IA HFMA-AAHAM Conference

WPS GHA Provider Outreach and Education

IA HFMA-AAHAM Conference

Mary Sue Gardner, RN/BSN – Outreach and Education Specialist
Karen Kroupa – Outreach and Education Specialist
WPS GHA

Time: 1:45 PM – 2:45 PM

Agenda

• Targeted Probe and Educate (TPE) process
• Current reviews and their findings
• Risk mitigation and documentation compliance
• Local Coverage Determination Changes
• Current Appeals Issues
• WPS GHA News and Updates

Disclaimer:
This program was designed for informational purposes only. The current Medicare regulations will always prevail. The provider alone is responsible for correct submission of enrollment applications. The official Medicare Program provisions change frequently and are contained in the relevant laws, regulations and rulings and can be found on the Centers for Medicare & Medicaid Services (CMS) website at www.cms.gov. Recording is not allowed; this includes audio, video, or photographic capture of educational material by any electronic or digital means, either original or copied/shared.
<table>
<thead>
<tr>
<th>Acronym/Abbreviation</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADR</td>
<td>Additional Documentation Request</td>
</tr>
<tr>
<td>ASC</td>
<td>Ambulatory Surgery Center</td>
</tr>
<tr>
<td>BILAT SURG</td>
<td>Bilateral Surgery</td>
</tr>
<tr>
<td>CMS</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
</tr>
<tr>
<td>CPT</td>
<td>Current Procedural Terminology</td>
</tr>
<tr>
<td>DRG</td>
<td>Diagnosis Related Group</td>
</tr>
<tr>
<td>EMR</td>
<td>Electronic Medical Record</td>
</tr>
<tr>
<td>ER</td>
<td>Emergency Room</td>
</tr>
<tr>
<td>FFS</td>
<td>Fee for Service</td>
</tr>
<tr>
<td>HCPCS</td>
<td>Healthcare Common Procedural Coding System</td>
</tr>
<tr>
<td>HBO</td>
<td>Hyperbaric Oxygen Therapy</td>
</tr>
<tr>
<td>ICD</td>
<td>International Classification of Diseases</td>
</tr>
<tr>
<td>ICR</td>
<td>Individual Claim Review</td>
</tr>
<tr>
<td>IOM</td>
<td>Internet-Only Manual</td>
</tr>
<tr>
<td>IRF</td>
<td>Inpatient Rehabilitation Facility</td>
</tr>
<tr>
<td>IVR</td>
<td>Interactive Voice Response Unit</td>
</tr>
<tr>
<td>LCD</td>
<td>Local Coverage Determination</td>
</tr>
<tr>
<td>MAC</td>
<td>Medicare Administrative Contractor</td>
</tr>
<tr>
<td>MLN</td>
<td>Medicare Learning Network</td>
</tr>
<tr>
<td>MAC</td>
<td>Medicare Administrative Contractor</td>
</tr>
<tr>
<td>MSI</td>
<td>MAC Satisfaction Indicator</td>
</tr>
<tr>
<td>MUE</td>
<td>Medically Unlikely Edit</td>
</tr>
<tr>
<td>SNF</td>
<td>Skilled Nursing Facility</td>
</tr>
<tr>
<td>UPIC</td>
<td>Unified Program Integrity Contractor</td>
</tr>
</tbody>
</table>
Targeted Probe and Educate (TPE)

Purpose
- Identify and correct those providers with high denials or unusual billing patterns
- Perform edits of 20-40 claims on these providers
- Reviews are specific to MAC data analysis
  - Providers selected for review are based off MAC data
- Most providers will never be on TPE
- Services identified by WPS GHA are listed on our Provider Portal (www.wpsgha.com)
- Goal of TPE reviews:
  - Help providers to quickly improve and correct any errors found in review
Are we on a TPE?

Determining if you are on review
- WPS GHA (your MAC) will contact you by phone and establish a point of contact
- Letter will be sent containing specifics of the probe
  - Electronic letter
  - Mail
  - Fax
Once Chosen for TPE...

After you are selected and notified, what do you do next?

