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Jurisdiction M Parts A and B Palmetto GBA Medicare Updates, Changes and Reminders VA AAHAM

October 19, 2023



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Disclaimer

The content in this presentation is intended for Jurisdiction M Part A and B providers and is current as of October 10, 2023. Any changes or new information superseding this information is provided in articles with publication dates after October 10, 2023, at:

www.PalmettoGBA.com/JMA

www.PalmettoGBA.com/JMB

www.CMS.gov

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Today's Agenda

- COVID-19 Public Health Emergency Update
- Updates and Changes
- CERT and Targeted Probe and Educate
- Resources and Reminders

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COVID-19 Waivers and Administrative Flexibilities

- Blanket waivers ended at the end of the Public Health Emergency (PHE) for COVID-19 (end of the day on May 11, 2023)
- Waivers granted by request apply only to the requestor
- Flexibilities are regulatory authorities to enable flexibilities so providers could rapidly respond to people impacted by COVID-19
 - Some COVID-19 PHE flexibilities and policies have already been made permanent or otherwise extended for a period of time
 - Some flexibilities have ended

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- Current emergencies | CMS



Frequently Asked Questions:

CMS Waivers, Flexibilities, and the End of the COVID-19 Public Health Emergency

While some FAQs are relevant for all programs, including Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and private insurance, other questions are program specific as indicated below.

1. When is the COVID-19 Public Health Emergency expected to end?

Based on current COVID-19 trends, the Department of Health and Human Services (HHS) is planning for the federal Public Health Emergency for COVID-19 (PHE) declared by the Secretary of the Department of Health and Human Services (Secretary) under Section 319 of the Public Health Service (PHS) Act to expire at the end of the day on May 11, 2023.

2. On April 10, 2023, the President signed H.J.Res.7, into law, which terminated the national COVID-19 emergency immediately. Did this end the COVID-19 PHE declared by the Secretary?

The PHE for COVID-19 declared by the Secretary under section 319 of the PHS Act is not the same as the COVID-19 National Emergency declared by President Trump in 2020, which ended when President Biden signed H.J.Res.7. Therefore, the end of the COVID-19 National Emergency generally does not impact current operations at HHS, and it does not impact the expected May 11, 2023, expiration of the federal PHE for COVID-19 or any associated unwinding plans. Further, any existing waivers currently in effect and authorized under section 1135 of the Social Security Act will remain in place until the end of the PHE for COVID-19 declared by the Secretary under section 319 of the PHS Act.

3. Many of the flexibilities and waivers in place are tied to emergency declarations, legislative actions by Congress, and regulatory actions across government. Can the Centers for Medicare & Medicaid Services (CMS) extend Medicare, Medicaid, and Marketplace flexibilities beyond May 11, 2023, when the Administration is planning to end the PHE?

Thanks to the Administration's whole-of-government approach to combatting the virus, we



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COVID-19 Updates

- **During the PHE:** COVID-19 vaccinations were covered under Medicare Part B without cost sharing, and **this will continue**
- **Modifier CR** (catastrophe or disaster-related services): only append during the PHE
- **Modifier CS** (Cost-Sharing is Waived [COVID-19]) medical visits that resulted in an order for or administration of a COVID-19 test; are related to furnishing or administering such a test or to the evaluation of an individual for purposes of determining the need for such a test
 - **Do not append CS modifier on services on or after May 12, 2023**



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Telehealth Documentation Reminders



- Medicare expects the same level of documentation that would ordinarily be provided if the services furnished via telehealth, were conducted in person
- Services and equipment furnished to patients must be reasonable and necessary. Accordingly, the medical record should be sufficient to support payment for the services billed (that is, the services were actually provided, were provided at the level billed, and were medically necessary). This flexibility applies only to clinical indications and not to other policy aspects, such as benefit category determinations, of NCDs and LCDs.
- Criteria specific to individual CPT® and HCPCS codes also apply and must be documented

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Medicare Reviews

- Any Medicare reviews conducted will be conducted using the CMS guidelines at the time the service was provided
- Documentation matters!

