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Virtual Conference - Medicare Essentials Medical Policy, Noncovered Charges & Beneficiary Notices

10/18/2022

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Today's Presenters

- Provider Outreach and Education Consultants
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- Attendees/providers are **never** permitted to record (tape record or **any** other method) our educational events
  - This applies to our webinars, teleconferences, live events and any other type of National Government Services educational events

Objectives

- To provide basic information on
  - NCDs and LCDs
  - Noncovered charges
  - Beneficiary Notices

- FYI: Acronyms used in this PPT are defined on the NGS Acronym Search Tool

Agenda

- Medical Policy
  - NCDs
  - LCDs
- Noncovered Charges
- Beneficiary Notices

Medical Policy

Basis for Covered Medicare Services

- Title XVIII of Social Security Act per Section 1862(a)(1)(A) excludes services not "reasonable and necessary" unless otherwise specifically noted
  - Coverage for services under Medicare are based on medical necessity and within the scope of Medicare benefit category

Role of CMS and MACs in Determining Covered Services

- The Centers for Medicare & Medicaid Services Internet-Only Manuals
  - Publication 100-02, *Medicare Benefit Policy Manual*
    - Details on scope of covered Part A and Part B services
  - Publication 100-03, *Medicare National Coverage Determination (NCD) Manual*
    - Sets policy for determining medical necessity for specific services
- MACs have discretion to make local coverage decisions when no national coverage policy exits, or needs clarification

Claim Denials are a Costly Problem

- Claim denials related to NCDs and LCDs make up a large percentage of denied claims
  - Denials represent major expense to providers in terms of time and money
- To prevent denials, providers must know how to access and correctly interpret Medicare NCDs, LCDs and policy articles

NCDs

- Nationwide coverage instructions
  - Binding on all contractors and providers
  - Applies to all Medicare claims
- CMS establishes NCDs
  - CMS develops through evidence-based process, with opportunities for public participation
  - Outside technology assessments and/or consultation with Medicare Evidence Development & Coverage Advisory Committee

NCDs

- NCDs assigned numeric identifier and published on CMS website
  - NCD alphabetical index and index by chapter/section on CMS Medicare Coverage Database
  - CMS IOM, Publication 100-03, *National Coverage Determinations Manual*
    - Organized into four "parts" based on NCD numeric identifier
  - New or revised NCDs are "announced" via Change Requests and instructions are manualized in applicable sections of IOMs

NCD Examples

- NCD 110.21 "Erythropoiesis Stimulating Agents (ESAs) in Cancer and Related Neoplastic Conditions"
- NCD 110.24 "Chimeric Antigen Receptor (CAR) T-cell therapy"
- Lab NCD 190.16 "Partial Thromboplastin Time (PTT)"
- Lab NCD 190.17 "Prothrombin Time (PT)"
- Noncovered:
  - NCD 80.7 "Refractive Keratoplasty"
  - NCD 130.8 "Hemodialysis for Treatment of Schizophrenia"

NCD Coding Updates

- Updates are made via Change Requests/MLN Matters articles as needed
  - Provide link to spreadsheet with coding changes
  - Updates are typically added to CMS IOMs
    - CMS IOM, Publication 100-03: *Medicare National Coverage Determinations (NCD) Manual* and additional IOMs as applicable
- CMS lists all previous NCD coding updates on the CMS ICD-10 section of CMS website
  - ICD-10
  - Lab NCDs - ICD-10

