MAC Education Day

Thursday, April 24, 2025

Questions and Answers AM Session:

Q1 If the Office of Inspector General (OIG) states that overpayments have been made, how far back do the recoupments go? 1 year, 2 years, etc.?

A1 According to a former OIG Agent, the answer is 7 years.

Q2 Is there an area that we can locate Targeted Probe and Educate (TPE) letters on the website?

A2 All TPE reviews are being done on a prepayment basis, so it is an Additional Documentation Letter (ADR) that is sent. These are loaded to our Secure Net Access Portal (SNAP). The official notification letter (at the start of the probe) is not loaded into SNAP. It is usually sent via hard copy to the medical review address on file, and it's emailed to the point of contact, if able to establish one.

Q3 You said National Coverage Determinations (NCDs) trumps Local Coverage Determinations (LCDs), so an LCD cannot be more restrictive than an NCD?

A3 An LCD cannot "overrule" guidance published in an NCD. However, an LCD can be more restrictive than an NCD.

Q4 Based on recently published information in the Integrated Outpatient Code Edits (IOCE), there is a CMS update that indicates MACs should not allow reporting of dementia with fatigue diagnosis as the primary diagnosis. Can this diagnosis be reported in the fourth position?

A4 The Integrated Outpatient Code Editor (IOCE) program used during claim processing for all outpatient institutional providers, including hospitals. MLN matters article MM11944 October 2020 Integrated Outpatient Code Edit (IOCE) Specifications Version 21.3 includes language that that pertains to implementation of edit 113 by CMS back in 2020. Based on the business requirements in Change Request 11944 and the subsequent updates to edit 113, all MACs, including WPS, must use the edit specifications during claim processing. Based on the April 2025 IOCE update, CMS indicated MACs should not allow reporting of dementia with fatigue diagnosis as the primary diagnosis. There is no reason this diagnosis may not be reported in the fourth diagnosis position.

Providers should report the diagnosis code that describes the signs, symptoms, or reason for the service rendered and documented in the medical record. Some services are governed by a local coverage determination (LCD). If so, use the coding and billing article to view covered CPT and diagnosis codes. The link to a coding and billing article is usually found near the end of the LCD.

Q5 Do you have information on APEA claim denials?

A5 All physicians, practitioners, and other suppliers who provide services to Medicare beneficiaries must enroll in the Medicare program before submitting claims. At the time of enrollment, Medicare assigns a two-digit specialty code that corresponds to the specialty type declared by the applicant on the enrollment form. The specialties listed in Provider Specialty Codes are the only specialties currently recognized by CMS for purposes of enrolling in Medicare. We can provide claim denial data only for enrolled providers.

Q6 How does Medicare currently define major vs minor surgeries? Are these still classified by global days, or, by the current CPT/AMA definitions?

A6 If a procedure has a global period of 090 days, it is defined as a major surgical procedure. If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. You can find this in CMS National Correct Coding Initiative (NCCI) Policy Manual, Chapter 4.

Q7: Can we bill for the psychometrician's services at the conclusion of the episode of care, or must we wait until the hardcopy's have been scanned into the medical record?

A7: Please refer to CMS MLN Fact Sheet titled Complying with Medical Record Documentation Requirements. The following is an excerpt:

We can deny payment for services with incomplete or illegible records. For a claim to be valid, the provider's or hospital's records must have sufficient documentation to verify the services performed were compliant with all CMS policies and required the level of care billed. If there's no documentation or insufficient documentation, then there's no justification for the services or level of care billed.

Questions and Answers PM Session

Q1: Based on example 1 given by CMS in MM13473, a PCP can add G2211 to all established patient encounters because they have a "longitudinal" relationship. This means that patients who've stayed with their PCP and developed a relationship are charged more for doing so. It's not about the chief complaint about the encounter, but more about how long the patient has been seeing the clinician. Am I understanding the use of this add on complexity code correctly?

A1: According to the Medicare Claims Processing Manual, Chapter 12, Section 30.6.19, code G2211 is an add-on payment for Office/Outpatient Evaluation and Management (E/M) services. It accounts for the added complexity and intensity involved when a provider serves as the primary point of care for a patient with a single, serious, or complex condition. Medicare coinsurance and deductible apply to this code.

Q2: When an infusion or hydration stop time is not documented, what is the coding guidance for these situations?

A2: When an infusion is administered but there is no documented start and/or stop time; or no total infusion time recorded, the medication may only be billed as an IV push, which does not require a documented time.