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New COVID-19 Treatments Add-On Payment Ends

- Through the New COVID-19 Treatments Add-On Payment (NCTAP), Medicare provided an enhanced payment for eligible inpatient cases that use certain new products with current FDA approval or emergency use authorization to treat COVID-19
- The NCTAP was effective November 2, 2020 – September 30, 2023

[2023-10-05-MLNC | CMS](#)

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PECOS 2.0 Is Coming Soon

- Benefits of PECOS 2.0 include:
 - Faster application times
 - Quick and easy revalidation process
 - Real-time status tracking
- Watch these videos to learn more:
 - Fast Applications Using PECOS (4:06)
 - Reimagining PECOS for Medicare Enrollment (2:09)
- CMS will provide updates on the launch in future editions

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New Provider Types 2024

- **Marriage and Family Therapists and Mental Health Counselors**
 - Provider types implemented January 1, 2024
 - May start submitting enrollment applications after the 2024 Physician Fee Schedule final rule is on display in the Federal Register
 - <https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers>
 - <https://www.cms.gov/files/document/marriage-and-family-therapists-and-mental-health-counselors-faq-09052023.pdf>

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Acute-Care Hospitals for Inpatient Claims Subject to the Post-Acute-Care Transfer Policy

- Prior OIG audits identified over \$563 million in overpayments so a follow-up audit was performed for dates of service from 1/1/2019 – 12/31/2022
- Some hospitals transferred patients to certain post-acute-care settings, such as skilled nursing facilities (SNFs), but claimed the higher reimbursements associated with discharges to home
- OIG recommended
 - Have Medicare contractors recover \$41.4 million in overpayments identified in audit
 - CMS direct MACs to notify appropriate providers so providers can exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule
- CMS will provide MACs with a list of affected providers and letters will be issued with instructions
- [A-09-23-03016 - Final Report.pdf](https://www.cms.gov/files/document/A-09-23-03016-Final-Report.pdf)

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Viewing MLN Matters Articles



<https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles>

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More Updates

- Influenza Vaccine Payment Allowances — Annual Update for 2023–2024 Season 
- New place of service code 27: Outreach Site/Street, which will be effective October 1, 2023 
 - At this time, Medicare won't use this code in claims processing
 - If you submit a claim with this code, we'll return it to you.

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CR 9613 and 9907

Jurisdiction M Part A — Reason Code 34977 (palmettogba.com)

The claim was returned due to one of the following:

- The service facility address submitted on the claim was not identified by the provider as a practice location address when the CMS-855A enrollment form was submitted: **Jurisdiction J/M Part A Provider-Based Billing Webinar:** <https://event.on24.com/wcc/r/4346992/E2E6A6F13C16EBEE19472DE1A06669C4>
- The service facility address submitted on the claim is not an exact match to the practice location address in PECOS

Jurisdiction M Part A — Reason Code 34978 (palmettogba.com)

One or more-line items on the claim do not contain a PO, PN or ER HCPCS modifier.

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DDE Users May Need to Adjust Screen Size

- Effective 10/1/2023, CMS recently issued Change Request 13138 “Implementation to Expand Monetary Amount Fields Related to Billing and Payment to Accommodate 10-Digits in Length (\$99,999,999.99) – Phase 1”
- As a result of this expansion, National Government Services is instructing all DDE users to ensure that your DDE screen size is adjusted to 43x80 so you can continue to review and enter claims effectively
- <https://www.cms.gov/files/document/r12155otn.pdf>

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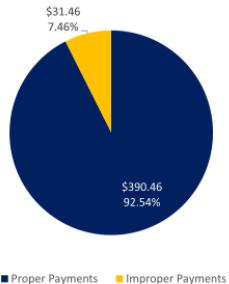
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Comprehensive Error Rate Testing (CERT) Program

92.54 Percent Accuracy Rate and 7.46 Percent Improper Payment Rate^{1,2,3} National Data

Figure 1: Payment Accuracy (in Billions)



[Medicare Fee-for-Service 2016 Improper Payments Report \(cms.gov\)](https://www.cms.gov/Research-Statistics-Programs/Programs-of-Interest/Improper-Payments/Downloads/2016-Improper-Payments-Report.pdf)

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National Improper Payment Rates and Projected Improper Payments by Claim Type (Dollars in Billions)

Claim Type	Claims Sampled	Claims Reviewed	Total Payments	Projected Improper Payments	Improper Payment Rate	Percent of Overall Improper Payments
Part A (Total)	28,676	18,528	\$306.6	\$20.5	6.7%	65.2%
Part A (Excluding Hospital IPPS)	8,001	7,088	\$193.4	\$17.1	8.9%	54.5%
Part A (Hospital IPPS)	20,675	11,440	\$113.3	\$3.4	3.0%	10.8%
Part B	14,420	14,072	\$106.6	\$8.8	8.2%	27.8%
DMEPOS	9,605	9,398	\$8.7	\$2.2	25.2%	7.0%
Total	52,701	41,998	\$421.9	\$31.5	7.5%	100.0%