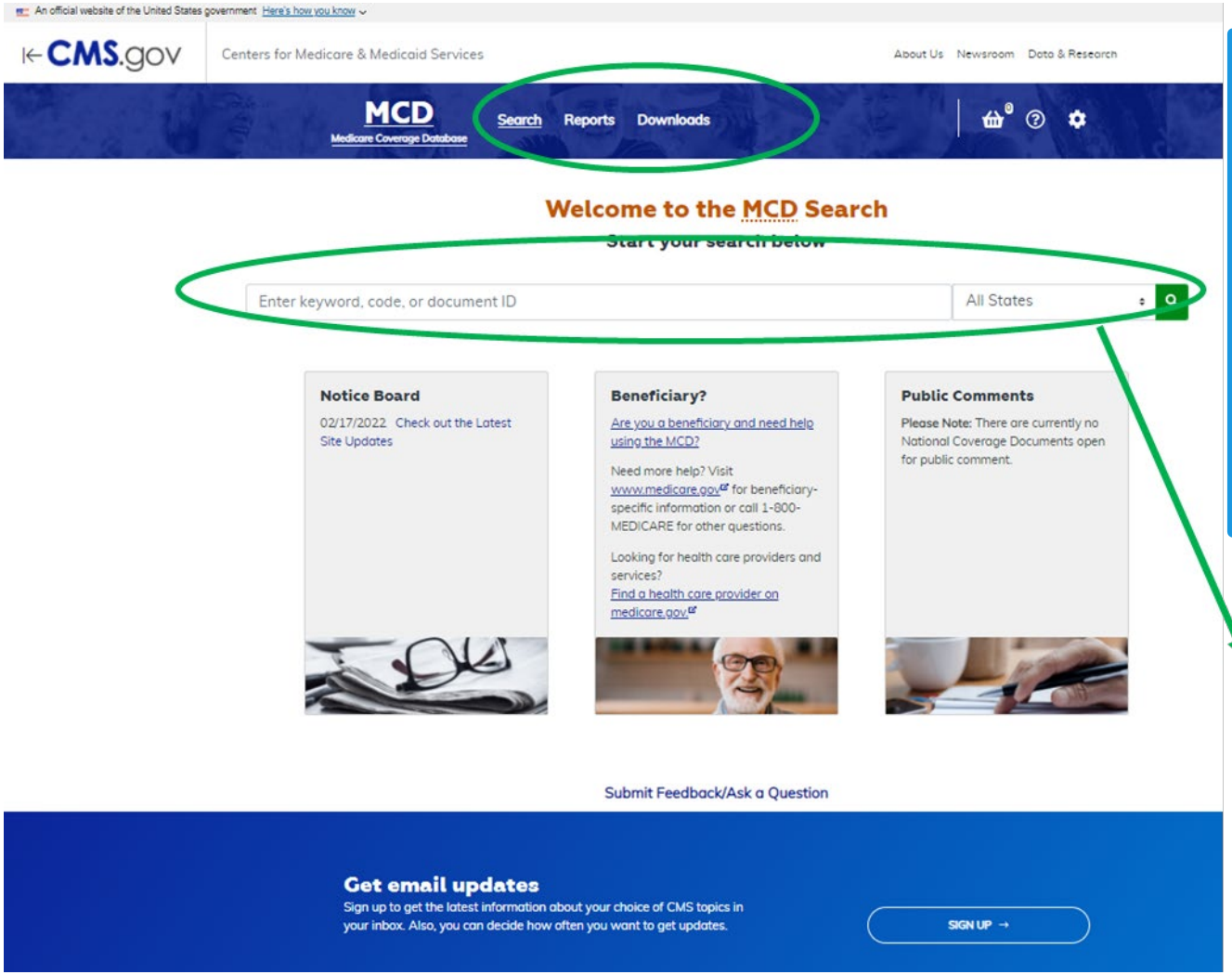
CMS Website

- Medicare Coverage – General Information
  - MCD link
  - ICD-10 link: Transmittal (change request) updates related to NCD
  - Lab NCDs –ICD-10: Files containing lab NCD coding updates
  - Medicare Coverage Determination Process
- Medicare Coverage Center
  - CMS "home" for coverage information with links to valuable resources
- Medicare Coverage Database
  - All NCDs & LCDs; Proposed NCD decisions; Local articles

Medicare Coverage Database

- Located on CMS website
  - Medicare Coverage Database
- Contains
  - All NCDs & LCDs
  - Proposed NCD decisions
  - LCD articles
  - Draft LCDs

Medicare Coverage Database



CMS Website Home > Medicare > Coverage > Medicare Coverage General Information > Search the Medicare Coverage Database

Search by:

