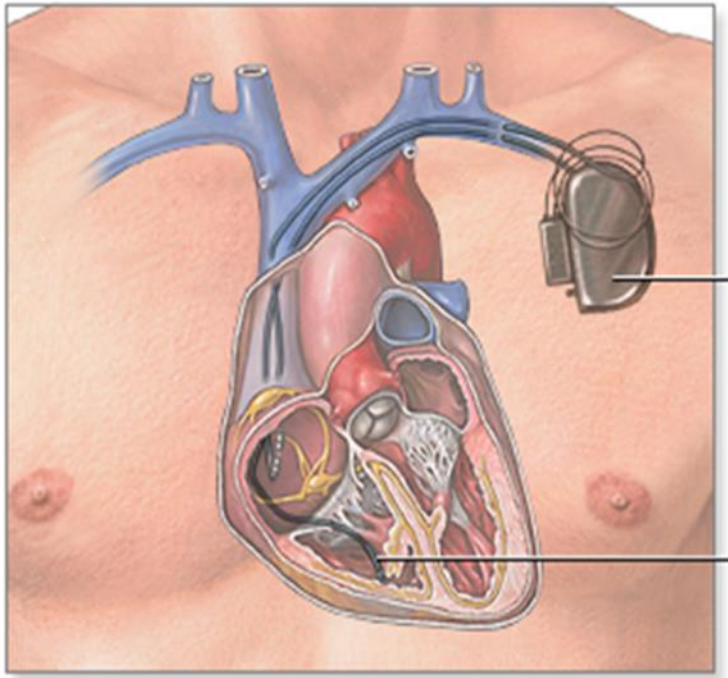
- There should be documentation of a multidisciplinary approach and of patient access to all forms of therapy for aortic valve disease (TAVR, SAVR, and palliative and medical care using an SDM process)
- NCD decision memo CAG-00430R states, “CMS requires a cardiac surgeon and an interventional cardiologist to evaluate the patient face to face to determine suitability for TAVR, SAVR or any other therapy that is in the best interest of the patient”
- Encounter must occur prior to the procedure

Common Denial Example

Medical Records Submitted: 1) History and Physical that does not provide documentation of required preoperative examinations by an independent Interventional Cardiologist regarding suitability for TAVR vs. open aortic valve replacement; 2) Operative Report that does not provide documentation of required preoperative examinations by an independent Interventional Cardiologist regarding suitability for TAVR vs. open aortic valve replacement; 3) Physician orders; 4) Progress Notes; 5) Nursing notes; 6) MAR; 7) Labs; 8) Discharge Summary.

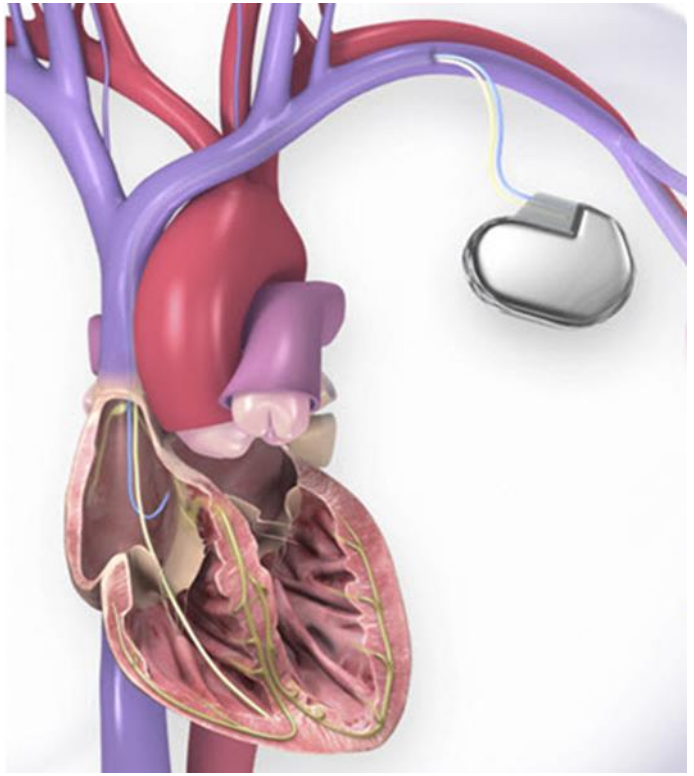
Medical Review Decision - Missing: 1) Independent examination of the patient, face-to-face, completed prior to surgery, 09/08/2022, including evaluation of the patient's suitability for TAVR vs. open aortic valve replacement (AVR) surgery and documentation of rationale for clinical judgment provided by an Interventional Cardiologist.

Implantable Cardioverter Defibrillator (ICD)



An implantable cardioverter-defibrillator (ICD) detects a rapid heartbeat coming from the bottom of the heart

A.D.A.M.