- Watch and wait for ADR requests
- Once a claim moves into an ADR request, gather and verify all documentation for submission
  - Review ADR request for all information requested as well as any other supporting documentation
  - If documentation to support medical necessity resides somewhere other than the billing entity, the billing entity is responsible for gathering that information for submission
- Attach a copy of the ADR request to the documentation
- Submit within 45 days of the ADR notification
Submission of Documentation

- WPS GHA Provider Portal
- Hardcopy
- Fax
- CD
- Electronic Submission of Medical Documentation (esMD)

Methods in Which to Submit Documentation

WPS GHA Provider Portal
- Best and fastest way
- 15 MB size limitation
  - Files can be split to accommodate file size limitations

Hardcopy
- Submit individual files clipped together. No staples
- Full size sheets, single sided
- Refer to WPS GHA Provider Portal for additional information on hardcopy submission

Fax
- Fax number is located on WPS GHA Provider Portal
- Fax each request individually
- Full size sheet, single sided

CD
- Images must be in PDF or multipage TIF format
- May submit multiple ADR requests on 1 CD, but each must be separate PDF or TIF
- ADR request must be first thing under each file
- Must be password protected, password must be sent to secure email listed on WPS GHA Provider Portal
- Follow all directions on WPS GHA Provider Portal

esMD
- Follow information as directed on the WPS GHA Provider Portal

ADR request MUST be submitted with documentation with whatever method of submission is chosen

Notes:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Review of Documentation

- Submit ADR request within 45 days of the notification
- The nurse analyst will review documentation as it is received
- The nurse analyst assigned to your review may contact you via phone or email for additional documentation, if necessary, or to alert you to issues that can be resolved easily in your facility during the reviews
- One on one provider education will be offered to all providers with denials in their sample
  - Education will guide providers on how to avoid or fix findings for future reviews
Help Yourself!

• Once claim decision is made
  – Log into WPS GHA Provider Portal to review individual claim review
  – Start making necessary facility/prov ender changes
  – Start preparing for appeal
  • 120 days from date denial decision appended

Help Yourself!

The leading cause of denials in TPE reviews is due to insufficient documentation

What providers can do to help themselves during this process
• Log into the WPS GHA Provider Portal and review any Individual Claim Reviews (ICR) for denied claims
• Start making any necessary changes in your facility
• Start preparing for appeal on denied claims that you feel are, in fact, reasonable and necessary
  • 120 days from date of denial decision

Remember: Mistakes on Medicare claims, and incomplete supporting documents can mean delays in getting reimbursed or not getting reimbursed at all!
Round 1: Coming to a Close

- WPS GHA will determine which providers will need additional rounds
- WPS GHA will determine which new services we are adding
- Take advantage of 1:1 education
- Round 2 starts 45 days from end of round 1 reviews
- Newly identified review services are starting to post on our WPS GHA Provider Portal

What’s going to round 2 of the first identified services for J5 Part A
- IRF - Almost all providers
- ER 99285 – Very few providers
- SNF – Almost all providers
- HBO – About ½ of the providers

What’s going to round 2 of the first identified services for J5 B
- 99215 – Outpatient evaluation and management – About ¼ of providers
- HBO – Physician services 99183 – Almost all providers
- 99223 – Inpatient evaluation and management – Almost all providers
- 99285 – Emergency room visit – More than ½ of providers
- Ambulance – Almost ½ of providers

Notes:

_______________________
_______________________
_______________________
_______________________
_______________________
_______________________
_______________________
_______________________
_______________________
_______________________
_______________________
_______________________
_______________________
_______________________
_______________________
_______________________
New Review Topics for J5 Part A

• Inpatient Psychiatric Facility
  – DRG 885 Psychosis
    • Length of stay > 3 days
• Wound Care
  – Debridement codes based on LCD L37228 (Wound Care)
  – Negative Pressure Wound Therapy (NPWT)

What’s New for Part A

Inpatient Psychiatric Facility
• DRG 885 Psychosis
  • Length of stay > 3 days

Wound Care
• Debridement codes based on LCD L37228
• Negative Pressure Wound Therapy (NPWT)

Outpatient Rehabilitative Therapy
• 97110 – Therapeutic procedure

DRG Validation
• Malnutrition as a secondary diagnosis

Outpatient Observation
• Services > 48 hours

Notes:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
**New Review Topics for Part B**