- Keyword
- Code
- Document ID

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LCD

- Definition: SSA section 1869(f)(2)(B)
  - Determination by a MAC
    - Whether or not a particular item or service is covered on a contractor–wide basis in accordance with SSA section 1862(a)(1)(A)
- Identification
  - LCD number: L followed by five digits
  - Billing and Coding Article: A followed by five digits
  - Response to Comments article: A followed by four digits

Benefits of LCDs

- Administrative and educational tools
  - Assist provider to provide services and submit correct claims for payment
- Help define Medicare coverage limitations for certain services
- Help reviewers make consistent, accurate coverage decisions
- NCDs supersede LCDs
  - However, LCD may expand/clarify coverage/coding for an NCD

Local Coverage Determinations

- MACs develop LCDs on as needed basis
  - Determines that item or service should not be covered under certain circumstances
  - Discovers problem that demonstrates significant risk to Medicare trust fund
  - Detects overutilization or misuse of items or services
  - By request from external parties (beneficiaries, providers, or manufacturers)

Local Coverage Determinations

- Contractors must ensure all LCDs are
  - Consistent with existing statutes, rulings, regulations, national coverage, payment and coding policies
    - Can supplement existing NCD but cannot supersede
  - Created and approved within established protocols
    - Allows for notification, review and comment by interested parties within specific timeframes
    - Three stages
      - Comment Period, Notice Period, Active Period

Billing & Coding Articles

- Include important coding guidelines and billing instructions not related to medical necessity
  - Each LCD typically has at least one related article
  - Links are found in Associated Documents section at bottom of an LCD
  - A link to related LCD is also found at end of each article
    - Links are only "live" in active LCDs and articles

Did You Know…

- Where no written coverage guidelines for particular non excluded service exists
  - Providers can request creation of new LCD to clarify coverage policy
  - Decision to create new LCD will ultimately be at our discretion
- LCD Request Process
  - New Local Coverage Determination (LCD) Request Process (A56198)

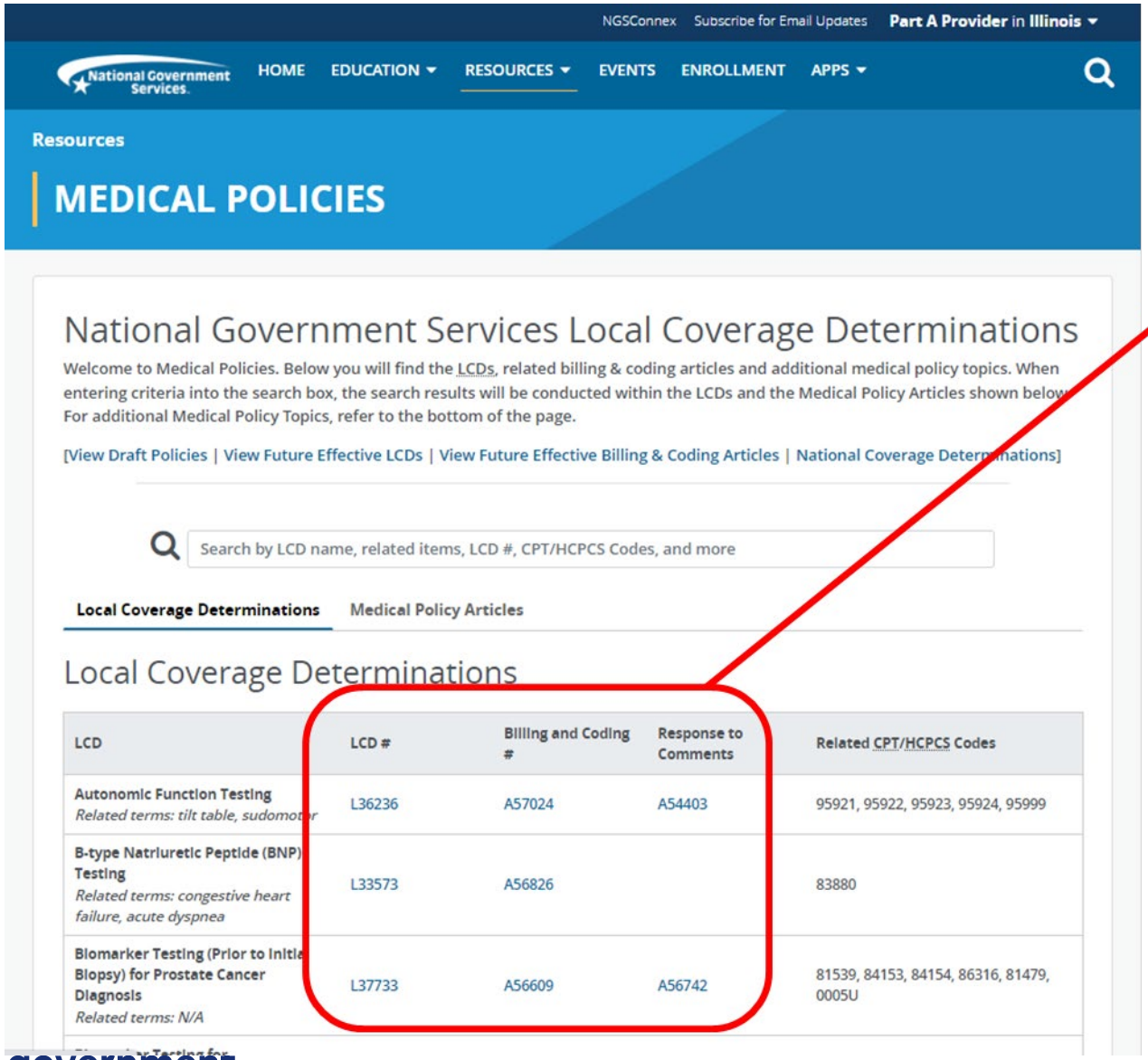
What Information Can Be Found in LCDs?