ICD

- Used to prevent sudden death in patients with high risk of life-threatening ventricular tachyarrhythmias such as ventricular tachycardia (VT) or ventricular fibrillation (VF)
- Transvenous ICDs are dual function, serving as both pacer and cardioverter
- Guidance can be found in NCD 20.4
- We will not cover leadless pacemakers NCD 20.8.4

ICD

- Battery powered device placed under the skin which monitors the heart rhythm. If an abnormal rhythm is detected, a, electric shock will be delivered to restore sinus rhythm.

Procedure

- Usually done with local anesthesia and conscious sedation
- Device is implanted in a subcutaneous pocket created on the chest wall, usually in the pectoral region. The device generator is implanted, then the leads are hooked to the generator at one end and the other end is inserted into the appropriate chamber of the heart via the subclavian vein.
- The device is then tested for defibrillation thresholds and optimization and the subcutaneous pocket is then closed
- Same day discharge or observed overnight

Indications

- Personal history of sustained VT or cardiac arrest due to VF without correctable causes
- Prior MI and a measured left ventricular ejection fracture (LVEF) of less than or equal to 30
- Severe ischemic, dilated cardiomyopathy w/o history of sustained VT or cardiac arrest due to VF, Class II or III heart failure, LVEF 35% or less
- Severe, non-ischemic cardiomyopathy, but no history of sustained VT or cardiac arrest due to VF and have Class III or IV heart failure, a LVEF of 35% or less

Indications (cont.)

- Documented history of familial or genetic disorder with a high-risk of life-threatening arrhythmias, such as sustained VT and VF, long QT syndrome, hypertrophic cardiomyopathy, Brugada Syndrome, cardiac sarcoidosis
- Left Ventricular (LV) dysfunction, less than 30%, with previous MI or post MI at least 40D with out without heart failure II or III
- EF less than 40% due to previous MI or at least 40 days post-MI and inducible VT/VF on electrophysiologic study (EPS)

Indications (cont.)

- Syncope of unknown origin with inducible VT/VF on EPS (intracardiac electrophysiology study)
- Sustained VT with structural heart disease
- Patients with an existing ICD who require a replacement

Contraindications

- Reversible causes of VT/VF (e.g., myocardial ischemia, sepsis, hypoxia, electrolyte imbalances, electrocution)
- Atrial arrythmias without VT/VF and incessant VT/VF
- Class IV Heart Failure
- Had a coronary artery bypass grafting (CABG) or percutaneous coronary intervention (PCI) in the past three months
- MI in the past 40 days
- Patient requires coronary artery revascularization

Contraindications (cont.)

- Severe, ischemic cardiomyopathy, but no history of sustained VT or cardiac arrest due to VF and have Class III or IV heart failure, a LVEF of 35% or less AND had a CABG in the past three months, an MI in the past 40 days, signs or symptoms of needing coronary revascularization
- Severe, non-ischemic cardiomyopathy, but no history of sustained VT or cardiac arrest due to VF and have Class II or III heart failure, a LVEF of 35% or less AND had a CABG or PCI in the past three months, an MI in the past 40 days, signs or symptoms of needing coronary revascularization

Complications

- SHORT-TERM COMPLICATIONS
  - Thrombosis of the subclavian or axillary veins
  - Bleeding at the site
  - Bleeding around the heart
  - Pneumothorax/hemothorax
  - Deep Vein Thrombosis
  - Pulmonary Embolus
  - MI/arrhythmias
  - CVA

Complications (cont.)

- SHORT-TERM COMPLICATIONS
  - Lead fracture
  - Infection, device related or endocarditis.
  - PEA
  - Death
  - Pocket pain or hematoma.
  - Twiddler Syndrome, twisting and misplacement of the device.
  - Lead displacement
- LONG-TERM COMPLICATIONS
  - Device related pain

Complications (cont.)

- **LONG-TERM COMPLICATIONS**
  - Device related pain
  - Anxiety. Especially about the limitations caused by having the device implanted, the battery life, malfunction of the device, as well as pain from the shock of the device.
  - Inappropriate shock delivery
  - Phantom Shock
  - Device erosion, through the skin
  - Device infection
  - Immunologic rejection

NCD 20.4

- Beneficiary must have documented sustained VT or cardiac arrest due to VF

- A prior MI and an LVEF of 30% or less. Without: NYHA Class IV heart failure, CAGB or PCI with angioplasty and/or stenting within the past three months, an MI in the past 30 days, clinically require coronary revascularization
- Severe ischemic dilated cardiomyopathy w/o VT or VF, NYHA Class II or III HF and LVEF 35% or less without CABG/PCI with angioplasty with or without stenting in the past three months, an MI in past 30 days, clinically require coronary revascularization

NCD 20.4 (cont.)