- Outpatient Therapy
  - 97110 (Therapeutic procedure)
- Rituximab (J9310)
- Drug Screening
  - LCD L34645 Drug Testing
- Psychotherapy
  - 90853 Group psychotherapy (other than of a multiple-family group)
  - LCD L34616 Psychiatry and Psychology Services

**What’s New for Part B**

- Outpatient Therapy
  - 97110
- Rituximab
- Drug Screening
  - LCD L34645 Drug Testing
- Psychotherapy
  - 90853 Group psychotherapy
    - LCD L34616 Psychiatry and Psychology Services

**For More Information on TPE Reviews:**
Check the WPS GHA Provider Portal
[www.wpsgha.com](http://www.wpsgha.com)
Topic Center > Claim Review

Notes:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Risk Mitigation and Compliance

Purposes of Medical Record

• Document condition
• Record of services
• Follow condition changes
• Communication with other providers
• Document who is involved
• Determine quality of care
• Establish reimbursement

Notes:

_______________________
_______________________
_______________________
_______________________
_______________________
_______________________
_______________________
_______________________
_______________________
_______________________
_______________________
_______________________
_______________________
_______________________
_______________________
_______________________
_______________________
_______________________
_______________________
_______________________
_______________________
_______________________
_______________________
_______________________
_______________________
_______________________
_______________________
_______________________
_______________________
_______________________
_______________________
_______________________
_______________________
Electronic Medical Records (EMR)

- Make sure your EMR gives you the opportunity to “paint the whole picture”
  - Does your documentation support medical necessity of services?
  - Would it stand up in court?
    - Imagine being asked Who, What, Where, When and Why in 20 years
- Copy/Paste is not a recommended method of charting
- Charting by exception doesn’t always “paint the picture”
  - If it wasn’t charted, it wasn’t done
    - Only captures exceptions to the baseline
- Document to support medical necessity
Things to Document

• Document things you may need to remember in 20 years
• Be as specific and thorough as you can when charting (tell the story of the care)
• Educate those gathering information to submit
  • HIM departments must be aware of the participation agreements of Medicare and what documentation to submit when requested
  • Provide all documentation that supports medical necessity of the service provided and under review

Notes:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Local Coverage Determination (LCD) Changes

- 2016 21st Century Cures Act included changes to LCD process
  - MACs must make available, at least 45 days before effective date
  - Determination in its entirety
  - Where and when proposed determination was first made public
  - Hyperlinks to proposed determination and response to comments
  - Summary of evidence considered
  - Explanation of rational

Local Coverage Determination (LCD) Changes

The 2016 21st Century Cures Act included changes to the LCD process, adding language to the social security act that requires MACs that develop LCDs to make available on the contractor website, at least 45 days before the effective date of such determination, the following information:

- Such determination in its entirety
- Where and when the proposed determination was first made public
- Hyperlinks to the proposed determination and a response to comments submitted to the contactor with respect to such proposed determination
- A summary of evidence that was considered by the contactor during the development of such determination and a list of the source of such evidence
- An explanation of the rationale that supports such determination
New LCD Process

The key parts of the new LCD process are as follows:
1. The new LCD process may begin with informal meetings in which interested parties within the MAC’s jurisdiction can discuss potential LCD requests
2. New LCD requests
3. Clinical guidelines, consensus documents and consultation
4. Publication of the proposed LCD
5. Contractor Advisory Committee (CAC)
6. Open meetings
7. Publication of the final determination
8. Response to public comments
9. Notice period

Notes:
To Use or Not to Use Modifier 50?

That is the Question

<table>
<thead>
<tr>
<th>Appropriate Use of Modifier 50</th>
<th>Inappropriate Use of Modifier 50</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Procedures performed on both sides of the body during the same operative session</td>
<td>• Procedures identified by terminology as bilateral or unilateral</td>
</tr>
<tr>
<td>• Bilateral procedure reported on one line item as a single unit</td>
<td>• Modifiers LT and RT are not reported when Modifier 50 applies</td>
</tr>
</tbody>
</table>

Using Modifier 50

Modifier -50 may be used

• To report bilateral procedures that are performed at the same operative session as a single line item
  • Do not use modifiers RT and LT when modifier - 50 applies.
  • Do not submit two line items to report a bilateral procedure using modifier - 50.
  • Modifier -50 applies to any bilateral procedure performed on both sides at the same operative session.
    • The bilateral modifier -50 is restricted to operative sessions only
  • Used when BILAT SURG indicator is 1 or 3