- LCDs cover only "reasonable and medically necessary" services
  - Provide coverage indications, limitations and/or medical necessity information for reasonable and necessary tests, items and services
  - Documentation requirements
- Billing and Coding articles
  - Provide coding guidelines, billing instructions as well as other instructions

What If There Is No LCD or NCD?

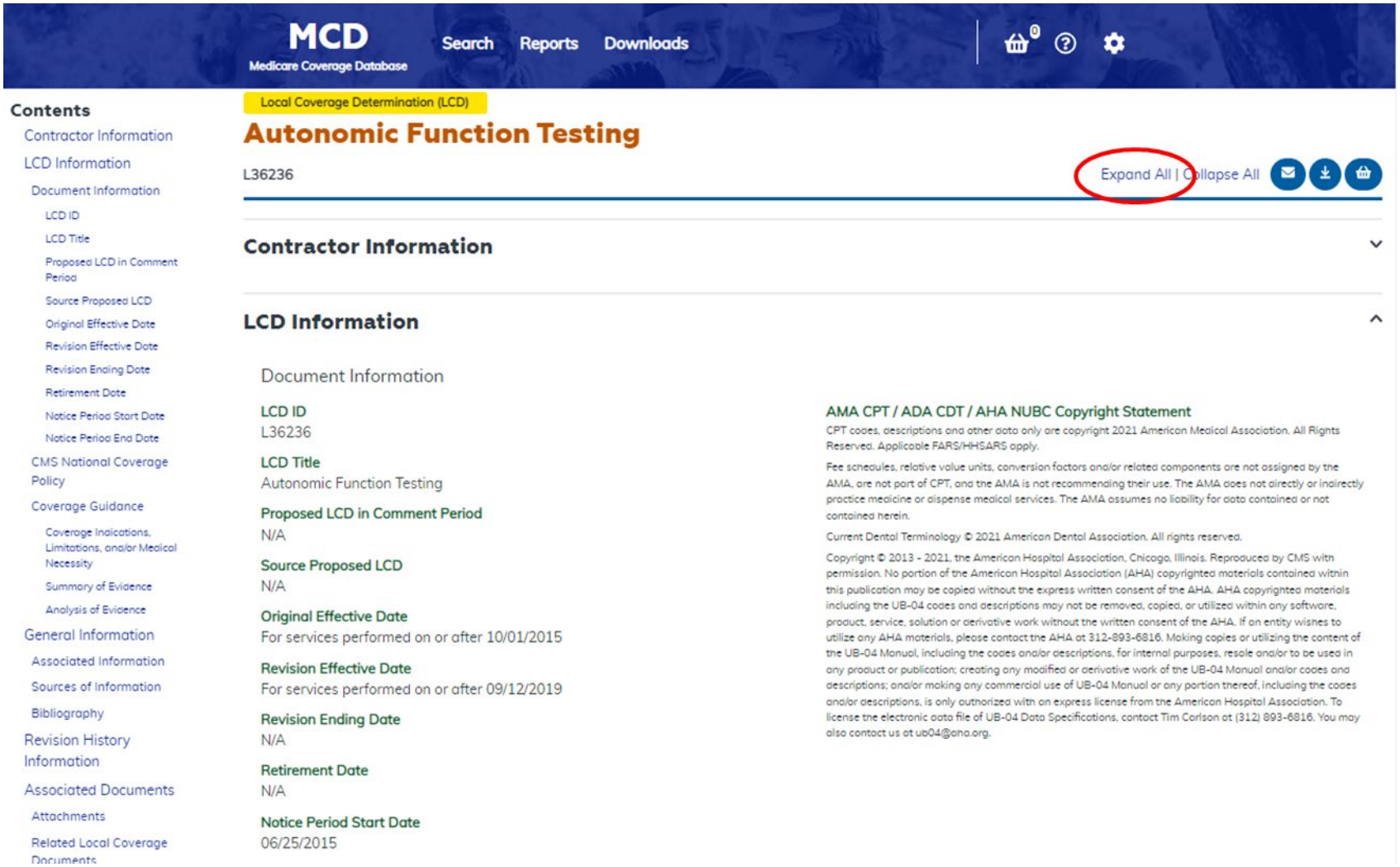
- No active LCD, LCD article, or NCD
  - Check for coverage guidelines in CMS IOMs, CRs, MLN Matters articles
  - Check our website
  - Check for related medical policy article
  - Make sure service not statutorily or administratively excluded
    - CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 16, "General Exclusions From Coverage"
    - LCD L32456 "Noncovered Services"

NGSMedicare.com > Resources >



Hyperlink(s) to specific document(s) in CMS database

CMS MCD Example: LCD L36236



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Outpatient Noncovered Charges & Beneficiary Notices

Did You Know

- Not all services provided to Medicare beneficiaries are covered/payable under the Medicare Program
- Examples of noncovered services include, but are not limited to
  - Foot care
  - Custodial care
  - Personal comfort items
  - Cosmetic surgery
  - Dental surgery
  - Services not reasonable and necessary

Medicare Coverage

- Statutory ability to shift liability only applies to items/services usually covered as part of an established Medicare benefit per Title XVIII of the Social Security Act
  - Benefits not addressed in Title XVIII are statutorily excluded from Medicare coverage
    - Medicare not authorized to cover/reimburse

Medicare Coverage

- Financial liability occurs when items/services are not covered by Medicare due to specific sections of the SSA stated below
  - Section 1862(a)(1): Services that otherwise may be covered but which are not medically reasonable and necessary in the individual case
  - Section 1862(a)(9): Custodial care which Medicare never covers

Medicare Coverage

- Section 1879(g)(1): Home care given to a beneficiary who is neither homebound nor needs intermittent skilled services at home
- Section 1879(g)(2): Hospice care given to someone not terminally ill

- Beneficiary must be informed via written notice prior to receiving such services and notice must specify the reason
  - e.g.: Advanced Beneficiary Notice of Noncoverage

Best Practices

- You should
  - Review planned services as well as potential coverage/ noncoverage for all applicable insurers
  - Determine any potential beneficiary liability and reason for anticipated Medicare noncoverage
  - Discuss planned services with beneficiary including any potential financial liability and cost estimate