- Severe non-ischemic dilated cardiomyopathy w/o VT or VF, NYHA Class II or III HF and LVEF 35%or less without CABG/PCI with angioplasty with or without stenting in the past three months, an MI in past 30 days, clinically require coronary revascularization
- Documented, familial or genetic disorders with a high risk for life threatening arrythmias
- Beneficiaries with an existing ICD who require a replacement due to end of battery life, ERI (elective replacement indicator)or device/lead malfunction

NCD 20.4 (cont.)

- Each of the six aforementioned must also meet the following criteria:
  - **Clinically stable;**
  - **Must have a measured LVEF;**
  - **Must not have irreversible significant brain damage;**
  - **Diagnosis (other than cardiac) with a less than one year survival; or**
  - **Supraventricular tachycardia (e.g., AF) with poorly controlled ventricular rate**

Key Points to Prevent Denials

- NCD decision memo (CAG-00157R4)
- SDM encounter prior to initial ICD implantation is a critical step in empowering patient choice in their treatment plan.
- Be performed by **an independent physician or qualified nonphysician practitioner**
- Must be documented in the medical record
  - **Documentation that includes discussions with the patient and/or signed informed consent forms is insufficient**
  - **Tool used on ICDs**
  - **Analysis section of decision memo gives an example of an existing SDM tool for ICDs**

Common Denial Example

Medical Records Submitted: 1. Authenticated 10/03/2022 and 10/13/2022 Cardiology office visits with Paul Metto, MD, which did not include a shared decision-making tool as required by the NCD. 2. Authenticated Physician's Operative report. 3. Authenticated Physician's Operative/procedure report. 4. Authenticated Physician's Inpatient admission order. 5. Authenticated Physician's Progress notes. 6. Labs. 7. Radiology. 8. MAR.

Medical Review Decision — Missing: 1. Authenticated formal shared decision-making encounter that must occur between the patient and a physician using an evidence-based decision tool on ICDs prior to initial ICD implantation. The shared decision-making encounter may occur at a separate visit.

Resources

- Jurisdiction J Part A — Cardiac Procedures Checklist
- Jurisdiction M Part A — Cardiac Procedures Checklist

This document goes over all necessary documentation, records, reports and notes and is available on the Palmetto GBA website.

- Jurisdiction J Part A — Comprehensive Error Rate Testing (CERT)
- Jurisdiction M Part A — Comprehensive Error Rate Testing (CERT)
- C3HUB — CERT Contractor Provider Website
- Collaborative Patient Care Is a Provider Partnership — CMS MLN 909340
- CMS CERT A/B MAC Outreach & Education Task Force

Panel Discussion

PALMETTO GBA®
A CELERIAN GROUP COMPANY

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Connect With Us

FACEBOOK

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

X (TWITTER)

#StayConnected on X for quick access to news and information

YOUTUBE

Go to YouTube for educational videos, tips and strategies

LINKEDIN

LinkedIn is your source for the latest Palmetto GBA news

Customer Experience Survey

Overall, how satisfied are you with your MAC?

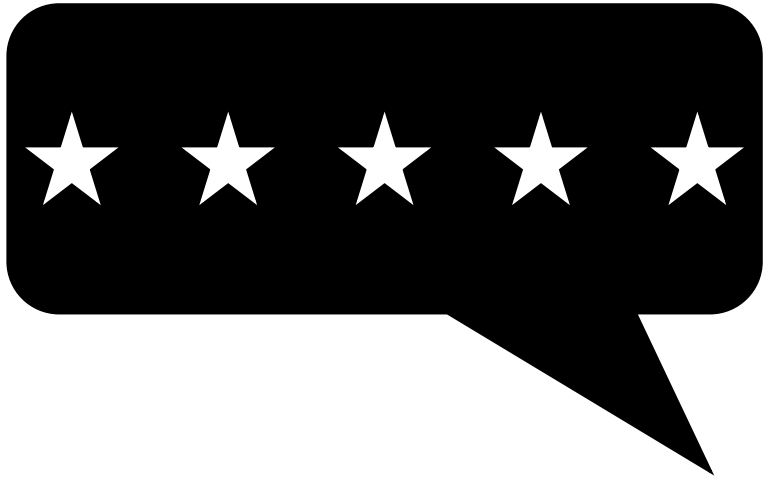
- ☐ **Extremely satisfied**
- ☐ **Somewhat satisfied**
- ☐ **Neither satisfied nor dissatisfied**
- ☐ **Somewhat dissatisfied**
- ☐ **Extremely dissatisfied**

Customer Experience Survey

How likely are you to recommend our education to a colleague or peer?

Customer Experience Survey

FEEDBACK



Don’t forget to complete the feedback survey!

THANKS FOR ATTENDING!