[Medicare Fee-for-Service 2016 Improper Payments Report \(cms.gov\)](https://www.cms.gov/Research-Statistics-Programs/Programs-of-Interest/Improper-Payments/Downloads/2016-Improper-Payments-Report.pdf)

National Data

Table A3: Improper Payment Rate Categories by Percentage of 2022 Overall Improper Payments (Adjusted for Impact of A/B Rebilling)

Error Category	Percent of Overall Improper Payments
No Documentation	3.8%
Insufficient Documentation	63.6%
Medical Necessity	13.8%
Incorrect Coding	10.5%
Other	8.3%
Total	100.0%

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CERT Documentation Tips

- Verify date of service and each service included in the education request
- Verify right patient, right date, right services, and send complete documentation
- Some documentation may be in a note or record prior to the date of service
- Some documentation may be from a different provider or at a different location



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CERT and TPE Tips

- Make sure you are faxing to the correct fax number (verify on the additional documentation request letter)
- Respond timely
- Work with your outsourced medical record department to make sure they understand Medicare requirements and timeliness
- Diagnostic services need order or referral and documentation to support the medical necessity of the service (not just an ICD-10 diagnosis code)

APPEAL **APPEAL** **APPEAL**

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CERT Resources

www.PalmettoGBA.com/JMB

- CERT
- All MAC CERT Task Force
- E/M Help Center
- Medical Policies (LCDs)

www.CMS.gov

CERT Website: C3HUB

<https://c3hub.certrc.cms.gov/>



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Targeted Probe and Educate (TPE)

Jurisdiction M Part B — JM Parts A, B and Home Health and Hospice Targeted Probe and Educate Active Medical Review List (palmettogba.com)

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Search for:

Medical Review

Ambulance Prior Authorization

Outpatient Department Prior Authorization (PA)

Targeted Probe and Educate

Contact Medical Review 
 Our representatives are ready to assist you.

JM Parts A, B and Home Health and Hospice Targeted Probe and Educate Active Medical Review List

Published 09/01/2022

Search:

LOB	Code Type	Specific Code	Edit Topic	Edit Description
Home Health	Bene Sharing	All	Home Health Services for Eligibility and Medical Necessity Bene Sharing	Review of claims submitted for home health services for eligibility and medical necessity bene sharing
Home Health	HIPPS	All	Home Health Services for Eligibility and Medical Necessity	Review of claims submitted for home health services for eligibility and medical necessity
Hospice	Bene Sharing	All	Hospice Services Bene Sharing	Review of claims submitted for hospice services bene sharing
Hospice	Rev Code	General Inpatient Care (GIP)	General Inpatient Care (GIP)	Review of inpatient claims for inpatient hospice care greater than or equal to 7 days for revenue code 056 and place of service codes Q5004-Q5009
Hospice	Rev Code	New Hospice Providers	New Hospice Providers	Review of new hospice provider claims
Hospice	Rev Code	0651, 0652, 0655, 0656	Hospice-Length of Stay (LOS) Greater than 365 Days	Review of claims submitted for Hospice-Length of Stay (LOS) Greater than 365 Days
Hospice	Revenue Code	Routine Home Care (RHC-Rev Code 651)	Routine Home Care (RHC-Rev Code 651)	Review of Hospice Routine Home Care (RHC-Rev Code 651)
Hospice	Revenue Code	0652	Hospice Services Continuous Home Care	Review of claims submitted for hospice services continuous home care
Hospice	Diagnosis Codes	Non-Cancer Length of Stay (NCLOS)	Non-Cancer Length of Stay (NCLOS)	Review of hospice claims for Non-Cancer Length of Stay (NCLOS)
Part A	CPT*	27130/27447	Total Hip Arthroplasty/Total Knee Arthroplasty	Review of claims for total hip arthroplasty/total knee arthroplasty
Part A	CPT*	97110	CPT* 97110 – Therapeutic Exercise	Review of outpatient claims for CPT* 97110 – Therapeutic Exercise