Best Practices

- Issue any involuntary/voluntary notice per liability determination
- Allow beneficiary to determine whether accepting any financial liability for identified services
  - Beneficiary has right to refuse service/not accept financial liability
- Render services per beneficiary decision and bill accordingly

Three Payment Liability Conditions

- Only one of the following three payment liability conditions can apply to a given item or service, or to a given line of a claim
- When possible, split claims so that one of these three conditions apply per claim
  - It is understood that splitting claims is not always possible and that multiple conditions and notices may apply to a single claim
    - E.g.: claims paid under OPPS requires all services provided on the same day to be billed on the same claim with few exceptions

Payment Liability Condition One

Scenario	Payment Condition One
Description	Items and services being billed are statutorily excluded from Original Medicare coverage, meaning item(s)/ service(s) are not defined as a specific Medicare benefit per the SSA ; therefore, such services are never paid
Notification (prior to billing)	Liability notices are voluntary (i.e., voluntary ABN); for statutory exclusions, there are no required Medicare notices
Billing	Items and services may be billed as noncovered on Medicare claims
Liability	Always denied in Medicare claims processing; beneficiaries are liable for these denials unless providers code their claims to transfer liability to themselves

Payment Liability Condition One: Exclusions from Medicare Coverage

- Ensure beneficiary informed service would be billed as noncovered and patient would be financially liable
  - Ensure a clear specific reason for Medicare noncoverage was conveyed to beneficiary and documented
- When beneficiary is informed of noncoverage of service the medical record must include documentation
- ABN not required if patient elects to receive services excluded from Medicare by statute
  - ABN may be used for voluntary notification purposes

Voluntary ABN

- Voluntary use of ABN is allowed (not required) for certain services to serve as courtesy/ forewarning of impending financial obligation
  - Beneficiary not asked to choose option box or sign notice
- Voluntary ABN can be issued for care:
  - Statutorily excluded (SSA Section 1862) from coverage
  - Fails to meet technical benefit requirement (SSA Section 1861)

Payment Liability Condition Two

Scenario	Payment Condition Two
Description	Items and services being billed are either a reduction or termination of Medicare coverage, or are otherwise expected to be denied, leaving financial liability for a beneficiary or provider
Notification (prior to billing)	Liability notices are required • i.e.: expedited determination notice, ABN
Billing	Billing of such items and services can vary, and can depend on the ability to segregate into covered and noncovered portions (if both exist)
Liability	For any services that are not paid by Medicare itself, properly notified beneficiaries are usually liable for resulting denials

Payment Liability Condition Two

- Provider determines service typically covered by Medicare not medically reasonable/ necessary for specific beneficiary/situation
  - Examples:
    - Outpatient therapy exceeding the threshold and provider determines does not qualify for exception
      - Beneficiary received physical therapy and at some point physician/therapist determines therapy is no longer reasonable/ necessary due to no further improvement anticipated; services mow considered maintenance but beneficiary requests to continue PT

Payment Liability Condition Two

- Provider must issue ABN
  - When services reduced or terminated and thought to be not covered
    - Delivery of ABN can permit shift of liability
    - Provider must issue ABN to beneficiary before services are delivered
    - Failure to issue ABN when required means provider will not be able to shift liability to beneficiary
    - Must document in medical records when issue mandatory ABN
      - Example: Provider determines physical therapy no longer medically necessary (met all goals) but beneficiary wants to continue PT

What Is an ABN?

- Written notice given to beneficiary before certain outpatient services are furnished when physician, supplier, or provider believes that Medicare probably or certainly will not pay for some or all of the items or services
  - Shifts liability to beneficiary
- CMS IOM Publication, 100-04, *Medicare Claims Processing Manual,* Chapter 30, Section 50

When Should an ABN be Issued?

- Issue ABN prior to rendering service(s) when there is an expectation of Medicare denial
  - Must state the reason provider believes services will not be covered
  - Services not reasonable/medically necessary
    - Examples: Preventive service exceeding frequency limitation
  - Care considered custodial
  - Therapy services above cap that do not qualify for therapy cap exception

When Should an ABN be Issued?