Modifier -50 may not be used

• To report surgical procedures identified by their terminology as “bilateral,” or
• To report surgical procedures identified by their terminology as “unilateral or bilateral”.
• Reporting when performing surgery on different areas of the same side of a body
• Removing a lesion on the right arm and one on the left arm
  • Use RT and LT modifiers
• Using modifier 50 for multiple procedures on one organ
• With procedure code that has bilateral or unilateral in it’s CPT description
• Reporting 2 lines for a bilateral service and appending modifier 50 to 2nd line
• Cannot be used when BILAT SURG indicator is 0, 2 or 9

Notes:

__________________________________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________
Bilateral Surgical Indicator

Modifier 50 is a payment, rather than informational, modifier.

Modifier could affect payment depending on the procedure code and the BILAT SURG indicator.

BILAT SURG indicator 0 = 150% payment adjustment for bilateral procedures does not apply

BILAT SURG Indicator 1 = 150% payment adjustment for bilateral procedures applies

BILAT SURG Indicator 2 = 150% payment adjustment does not apply

BILAT SURG Indicator 3 = The usual payment adjustment for bilateral procedures does not apply

BILAT SURG Indicator 9 = The bilateral payment adjustment concept does not apply
Ambulatory Surgical Center (ASCs)

Bilateral surgical procedures furnished by certified ASCs may be covered under Part B.

However:
• 50 modifier is not prohibited according to Medicare billing instructions but is not recognized for payment purposes and if used, may result in incorrect payment to ASCs.
• Bilateral procedures should be reported as
  • A single unit on two separate lines or
  • A single service with "2" in the unit field on one line
• The multiple procedure reduction of 50 percent will apply to all bilateral procedures subject to multiple procedure discounting
• Correct billing examples found in SE 0742
Using Q0 and Q1 Modifiers

Q0 and Q1 modifiers used on outpatient provider claims for items/services provided in Medicare qualified clinical trials/studies. These include trials that fall under the 2007 Medicare Clinical Trial Policy, trials that are required by a specific National Coverage Determination (NCD), and Investigation Device Exemption (IDE) trials.

**Q0 – Investigational clinical service defined:**

- Items and services being investigated as an objective within a study
  - May include items or services that are:
    - Approved
    - Unapproved
    - Otherwise covered (or not covered) under Medicare

**Q1 – Routine clinical service defined:**

- Covered Medicare covered services outside clinical research studies
- Used for direct patient management within clinical study
- Do not meet the definition of investigational clinical services
  - May include items or services required solely for the provision of the investigational clinical service
    - Administration of a chemotherapy agent
  - Clinically appropriate monitoring (required or not by the investigational clinical service
  - Items or services required for preventing, diagnosis, or treatment of research related adverse events
Billing Q0 and Q1

On all outpatient clinical trial claims report:

• Condition code 30
• ICD-9 diagnosis code V70.7, if applicable (primary or secondary position)
• ICD-10 diagnosis code Z00.6 if applicable (primary or secondary position)
• Identify all lines that contain an investigational item/service with a HCPCS Q0 for dates of service on or after 1/1/08
• Identify all lines that contain a routine service with a HCPCS modifier of Q1 for dates of service on or after 1/1/08.

Refer to:
IOM 100-04 Medicare Claims Processing Manual;
Chapter 32; Section 69.6

Notes:

________________________________________________________________________________________

________________________________________________________________________________________
Documentation Errors for Diagnostic or Radiologic Services

# 1 problem – Lack of documentation

- **Incomplete** progress notes
  - For example, unsigned, undated, insufficient detail
- **Unauthenticated** medical records
  - No provider signature
  - No supervising signature
  - Illegible signatures without a signature log or attestation to identify the signer
  - An electronic signature without the electronic record protocol or policy that documents the process for electronic signatures
- **No documentation of intent to order** services and procedures
  - Incomplete or missing signed order
  - *Progress note describing intent for services to be provided*

Notes:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
While a physician order is not required to be signed, the physician must clearly document in the medical record, his or her intent that the test be performed.

**Clearly Document Intent**

• While the physician order is not required to be signed, the physician must clearly document, in the medical record, his or her intent that the test be performed.