Medicare should not pay for infusion codes billed without supporting time in the documentation. If payment is made, it is considered an overpayment. If discovered during review of a claim, Medicare would deny payment.

This was discussed in a 2024 education event regarding infusion services, and I have included a link Encore: Medical Review Findings in Infusion Services.

Q3: The slides show the External Definition as the different specialty or subspecialty, different facility, or organization. I just want to make sure I understand this correctly. I have been watching some webinars, and it was repeatedly emphasized that review of hospital records is once source, so it only counts as 1 point. But if there are multiple specialties within the record how does that work? For example, if a primary care physician who works for the same organization & reviews the hospital encounter and there are references to cardiac, pulmonary, urology notes (so different specialties) would that be 1 point or 3 points? Or does that only apply to a primary care physician who works for a different organization? And do they have to specify the different specialty, or do I try to determine that?

A3: CPT defines external as records, or communications and/or test results are from an external physician or other qualified health care professional, facility or health care organization

External physician or other qualified health care professional is defined as not in the same group practice or if of different specialty or subspecialty. This includes licensed practitioners practicing independently. This may also be a facility or organizational provider such as hospital, nursing facility or home health agency

In the example provided, if the providers were the same specialty, it counts once because they are not an external source because they are the same specialty and same organization. If the cardiologist is reviewing the medical record of the internal medicine from the same group, this

counts as a unique source. The specialty is part of the providers' enrollment record; however, you would need to know the specialty to determine if the data can be counted.

Q4: For medication I have watched a webinar that does say not all prescription meds are going to be moderate risk. I believe you said the provider must document the risk, is this correct? I know the chemo meds are high risk due to the toxic component, as well as insulin—is that the exception? Does there have to be active monitoring of the medication for the high level? Would the high level apply to meds for Crohn's and UC—I have noticed they seem to cause a lot of immune adverse effects, so I have been looking up the medication to see if it is considered high risk or toxic. Or is this again dependent on the individual patient?

A4: Risk is not diagnosis or procedure code based. CPT lists prescription management as an example only. The provider must assign and document the patient's risk of complications, morbidity and mortality from the medical decisions made. Documentation must support the moderate risk level. Risk level will be dependent upon the patient condition and plan of care.

Q5: If the teaching physician sees the patient independently from the resident and the resident documents a complete note, what would be an acceptable attestation from the teaching physician? Can they state, "I have seen, evaluated, and agree with the resident's note"? Considering payment is based on the work of the teaching physician and not that of the resident; to support their work, must the teaching physician personally document all of the medical decision-making (MDM) components used to level the service, rather than simply attesting to and agreeing with the resident's work?

A5: The Medicare Claims Processing Manual, Chapter 12, Section 100 – Teaching Physicians stated The teaching physician must document their own presence and participation in the patients care. Physicians cannot simply attest they agree with the resident's work.

Q6: Is the GC modifier required only when the resident and the teaching physician see the patient together, or is it also required when they see the patient independently and the teaching physician attests to the resident's note?

A6: Claims must include the GC modifier on each service unless you provide the service under the primary care exception. Use GE when performed services fall under the primary care exception, meaning the teaching physician is not present. Eligible codes are listed in the Guidelines for Teaching Physicians, Interns & Residents.

Q7: Scenario: In a hospital setting, a neurologist is consulted and reviews the evaluation and management (E&M) notes from the Emergency Department (ED), and the Hospitalist, as well as the labs ordered by the Hospitalist. Question: Do all of these documents count as: one source since they are all part of the same health system, or does the ED note count as one source, the Hospitalist's notes as another, and the lab results count as a review of each unique test

A7: CPT defines unique source as a physician or other qualified heath care professional in a distinct group or different specialty or subspecialty or unique entity. Based on the scenario described, each source contributes unique information that helps the neurologist understand the patient's condition. and would count as a unique test.

Q8: Can you help define the Complexity of the Problem Addressed and the Risk for a patient admitted for chemotherapy treatment?

A8: The way you assess, and document risk is not different for a patient admitted for chemotherapy treatment. However, you may be managing different potential side effects, monitoring adverse side reactions, possible comorbidities, and complications from existing medical conditions.

Q9: Have you looked at the 2023 Emergency Department Evaluation and Management Guidelines | ACEP Q&A for profile MDM selection? My question involves #68 specifically when a CT with contrast is ordered and performed, this qualifies as High Risk. Does CMS or WPS consider a CT with contrast as High Risk?

A9: There is no guidance identifying risk by diagnosis and procedure codes. Providers must document their assessment of the patient's risk of complications, morbidity and mortality from the medical decisions made and treatment plan.