- Beneficiary must comprehend contents
  - Cannot be under duress
  - Cannot be coerced
  - Informed consumer choice

Routine ABN Notice Prohibition

- Routine use not effective
  - Routine – issue ABN when no specific identifiable reason to believe Medicare will not pay
- Provider must have some doubt that Medicare will make payment
- Routinely issued = defective notice

Routine ABN Prohibition – Exceptions

1. Services always denied for medical necessity – NCD provides service never reasonable and necessary
2. Experimental items and services
3. Services where Medicare established statutory or regulatory frequency limitation on coverage or frequency limitation on coverage based on NCD/LCD
4. DME/Medical equipment related

Delivery Requirements

- ABN considered to be effective when
  - Delivered to capable recipient by suitable notifier
  - Issued appropriate, fully completed ABN form
  - Delivered in person (if possible)
  - Provided far enough in advance – patient considers all options
  - Explained in full – patient questions answered
  - Signed by recipient

Liability

- Beneficiary
  - Issued properly written and delivered ABN and agrees to pay knowing he/she may be held liable
- Provider
  - Provider will be liable if knew or should have known that Medicare would not pay and fails to issue ABN when required or issues defective ABN
- **Note:** Beneficiary relieved of liability if did not receive proper notice when required

Emergency/Urgent Situation

- Must not issue ABN in medical emergency or when beneficiary is under duress
- ABN issued in ER may be appropriate in some cases
  - Is beneficiary medically stable with no emergent health issues?
- When EMTALA applies, no ABN should be issued
  - May reconsider if beneficiary is capable after completion of medical screening exam and stabilization of any emergency medical condition

Period of Effectiveness/Repetitive or Continuous Noncovered Care

- ABN may remain effective up to one year as long as no other triggering event occurs
  - New triggering event = new ABN must be issued
- Allegations of improper or incomplete notices will be investigated by MAC
  - If ABN is found to be improper or incomplete – patient will not be held liable

Voluntary ABN

- Issuance not required for care either
  - Statutorily excluded (SSA Section 1862[a][1] and [9]) from coverage under Medicare (never covered) or
  - Care that fails to meet technical benefit requirement (lacks required certification)
    - ABN may be issued voluntarily
      - Serves as courtesy to beneficiary in forewarning of impending financial obligation
        - » Beneficiary should not be asked to choose an option box or sign notice

Payment Liability Condition Three

Scenario	Payment Condition Three
Description	Items or service is presumed to be a Medicare benefit and can be paid
Notification (prior to billing)	Liability notices, mandatory or voluntary, are never used in advance of such billing
Billing	Items and services are billed as covered
Liability	If Medicare doesn't pay as expected, the specific reason for rejection or denial will determine liability according to established Medicare policy

Outpatient Beneficiary Notices

- Beneficiary Notices Initiative (BNI)
  - ABN (Form CMS-R-131)
    - To deliver a valid ABN, a provider must use the most recent version of the CMS-R-131
    - Additional information on ABN
  - SNF ABN (Form CMS-10055)
    - Used to transfer financial liability to beneficiary before providing Part A item/ service that is usually covered, but may not be covered due to being medically unnecessary or custodial care

Outpatient Beneficiary Notices

- FFS and MA MOON
  - Hospitals and CAHs are required to provide a MOON to Medicare beneficiaries informing them that they are outpatients receiving observation services and are not inpatients of a hospital or CAH
    - CMS IOM Publication, 100-04, *Medicare Claims Processing Manual*, Chapter 30 Financial Liability Protections, Section 400 "Part A Medicare Outpatient Observation Notice"

Outpatient Beneficiary Notices

- SNF ABN (Form CMS-10055)
  - Used to transfer financial liability to beneficiary before providing a Part A item/ service that is usually covered, but may not be covered due to being medically unnecessary or custodial care