• Communicate in the order that a diagnostic test be perform
  • What test to perform

• Order can conditionally request addition diagnostic test if the results of the initial test yields an certain value specified by the ordering physician
  • If test X is negative, then perform test Y

Notes:

__________________________
__________________________
__________________________
__________________________
__________________________
__________________________
__________________________
__________________________
__________________________
__________________________
__________________________
__________________________
__________________________
__________________________
__________________________
__________________________
__________________________
__________________________
Orders for Diagnostic Tests

Written, signed by physician
• Hand delivered, mailed, faxed
• May conditionally request additional diagnostic test
  • If initial test order yields certain results specified by ordering provider
Telephone call
• Both ordering provider and testing facility must document call in medical record
Electronic mail
• Part of the medical record

Refer to:
IOM 100-02 Medicare Benefit Policy Manual; Chapter 15; Section 80.6 – 80.6.1

Notes:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
What is a MUE?

- Maximum units that should be reported for a HCPCS/CPT code
- On the vast majority of appropriately coded claims
- To a single beneficiary
- On the same date of service

Exceeding Medically Unlikely Edits (MUE) Values

An MUE for a HCPCS/CPT code is the maximum number of units of service (UOS) under most circumstances allowable

- By the same provider
- For the same beneficiary
- On the same date of service.

The ideal MUE value for a HCPCS/CPT code is the unit of service that allows the vast majority of appropriately coded claims to pass the MUE.
### Appealing MUE Denials

- Request a Level 1 Appeal
  - Submit Redetermination request to WPS GHA within 120 days of date on Remittance Advice (RA)
  - Include documentation to show the medical necessity of additional services
- Request can only be submitted in writing for Part A providers
- Request can be submitted via fax, in writing or the Portal for Part B providers

### Billing in Excess of MUE Values

Modifiers may be appended to HCPCS/CPT codes only if the clinical circumstances justify the use of the modifier.
- A modifier should not be appended to a HCPCS/CPT code solely to bypass an MUE edit if the clinical circumstances do not justify its use.

### Appealing MUE Denials

Submit request within 120 days of the date on the Remittance Advice (RA)
- All requests must be made in writing for Part A providers
- Forms available, but no specific format is required
- CMS - Medicare Redetermination Request (CMS-20027)
- WPS GHA - Redetermination Request Form (Part A and Part B have unique forms)
Documentation for Appeal of MUE Denial

CMS publishes most MUE values on its website, however other MUE values are confidential.
• To find out if the MUE value is available for your procedure, you can view the Facility Outpatient Services MUE table on the CMS web page Medically Unlikely Edits.

Services denied because of an MUE are considered a coding error.
• You cannot bill your patient.

Providers that use the WPS GHA Portal can log into their account to get specific information about claim denials.
Surveys
Tell us what you think – We'll listen!

• ForeSee survey
  – WPS GHA Portal feedback
    • Suggestions have lead to improvements and innovation
• MAC Satisfaction Indicator (MSI)
  – Provides insight that drives improvements
  – Objectively measures processes and service delivery

• ForeSee survey
  • WPS GHA Portal feedback
    • Suggestions have lead to improvements and innovation
• MAC Satisfaction Indicator (MSI)
  • Provides insight that drives improvements
  • Objectively measures processes and service delivery

• MSI link for J5 providers:
  https://www.surveygizmo.com/s3/4826847/?MAC_BRN_C=14&MAC=J5-WPS
Resources

• CMS Internet-Only Manual, Publication 100-08, Medicare Program Integrity Manual, Chapter 3, Section 3.2.5

• CMS IOM 100-04, Claims Processing Manual, Chapter 29

• CMS.gov: Home>Research, Statistics, Data and Systems> Medicare Fee-for-Service Compliance Programs> Medical Review and Education> Targeted Probe and Educate (TPE)

• WPS GHA Provider Portal > Claim Review

• CMS IOM, 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 80.6.1

• WPS Provider Portal > Claims > Guides and Resources > Modifier 50 Fact Sheet

• MLN Matters Number: SE0742

• CMS IOM, Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 80.6.1

• CMS IOM, Publication 100-04, Medicare Claims Processing Manual, Chapter 32, Section 69.6

• CMS.gov > Medicare > National Correct Coding Initiative > Medically Unlikely Edits