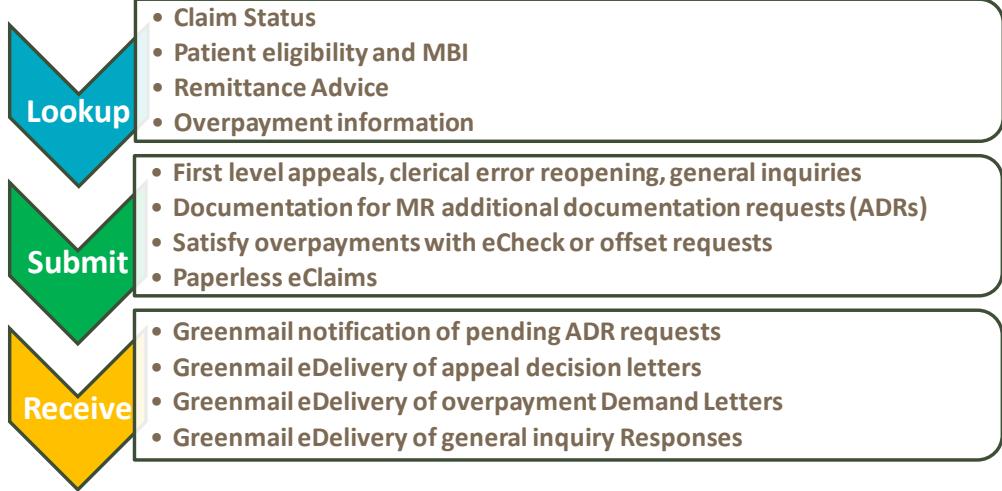
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Reminders and Resources

eServices Portal



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eServices Enhancement – Pending ADRs

ADR Pending Claims Dashboard

To view pending requests, select the tab with corresponding pending days (40, 30 total).

The following information will be displayed:

- Claim Number (ICN)
- Medicare ID of beneficiary
- Number of days pending
- Action link for response/submission

Home Claims (MCS) Remittance Eligibility MBI Lookup Financial Tools Messages Forms **ADR** eReview Support Admin My Account eDelivery

Pending ADR

ADR Pending Claims

Palmetto GBA is pending response from your agency for an ADR for one or more claims. If the provider fails to send the requested documentation or request an extension within 45 days, the review determination will be to deny the claim as not reasonable and necessary as per the Social Security Act, Sections 1815(a), 1813(d), and 1862(a)(1)(A). Please also see rule <https://www.palmettoga.com/palmetto/mcs/rule/DICCA/2019/180-Medical%20Review%20-%20get%20apro%20and%20a%20rule>

40 Days	30 Days	Total	
Show <input type="button" value="10"/> entries			
Claim Number (ICN) 	Medicare ID 	Days 	Action 
		41	 Response
		44	 Response
		43	 Response
		43	 Response
		43	 Response
		43	 Response
		43	 Response
		42	 Response
		42	 Response

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JM Part A and B Websites

www.PalmettoGBA.com/JMA
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Claims Payment Issues Log (CPL)

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Part A Open CPIL



OPEN: ESRD Claims Type of Bill 72X with Reason Code 37187

Published: 9/6/2023 Topic: *Claims Payment Issues Log*

OPEN: Part A Claims Rejected with Reason Code 7ESA1

Published: 9/6/2023 Topic: *Claims Payment Issues Log*

OPEN: Bypassing the Fiscal Intermediary Share System Consistency Edit to Validate the Attending Physician NPI for Claims Submitted with "AB" Modifier

Published: 7/14/2023 Topic: *Claims Payment Issues Log*

OPEN: OPPS Status Indicator Change for HCPCS Code J9322

Published: 7/5/2023 Topic: *Claims Payment Issues Log*

OPEN: Revision to Medically Unlikely Edit for Ranibizumab, via Intravitreal Implant

Published: 5/30/2023 Topic: *Claims Payment Issues Log*

Part B CPIL

OPEN: Certain Ambulance Claims Incorrectly Paid

Published: 8/8/2023 Topic: *Claims Payment Issues Log*

OPEN: Revision to Medically Unlikely Edit for Ranibizumab, via Intravitreal Implant

Published: 5/25/2023 Topic: *Claims Payment Issues Log*

OPEN: Revision to National Correct Coding Initiative (NCCI) Procedure-to-Procedure Correct Coding Modifier Indicator

Published: 5/12/2023 Topic: *Claims Payment Issues Log*

MLN Connects

- Issued weekly by CMS as a single source document
- The [MLN Connects® newsletter](#) features a Provider Compliance section. If you don't already get it, [subscribe now](#).

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Educational Events

- Upcoming Events/Webinars
- Webcast Library
 - On the “Events and Education” webpage
 - Weekly Listserv Messages

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Jurisdiction M Part B

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Opportunities



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videos, tips and strategies



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latest Palmetto GBA news



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Customer Experience Survey!

FEEDBACK

Don't forget to complete
the feedback survey!

Thanks for Attending!

<https://tinyurl.com/yunh6cmj>