Inpatient Beneficiary Notices

Inpatient Beneficiary Notices

- Beneficiary Notices Initiative (BNI)
- Important Message from Medicare (Form CMS-10065)
  - Inform inpatient beneficiary of impending hospital discharge and Medicare appeal rights
- Detailed Notice of Discharge (Form CMS-10066)
  - Issued when beneficiary requests expedited review of discharge decision

Inpatient Notices

- Hospital Issued Notice of Noncoverage
  - HINN 1 – Preadmission/Admission HINN: Use before an entirely noncovered stay
  - HINN 10 – Notice of HRR: Use for FFS and Medicare Advantage Program (Part C) patients when requesting QIO discharge decision review without provider agreement

Inpatient Notices

- HINN 11 – Noncovered Service(s) during Covered Stay: Use for non-covered items and services during an otherwise covered stay
- HINN 12 – Noncovered Continued Stay: Use with the Hospital Discharge Appeal Notices to inform patients of their noncovered continued stay potential liability

Resources

Resources: NGS Medical Policy

- NGS LCDs and Additional Information
- Contractor Advisory Committee (CAC)
- Investigational Device Exemption Requests
- LCD Open Meeting
- Local Coverage Determination (LCD) Reconsideration Process - Medical Policy Article A52842

CMS Resources

- CMS IOM Publication
  - 100-02, *Medicare Benefit Policy Manual*
  - 100-03, *Medicare National Coverage Determinations (NCD) Manual*
  - 100-04, *Medicare Claims Processing Manual*
  - 100-08, *Medicare Program Integrity Manual,* Chapter 13 - Local Coverage Determinations

Resources: NGS Medical Policy

- Medical Policy Contact Information
- New Local Coverage Determination (LCD) Request Process A56198
- Self-Administered Drug Exclusion List: Medical Policy Article A53021
- NGS article on claim adjustments: Submit an Adjustment to Correct Claims Partially Denied by Automated LCD-NCD Denials
- NGS Part A Appeals

Resources: CMS Medical Policy

- Federal Register / Vol. 78, No. 152 / Wednesday, August 7, 2013 / Notices
  - Medicare Program; Revised Process for Making National Coverage Determinations
- CMS *MLN Matters® Article MM10901 "Local Coverage Determinations" (LCDs)*

Resources: CMS NCD ICD-10 Updates

- ICD-10 and other coding updates specific to NCDs - included in quarterly releases as needed
  - No policy-related changes are included with these updates.
  - Any policy-related changes to NCDs continue to be implemented via the current, long-standing NCD process
- ICD-10 Updates to NCDS:
  - NCDs other than Lab
  - Lab NCDs

Resources: Beneficiary Notices

- Beneficiary Notices Initiative (BNI)
  - FFS ABN Form and Instructions
- CMS Internet-Only Manuals
  - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 30 - Financial Liability Protections
  - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 1 - General Billing Requirements, Section 60 - Provider Billing of Non-covered Charges on Institutional Claims
  - CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 16 - General Exclusions From Coverage
  - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 18 – Preventive and Screening Services

Resources: Beneficiary Notices

- CMS MLN® Booklet
  - *Medicare Advance Written Notices of Noncoverage*
  - *Items and Services Not Covered Under Medicare*
- CMS MLN® Educational Tool: *Advance Beneficiary Notice of Non-coverage Interactive Tool*
- CMS CR7228: Auto Denial of Claims Submitted With a GZ Modifier

Official UB-04 Data Specifications Manual (NUBC Manual)

- The Official UB-04 Data Specifications Manual is available from the NUBC website
- The NUBC
  - The NUBC is a voluntary, multidisciplinary committee that develops data elements for claims and claim-related transactions, and is composed of all major national provider and payer organizations (including Medicare)
  - Maintains the codes needed to complete the Form CMS-1450 (UB-04 claim) and compliant X12N 837 institutional claim
  - Is responsible for the design and printing of the UB-04 form
  - Data elements referenced in manual are also used in the electronic claim standards and the manual contains a Mapping crosswalk between the UB-04 and the HIPPA 5010 (837) electronic transaction

Thank You!

- Follow-up email
  - Attendees will be provided a Medicare University Course Code
- Questions?

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